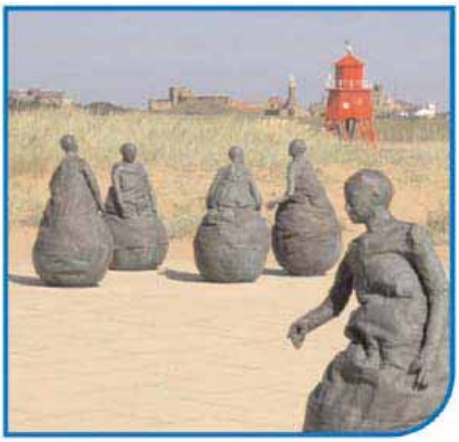


South Tyneside
Joint Strategic Needs Assessment
2009

South Tyneside Council

South Tyneside NHS
Primary Care Trust

Foreword

This is the second Joint Strategic Needs Assessment (JSNA) for South Tyneside. South Tyneside Primary Care Trust, South Tyneside Council and a range of partners and local people have contributed to producing this assessment of local health and social care needs. The purpose of producing the JSNA is for us to agree what the biggest priorities are for the Borough so that we can help shape decision making around how funding is allocated, where we need to target services most and how we can help to improve lives for local people.

I would personally like to thank the following individuals and their staff for their support and contributions - without this our JSNA would not have been possible:

- Director of Public Health
- Executive Director Children and Young People
- Executive Director Neighbourhood Services
- Head of Adult Social Care

We recognise the strong link between issues like low income and unemployment and poor health and we are committed to continue to work with all partners and local communities to address inequalities in health and the different health and life experiences of some of our children and adults.

In carrying out this JSNA we hope it will help us to understand not just what the issues are (which we largely know already) but how different health problems are experienced across the Borough and by specific groups of people, for example;

- How some of the major disease live cardiovascular disease and cancer affect people differently, who is affected most, and how adequately these people are supported and treated;
- What are the relationships between people's life circumstances and how they experience health and illness and also and health and social care and what can be done about this.

This 2009 -10 JSNA builds on previous understanding and sharing of information and we will be developing the process further in 2010-11. Our vision is for local people and partners not just to be able to understand and describe what the health and social care issues are in South Tyneside but to be part of the solution to making things better.

Stephen Clark
Chair, South Tyneside Primary Care Trust

Contents

Executive Summary

This is the second Joint Strategic Needs Assessment (JSNA) for South Tyneside. The purpose of producing this JSNA is to agree the priorities for the Borough so ensuring that we target interventions and services effectively to improve the lives of local people. In particular we are aiming to:

- 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;
- get all partners to work 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 process in South Tyneside

The JSNA has been structured around key population groups and themed sub-sections to understand local needs. There is considerable data in the JSNA but the full, and most up-to-date, data can be accessed via the South Tyneside Council information website https://sim.southtyneside.info. In addition, further analysis and benchmarking has been carried out to allow comparison of South Tyneside with other areas. To further analyse and understand neighbourhoods within the Borough small area analyses have been undertaken. The aim has been to increase access and broaden understanding of health inequalities and health needs.

A JSNA Executive Group was established to carry out prioritisation in relation to investment/disinvestment and heath and social care 'Must Shifts'. This prioritisation process has been closely linked with the Local Authority and PCT annual planning and resource allocation processes. A JSNA Working Group meets monthly to monitor JSNA developments and incorporate new data onto the website.

What the JSNA is telling us

- Residents in South Tyneside are generally happy living in their local areas and get on well with their neighbours;
- 78% of local people are satisfied with their area - up from 73% in 2006;
- 70% of people reported their health as good, similar to the average for Tyne and Wear, but below the national average of 76%; only 7% of respondents reported their health as bad or very bad. Good health is more likely to be reported amongst those aged 18 – 34, in full time work and not in social rented accommodation.

People living in the most **deprived areas** have worse health and health indicators than those in the most affluent areas. People in deprived areas are likely to have a higher exposure to negative influences on health and to lack resources to avoid their

effects. Income, poverty and employment are considered to be the best indicators of deprivation for health inequalities[1].

In 2007, the estimated total population of South Tyneside was 151,000 with 23.8% of the population aged 19 years or under.[2] There are 25,100 **children** aged 1-15 years of which 52% are in low income families compared with 49% across the North East and 42% across England. This means that 13,000 children in South Tyneside are living in low income families. Half of these children live in families receiving workless benefits and half live in families receiving tax credits. However, there has been a 23% reduction in the proportion of children living in **families dependent on income support** in South Tyneside – this compares to 20% reduction for the North East and a 15% reduction for England. This indicates that the inequality gap between South Tyneside and England has narrowed in recent years.

Nevertheless, it is estimated that almost 20% of children in South Tyneside live in areas classed among the most deprived 20% in the country and in some areas as many as 65% of children live in income deprived families.[3]

Unemployment is known to be a potential risk factor for ill health and South Tyneside is significantly higher than the national average with 6.9% of the working age population claiming Job Seekers Allowance compared to a national average of 4% (November 2009). Between 2004 and 2008 the employment rate in South Tyneside has risen by 2 percentage points. During this time the gap in employment rate between South Tyneside and England reduced from 7% to 5%.

In relation to **housing, fuel poverty and excess winter deaths**, there is currently no data to show where the decent and non decent homes are situated in South Tyneside but in May 2009, 50% of homes did not meet the Decent Homes standard. Overcrowding can contribute to ill health and there are areas in the Borough where households can be defined as being overcrowded. The number of households considered homeless has reduced by over 60%; from 597 in 2003-4 to 213 in 2007-2008 This translates as a rate per 1,000 of 3.2 compared with 6.4 in North Tyneside. Of the 12 councils in the North East South Tyneside is ranked 5th which is just above average.

In 2007 it was estimated that 50% of all older people and 20% of families with children in South Tyneside were living in **fuel poverty**. One of the impacts of a poorly heated home is cold related deaths. People in poorly heated homes are more vulnerable to death from heart attacks and stroke. People in local authority or housing association dwellings are especially likely to have low indoor temperatures if their heating costs are high. In 2006 provisional data shows that there were 117 excess winter deaths in South Tyneside, which is significantly higher than Gateshead, Sunderland, the North East and England.

The level of **crime and fear of crime** have a significant impact on people's quality of life and there are many links between crime and health. In South Tyneside between 2003-4 and 2007-8 there was a 29% reduction in total recorded crime. From April

[1] Long-term monitoring of health inequalities: Headline indicators. The Scottish Government September 2009
[2] ONS mid-year 2007
[3] IMD 2007

2008 to March 2009 South Tyneside showed an 11% decrease in total recorded crime compared to the previous year. This is almost double the improvement of the next best performing Local Authority, North Tyneside (6%). Drug and alcohol are key factors in many crimes.

The gap between **life expectancy** in South Tyneside and nationally is increasing and continues to be greater for men than women. The mortality rate due to all causes (age standardised) is falling although in 2005-7 it was higher (692 per 100,000 population) compared to the North East (671) and England (595). Premature mortality under the age of 75 years due to **circulatory diseases** has seen a reduction of 40% between 1995-7 and 2005-7 from a rate of 167.3 per 100,000 per population to 100.3. The rate reduction for England was even greater (44%) resulting in an increasing gap between local and national figures. Premature mortality due to all **cancers** decreased between 2005-7 from 178.7 per 100,000 to 145.1 and the inequality gap between these figures and those of England has reduced. In 2004-6, there were around 500 deaths each year due to cancer, which represents 28.9% of all deaths and is higher than England (26.7%). During this time in South Tyneside, 27.7% of cancer deaths were caused by lung cancer, followed by 10.5% due to colorectal cancer.

Falls in older people is a particular issue in South Tyneside as the hospital admission rate for falls in 2006/7 was significantly higher than England (2,302 compared to 1,920 per 100,000). South Tyneside also has a higher rate of hospital admission for hip fractures at 98.3 per 100,000 population compared with England at 77.7.

Pregnancy and the first years of life are very important for future health and wellbeing. Factors which are key to giving a child the best start in life include a healthy pregnancy, a healthy birth weight and breastfeeding for the first six months. **Smoking in pregnancy** has a particular impact on low birth weight of babies and is also a major issue for South Tyneside. The prevalence of smoking in pregnancy is considerably higher than the national average with an estimated prevalence of 28% in South Tyneside compared to a national average of 17%. With regard to achieving **immunisation** coverage, South Tyneside ranks amongst the best regionally and nationally although there remains some variation between practices and geographical areas in the Borough.

Childhood obesity: In 2008/09, 9.1% of children starting school were obese, rising to 21.0% of children in Year 6. Although the percentage of reception children were lower than the North East and England, at year 6 South Tyneside was higher.

Before 2007, **teenage conceptions** rates had seen a significant reduction from 1998. However, in 2006 the rate increased from 40.5 per 1000 young women aged 15-17 years to 55.7 in 2007. While this demonstrates a significant increase, similar increases were seen regionally and nationally and South Tyneside was the best performing area in the region.

What we need to do to achieve the best outcomes

Health inequalities refer to the avoidable and unjust gap in health outcomes between those at the top and bottom ends of the social scale. Health inequalities are unacceptable; they start early in life and persist not only into older age but into

subsequent generations. Tackling health inequalities is our top priority and we need concerted effort around narrowing the health gap between disadvantaged groups, communities and geographical areas within South Tyneside as well as with the rest of England.

In the JSNA there are a wide range of recommendations about how we achieve the best outcomes for the people of South Tyneside. There are a number of specific interventions that are most likely to contribute to closing the life expectancy gap and reduce health inequalities. Outlined below are the actions for South Tyneside that will have the largest impact on reducing health inequalities. A full list of recommendations can be found in the full JSNA.

Action
Wider Determinants of Health
Increase affordable and social housing
Increase the proportion of homes that meet the Decent Homes Standard
Address fuel poverty by expanding initiatives for disadvantaged groups to maintain a warm home at an affordable cost
Ensure that working age people who face disadvantage are supported to develop relevant skills for employment
Support short and long term unemployed people back into work
Develop integrated transport that promotes health and well being and reduces local car travel
Implement the requirements of the Equality Bill
Early Life
Increase breastfeeding in lower socio-economic groups
Reduce tooth decay in the under 5s
Reduce the numbers of women smoking in pregnancy
Reduce childhood obesity through targeted initiatives in schools
Reduce conceptions for those under 18 years of age
Target Chlamydia screening for under 25s who are at a high risk or vulnerable
Improve mental and emotional health, including support, for children and young people
Improve support to families and looked after children and young people
Narrow the gap in attainment levels, especially in marginalised groups
Increase the number of children from disadvantaged areas in early years education
Improve support for disabled children
Address anti-social behaviour and reduce alcohol use in under 18 year olds
Increase number of 16-18 year olds in education, employment and training
Reduce child poverty levels
Working Age and Later Life
Strengthen safeguarding adults arrangements
Reduce adult obesity particularly in disadvantaged areas
Reduce alcohol consumption and alcohol related injury

Reduce the numbers of people who smoke, particularly from routine and manual workers
Reduce the number of people dying early due to cancer
Reduce the number of excess winter deaths
Reduce the number of falls in older people
Reduce the number of repeat incidents of domestic violence
Reduce the prevalence of depression
Identify people at high risk of CVD and Diabetes
Diagnose dementia earlier and provide secondary prevention including memory clinics
Vulnerability
Reduce the number of households living in temporary accommodation
Reduce the fear of crime for older people and those experiencing vulnerability
Ensure local housing and support meets local need, especially older people
Support for older people with learning disabilities
Increase and promote self directed support and support for carers, including clear information and advice
Promote independent living and provide clear information and advice
Engage with new BME Communities including a Health Needs Assessment
Develop further ways of engaging with communities
Expand opportunities for local people to influence decisions in their local area
Support opportunities for regular volunteering
Strengthen commissioning arrangements with the third sector

Chapter 1. Background to Joint Strategic Needs Assessment

1. Context

In 2007, the Department of Health acknowledged that, "our health service is still too focused on commissioning for volume and price, rather than for quality and outcomes. Too much long-term care is provided in institutional settings. Health inequalities still exist. There is too much of a focus on treating illness rather than preventing it."[4]

Out of this commissioning framework came the requirement for a Joint Strategic Needs Assessment (JSNA) as a means by which, '*PCTs and local authorities describe the future of health and wellbeing needs of local populations and the strategic direction of service delivery to meet those needs*.'[5] It is a joint approach between local authorities, PCTs and practice based commissioners and re-affirms the strong emphasis on closer working between health and local government. The JSNA underpins the commitment to improve the five **Every Child Matters (2003)** outcomes for children, young people and their families: be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing and the seven outcomes for adults identified in **Our Health, Our Care, Our Say (2006)**: Improve health and wellbeing, improve quality of life, making a positive contribution, increased choice and control, freedom from discrimination, economic wellbeing and maintain personal dignity and respect. All these documents place a strong emphasis on closer working between health and local government and the JSNA should be used to inform the **Sustainable Communities Strategy (SCS)** and **Local Area Agreement (LAA).**

The JSNA also forms an important platform for evidence of the joint work required by the **Comprehensive Area Assessment (CAA**) process. The success of the JSNA will rely on its ability to inform Neighbourhood Plans, LAA, the Primary Care Trust (PCT) and Local Authority commissioning strategies. It will be refreshed each year but will have a more radical re-write on a three yearly cycle. This will be chosen to tie in with year three of the PCT's five year Strategic Plan and the LAA refresh in 2011.

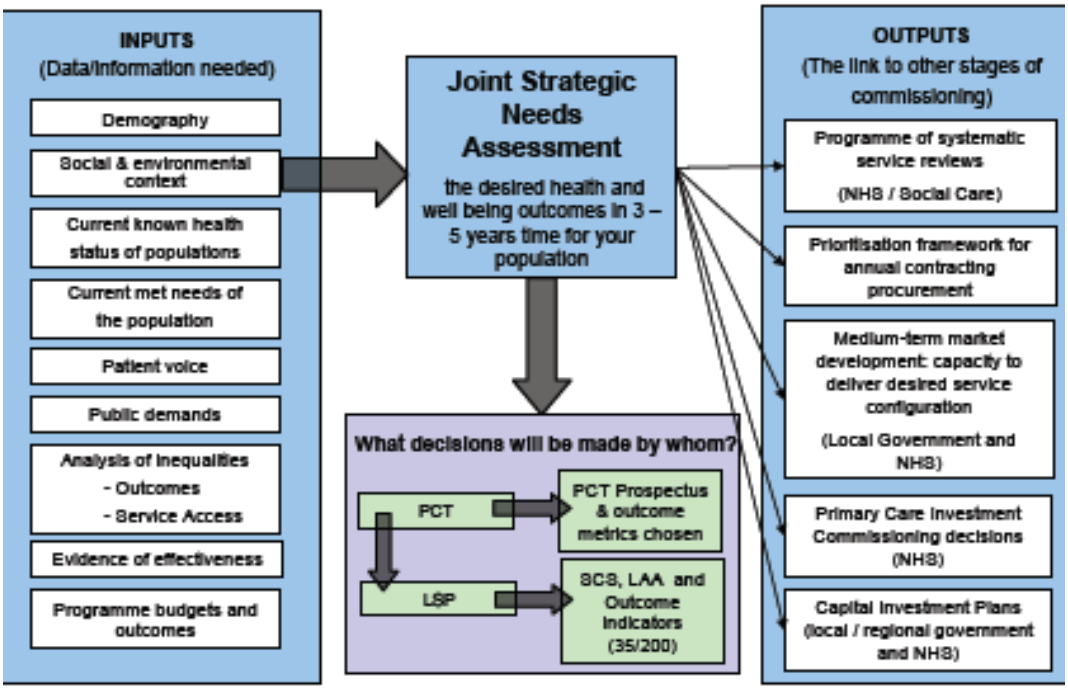
JSNAs have been produced in response to the Department of Health's consultation document, *Commissioning Framework for Health and Well-Being* 2007. They are intended to help achieve a:

- shift towards services that are personal, sensitive to individual need and that maintain independence and dignity;
- strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs;
- stronger focus on commissioning services and interventions that will achieve better health and improve the quality of life with all partners working together to promote inclusion and tackle health inequalities.

[4] Department of Health (2007) Commissioning Framework for Health and Wellbeing, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604
[5] Department of Health (2007) Commissioning Framework for Health and Wellbeing, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

The JSNA does, however, form an integral part of the commissioning cycle by providing an assessment of current and future need and identifying gaps in current provision. By providing an analysis of data to show the health and wellbeing status of local communities, defining where inequalities exist and using local knowledge alongside evidence of effectiveness of interventions, the JSNA can inform more effective commissioning for health and wellbeing in both the short and long term. Local plans should be reviewed in the light of the findings and recommendations of the JSNA. In turn, the development of the evidence base and JSNA should be informed by the gaps in knowledge that are identified by this ongoing review.

The diagram below shows the process of JSNA in relation to linking with commissioning decisions and the other stages of the commissioning cycle.



Source: Department of Health

Joint Strategic Needs Assessment relates to a number of themes and is expected to act as a supporting tool for these changes. These themes include:

- A greater focus on prevention and early intervention for improved health, independence and wellbeing;
- Tackling inequalities and improving access to services;
- An emphasis upon the potential benefits to be gained from effective commissioning;
- Developing joint commissioning between the PCT and Local Authority;
- Working to develop integrated and effective performance management;
- A recognition that partnership working is at the core of successful planning and provision.

2. How our JSNA developed

The JSNA has been structured around key population groups and themed sub sections to provide quick and easy access for commissioners, a wide range of partners and the public in terms of understanding local needs. The main method of accessing data locally however is via the South Tyneside Council information website https://sim.southtyneside.info. This portal allows commissioners and other to access the most up to date data and to focus on data and consultation in relation to neighbourhoods.

The process of producing the JSNA has been developed considerably during 2009 compared with the previous 2007-8 version. The minimum data set for JSNA has been utilised to ensure coverage of key data to support the understanding of local needs. In addition, further analysis and benchmarking has been carried out to allow comparison of South Tyneside with other areas and to further analyse and understand neighbourhoods within the Borough. The aim has been to increase access and broaden understanding of health needs.

A JSNA Executive Group (see membership list below) has been established to carry out prioritisation in relation to investment/disinvestment and heath and social care 'Must Shifts'. This prioritisation process has been closely linked with the Local Authority and PCT annual planning and resource allocation processes. In addition to the Executive Group a JSNA Working Group has been meeting on a monthly basis and will continue to meet to monitor JSNA developments and incorporate new intelligence into the existing online information store.

JSNA Executive Group membership:

- Lead Member for Independent and Health Lives
- Executive Director of Neighbourhood Services
- Executive Director Children and Young People
- Director of Public Health
- Head of Adult Social Care
- Head of Health and Social Inclusion
- Head of Housing Strategy and Regulatory Services
- Chief Executive South Tyneside Homes
- Chief Executive Blissability
- Healthnet & BME representative
- Chief Operating Officer NHS South of Tyne and Wear
- Chair South Tyneside NHS Foundation Trust
- Director of Finance South Tyneside NHS Foundation Trust
- Chair of the Alliance PBC Group and GP representative

As part of the JSNA process the following analysis and consultation has been undertaken:

- Benchmarking of South Tyneside data and health status compared with international and national comparators for the following indicators:
    - Life expectancy;
    - Premature Mortality due to CHD;

    - Premature Mortality due to all cancers
    - Smoking during pregnancy;
    - Breastfeeding.
- Extensive mapping of current 'healthy lifestyle' service provision in neighbourhoods to identify both the type of provision and geographical location to enable the identification of service gaps alongside service access/equity analysis;
- Extensive small area analysis in relation to key priority neighbourhoods. In order to show how health, lifestyles and wider health-related issues vary in these communities. The following indicators have been compared which will enable better targeting of service delivery and more focussed/specific commissioning based on need:
    - Educational attainment
    - Access to key services
    - Proportion of households claiming housing benefit
    - Life expectancy
    - Proportion of adults who smoke
    - Proportion of adults who regularly drink heavily
- Consultation with a range of service users and community groups in relation to local health needs, gaps in service provision and health priorities. This consultation has included qualitative information on community and groups of special interest gathered by the Local Involvement Network and a range of community consultation exercises with adult groups and young people;
- Predictive modelling in relation to population changes and future health and social care needs. This includes population predictions up to 2020 and future adult, older people and children's social care data.

JSNA Protocol

A JSNA protocol was developed for South of Tyne and Wear in order to demonstrate the consistent principles and process underlying the way in which South Tyneside, Gateshead and Sunderland Primary Care Trusts develop and use their JSNA Assessment. This was undertaken with the North East NHS World Class Commissioning (WCC) Competency 5, Level 3 Checklist in mind. It recognises that because each PCT is working with a different Local Authority, there will continue to be differences in practice, and in the priorities identified.

The protocol includes an action plan which picks out decisions that need to be made, including actions to be carried out for South Tyneside's JSNA to contribute to South of Tyne and Wear meeting the criteria in WCC Competency 5.

3. Shared understanding of health inequalities

The main role of South Tyneside PCT is to reduce health inequalities. Health inequalities are the avoidable and unjust gaps in health outcomes between those at the top and bottom ends of the social scale. People in higher socio-economic groups are more likely to live longer and enjoy more years of good health than those in lower

socio-economic groups. There are also differences in the health experiences of men and women.

As health inequalities often mirror social inequalities, addressing the social determinants of health can impact positively on health inequalities.[6] It is crucial that our policies need to continue to tackle both the wider determinants of 'Healthy Life Expectancy'[7] and specific risk factors because the World Health Organisation (WHO) have argued that previous attempts to reduce inequalities in health have failed because:

- the increasing inequality in society has not been addressed;
- national inequalities targets have focused on death and disease rather than the social determinants of health;
- 'Spearhead' areas at local authority level have been identified ignoring pockets of health inequality in many other areas;
- the most deprived have been targeted rather than providing universal interventions across the social gradient.[8]

The scale and variety of health inequalities affecting communities in South Tyneside are recognised as a key challenge to be addressed in the planning and delivery of services. Effective outcomes require good partnership working to:

- address the issues;
- target initiatives on those who need them most; and
- obtain value for money from available funding.

As local leaders and decision-makers we need to further develop a shared understanding of the health and social care needs of our local population, a joint vision and an integrated approach to improving health and well-being, reducing inequalities and promoting health equity. This shared understanding will allow us to commission services and interventions that are based on need and, in turn, reduce inequalities and achieve better health and wellbeing outcomes.

The following checklist of different dimensions of inequalities can be used when measuring inequalities and when developing local strategies and policies[9]:

- Inequality of the wider determinants of health (housing, education, transport, employment, nutrition);
- Financial and geographical inequality (some areas may receive a disproportionate amount of financial resources which are not based on need);
- Inequality of service provision (services vary unfairly between populations);
- Inequality of access to services (unequal opportunity to use services, inaccessibility to some members of the community);

[6] Health Impact Assessment (November 2008) Guidance Institute of Public Health in Ireland
[7] Healthy life expectancy is the expected years of life in good health. The difference between life and healthy life expectancy can be regarded as an estimate of the number of years an individual is expected to live in poor health
[8] World Health Organisation
[9] Closing the gap: setting local targets to reduce health inequalities Health Development Agency 2000

- Inequality of service use (poor uptake of benefits advice, lack of awareness of services or the right to use them);
- Inequality of heath and illness between individuals and groups (different illness and death rates for people from different social, ethnic groups and for men and women).

The Marmot Review was published in February 2010[10]. The aim of the Marmot Review is to propose an evidence based strategy for reducing the health inequalities from 2010. The strategy will include policies and interventions that address the social determinants of health inequalities. The findings of this review need to be applied to strategic developments locally.

A local strategy and framework for tacking health inequalities will be developed during 20010-11 which contains specific targets for measuring outcomes in relation to a range of locally agreed indicators. The following steps might be undertaken in relation to the development of local indicators;

1. Priorities for reducing inequalities are agreed and reflect national priorities, the local vision and a framework combining audit results and community involvement;
2. Data is used to set objectives and targets for reducing health inequalities. These become part of the performance management systems across the partner organisations and are built into t he development of service agreements and commissioning;
3. Different types of targets are identified as necessary, to reflect processes, activity and outcomes and in relation to different aspects of inequalities.

4. Ensuring good financial management and value for money in the use of resources

Programme Budgeting

This is a well-established technique for assessing investment in health programmes rather than services and PCTs in England have been required to submit a programme budget return since 2003/4. The Department of Health National Support Team's review of programme budgeting in South Tyneside for 2007-8 highlighted that:

- the PCT spent almost £2 million less than the average PCT on the 23 programme budget categories;
- the PCT spent significantly more than the average PCT on cancers and tumours, circulation problems, respiratory problems, dental problems, GI system problems and learning disabilities problems;
- most of the areas of overspend were matched by prevalence and admissions data, apart from GI system problems and learning disability problems;
- there are significant underspends in comparison to the average on social care needs and categories; and

[10] The Marmot Review, (February 2010) Strategic Review of Health Inequalities in England Post 2010

- an area of particular success is circulation problems, where spend is in the top 25% and prevalence is high, but admissions are lower than expected.

The following table and chart shows PCT spending in 23 key areas compared with the spending average for all PCTs (figures in bold suggest either a higher or lower spend).

Table 1: Programme spend per weighted head of population for South Tyneside compared to the national average

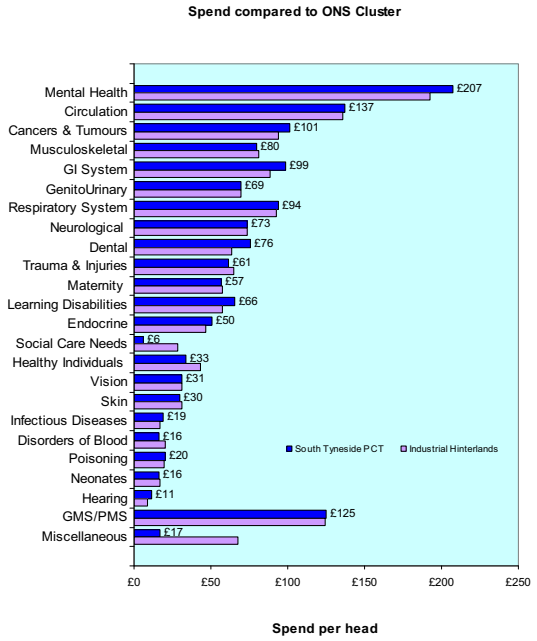
Key	Category	South Tyneside PCT		National Average (median)	
1	Infectious Diseases	£20.20	1.6%	£17.53	1.3%
2	Cancers and Tumours	**£97.88**	7.6%	£80.17	6.0%
3	Disorders of Blood	**£11.99**	0.9%	£16.52	1.2%
4	Endocrine, Nutritional and Metabolic	£36.20	2.8%	£35.87	2.7%
5	Mental Health Disorders	£165.61	12.8%	£163.16	12.2%
6	Problems of Learning Disability	£43.23	3.3%	£47.99	3.6%
7	Neurological	£50.40	3.9%	£53.34	4.0%
8	Problems of Vision	£24.70	1.9%	£26.16	2.0%
9	Problems of Hearing	**£2.94**	0.2%	£6.26	0.5%
10	Problems of Circulation	£119.96	9.3%	£121.08	9.1%
11	Problems of the Respiratory System	£70.91	5.5%	£64.52	4.8%
12	Dental Problems	**£66.62**	5.1%	£53.13	4.0%
13	Problems of Gastro Intestinal System	**£91.17**	7.0%	£72.62	5.4%
14	Problems of the Skin	£23.94	1.8%	£26.58	2.0%
15	Problems of Musculoskeletal System	£62.21	4.8%	£65.26	4.9%
16	Problems due to Trauma and Injuries	**£76.40**	5.9%	£56.42	4.2%
17	Problems of Genito Urinary System	£67.43	5.2%	£66.61	5.0%
18	Maternity and Reproductive Health	£60.37	4.7%	£56.84	4.3%
19	Conditions of Neonates	**£9.56**	0.7%	£13.55	1.0%
20	Adverse effects and poisoning	£13.93	1.1%	£13.96	1.0%
21	Healthy individuals	£25.48	2.0%	£24.43	1.8%
22	Social Care Needs	£21.14	1.6%	£22.79	1.7%
23	Other (including General Medical Services /Primary Medical Services)	**£133.79**	10.3%	£192.68	14.4%
	Total	**£1,296.03**	**100.0%**	**£1,336.16**	**100.0%**

For 2008/9 the Department of Health commissioned the Association of Public Health Observatories (APHO) via Yorkshire & Humber PHO to produce a factsheet for each PCT in England. This presents an overview of spend and outcomes. For South Tyneside PCT the key facts identified for 2008/09 were:

- the highest spend areas, excluding programme 23 (Other), are £207 per head per year on Mental Health, £137 on Circulation and £101 on Cancers & Tumours;

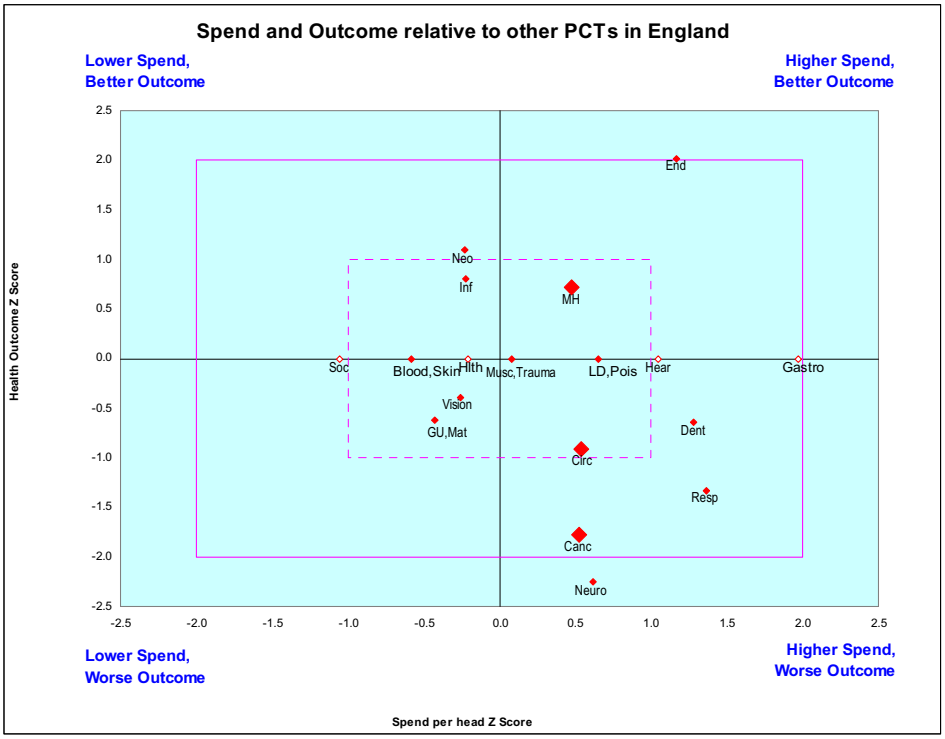
- there are no spending outliers but there are outcomes outliers in the areas of): Endocrine, Nutritional & Metabolic (programme 4) and Neurological (programme 7).

The following chart shows spend by programme for 2008/9 compared with PCTs in the same ONS cluster.



Source: Yorkshire & Humber Public Health Observatory

The APHO's work includes a diagram that categorises each of the 23 programmes into four quadrants in terms of spend and outcome. This allows easy identification of those areas that require priority attention by the PCT; the diagram for South Tyneside is given below:



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Annual Health Check

South Tyneside PCT has maintained its "good" standard for quality of financial management in the annual assessment of the NHS by the Care Quality Commission. The Commission rates each organisation as excellent, good, fair or weak on financial management and overall quality. PCTs are expected to use a wealth of data to improve commissioning and performance, and in doing so, to benchmark themselves against their peers. Sources of evidence include:

- Programme budgets (how are you spending the money?)
- Output/outcome proxies (what's the money achieving?)
- Reference cost index (how efficient is your own service provision?)

A summary of the metrics used to assess this are:[11]

[11] Use of Resources Profile, South Tyneside Primary Care Trust Audit 2008/09, November 2008

Table 2: Metrics used to assess Annual Health Check

	South Tyneside PCT	National Average (median)
Spending		
Total spending per head (unified, weighted) £ 2006/07	1,296	1,336
Primary care		
GPs per 000 weighted population 2006/07	0.49	0.58
Patient perception (2007 survey)		
Offered choice of provider %	96.6	93.4
Able to get appointment within 48 hours %	86.5	84.3
Mortality (per 100,000, directly standardised)		
All causes (2004/06)	717	627
Amenable causes (2004/06)	136	115
Avoidable admissions		
% emergency admissions with ACS diagnosis 2007	14.9	11.6

5. Linking JSNA to strategic objectives

The South Tyneside JSNA analysis and recommendations have also been aligned to the following key planning and investment strategies, namely;

Local Area Agreement - Priorities and National and Local Indicators

Independent and Healthy Lives Theme Plan Priorities and Must Shifts

NHS South of Tyne and Wear Strategic Plan priorities and outcomes:

Priorities

- Staying healthy
- Children's health and health services
- Maternity
- Urgent and Planned care
- Mental Health
- Long Term conditions
- End of Life care

Outcomes

- Hypertension prevalence
- Childhood obesity at year 6
- Hospital admissions (alcohol)
- Cholesterol control and
- Hypertension control among people with established
- coronary heart disease
- Prompt first cancer treatment (62 days from referral to
- treatment)
- Smoking prevalence among people with a chronic condition
- Emergency hospital admissions

STRATEGIC OBJECTIVE	OUTCOME
Reducing CVD and Cancer Mortality	➢ Improve life expectancy ➢ Reduce health inequalities ➢ Reduce childhood obesity at Year 6 ➢ Halt the rise in alcohol-related admissions
Best start in life	➢ Increase breastfeeding ➢ Reduce smoking in pregnancy
Identification & care for people with long term conditions & risk factors	➢ Reduce smoking in people with a long term condition
High quality intermediate care & rehabilitation	➢ Increase hypertension control following TIA and stroke
Streamlining high quality urgent care	➢ Reduce ambulatory care sensitive admissions
Providing more, high quality planned care closer to home	➢ Increase numbers & proportion of planned procedures in primary and community settings
Changing the provision of Mental Health services	➢ Increase numbers in receipt of psychological therapies ➢ Earlier access to dementia diagnosis and interventions
Providing those at the end of life with a good death	➢ Increase in deaths which take place outside of hospital

Department of Health National Support Team (NST)

The NST visited the South of Tyne and Wear PCTs in September and October 2008 and provided feedback to the PCT and Council that identified both strengths and recommendations for improvement.

The visit recognised that South Tyneside PCT has put effort into establishing structures and processes which support the achievement of our vision and strategy. They acknowledged that we had made a good start with progressing the NST recommendations, recognising that initial actions were about raising awareness and improving collaboration between the PCT and Council. The production of the JSNA is a testament to this improved collaborative approach.

The NST particularly identified cardiovascular disease (CVD), Chronic Obstructive Pulmonary Disease (COPD) and cancer as important areas for improvement in South Tyneside, as we have has some of the highest levels of inequality. We have, however, made significant progress in addressing CVD, having undertaken detailed predictive modelling, introduced screening in primary care and started analysing the impact of interventions to help prioritise funding. We have to recognise that in COPD and cancer we have made less progress.

6. Building on the JSNA

Although this JSNA report is now being published, it is not the end of the process; a good JSNA is a continual process of reviewing the evidence, assessing new developments and identifying the gaps for future commissioning priorities.

Commissioning Services

The intention is that the JSNA findings will be used to inform commissioning decisions in relation to key service developments and investment in South Tyneside. The JSNA has already influenced the Local Strategic Partnership's 'must shifts' and will continue to influence the commissioning services on behalf of residents. This involves:

- matching services to the healthcare needs of local people, making sure they get good quality care, in the right place at the right time;
- making sure that tax payers are getting value for money and that money is being spent where it is most needed;
- being fair to the organisations providing the services by setting them challenging but achievable goals;
- monitoring the services to make sure that the providers are doing what we have asked them to do.

Assessing Needs

To support our objectives, a number of health needs assessments have been undertaken over the year that support the strategic objectives. These have included:

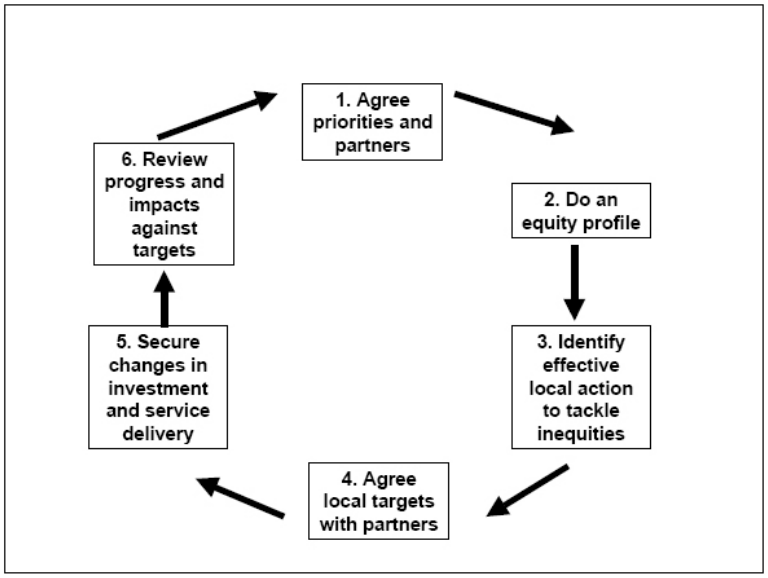
- South Tyneside Children with Disabilities
- South Tyneside Tier 3 CAMHS Review
- South Tyneside Young People's Needs Assessment: Tackling Drugs, Changing Lives
- South of Tyne and Wear Mental Health
- South of Tyne and Wear BME Mental Health
- South of Tyne and Wear Perinatal Mental Health (stage one)
- South of Tyne and Wear Transient Ischemic Attacks (TIA)

A programme of more detailed needs assessments for South Tyneside are required to be drawn up at the beginning of each year in line with the commissioning cycle and to inform commissioning and investment decisions for the following financial year. This will need to include consideration of equity of access and assessing the impact of future developments. There are a number of methods and tools available that can be used to achieve this.

Health Equity Audits (HEAs) identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas and the priority action to provide services relative to need. The purpose of HEA is to help services narrow health inequalities by using evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery and to review the impact of

action on inequalities. HEA should focus action on issues with the highest impact on health inequalities, remembering that the socio-economic dimension of health inequality has a social gradient, to then fairly allocate resources to act on the social determinants of health. In this way, addressing inequities is about the breadth of the whole distribution, not just the extreme end, i.e. this is not just about those people facing vulnerabilities.

Health Equity Audit cycle



The issues which will have rapid impact and support achievement of the 2010 health inequalities target are cancer, circulatory disease, respiratory disease, maternal health and infant mortality.

Health Impact Assessment (HIA) systematically and transparently assesses policies, programmes and developments (including capital developments) in terms of their impact on health and health inequalities. HIA seeks to inform and enhance the decision-making process in favour of health and health equity. It aims to maximise potential positive health impacts and minimise potential negative health impacts of a proposal.[12] Assessment should compliment and work alongside other assessments, in particular Equality Impact Assessment and Environmental Impact Assessment. To be most effective HIA needs to be built into a policy, programme or development process to ensure that the timing of funding and deadlines fit with decision making.

It is recommended that HIA is carried out more consistently in South Tyneside with, for example, rapid HIA being used for new policies with more comprehensive HIA used for larger developments (i.e. new sports or health centres).

The next JSNA

It is planned that the JSNA will be refreshed each year with a more radical re-write on a three yearly cycle. In anticipation of this, during 2010, the Project Board has plans to regularly review the evidence base that supports the JSNA and develop a programme

[12] Health Impact Assessment Guidance (November 2009) Institute of Public Health in Ireland

of work that addresses the JSNA's identified gaps. In addition, we will improve and develop the JSNA website by:

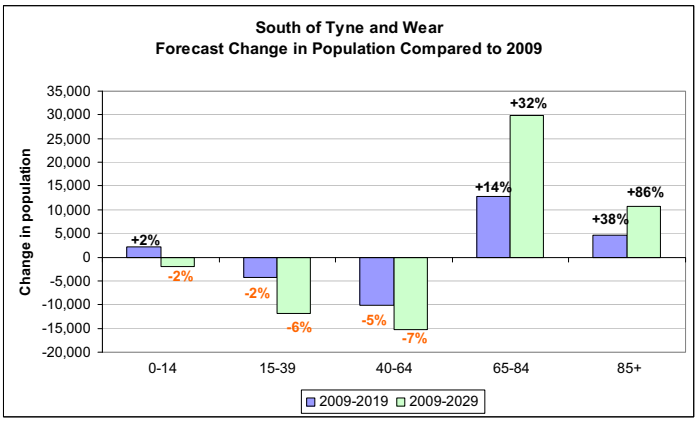
- Implementing governance and co-ordination arrangements to ensure that the website is regularly reviewed and updated;
- Institute arrangements to refresh the core data set and identify new areas for data collection;
- Further analysis and enhancement of the neighbourhood mapping facilities.

CHAPTER 2 Population and Demography

1. Introduction

Population projections

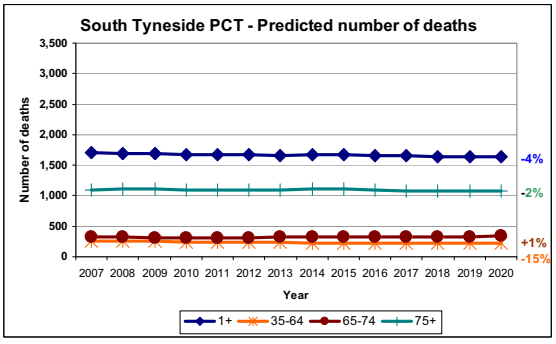
ONS have forecast that across South of Tyne and Wear there is likely to be a small increase in the overall population of 2%. This will be reflected with a large increase in the over 65 year olds, equating to a 14% change in 65-84 year olds and 38% in 85 years and older, when compared with 2009.

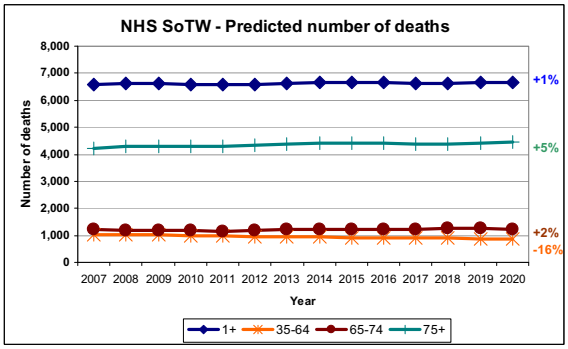


Death projections

Based on the ONS population projections, forecasts about future age specific mortality rates per 100,000 have been calculated for South Tyneside and South of Tyne and Wear areas. Two scenarios are considered: predictions based on decreasing or static mortality rates over time for all ages. Assuming a decreasing mortality rate over time, South Tyneside could see an overall reduction in deaths of 4% compared to a small increase of 1% for South of Tyne and Wear as a whole. This is dominated by the over 75s age group.

Death Predictions based on decreasing mortality rate over time

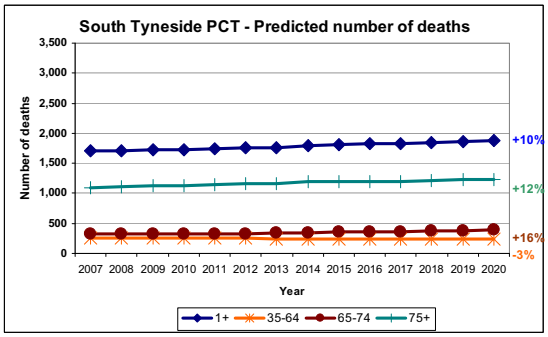


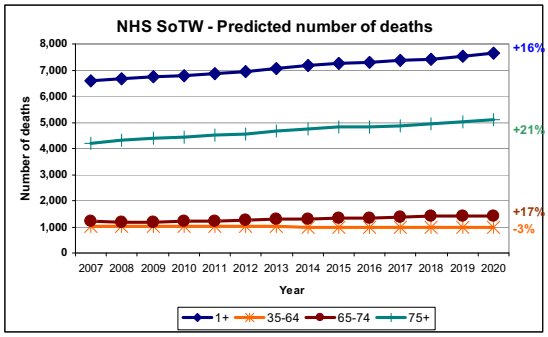


Source data: Number of deaths by PCT 2007, NCHOD; Population forecasts by PCT 2006 based, ONS; Deaths: by gender and age, 1961 to 2021: Social Trends 30, ONS

Assuming a static mortality rate over time, South Tyneside are predicted to have a significant increase in deaths for all ages of 10% but lower than South of Tyne and Wear (16%). This rise is largely amongst the over 75 year olds at 12% increase in South Tyneside and 21% for South of Tyne and Wear.

Death Predictions based on static mortality rate over time





Source data: Number of deaths by PCT 2007, NCHOD; Population forecasts by PCT 2006 based, ONS; Deaths: by gender and age, 1961 to 2021: Social Trends 30, ONS

These increases have significant implications for health services, particularly as older people use services more often, have more complex needs and stay longer in hospital. Modelling for South of Tyne and Wear shows that in ten years, if we do nothing differently, we will need over 400 extra beds which our hospitals do not have, at a cost of over £50m which we cannot afford.

The Index of Multiple Local Deprivation (IMLD): The Indices of Multiple Deprivation 2007 (commonly known as the IMD 2007) are a measure of multiple deprivation at small area level. They show whether an area is deprived relative to other areas, in the sense that a higher proportion of the population of that area experiences a particular type or types of deprivation. Low income is a central component of the indices, and the income deprivation domain reflects the standard income-poverty measure, namely households below 60% of the median income.

All age all cause mortality: Improving overall life expectancy and tackling inequalities in health is key to achieving better health and well-being for all. A focus on improving health and tackling health inequalities helps people to live longer and have healthier lives particularly for those who are at greatest risk of poor health. This indicator is a proxy for life expectancy, and will include mortality from all causes of death.

The inequality in health outcomes experienced by those living in deprivation needs to be addressed and local people need to have equal opportunities to participate both socially and economically.

Analysis of recent data shows that Healthy Life Expectancy is not rising at the same rate as life expectancy. Healthy life expectancy is influenced by a range and complex interaction of factors in relation to each individual's life, from conception to death. These include:

- Maternal health and wellbeing, including teenage pregnancy, smoking, drinking, drugs and diet;

- Parental relationships and influences in the early years of life, including breastfeeding, mental health, diet, physical activity, dental health and support for cognitive and educational development;
- Later health-related behaviours and lifestyle choices;
- Access to health and other services;
- Wider factors influencing health such as income, education, skills and employment.

We need to increase healthy life expectancy at birth in the most deprived areas.

2. Where are we now?

Small area assessment

South Tyneside has six "Community Area Forums" – Boldon, Cleadon & Whitburn, East Shields, Hebburn, Jarrow, Riverside and West Shields. These are groups of elected councillors and local residents who meet to discuss local issues and work to improve services. South Tyneside Council, in consultation with these Forums, have identified 21 "Priority Neighbourhoods" that have been chosen because they have a range of issues that include poor health, high unemployment, poor housing, low educational attainment, high crime rates or low average income. Used alongside data from the *English Indices of Deprivation 2007,* neighbourhood analysis provides a more detailed understanding of the spread of deprivation in the Borough.[13] These assist partners, including the Council and the PCT, to understand better the needs of local communities and improve the way in which resources are targeted. A map of each neighbourhood is also included showing community resources which could be the focus for health-improvement programmes such as weight management groups or healthy eating sessions.

To show how health, lifestyles and wider health-related issues vary in these different communities, a selection of indicators has been chosen and shown on a 'spider's web'. The indicators used in the 'spider's web' are:

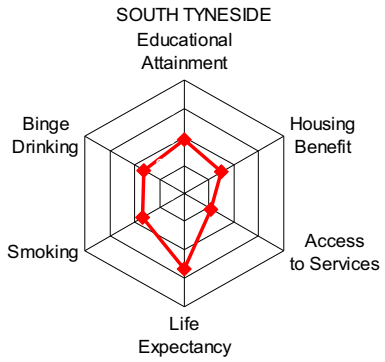
- life expectancy;
- proportion of adults who smoke;
- proportion of adults who regularly drink heavily;
- educational attainment;
- proportion of households claiming housing benefit;
- access to key services.

Points on or near the outside of the 'spider's web' indicate issues linked to poor health; low educational attainment, a high proportion of households claiming housing benefit, poor access to services, low life expectancy, a high proportion of adults that smoke and a high proportion of adults that regularly drink heavily. Although these are calculated for neighbourhood populations with an average size of 2,000, many of the indicators are based on small numbers of observations e.g. numbers of deaths or

[13] For further information see: http://www.southtyneside.info/search/document_view.asp?cls=633

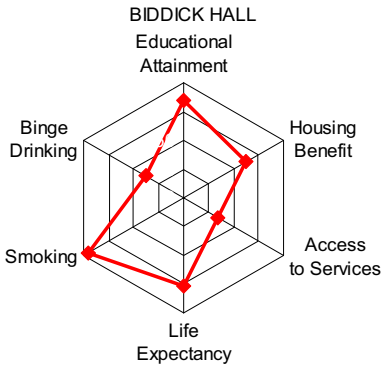
numbers of children sitting their GCSEs. Therefore, data has been pooled together for several years, e.g. the measure of life expectancy is based on the ages at which people have died over a three year period between 2005 and 2007.

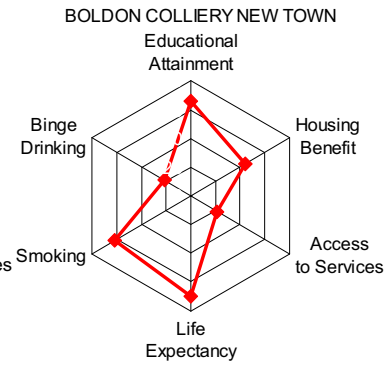
For South Tyneside as a whole, average life expectancy is 77.8 and is lower than England as a whole. This also masks differences between men (76.2) and women (80.3) in South Tyneside – both of which are lower than England (77.9 and 82.0 respectively). The 'spider' summary for South Tyneside is as follows:

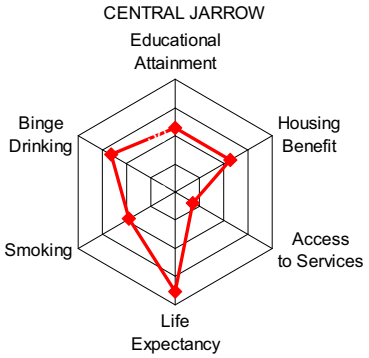


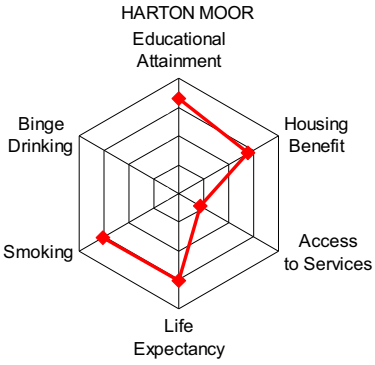
Comparing this with individual neighbourhoods in South Tyneside, it can be seen clearly that there is substantial variations across the Borough. For example there is a difference in life expectancy of over 7 years between the Woodbine Estate (78.8) and Hill Park and Lawson Estate (71.5). For smoking, the gap is even greater with 26% of people in Harton stating that they smoke compared to 50% in Victoria Road, Lonnen and Laygate. In relation to achieving 5 A*-C GCSEs some neighbourhoods in South Tyneside exceed both the South Tyneside and England figures (The Nook: 70%; Scotch Estate: 64% and Hebburn New Town: 63%) yet there remains areas of the Borough where only a third of students achieve this level (John Clay: 31% and Horsley Hill: 33%).

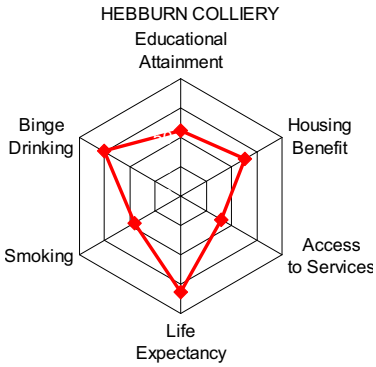
The summaries for the 21 priority areas are listed below, both in 'spider' diagrams and in table format.

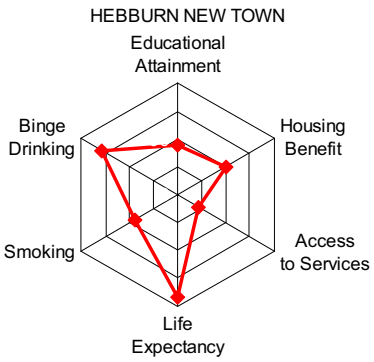


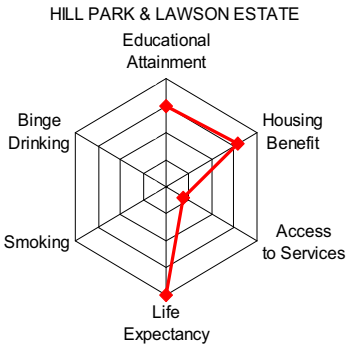


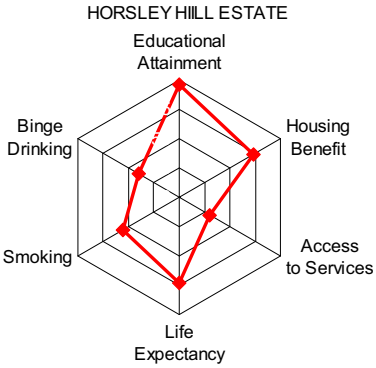


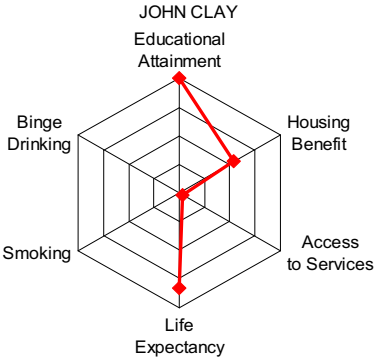

HARTON MOOR
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking

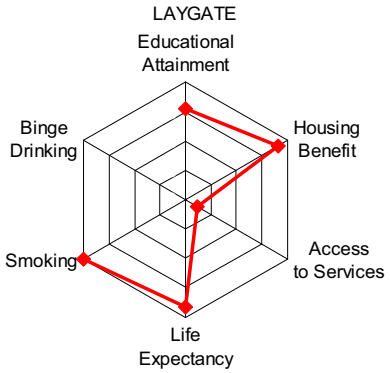

HEBBURN COLLIERY
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking

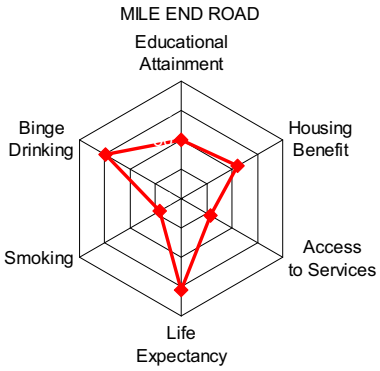

HEBBURN NEW TOWN
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking

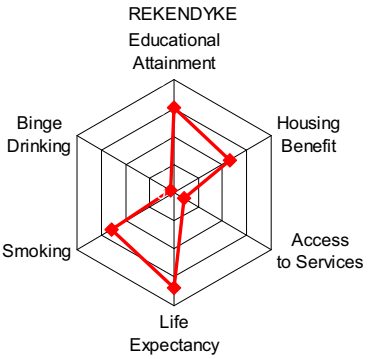

HILL PARK & LAWSON ESTATE
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking

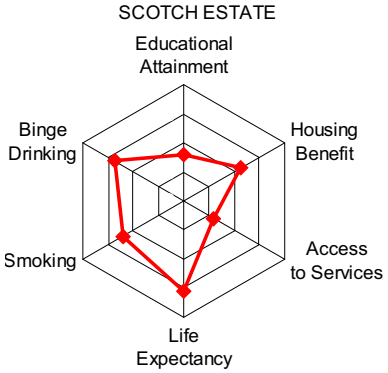

HORSLEY HILL ESTATE
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking

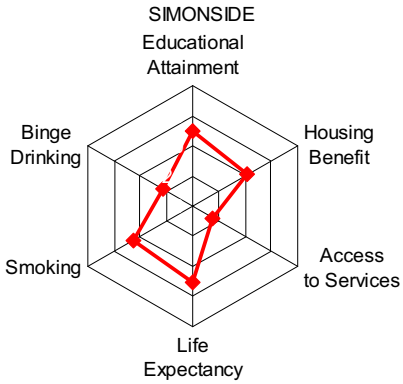

JOHN CLAY
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking

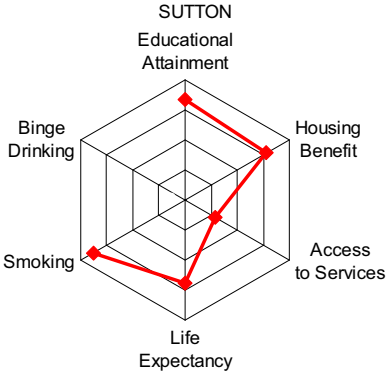

LAYGATE
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking


MILE END ROAD
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking


REKENDYKE
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking


SCOTCH ESTATE
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking


SIMONSIDE
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking


SUTTON
Educational Attainment
Housing Benefit
Access to Services
Life Expectancy
Smoking
Binge Drinking

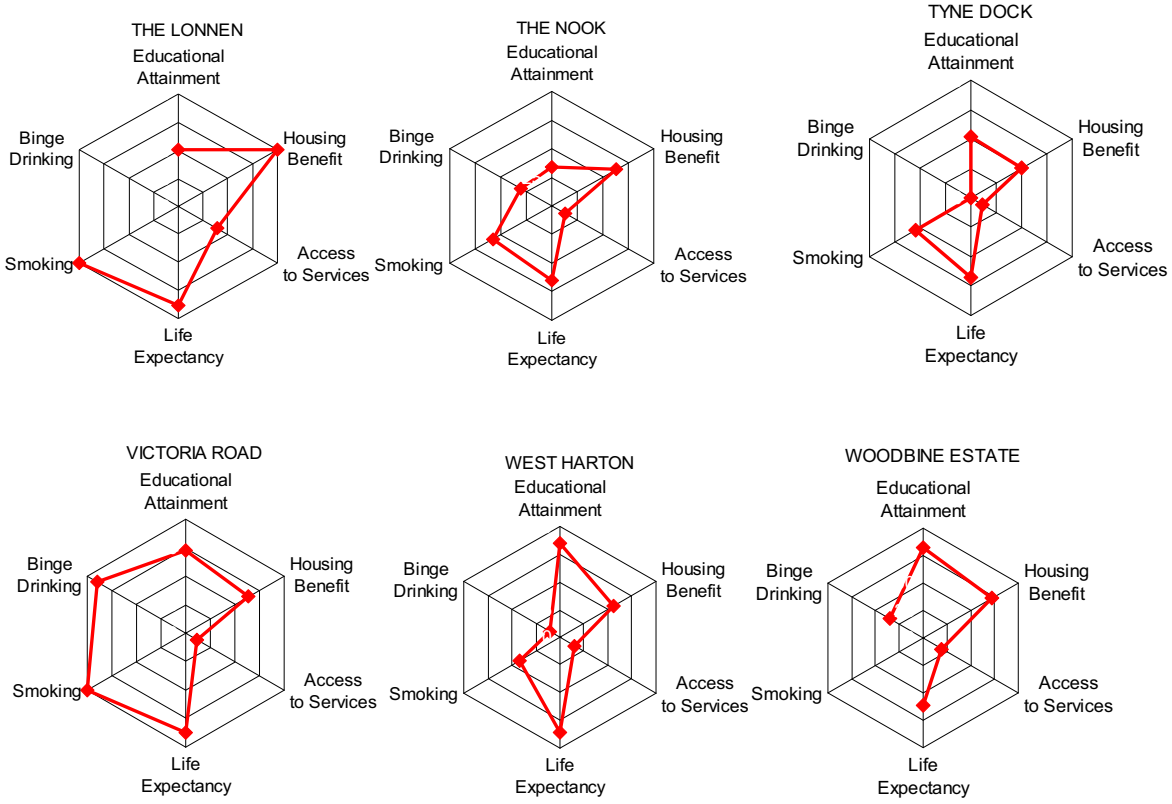


Table 3: Summary of results of small area analysis

Priority Neighbourhood	% Achieving 5 A-C GCSEs	Rate of claiming housing benefit per 1,000 households	Average time to key service (minutes)	Life expectancy	% that smoke	% that binge drink
Biddick Hall	40	399	12	75.9	48	32
Boldon Colliery	41	353	11	73.9	40	29
Central Jarrow	57	361	9	73.6	28	42
Harton Moor	42	443	10	76.1	40	-
Hebburn Colliery	57	406	13	75.0	27	45
Hebburn New Town	64	313	10	73.0	27	46
Hill Park & Lawson Estate	46	499	9	71.5	-	-
Horsley Hill	33	466	11	76.5	32	33
John Clay	31	345	6	74.6	-	-
Laygate	44	576	8	73.2	50	-
Mile End Road	61	355	11	75.6	17	45
Rekendyke	45	364	7	74.4	35	21
Scotch Estate	66	358	11	75.7	33	43
Simonside	53	328	9	78.4	32	29
Sutton	41	494	11	77.2	45	-
The Lonnen	60	637	13	73.6	50	-
The Nook	70	400	8	78.0	32	30
Tyne Dock	59	315	8	77.5	31	19
Victoria Road	47	403	8	73.9	50	50
West Harton	40	359	8	74.2	26	23
Woodbine Estate	41	458	9	78.8	-	31
South Tyneside	**62**	**239**	**11**	**77.8**	**26**	**33**
England	**63**	**N/A**	**N/A**	**N/A**	**22**	**20**

3. What are we doing?

Life expectancy in South Tyneside

To reduce inequalities in healthy life expectancy, action should be prioritised in these areas[14]:

- Children's very early years, where inequalities may first arise and influence the rest of people's lives;
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing;
- The "big killer" diseases: cardiovascular disease and cancer. Some risk factors for these, such as smoking, are strongly linked to deprivation;
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

Locally, the London Health Observatory's 'Health Inequalities Intervention Tool' identified that over 60% of the life expectancy gap is caused by higher than average mortality from CVD, cancer and respiratory diseases. This "Bridging the Gap" exercise also identified a set of high impact, evidence-based interventions for reducing mortality in these areas. This formed a key part of the evidence used in establishing our strategic objectives and our choice of key outcome measures for WCC.

Future needs

There are predicted capacity issues for social and health care, particularly as a result of the aging population. These issues include;

- an increasing demand for supported accommodation as an alternative to long-term care;
- a greater requirement for services to meet the increasing level of those with complex needs, especially amongst the 80+;
- the escalating costs of care;
- organisational challenges and opportunities associated with increased joint working between social and health care services.

4. What should we be doing next?

- Further, more detailed analysis is carried out on predicted population change and impact on services;
- Commissioning plans for services to take account of population changes, and to develop new models of preventative and rehabilitative services;
- Use small are analysis to identify top priorities in key neighbourhood.

[14] The Scottish Government (2008) Equally Well Report of the Ministerial Task /force on Health Inequalities

CHAPTER 3 Wider Determinants of Health

1. Introduction

Health inequalities refer to the avoidable and unjust gap in health outcomes between those at the top and bottom ends of the social scale. People in higher socioeconomic groups are more likely to live longer and enjoy more years of good health than those in lower socioeconomic groups. There are also notable differences in the health experiences of men and women and between different ethnic groups for example. Health inequalities often mirror social inequalities so addressing the social determinants of health can impact positively on a population's health.

2. Where are we now?

South Tyneside is in the worst quartile nationally for most health inequalities indicators and the gap is widening for both men and women in terms of life expectancy. Health inequalities are the result of a complex and wide ranging factors and these include;

- Overall deprivation
- Poverty or low income
- Lack of or insecure employment
- Poor housing
- Homelessness
- Lower educational attainment
- Crime and disorder (or fear of)
- Poor access to transport
- Poor physical environment

Income, poverty and employment are considered to be the best indicators of deprivation for health inequalities[15]. People who experience one or more of these are more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population. Overall improvements in services, together with reductions in inequalities in wider determinants of health, should help narrow the gap in health outcomes between those who have more affluent and stable life circumstances and those who do not.

The characteristics of policies more likely to be effective in reducing inequalities in health include:[16]

- Structural changes in the environment: (e.g. installing affordable heating in damp cold houses);
- Legislative and regulatory controls (e.g. smoking bans in workplaces);
- Fiscal policies (e.g. increase price of tobacco and alcohol products);
- Income support (e.g. tax and benefit systems, professional welfare rights advice in health care settings);
- Reducing price barriers (e.g. free prescriptions);

[15] The Scottish Government, September (2009) Long-term monitoring of health inequalities: Headline indicators
[16] The Scottish Government (2008) Equally Well, Report of the Ministerial Task Force on Health Inequalities

- Improving accessibility of services (e.g. location and accessibility of primary health care and other core services);
- Prioritising disadvantaged groups (e.g. multiply deprived families and communities, the unemployed, fuel poor, rough sleepers and the homeless);
- Offering intensive support (e.g. systematic, tailored and intensive approaches involving face to face or group work, home visiting);
- Starting young (e.g. pre- and post-natal support and interventions, home visiting in infancy, good quality pre-school day care).

There has been a considerable amount of health policy published in relation to tackling the wider determinants of health for example; in 2003 the Department of Health published its national strategy to tackle inequalities in health. Core themes within *Tackling Health Inequalities: A Programme for Action* included the requirement to address underlying determinants of health. In 2004 the Wanless report *Securing Good Health for the Whole Population* assessed the resources required to provide future high-quality health services. The report focused on the prevention of ill health, on tackling wider determinants of health, and on the cost-effectiveness of action that can be taken to improve the health of the whole population, as well as reducing health inequalities.

However it has been recognised that locally focussed plans and partnerships are essential for tackling health inequalities and health improvement, and bringing in line health and Local Authority priorities. Local Area Agreements are key to this joint strategy and partnership. "Local Area Agreements are an opportunity to reconsider local health priorities and embed wider determinants of health in each agreement"[17].

There are numerous policies and interventions that have a positive influence on the health of the general population. However such policies may not necessarily reach those in a more vulnerable socio-economic position, and could thereby even increase social differentials. Interventions must therefore be tailored to address the needs and conditions of the relevant groups concerned[18].

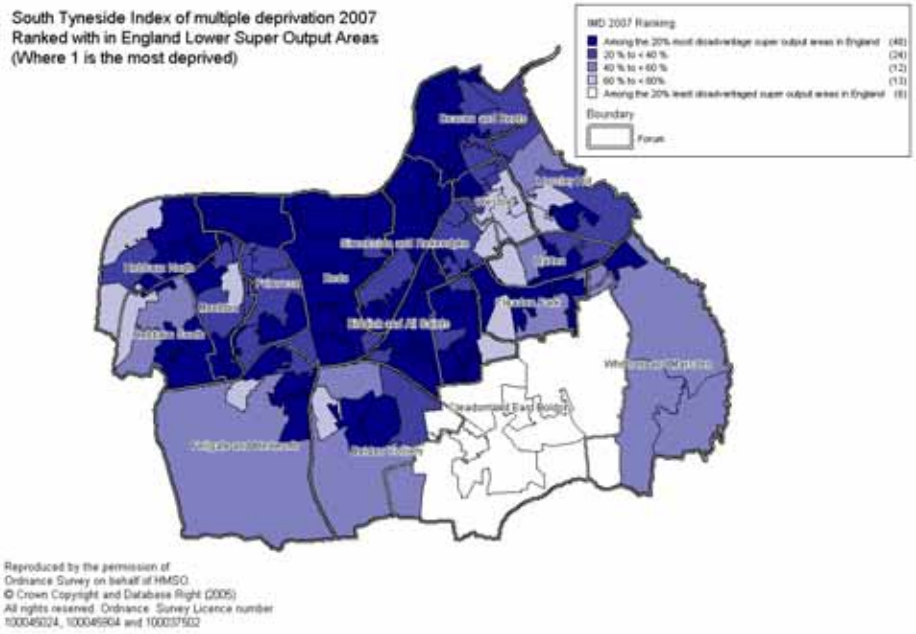
Deprivation

There is a substantial amount of evidence to support the fact that people living in the most deprived areas have worse health and health indicators than those in the most affluent areas. People in deprived areas are likely to have a higher exposure to negative influences on health, and to lack resources to avoid their effects. The 2007 Index of Multiple Deprivation measures socioeconomic disadvantage across seven domains;

- Income;
- employment;
- health;
- education;
- barriers to housing and services;
- crime;
- physical environment.

[17] Improvement and Development Agency (I&DeA)
[18] DETERMINE Consortium (July 2008) Improving Health Equity via the Social Determinants of Health in the EU

The overall Index of Multiple Deprivation is a weighted average of the indices for the seven domains. The map below shows those lower tier super output areas (areas with a population of around 1,500 people) in South Tyneside that are among the most disadvantaged fifth of all areas across England.



Resilience to inequality and deprivation

Resilience is an important factor in health inequalities. Most people will experience hardship at some point during their lives. Whilst some people are able to deal with problems without any serious impact upon their health and wellbeing, for others difficult circumstances will impact significantly their mental wellbeing and physical health. Some individuals have greater resilience and at a population level some communities have greater resilience. Some communities experiencing severe deprivation will experience poor health outcomes whilst some will continue to function and cope with their problems. Research has suggested that resilience factors play a role in protecting some communities from the health effects inequality and deprivation.

The following key factors have been identified as those which appear to provide this resilience and are all linked to improved health outcomes;

- Improved social capital;
- Community cohesion;
- Personal wellbeing;
- Satisfaction with the local area;
- Community safety;
- Personal skills.

Social capital

Social capital can be considered a measure of community. It means that people feel they are connected and can contribute to the everyday life of society, trust other people and can access social support. Social capital is the social glue that helps people, organisations and communities work together towards shared goals.

Table 4: Causal route of the relationship between social inequality and health inequality

Address material deprivation	Promote resilience to inequality and deprivation	Make healthier behaviours easier	Providing accessible equitable and effective support services
▪ Income maximisation programmes ▪ Improve housing ▪ Reduce homelessness ▪ Support the local economy ▪ Increase employment	▪ Increase social capital (people feel they are connected and can contribute) ▪ Improve community cohesion (people from different communities get on together) ▪ Promote personal well-being (people feel happy, fulfilled, valued, positive and in control) ▪ Increase satisfaction with the local environment (people feel comfortable with their surroundings) ▪ Increase community safety (people feel safe) ▪ Increase skills (people are able to make a positive contribution)	▪ Enforce smoke free legislation ▪ Urban planning for active communities ▪ Improved access to affordable nutritious food ▪ Use opportunities within the licensing law ▪ Implement healthier working practices ▪ Enforce responsible alcohol sales ▪ Social marketing ▪ Provide behaviour change support to individuals	▪ Prevention, treatment & support services reach, and are effective for, those in greatest need and are equitably resourced ▪ Develop integrated one-stop shops ▪ Provide accessible advice services ▪ Commission effective health and social care services ▪ Undertake equity audits

Areas where there is an active community, where people feel they matter, are respected and able to contribute, tend to be those where health and wellbeing is highest.

The 2008 Place Survey provides information on people's perceptions of their local area and the local services they receive. The survey collects information on 18 national indicators for local government, used to measure local government performance for councils across the country.

The Place Survey 2008 for South Tyneside found that:

- Residents in South Tyneside are generally happy living in their local areas and get on well with their neighbours;
- These are some of the main results of the 2008 Place Survey which found that 78% of local people are satisfied with their area - up from 73% in 2006;
- The survey also found that on the whole anti-social behaviour is now seen as significantly less of a problem with only 20% of residents regarding anti-social behaviour as a serious problem in their area. This compares with 28% of people who viewed it as a problem in 2006. The highest level of concern continues to be about teenagers hanging around the streets, although the number of residents viewing this as a problem has reduced from 61% in 2006 to 47% in 2008.

Other findings from the Place Survey are:

- 84% of people over 65 are satisfied with both their home and neighbourhood;
- 77% of people agree that their local area is one where people from different backgrounds get on well together;
- 73% of people said that they had been treated with respect and consideration by local public services in the last year while 6% of residents said that they had rarely or never been treated in this way;
- 70% of people reported their health as good, a figure consistent with the average for Tyne and Wear, but below the national average of 76%; Good health is more likely to be reported amongst those aged 18 – 34, in fulltime work and not in social rented accommodation;
- Only 7% of respondents reported their health as bad or very bad;
- 64% feel they belong to their immediate neighbourhood.

The survey also highlights some areas for improvement such as keeping residents feel informed about what to do in the event of large scale emergencies.

Residents views were sought on whether older people in South Tyneside are getting the support and services they need to live independently, to inform a new national indicator (NI 139). South Tyneside is performing well with an NI score of 38 which is higher that the National Place Survey average. It should be noted that “don’t know” responses were high. This would be expected as many residents are unlikely to have any experience to base an opinion. Agreement is higher amongst white people, those aged over 55 and disabled people.

In South Tyneside an additional question was added to find out how satisfied people are with life. Nearly three quarters (74%) of respondents said they were satisfied, while 9% expressed dissatisfaction, 14% said they were neither satisfied nor dissatisfied. Satisfaction was highest among the over 55s. Residents were satisfied with their GP (86%), local hospital (78%), and dentist (79%). South Tyneside is also performing better than Tyne and Wear overall in terms of satisfaction levels across public services. Most residents (55%) agreed that local services were helping people lead healthier lives, but just under a third (29%) were undecided on the issue.

Poverty and low income

The traditional approach to measuring poverty involves looking at how many people live in households below particular low income thresholds. Nationally in terms of child poverty the overall aim is to halve the number of children in poverty by 2010-11, on the way to eradicating child poverty by 2020 (Public Service Agreement 2007). Poverty is generally regarded as the most important determinant of health, and also one of the most difficult areas in which to achieve change. The relationship between health and low income exists across almost all health indicators. Some of the most obvious effects of health inequality are as follows:

- Children born into poverty are more likely to die in the first year of life;
- Babies in low income families are more likely to be bottle fed;
- Premature mortality rates (i.e. before age 65) in the most deprived boroughs are nearly double those in the least deprived;
- Infant mortality rates tend to be higher in the more deprived communities;
- Low birthweight (as a result of inappropriate nourishment or smoking for example) is associated with a range of health problems in later life;
- Poor nutrition and consequent poor physical development can affect cognitive development in children;
- Depression in adults has been linked to low income and people on low income with depression are less likely to respond to treatment;
- Smoking, poor diet and lack of exercise can be more common in lower income social groups;
- Hospital emergency admissions are much higher in the most deprived areas;
- Accidents and injury to children tend to be more common in low income groups;
- Communicable diseases: including respiratory and gastrointestinal disease tend to be higher amongst families in poor quality housing.

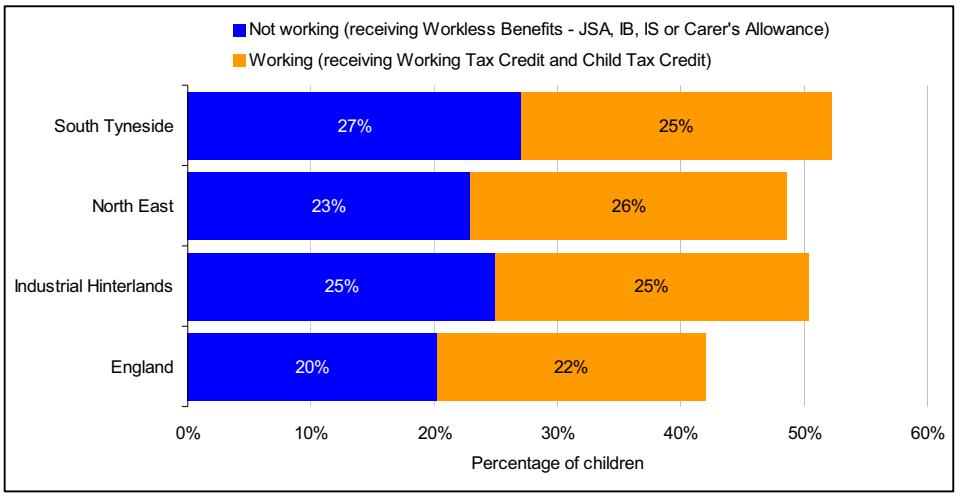
Local position

There are currently 25,100 children aged 1-15 years resident in South Tyneside[19]. 52% of the children in South Tyneside are in low income families compared with 49% across the North East and 42% across England as a whole. This means that 13,000 children in South Tyneside are living in low income families. Half of these children live in families receiving workless benefits and half live in families receiving tax credits.

It is estimated that almost 20% of children in South Tyneside live in areas classed among the most deprived 20% in the country. As many as 65% of children live in income deprived families in the worst of these areas. Table 5 below shows the percentage of children in low income families in South Tyneside compared with other comparable boroughs, the North East and England.

[19] mid-year 2007 estimates of resident population, Office for National Statistics

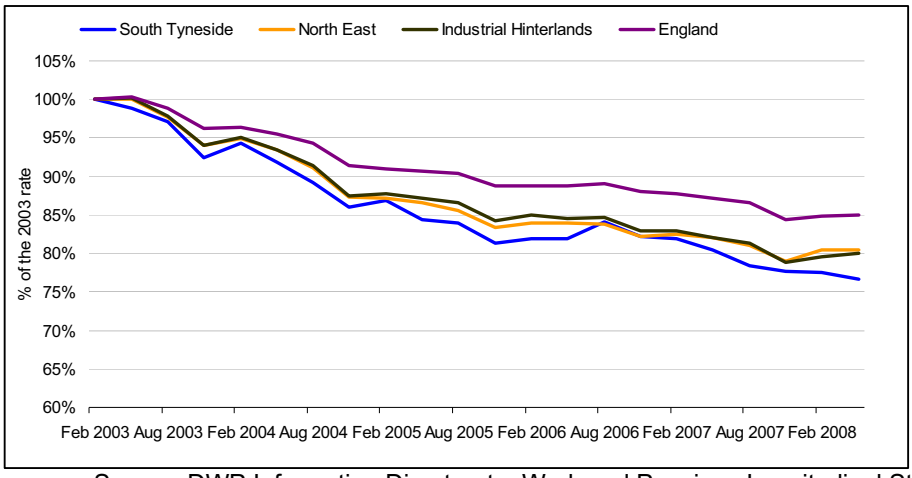
Percentage of Children in Low Income Families Indicator



Source: HM Customs and Revenue, 2006

As shown in the graph below between 2003 and 2008 there has been a 23% reduction in the proportion of children living in families dependent on income support in South Tyneside. This compares to a 20% reduction across the North East and a 15% reduction across England as a whole. The inequality gap between South Tyneside and England has narrowed in recent years.

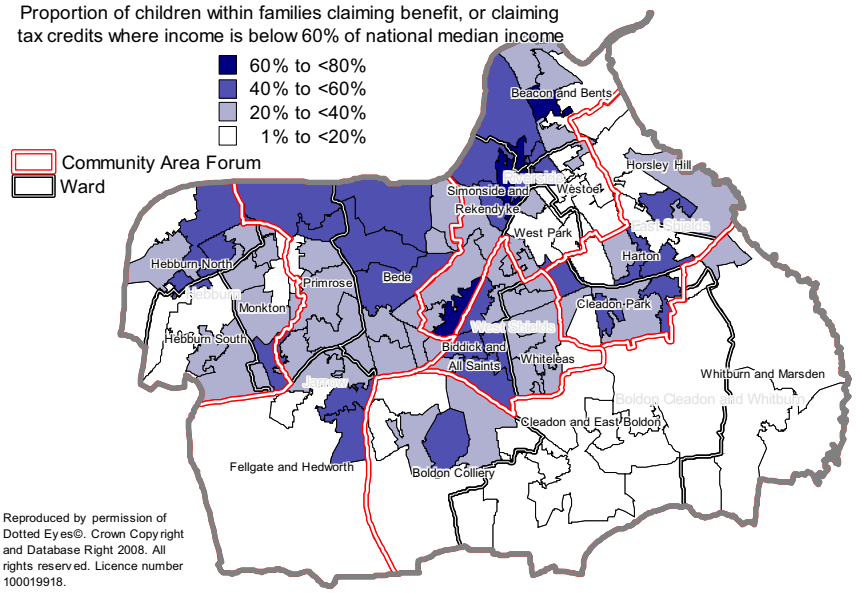
Change in the percentage of children in workless families since February 2003



Source: DWP Information Directorate, Work and Pensions Longitudinal Study

Over half of children in South Tyneside living in families receiving workless benefits live in lone parent households. Within small areas of South Tyneside, the proportion of children living in families receiving workless benefits or tax credits varies considerably. Wards where there are areas with a particularly high proportion of children in low income families are Beacon and Bents, Simonside and Rekendyke.

The map below shows the proportion of children within families claiming benefit, or claiming tax credits where income is below 60% of national median income before housing costs in South Tyneside, 2007 Indices of Deprivation.



Source: Department for Communities and Local Government, 2007 Indices of Multiple Deprivation, Income Deprivation Affecting Children Index (IDACI)

Average earnings

In terms of the average earnings of people in employment in South Tyneside it is possible to compare the average gross pay between South Tyneside and neighbouring districts, the North East and England. In the table below it can be seen that although the average gross weekly pay in South Tyneside is lower than the North East and England it is increasing by 6.2% annually.

Table 5: Weekly pay (gross £) for all employees, 2008

	Number of jobs (thousands)	Median gross weekly pay (£)	Annual % change
County Durham	173	358.7	4.4
Darlington UA	36	348.9	-2.5
Gateshead	83	353.2	6.3
Hartlepool UA	31	375.4	4.4
Middlesbrough UA	50	307.8	10.4
Newcastle upon Tyne	97	338.6	2.8
North Tyneside	90	344.5	5.0
Northumberland	131	340.5	3.0
Redcar and Cleveland UA	44	339.7	8.0
South Tyneside	49	337.2	6.2
Stockton-on-Tees UA	80	344.1	-0.7
Sunderland	105	347.3	4.4
North East	968	346.0	3.9
England	20,163	395.6	3.3

Source: Office for National Statistics, Annual Survey of Hours and Earnings 2008, published November 2008, next publication due November 2009

Employment

The government published its White Paper Building Britain's Recovery: Achieving Full Employment in December 2009 which sets outs its ambition to get over one million more people into work over the next five years. Local Area Agreement targets focus on reducing the gaps in employment and benefit claimant rates between the worst performing neighbourhoods and national average.

Key indicators include;

NI 151	Overall employment rate (working age)
NI 152	Working age people on out of work benefits
NI 153	Working age people claiming out of work benefits in the worst performing neighbourhoods

Unemployment is a significant risk factor for a number of health indicators. The effects can be linked to poverty and low income amongst the unemployed. There are also significant psychological consequences from being out of work, especially for the long term unemployed. In addition, work can play an important role in social networks and the role people have in their community. Unemployed people are found to have:

- Lower levels of psychological well-being which may range from symptoms of depression and anxiety through to self harm and suicide.
- Higher rates of morbidity - such as limiting long term illness.
- Higher rates of premature mortality, in particular for coronary heart disease and injuries and poisoning including suicide.

People with poorer health are more likely to be unemployed - this is particularly true for people with long term disabilities. However, this does not explain the finding of poorer health amongst the unemployed. It is thought that the ways that unemployment leads to poorer health include:

- Effects of increased poverty and material deprivation; these can be particularly acute for people in manual occupations, who tend to be on lower incomes;
- Social exclusion, isolation and stigma;
- Changes in health related behaviour;
- Disruption to longer term careers.

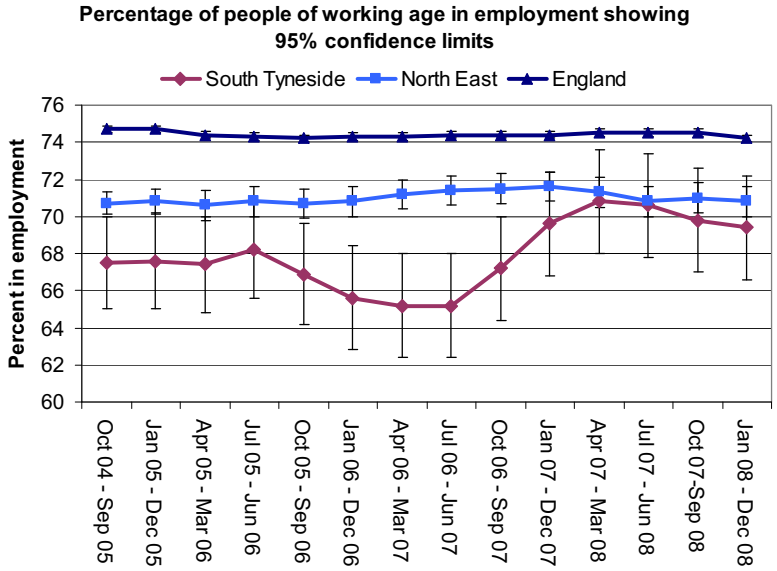
Policies that increase levels of employment are likely to have a significant health benefit for individuals and for the local community. There are also policies which can indirectly improve opportunities for work. In particular, education and training programmes can help to enhance the chances of obtaining a job. For the parents of young children, access to day care and family friendly employment policies can also make a critical difference in terms of being able to work or not.

For people in paid employment, there are aspects of work that can affect health. Job security has been recognised as important for well-being. The move towards less secure, short term employment is especially important for less skilled manual workers. A number of studies have shown how having a greater degree of control over our work is associated with positive health benefits, lower coronary heart disease,

musculoskeletal disorders, less mental illness and fewer episodes of sickness absence.

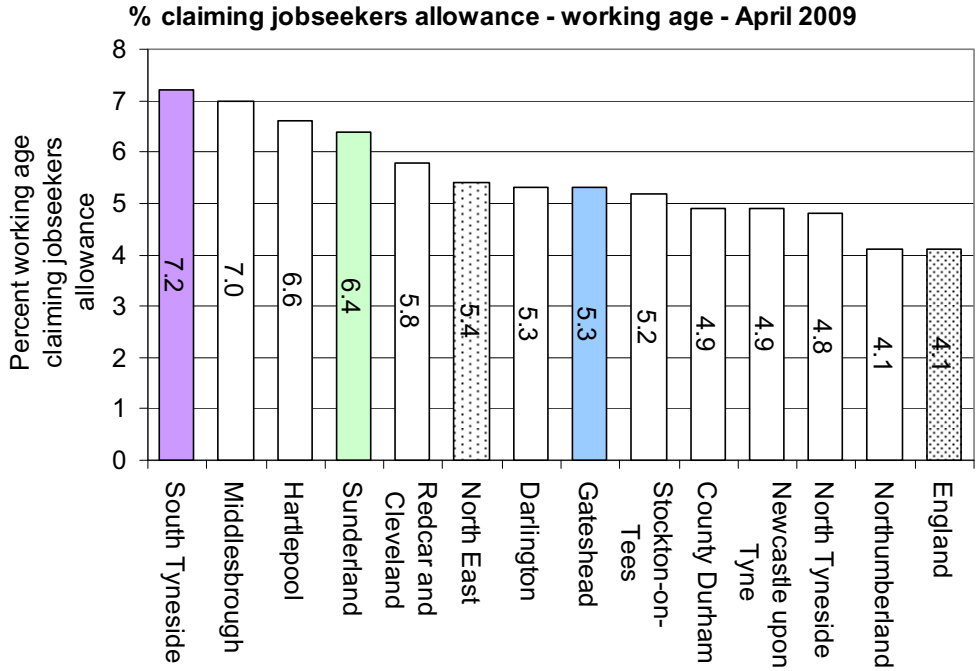
Local position

Unemployment is known to be a potential risk factor for ill health. Although unemployment in South Tyneside is significantly higher than the national average with 6.9% of the working age population claiming Job Seekers Allowance compared to a national average of 4.1% as at November 2009. The overall employment rate is the proportion of the working age population (16-59 for females and 16-64 for males) who are in employment according to the International Labour Organisation (ILO) definition. The graph below shows the changes in the overall employment rate for South Tyneside compared with the North East and England.



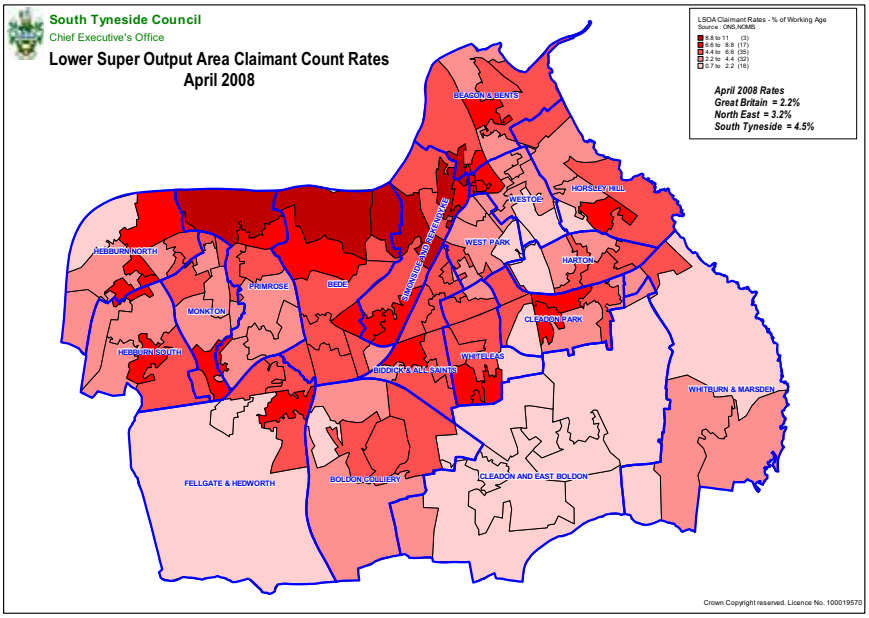
The graph shows that between 2004 and 2008 the employment rate in South Tyneside has risen by 2 percentage points. During this time the gap in employment rate between South Tyneside and England reduced from 7% to 5%.

The graph below shows the number and percentage of the working age population claiming Job Seekers Allowance by North East Local Authority area compared with England April 2009. It can be seen that South Tyneside had the highest percentage of people claiming.



Source: Office for National Statistics

The map below which shows the unemployment claimant rate in Lower Super Output Areas[20] across South Tyneside. Understanding where the highest levels of unemployment are can help to target supportive health interventions.

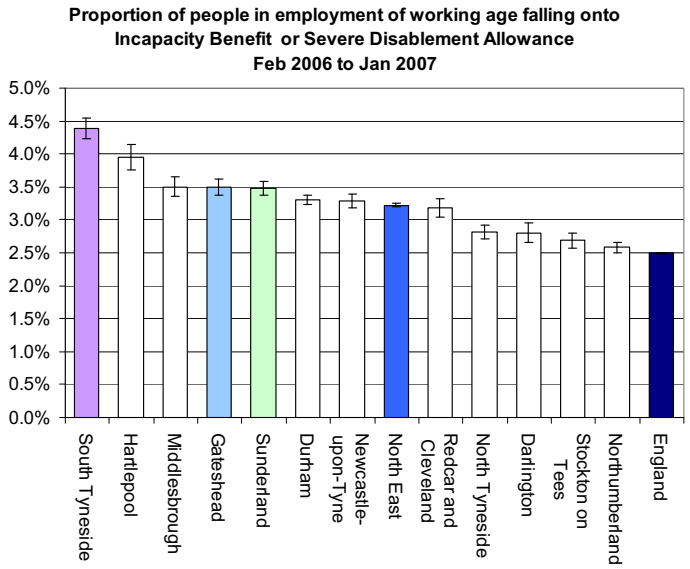


[20] Super Output Areas (SOAs) are a set of geographies developed after the 2001 census. The aim was to produce a set of areas of consistent size, whose boundaries would not change (unlike electoral wards). They are an aggregation of adjacent Output Areas with similar social characteristics. **Lower Layer SOAs** typically contain 4 to 6 OAs with a population of around 1500. **Middle Layer SOAs** on average have a population of 7,200. **Upper Layer SOAs** are still being calculated; they are expected to cover a population of at least 25,000 each

From work to incapacity benefits: A further measure of those out of work is the proportion of the working population who move directly from employment, including those in receipt of employer's sick pay onto incapacity benefits. The number of those claiming incapacity benefits refers to those:

- claiming Incapacity Benefit , Severe Disablement Allowance (SDA) or Income Support paid on the grounds of ill health or incapacity (from 2008 these benefits will be replaced for new claimants with Employment and Support Allowance);
- who were employed immediately prior to claiming incapacity benefits;
- those living in the local authority area at the time of their claim.

The graph below shows the proportion of people previously in employment in South Tyneside who moved onto incapacity benefit or SDA between February 2006 and January 2007. It can be seen that South Tyneside had the highest proportion of residents on incapacity benefit or SDA compared with other boroughs in the North East.



Source: Employment figures - Annual Population Survey published at www.nomisweb.co.uk, benefit figures - Department of Work and Pensions at www.dwp.gov.uk

Young people and unemployment: Reducing the number of 16 to 19 year olds Not in Education Training or Employment (NEET) is a key local target. In 2005/6 almost 14 per cent of youngsters were classed as NEET and this improved to around 10 per cent in 2008/9.

Housing

A suitable home in reasonable condition is a basic need for all and an essential element for building sustainable communities. There are approximately 69,159 dwellings in South Tyneside, 18,294 are Local Authority dwellings, managed by South Tyneside Homes, 4,495 are owned by Registered Social Landlords and 46,565 are private dwellings (about 4% of which are for private rent).

The Local Authority seeks to ensure a balanced housing market with good quality housing stock in a range of tenures and types, providing choice for current and future

residents. In addition to addressing the physical housing stock, the council also seeks to ensure that residents have the support they need to ensure they have a good quality of life and can fully contribute in their community.

Improving housing conditions across all tenures to meet the decent homes standard is a top ten priority objective in the Local Area Agreement. A key national focus is on improving conditions for both rented and owner occupied housing, providing additional social housing and improving affordability.

Key indicators include:

Ref	Performance indicator	Baseline	Targets		
			2008/09	2009/10	2010/11
NI 154	Net additional homes provided	0	340	220 (340)*	280 (340)*
NI 158	Percentage of non decent council homes	62%	52%	55%	29.65%

*These were the original targets. In 2009 the local authority renegotiated some LAA targets, including this one, as government recognised that the recession had made some of the economic targets unachievable.

From the Regional Spatial Strategy, the average number of net additional homes provided in South Tyneside are expected to be:

2004-11	320pa
2011-16	415pa
2016-21	450pa
2004-21	overall average 420pa

Poor housing environments contribute to ill health through: poor amenities, shared facilities and overcrowding, inadequate heating or energy inefficiency. The highest risks to health in housing are attached to cold, damp and mouldy conditions. In addition, those in very poor housing, such as homeless hostels and bedsits, are more likely to suffer from poor mental and physical health than those whose housing is of higher quality.

Many studies have investigated the effect of poor housing conditions, such as inadequate heating and dampness, on health. Studies have confirmed that dampness in homes contributes to, and exacerbates, respiratory illness. The report 'Home Sweet Home: The Impact of Poor Housing on Health'[21] stated that those who had experienced overcrowded housing conditions in childhood had a higher likelihood of infectious disease, notably tuberculosis, as adults. In adulthood, overcrowding was also linked to increased likelihood of respiratory disease. In addition, cold homes can reduce resistance to respiratory infections in older people and may increase the likelihood of respiratory problems, diarrhoea and vomiting in young children. Mental health issues such as depression and anxiety have also been associated with dampness, poor quality housing, neighbourhood noise and housing structural problems.

[21] 'Home Sweet Home: The Impact of Poor Housing on Health' Marsh, Alex et al. October 1999 Policy Press

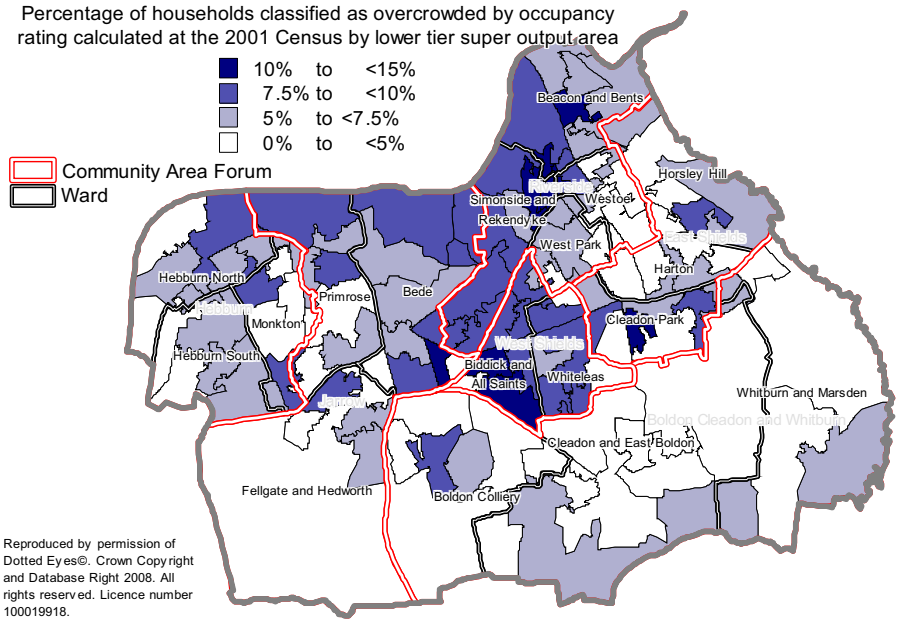
Housing condition is assessed according to whether a home is 'Decent' or 'Non-Decent'. The Decent Homes Standard for a property means a home must:

- meet the minimum standard for housing;
- be in a reasonable state of repair;
- have reasonably modern facilities and services;
- have a degree of thermal comfort (heating, insulation, etc.).

Local Position

Decent homes: In May 2009 50% of the council's housing stock did not meet the government's decent homes standard. There is limited information available on the state of the housing stock in the private sector and research into this is scheduled to be carried out in 2010. Historic under investment in private stock, information on need for improvements and repairs from the housing needs survey and anecdotal evidence suggests that parts of the Borough are home to private stock in significant disrepair.

Overcrowding is considered to be a poor housing environment, which may contribute to ill health. The map below shows the percentage of households with an occupancy rating of -1 or less at the 2001 Census by South Tyneside Lower Tier Super Output Area. The occupancy rating compares the number of rooms in a house with the number of occupants. Households with an occupancy rating of less than zero are defined as being overcrowded.



Housing and support needs:

There are a range of specialist housing needs within the Borough, such as frail older people, those with physical, learning or mental disabilities, those with health problems and vulnerable young people. The Council's older person strategy seeks to enable older people to stay in their own homes through improvements and adaptations. This provides additional affordable housing that suits older peoples' needs as well as catering for specialist residential care needs.

As part of the **Housing Plan for People with Learning Disabilities 2009–2012** people with learning disabilities sit on the housing sub group and have helped to discuss how South Tyneside should take forward priorities. The group meets monthly to look at the housing priorities from the Valuing People document. The easy read version of the strategy was developed with the help of the Equal People group, a group of people with a range of learning disabilities. The Equal People group is chaired and run by people who have learning disabilities. A survey was sent out to 622 people with learning disabilities receiving Council services and there was a 55% response rate.

The survey highlighted:

- most people with a learning disability in South Tyneside live in supported living or with parents and family. Only 11% live in their own home;
- 82% of people were 'very happy' with the way they were living;
- 72% of people stated they did not wish to move;
- of the 28% who expressed an interest in moving, the most common reason was to be more independent, followed by a dislike of staff supporting them;
- over 55% of people received support from paid staff and 42% had support from family members;
- of those receiving support, nearly 50% had a care manager to make arrangements. Family members or partners arrange 37.4% of the support. Only 3.8% of people arrange their own transport;
- over 60% of people require 24 hour support;
- only 6% of people did not need any support at all during the night. However 6.7% stated they only needed someone on the end of the phone;
- most people require support with bills and filling in forms and also preparing meals and personal care.

A greater insight is needed into the housing needs of those with alcohol and drug misuse problems, vulnerable young people and frail older people, research into these issues will be carried out by the housing futures team in 2010 to ensure that the most effective type of housing and support is provided.

Fuel Poverty

Fuel poverty is defined as where a household spends over 10% of their disposable income heating their home to a reasonable level. Fuel poverty is one of the most clearly defined indications of the health and social divide in modern society. In 2007 it was estimated that 50% of all older people and 20% of families with children in South Tyneside were living in fuel poverty.

South Tyneside has an average energy rating (SAP) for the Borough's private housing of 58; a SAP of 65 is considered to be the minimum acceptable level, the level at which there is a minimal risk of a household being in fuel poverty. Through the council's energy efficiency improvement programmes 'Warmer Homes' the aim is to raise this rating from 58 to 65.

Excess winter deaths

One of the impacts of a poorly heated home is to contribute to cold related deaths. There are 40,000 more deaths in Britain in winter than during other months of the

year. People in poorly heated homes are more vulnerable to death from heart attacks and stroke. Dwellings that are old, have no or inadequate central heating, are costly to heat or occupied by household with a low income are more likely to have indoor temperatures below 16 degrees. People in local authority or housing association dwellings are especially likely to have low indoor temperatures if their heating costs are high.

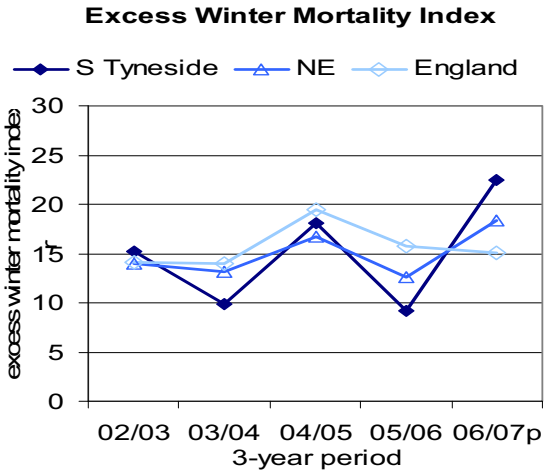
Excess winter deaths are the number of deaths between November and March, less the average number of deaths in the preceding and subsequent four month periods (August to October and April to July). Excess Winter Mortality Index (EWMI) is the number of excess winter deaths expressed as a proportion of the average number of deaths in the preceding and subsequent four month periods (August to October and April to July).

In 2006 provisional data shows that there were a total of 117 excess winter deaths in South Tyneside and an EWMI of 22.43 which is significantly higher than Gateshead and Sunderland and is above the regional and national average. This is illustrated in the table below.

Table 6: Number of excess winter deaths

	Number of excess deaths 2006-7 – all ages	Excess Winter Mortality Index
South Tyneside	**117**	**23.43**
Gateshead	69	11.18
Sunderland	114	13.10
North East	**1,500**	**18.32**
England, Wales & elsewhere	**23,900**	**15.11**

The graph below shows that the number of excess winter deaths increased in South Tyneside during the period 2002-3 and 2006-7.



Source: Annual Deaths Extract, Office for National Statistics.

Homelessness

The term 'homelessness' covers a range of circumstances and is not just "rooflessness", it describes a situation where a household does not have access to settled accommodation, or has accommodation but it is unreasonable to live there, or

is required to leave settled accommodation. It is recognised that homelessness can increase the risk of:

- experiencing mental illness including stress
- alcohol and or drug problems
- respiratory disease (including tuberculosis)
- poor perinatal health (such as low birthweight, infant mortality and adverse effects on child development).

Rates of long term illness among homeless people are also 2.5 times higher than among the general population. Homeless people may also experience problems in getting access to health services - in particular primary and community care. Conditions in temporary accommodation generally can be very poor with little privacy or security with shared kitchens and/or bathrooms. The accommodation may be damp, cold and overcrowded. Poor quality temporary housing has been associated with a number of health risks including respiratory and gastrointestinal infections, poorer pregnancy outcomes and mental health problems linked to stress.

For those who are living on the streets, hostel dwellers or using night shelters, there is a characteristic pattern of health needs that includes tuberculosis and chronic respiratory disease. In particular, such people may also suffer from problems associated with alcohol, drug misuse and poor mental health. Historically, homeless people have tended to be older men, but recent years have seen growing numbers of homeless women and younger men. Problems such as mental illness are probably important contributory factors in becoming homeless, and once homeless, make obtaining appropriate housing harder.

Local position

The number of households accepted as statutory homeless has significantly reduced from 597 in 2003-4 to 213 in 2007-2008 - a reduction of over 60%. It can be seen in the table below that the 213 applications for homelessness in South Tyneside in 2007-8 translates as a rate per 1,000. Out of all the 12 councils in the North East South Tyneside is ranked 5th which is just above average. South Tyneside has relatively low numbers of households in temporary accommodation compared to other local authorities.

Table 7: Numbers of homeless in priority need

	Number of households (2004 mid-year estimate)	Numbers Accepted as being homeless and in priority need	Number per 1,000 households
Gateshead	85	626	7.3
North Tyneside	87	557	6.4
Newcastle upon Tyne	115	484	4.2
Sunderland	120	418	3.5
South Tyneside	**67**	**213**	**3.2**
Stockton-on-Tees	77	242	3.1
County Durham	211	615	2.9
Hartlepool	39	82	2.1

Middlesbrough	57	95	1.7
Northumberland	134	208	1.6
Redcar and Cleveland	59	52	0.9
Darlington	43	11	0.3
NORTH EAST	**1,094**	**3,600**	**3.3**
ENGLAND	**21,063**	**63,170**	**3.0**

Source: DCLG Statutory Homeless Statistics 2007/08, table 627, published Nov 2008, next publication due Sept 2009

Reasons for becoming homeless in South Tyneside during 2007/8 are set out below:

Table 8: Reasons for becoming homeless

Reason	Number	%
Parents	66	31.13
Relatives and friends	11	5.19
Non-violent relationship breakdown	36	17.06
Domestic Violence – partner	18	8.49
Violence involving associated persons	2	0.94
Other forms of violence	3	1.42
Harassment	3	1.42
Mortgage arrears	14	6.6
Rent arrears: local authority or RSL	1	0.47
Rent arrears: private sector	11	5.19
Loss of an Assured Shorthold Tenancy (AST)	29	13.68
Reasons other than termination of AST	2	0.94
Required to leave NASS accommodation	3	1.42
Left prison or remand	1	0.47
Left HM Forces	3	1.42
Other reasons	9	4.25
Total	**212**	**100**

Source: South Tyneside Council

Educational attainment

Education is one of the critical factors that can determine the opportunities available in life. The level and quality of education can have both long and short term implications for health. Education plays a number of roles in influencing inequalities in health.

There is good evidence that education has an important role in influencing inequalities in socioeconomic position. Education is a traditional route out of poverty for those living in disadvantage. Education also has a role in preparing children for life in terms of health related behaviour, skills in developing relationships and dealing with conflict, and practical skills such as budgeting and cooking. The education system should also protect and promote the current health of children, by providing an environment and culture which is safe, healthy and conducive to learning.

A group of children at particular disadvantage are those who are excluded from school or who are frequent truants. School exclusion and truancy are associated with increased involvement in crime, as victims and perpetrators, substance misuse and

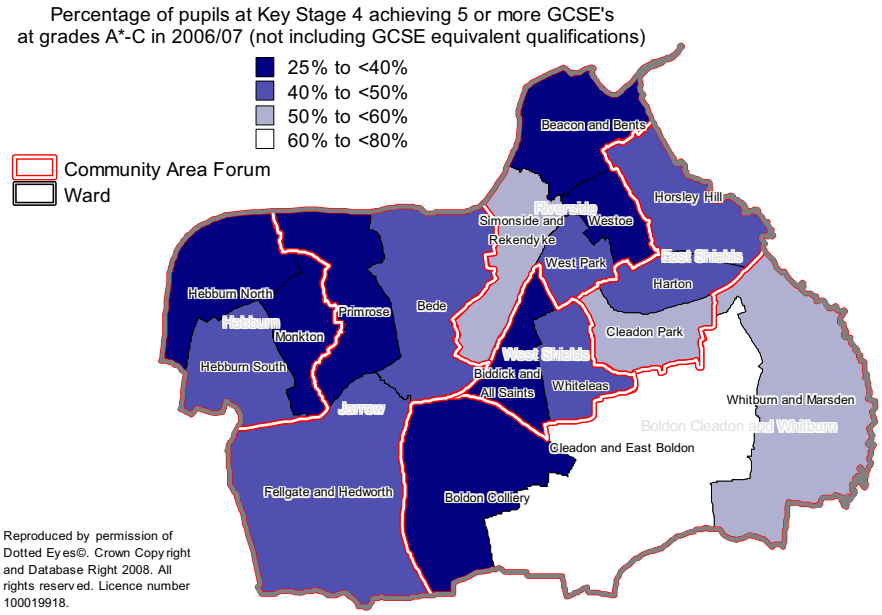
other dangerous activities. In the long term, school exclusion and truancy are associated with unemployment, imprisonment, homelessness and teenage pregnancy. Measures to reduce truancy and exclusion are essential if the educational opportunities of this vulnerable group of children are to be protected.

In terms of life long learning improved numeracy and literacy will enable adults to understand basic communications and messages around health and access to healthcare for example.

Key indicators include;

NI 87	Secondary school persistent absence rate – pupils missing 20% or more of the school year
NI 92	Narrowing the gap between the lowest achieving 20% of children in the Early Years Foundation Stage Profile and the rest.
NI 101	Children in care achieving 5 A*-C GCSEs (or equivalent) at Key Stage 4 (including English and Maths).
NI 107	Key Stage 2 attainment gap for pupils from black and minority ethnic groups.
NI 108	Key Stage 4 attainment gap for pupils from black and minority ethnic groups.

The other measure of disadvantage in terms of educational attainment relates to where children live and go to school in the borough. The map below shows the percentage of pupils at Key Stage 4 achieving 5 or more GCSEs at grades A*-C between 2003 and 2007 by South Tyneside lower level super output area. It can be seen that educational attainment is lower in more disadvantaged areas in the Borough. Improving attainment in the most disadvantaged children will directly impact on addressing health inequalities.



Source: South Tyneside Council, Local Education Authority

Crime and Disorder

Building respect in communities and reducing Anti Social Behaviour is a top ten priority objective in the Local Area Agreement. Reducing the harm caused by illegal drugs and alcohol and reducing key crimes particularly in crime hotspots are also key priority objectives in South Tyneside.

Key indicators include;

- NI 17 Perceptions of anti-social behaviour
- NI 20 Assault with injury crime rate
- NI 30 Re-offending rate of prolific and priority offenders
- NI 32 Repeat incidents of domestic violence
- NI 40 Number of drug users recorded as being in effective treatment

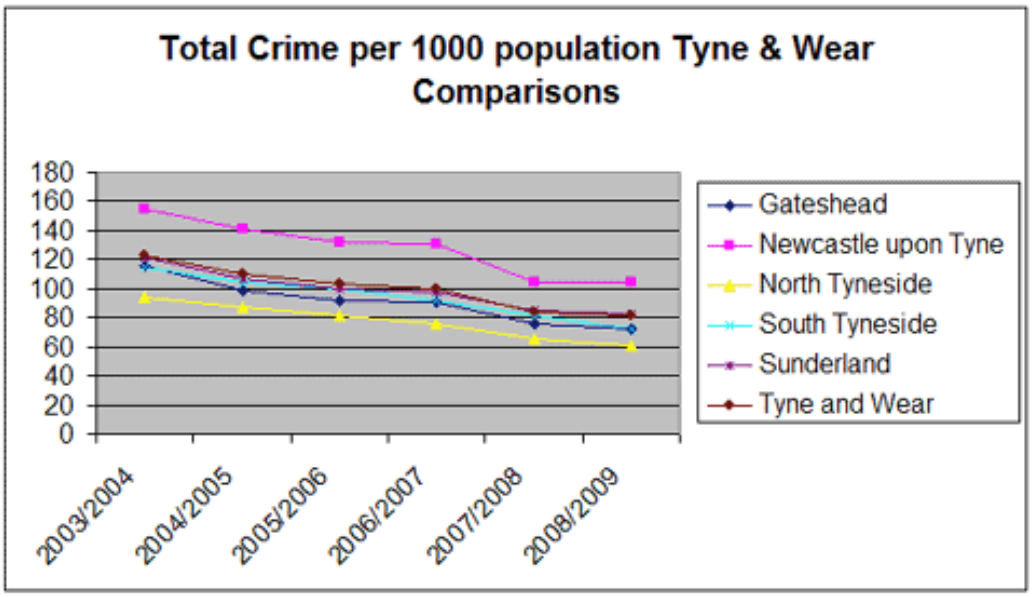
The level of crime and fear of crime have a significant impact on people's quality of life and there are many links between crime and health. Some of the most obvious are the effects of personal violence and assault, which can have both mental and physical consequences for health in the short and long term. The same social and environmental factors that predict geographic variation in crime rates may also be relevant to explaining community variations in health and well-being.

Perceptions of the incidence of crime and feelings of personal safety can have a widespread effect on the way people live their lives. Despite a low crime rate, only 33.4% of local people feel that the police and other public services are successfully dealing with anti-social behaviour and crime in their local area (this remains higher than England as a whole which has a rate of 26.3%).[22] The effects of fear of crime may be manifest in behaviour, for example avoiding going out of the home, which tend to reduce involvement in the local community, and increase isolation. Both these factors will have some health impact in terms of anxiety or depression for example.

Drug and alcohol are key factors in many crimes. Often drug related crime is non-violent and includes theft, shoplifting, burglary and prostitution. It is not always clear whether drug use leads to criminality or vice versa. There are strong associations between alcohol consumption and violent crime, particularly amongst men in the 15 to 25 year age groups.

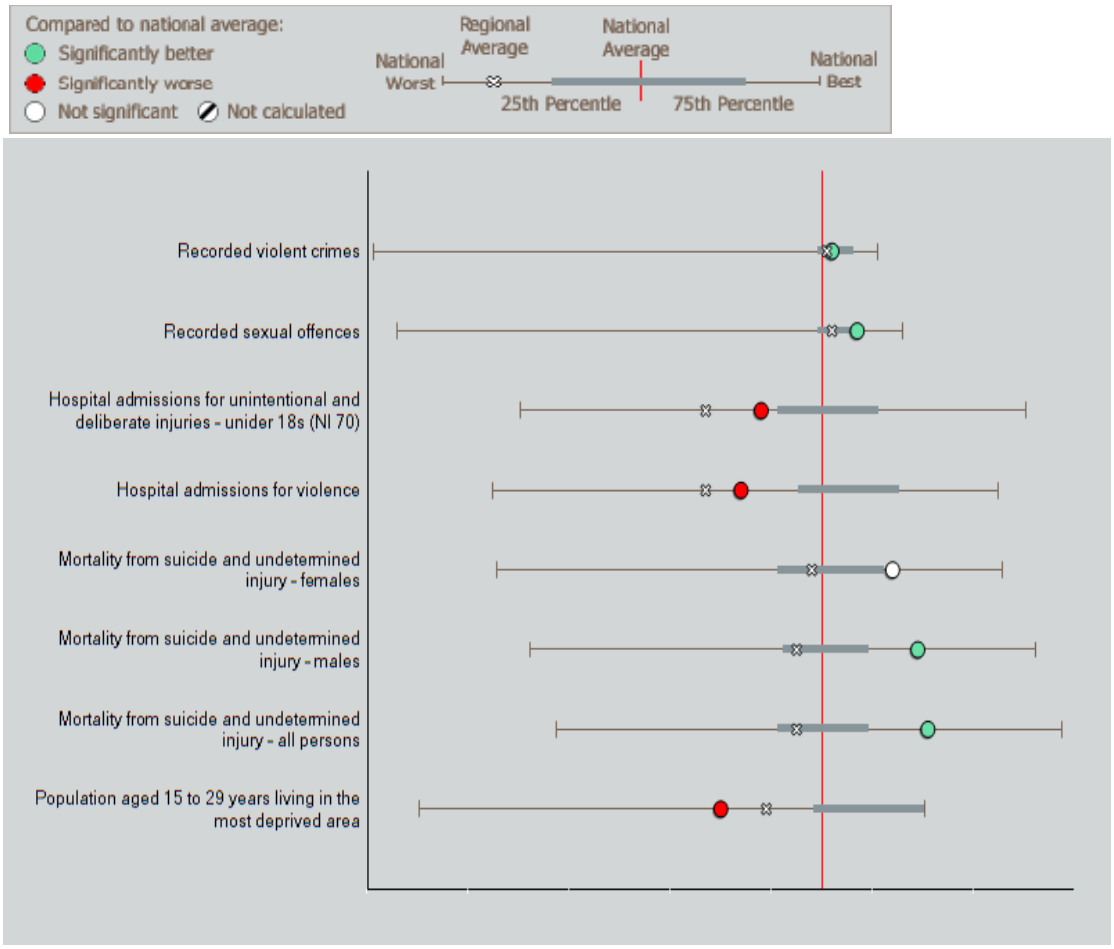
Between 2003-4 and 2007-8 a 29% reduction in total recorded crime was achieved. During the period April 2008 to March 2009 South Tyneside showed an 11% decrease in total recorded crime compared to the same period the previous year. This is almost double the improvement of the next best performing Local Authority, North Tyneside, which demonstrated an improvement of 6%. The Tyne & Wear average is 4%. This is illustrated in the graph below.

[22] Place Survey



Violence Indicator Profile

The diagram below provides key data (from 2006-7 and 2007-8) on a range of violence related indicators for South Tyneside compared with regional and national averages. It can be seen that locally rates are significantly worse for hospital admissions for unintentional and deliberate injuries in under 18's, hospital admissions for violence and the numbers of 15 – 29 years olds living in the most deprived areas.



Source: North West PHO

Antisocial behaviour

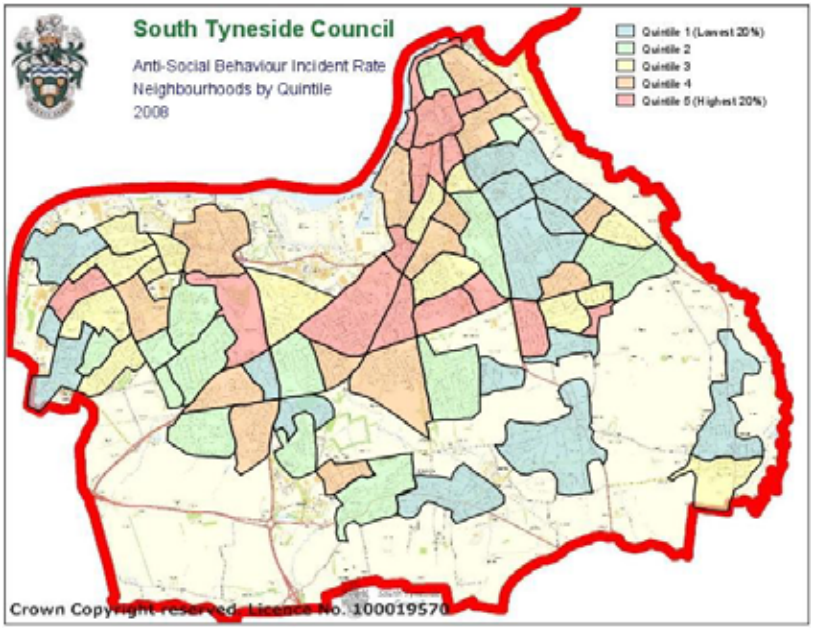
Anti-social behaviour can have a very negative impact on a person's quality of life and physical and emotional health. It is also recognised and acknowledged that some perpetrators of anti-social behaviour have mental health problems. There is a close link between mental health problems and drug/alcohol misuse for both perpetrators and complainants.

There is evidence to suggest that premature death and disability are strongly associated with antisocial behaviour at ages 8–10 and 27–32, convictions and impulsivity during adolescence and parental predictors of offending at age 8–10. Preventing childhood and adolescent antisocial behaviour and offending may also prolong life and prevent disability among those who would otherwise offend[23]. There are close links with a reduction in antisocial behaviour and living in stable appropriate housing.

There were 1,118 incidences of antisocial behaviour reported to the Anti Social Behaviour Unit in South Tyneside between October 2008 and September 2009. The majority of reports relate to noise, nuisance and rowdy behaviour.

[23] Impact of antisocial lifestyle on health: chronic disability and death by middle age. J P Shepherd, I Shepherd, R G Newcombe, D Farrington, Journal of Public Health Vol. 31, No. 4, pp. 506–511 June 2009

Antisocial behaviour is now recorded at neighbourhood level. This enables better targeting in terms of responses and early intervention. The graph below shows the incident rate of antisocial behaviour recorded in each neighbourhood during 2008.



Violent Crime

The impact of violent crime on victims of violence is difficult to assess, not only in relation to the initial offence but in relation to the longer-term effects on their health and wellbeing. High rates of self harm as well as illness are closely related to assaults, and violence leaves permanent physical and psychological scars[24].

Research conducted in 2004 suggests that violence is significantly underreported. It is estimated from this study that serious assaults are under recorded by at least 50% and possibly nearer 70%. 55% of the individuals who came into A&E during the period of the study stated they would not report their assault to the Police. Young men are at almost four times greater risk of being a victim of violence than the rest of the adult population.

Alcohol related crime is a growing problem in the UK and 44% of victims of violent crime perceived that the offender was under the influence of alcohol. The Home Office estimates that alcohol is the root cause of about half of all violent crimes, and linked with 70% of late-night admissions to A&E.

There is evidence to suggest that a tendency to violence and lack of empathy may be due to poor parenting in early life (under the age of 3) and that violence is likely to be triggered in people who already have the potential to be violent by external factors such as unemployment, poor housing, overcrowding and low income[25].

[24] Farrington DP Discussion Paper Violence. Journal of the Royal Society of Medicine, vol 86, Issue 2 89-92.
[25] Violence and what to do about it. The Wave Report 2005

The table below shows violent crimes committed in the North East during 2008-9. It can be seen that reported violent crime in South Tyneside is slightly lower than the average rate for the North East of 14.5 per 1,000.

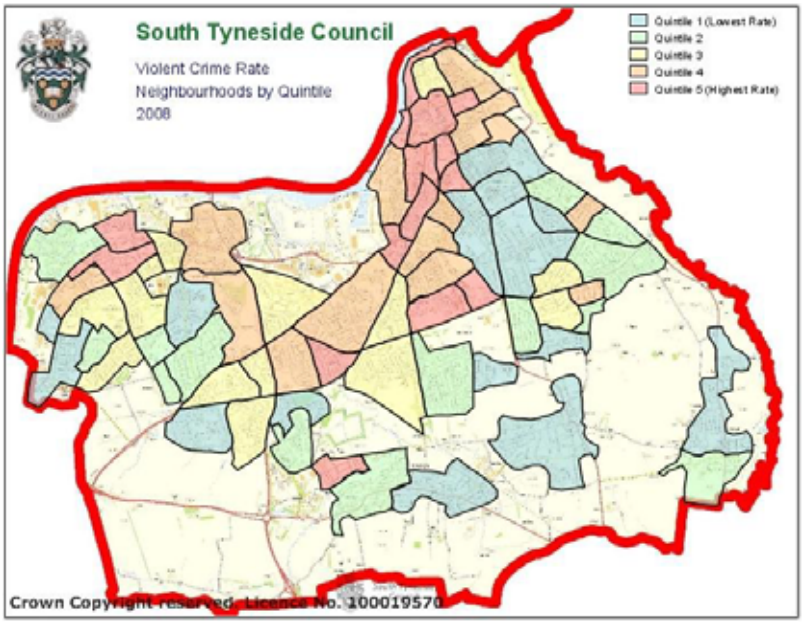
Table 9: Violence against the person, offences recorded per 1,000 population all ages 2008/09

Area	Number of offences	Indicator value	Lower 95% CI	Upper 95% CI	Signifcance*
Durham CC	5972	11.8	11.5	12.1	L
Darlington UA	1463	14.6	13.90	15.40	L
Gateshead MCD	2164	11.4	10.9	11.8	L
Hartlepool UA	1628	17.8	17.0	18.7	H
Middlesborough UA	4230	30.5	29.6	31.4	H
Newcastle upon Tyne MCD	4914	18.1	17.6	18.6	H
North Tyneside MCD	2297	11.7	11.3	12.2	L
Northumberland CC	3193	10.3	9.93	10.64	L
Redcar and Cleveland UA	2070	14.9	14.2	15.5	L
South Tyneside MCD	**2023**	**13.4**	**12.8**	**14.0**	**L**
Stockton-on-Tees UA	2734	14.4	13.8	14.9	L
Sunderland MCD	4556	16.3	15.8	16.7	-
North East	**37244**	**14.5**	**14.38**	**14.67**	**L**
England	**841082**	**16.5**	**16.43**	**16.50**	

* H = significantly higher than England rate at 95% confidence, L = significantly lower, - = not significantly different

Source: Home Office, British Crime Survey 2008/09, published July 2009

Violent crime is also recorded by neighbourhood in South Tyneside to enable targeting of interventions. The map below shows violent crime rate reported during 2008.



Domestic violence

Estimates suggest that domestic violence accounts for 25% of all violent crime in the UK; that 69% of domestic violence results in injury and that 90% of violent attacks are

witnessed by children. There are therefore significant threats to both short and long term physical and mental health.

The table below shows domestic violence incidents reported to the Police in South Tyneside between January and December 2009. Over half the incidents (53%) involved children. Over 20% of all incidents were classified as very high risk (5.9%) or high risk (15.9%).

Table 10: Domestic Abuse incidents, 2009

	Reported Incidents	Arrests Made	Involving Children	Repeat Victims	BME victims
January	274	86	138	n/a	14
February	259	81	133	n/a	23
March	255	91	138	n/a	14
April	271	83	140	74	20
May	287	100	157	79	16
June	249	85	120	67	8
July	292	93	154	75	9
August	280	92	164	61	13
September	248	53	136	70	29
October	267	53	151	84	18
November	259	85	139	99	19
December	286	96	139	96	8
TOTAL	**3227**	**998**	**1709**	**705**	**191**

Source: Northumbria Police

Reducing crime can free up NHS resources which are currently spent on crime-related ill health. This, in turn, can improve access to preventative and emergency services for the wider community. Working to reduce crime can help to achieve health targets to reduce inequalities, improve health and access to services such as:

- modernising primary care services by developing closer links with police and local authorities reducing waiting times by reducing the demands on services from crime-related ill health
- reducing pressures on emergency services
- improving the working conditions for NHS staff by reducing the chances of violent attacks
- reducing the mental health problems associated with the consequences and fear of crime
- promoting independence among vulnerable groups through partnerships to improve community safety
- improving the health of children and young people by preventing youth offending and supporting those at risk of violence

Access to Transport

Transport and health are closely linked. Transport has major health impacts – through accidents, levels of physical activity undertaken, effects on air pollution, and access to a range of services. The location of health services can add to or reduce all these

impacts, as well as making it more or less difficult for patients, relatives and staff to travel to and between healthcare settings.

There are significant inequalities in the impact of transport on the health of individuals and communities, both directly (e.g. through the social distribution of child pedestrian deaths); and indirectly (e.g. through the influence of planning decisions to accommodate car access):[26]

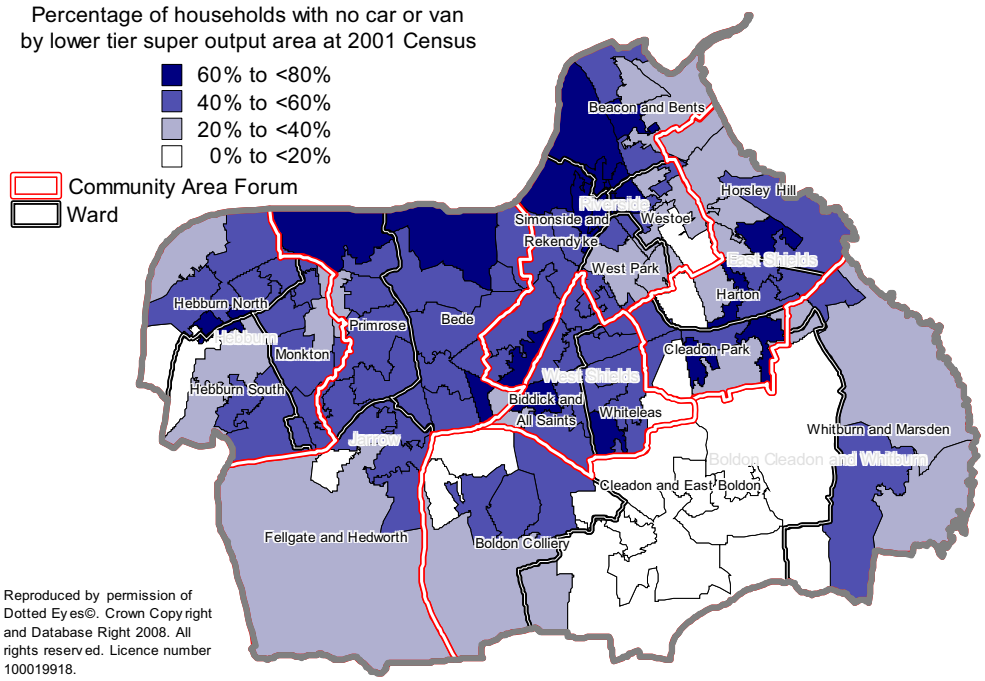
- Ownership/access to a car is highly related to social class – 62% of the poorest groups do not have a car, compared with 7% of those in the richest groups
- Exposure to air pollution tends to be greater for people experiencing disadvantage, who are less likely to own a vehicle
- Access to healthcare, shops, work and leisure is likely to be more difficult for poorer groups.
- Children in social class V are five times more likely than those in social class I to die as pedestrians

Local Position

In terms of how people travel in the Borough car trips constitute over 50% of journeys, with just under 25% are by bus, Metro, ferry or taxi, while walking accounts for nearly 25% of all journeys[27]. Car ownership in South Tyneside is below the national and regional average with 44% of households not owning a car.

The map below shows the percentage of households with no car or van at the 2001 Census by South Tyneside Lower Tier Super Output Area. It can be seen that the likelihood of not owning a car is higher in more deprived areas of the Borough and may therefore mean that people who need access to health services most have most difficulty accessing them.

[26] Making the Case: improving Health through Transport Health Development Agency 2005
[27] South Tyneside Integrated Transport Strategy 2008-11



Source: Office for National Statistics, 2001 Census

Physical Environment

Air quality

People with respiratory conditions are at greater risk from air pollution, especially if they are older. Daily changes in air pollution can trigger increased admissions to hospital and may contribute to the premature death of those who are seriously ill. Those with severe lung diseases or heart conditions might be more sensitive to changes in air pollution.

When pollutants are high or very high people should:

- Avoid vigorous activity, which increases the intake of pollutants into the lungs;
- Vulnerable individuals should avoid major roads with heavy traffic;
- Asthmatics who are affected by pollutants can get advice from their GP on increasing their use of medication to prevent and relieve symptoms.

In 2007 the government published the National Air Quality Strategy with the aim of setting future policy, protecting public health and the natural environment, identifying current and future levels of air pollution, and setting out what everyone can do to improve air quality.

Environment, open spaces and urban design

Open-air recreation and access to outdoor spaces is an important part of many people's daily lives. Urban green spaces are widely recognised as major contributors both to the quality of the environment, and to human health and well-being in inner city

and suburban areas. Research suggests that there are 5 key ways in which exposure to the natural environment is beneficial to human health.[28] These are:

- Enhanced personal and social communication skills.
- Increased physical health.
- Enhanced mental and spiritual health.
- Enhanced spiritual, sensory, and aesthetic awareness.
- Ability to assert personal control and increased sensitivity to one's own well-being

South Tyneside's Open Spaces and Playing Fields Strategies are currently being refreshed and will be published in 2010. The map below shows Recreational open spaces in South Tyneside, showing areas within 1km of the nearest open space.

Source: South Tyneside Council (2001) "Recreational Open Space Provision in South Tyneside", STMBC, South Shields

In terms of reducing crime research has also shown that compared with buildings that had little or no vegetation, buildings with high levels of greenery had 48% fewer property crimes and 56% fewer violent crimes. Even modest amounts of greenery were associated with lower crime rates. The research suggests that; greenery helps people to relax, reducing aggression, and that green spaces bring people together outdoors, increasing surveillance and discouraging criminals.

It is now also becoming acknowledged that physical and mental health cannot be separated from the design of streets, towns and cities. Transport and planning policies have created places that discourage physical activity so contributing poorer health outcomes. Designing and building healthy communities can improve the quality of life for all.

[28] N. Morris (July 2003) Health, Well-Being and Open Space Literature Review

'Building Health' by the Commission for Architecture and the Built Environment (CABE), the National Heart Forum and Living Streets concludes that sprawling suburbs can lead to spreading waistlines: the layout of towns, cities and buildings influence the amount of exercise which people take naturally in their daily lives. It advocates changing transport policies and locating housing, shops and services to encourage walking and cycling. It is estimated that three million new homes will be built by 2020, so planning and design decisions made now will affect the shape of communities and public health for the future.

3. What are we doing?

Poverty and low income

South Tyneside Council has achieved Beacon Council Status for their multi-agency work towards promoting financial inclusion and tackling debt. For example Money Answers South Tyneside Ltd (MAST) is a community development finance initiative that serves low income communities. MAST works closely with South Tyneside Credit Union Ltd and South Tyneside Citizens Advice Bureau in developing a co-ordinated strategic approach to poverty, debt and financial exclusion.

Specific initiatives are underway in relation to reducing financial exclusion and hardship, helping disadvantaged and under represented groups into employment and self-employment and improving life chances for children. Funding has been secured to pilot two Child Poverty programmes, one of which will be delivered in partnership with North Tyneside Council and other key agencies.

Employment

Jobs and enterprise are recognised as top priorities in South Tyneside. Key focus is on;

- Increasing employment, reducing unemployment and worklessness
- Increasing skill levels of people to meet business need
- Promoting the growth and sustainability of businesses

The table below shows progress with two key indicators;

Table 11: Progress on employment indicators

Indicator	Ref	Baseline	2008-9	2009-10	2010-11
Working age people on out of work benefits	NI 152	19.4%	18.9%	17.9%	16.4%
Proportion of population aged 19-64 for males and 19-59 for females qualified to at least Level 3 or higher	NI 164	43.5%	45.0%	46.5%	48.0%

Employment is a top priority due its impact on the wellbeing of individuals, their families and communities and that it is the principal factor in reducing child poverty. Six Employment Priority Areas have been identified as having the greatest

concentration of workless residents in South Tyneside; South Shields, Riverside, Horsley Hill, Jarrow, Hebburn, Mid Tyne and Hedworth.

Housing

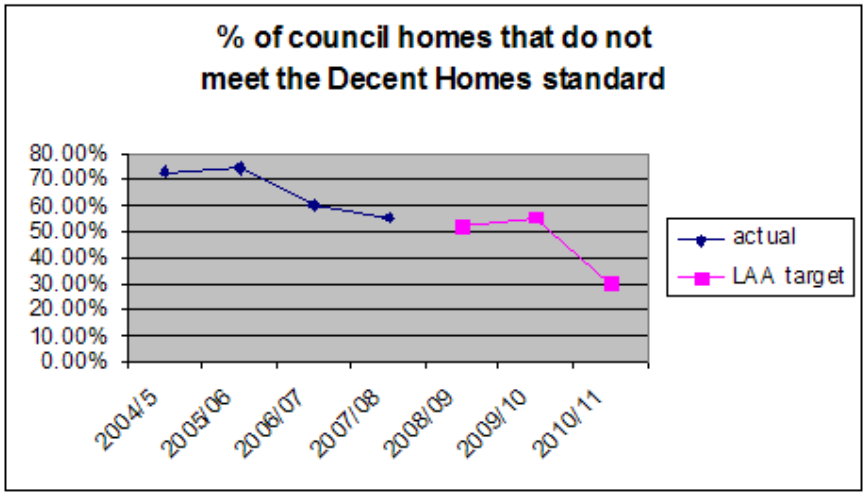
South Tyneside Council sets out the strategic direction for housing in the Borough through its housing strategy and the Local Development Framework (LDF). The 2008-12 housing strategy has four objectives;

- Strategic use of housing market information
- Improving housing conditions across all tenures to meet the decent homes standard.
- Developing a range of housing and support options and
- Delivering sustainable communities and improving the natural environment.

The LDF core strategy identifies a number of key sites for housing development and supplementary planning guidance 4 (SPD4), sets out the affordable housing requirement detailed in the core strategy should be provided through the planning system.

The council's housing strategy team are currently developing an integrated housing strategy, which will provide an overarching, holistic, 15 year strategy for housing in the local authority. The strategy will be accompanied by action plans detailing how the aims and objectives of the strategy will be delivered. This approach will provide detailed understanding of the links between the local authority's different housing issues and help deliver more effective investment.

Decent homes: South Tyneside Homes manages the council's housing stock and works to ensure that all the councils stock meets the decent homes standard by 2013 is currently being undertaken. A private sector stock condition survey will be carried out in 2010, the findings from which will help direct investment into the private sector stock.



Housing stock: The LDF sets out annualised average net additions to housing stock for the borough, which was 340 for 2008/09; however, the net completions figure for

that period was only 183. This under delivery is primarily due to the economic recession, which has led to a significant reduction in house building both regionally and nationally. The council will continue to help facilitate housing development by ensuring that there is a continuous 5 year supply of deliverable housing sites by updating the strategic housing land availability assessment (SHLAA) and working closely with Registered Social Landlords (RSLs) to deliver additional affordable units.

In 2008/09 there were 81 affordable housing completions in South Tyneside and the council has been successful in budding for Housing and Communities Agency (HCA) new build funding, which will help ensure the delivery of the right type of affordable housing in the right location for the identified needs of South Tyneside.

The delivery of more affordable units to meet the identified demand in the housing needs survey should help alleviate overcrowding and homelessness.

Affordable Warmth: The importance of an affordable warm home is recognised by the council through the affordable warmth strategy. The vision of this strategy is: *"To ensure that every resident of the Borough has the ability to maintain a warm home at an affordable cost and with minimal contribution to the Borough's overall carbon footprint*."

The Warm Zone initiative in South Tyneside is a two-year project (commenced in 2008) which will deliver home insulation improvements and energy efficiency advice to a target 10,000 homes. It is estimated that this scheme will provide up to £1 million savings in annual fuel bills for residents with the average householder in South Tyneside cutting their energy costs by up to £250, just by insulating their loft and cavity walls.

The key target groups in terms of eligibility for free home insulation through Warmzone have been extended to include; people over 70 years of age, families with children at home aged 16 or under, people with a disability or long-term illness and those receiving income and/or disability related benefits.

Homelessness

The vision in relation to homelessness in South Tyneside is *"Helping people realise their potential by preventing homelessness through a range of housing and support options and by positively tackling the causes of homelessness through increasing opportunities for housing, training and employment*[29]*".* The strategy sets out the key homeless issues for the borough and explains how the council, together with partners plans to;

- Prevent homelessness;
- Reduce impact of homelessness on people's lives;
- Increase housing, training and employment opportunities for people at risk of homelessness;
- Support vulnerable people in housing need; and
- Improve and develop services in partnership with service users and stakeholders.

[29] Homeless Strategy 2008-13

Since the introduction of the homelessness strategy in 2003 some significant improvements have been made including the reduction of homelessness acceptances have been reduced from 597 to 217 in 2008/09. More work is still needed on ensuring that homeless people get the right housing and support for their needs.

Supporting People
The Supporting People programme provides housing-related support to a wide range of vulnerable people. For 2008–2011 commissioning priorities have been identified as;

- older people
- people with learning disabilities
- people with mental health problems
- people with physical /or sensory disabilities
- those who are socially excluded;
  - people who are homeless or at risk of homelessness (single and families)
  - young people at risk
  - young parents
  - young care leavers
  - offenders, ex-offenders and those at risk of offending
  - people subject to violence (especially domestic violence)
  - people with substance misuse problems (e.g. drugs or alcohol)
  - refugees and asylum seekers
  - gypsies and travellers
  - people with hiv/aids

The majority of services commissioned by Supporting People in South Tyneside are for older people with support needs and for people with learning disabilities. Examples of the type of support and interventions to which Supporting People can contribute include:

- fewer failed tenancies - reducing homelessness applications and in particular repeat homelessness;
- reducing the use of bed and breakfast accommodation for homeless applicants including young people;
- the reduction in reconviction rates for offenders leaving prison and those subject to probation service supervision in the community;
- an improvement in physical and mental health;
- an increase in successful outcomes for drug and alcohol treatment services;
- helping to reduce unnecessary hospital admissions and facilitating quicker hospital discharges or shorter hospital stays - improving access and reducing waiting times;
- reducing the need for residential care placements and the subsequent costs of these placements;
- an improvement in employment opportunities.

Despite a reduction in the Supporting People grant from 2003–2008, the South Tyneside programme has delivered an increase in the level of support available for vulnerable people, with the number of service users supported increasing from 4,082 in April 2003 to 4,175 in April 2008.

Educational attainment

Whereas educational attainment is improving overall, for young people in South Tyneside we need to ensure that children and young people from the most deprived circumstances or who are most vulnerable are supported to achieve good educational qualifications to help them achieve a decent level of income and employment.

Key priorities in the Children and Young People's Plan include;

- Ensuring children have a high quality pre-school experience;
- Raising educational standards and reducing inequality gaps in our most disadvantaged neighbourhoods.

The Comprehensive Area Assessment for 2009-10 identified that, for example, there are inequalities in the achievement of some primary-aged pupils, particularly those who have special educational needs and those from an ethnic minority background; these children do less well by age eleven than in similar council areas.

In terms of educational attainment in vulnerable and more deprived groups although there have been some improvements there is still further progress needed. For example;

- looked after children still achieve below the average for other children of the same age although there has been some improvement;
- children with learning difficulties and/or disabilities make good progress in about two-thirds of schools, and satisfactory progress in the others;
- For children whose first language is not English, at key stage one, they perform as well as all other children (apart from Bangladeshi children); however at key stage two they perform less well.

In terms of schools in the deprived areas of the Borough generally they perform less well compared with schools in more affluent catchment areas.

Crime and disorder

An annual Strategic Assessment is produced to identify priorities in relation to tackling crime and disorder in South Tyneside. The 2009 priorities for crime and disorder in South Tyneside were identified as: violent crime including most serious violence and domestic violence, Anti-Social Behaviour (ASB) and the perceptions of ASB in the community, harm caused by alcohol and illegal drugs, reduce re-offending, reducing youth related crime, hate crime and organised crime groups.

A detailed Safer and Stronger Communities Strategy and action plan is produced annually. Examples of progress in relation to key priorities include;

- good progress in relation to the establishment of the multi agency risk assessment conference (MARAC) process for high risk victims (including children) of domestic violence;
- good progress with the establishment of a specialist court for domestic violence and the appointment of independent domestic violence advisors:
- South Tyneside recorded the largest shift in the region for a reduction in people's perception of anti-social behaviour:

- good progress has been made in relation to sharing information between South Tyneside district general hospital, police and trading standards around alcohol related assaults:
- successful youth diversionary activities have been carried out across the Borough:
- the Safestop scheme has identified a large number of potentially vulnerable children and young people on the streets and has worked with their parents and safeguarding and youth services to support them.

Environment, open spaces and urban design

Local Development Framework

South Tyneside's Local Development Framework (LDF) is a suite of planning documents that will guide future development and land uses within South Tyneside over the next 10 - 15 years. The planning documents and policies seek to deliver the strategic objectives set out in the adopted Core Strategy document; of which Objective 20 seeks to: *'To improve health and well-being, and reduce inequalities in health care and access to it for all'.*

The adopted Core Strategy sets out the overarching strategic policies for the borough; the document seeks to develop high standards of urban design (Policy ST2), promote new indoor sports and leisure facilities (Policy SC2), provide high quality recreational open space, playing fields and outdoor sporting and play facilities (Policy SC6) and seeks to preserve the best qualities of the built and natural environment (Policy EA1).

The proposed Green Infrastructure SPD will establish the borough's standards for the provision of all forms of green spaces and recreational open space; including playing fields, playing pitches, children's play areas and allotments.

Supplementary Planning Document 7 on Travel Plans is due to be adopted in Spring 2010. This document sets out supporting guidance to help encourage the use of sustainable forms of transport as part of new developments.

A Sustainable Modes of Travel to School Strategy has been adopted with the objectives of reducing car journeys and improving child health by encouraging more walk journeys. Direct and safe walking routes are being incorporated in all new developments through the planning process. A school travel plan coordinator to help schools in the Borough produce their own travel plans. Cycling is being promoted through travel plans. 23 traffic calming schemes have been developed and vehicle speeds in neighbourhoods successfully reduced.

Supplementary Planning Document 5 'Planning Obligations and Agreements' seeks to secure developer contributions for children's play facilities and contributions towards new and improved playing pitch facilities and public open space, through legally-binding Section 106 Agreements.

South Tyneside Council's 'Urban Design Framework' sets out a local vision to "*achieve a better future for South Tyneside's people"* and to make the area a place where people choose to live, work and visit. There is a commitment to improve the

quality of the natural and the built environment as part of the wider regeneration strategy for South Tyneside.

Air quality

South Tyneside Council reviews air quality conditions on an annual basis so that they can identify any changes and take action where we consider air quality may exceed national targets. Generally Air Quality within South Tyneside is good, being below the national air quality objective values. Measured and predicted air quality values for South Tyneside can be found on the UK National Air Quality website www.airquality.co.uk. In South Tyneside the main contribution to air pollution is made by traffic exhaust emissions, this is particularly the case in built-up areas where congestion occurs.

4. What is this telling us?

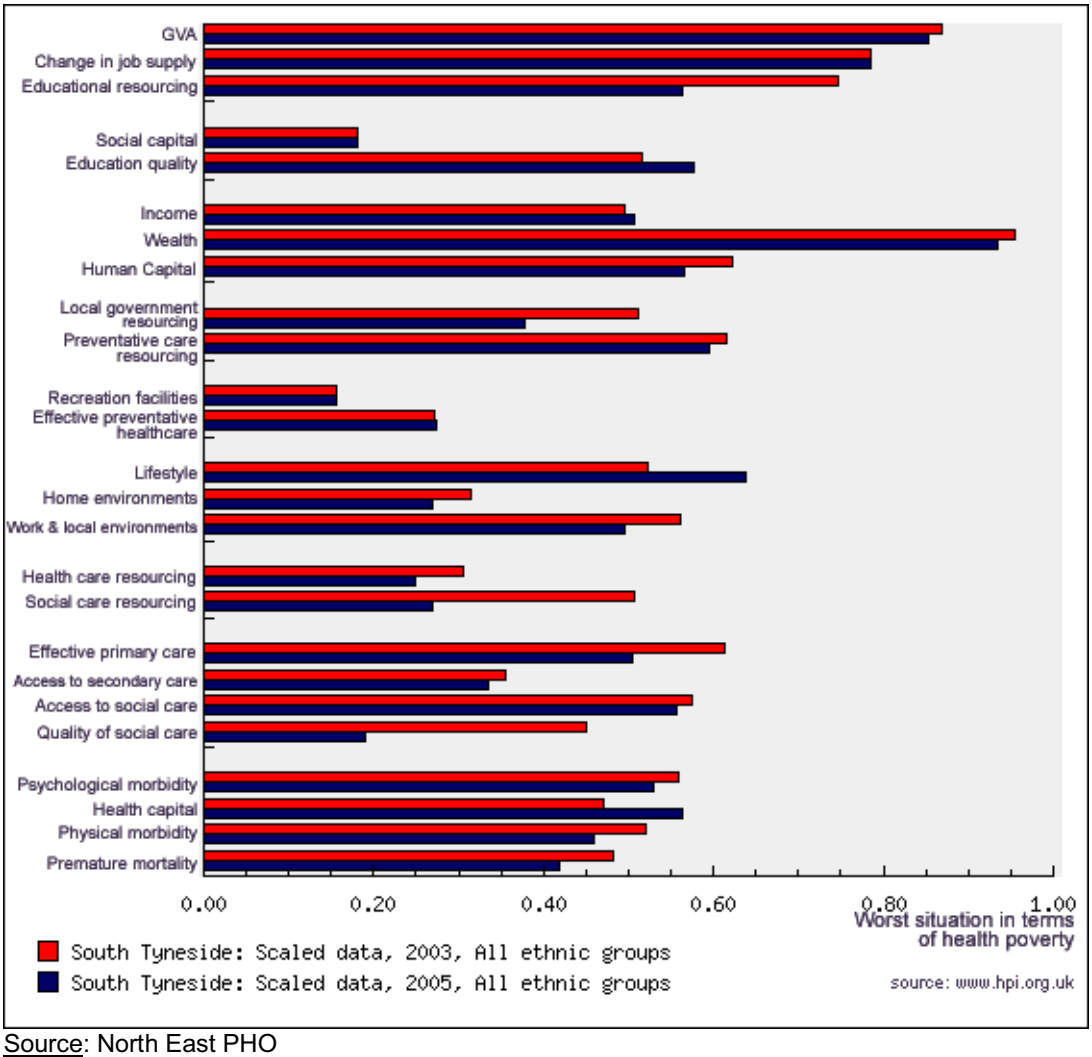
There are a number of emerging themes from this wide range of issues in relation to the wider determinants of health. South Tyneside remains one of the most deprived borough in the country and this is reflected in the poor health experienced by children and adults in the borough generally and also by the fact that alongside the poor health in the general population there is even more disadvantage in terms of health outcomes for the most vulnerable and economically deprived residents.

This means we have to be very clear that we have policies in place to address the needs of our most vulnerable and needy populations if we are to narrow the gap in health experience. It would help to have a set of local indicators that reflect all the interventions and actions required to address health inequalities. This would mean developing a set of indicators that are held together in one place and from which a baseline can be established to measure progress[30].

Is what we are doing working?

One of the key challenges for any area is to assess whether interventions and investments are having an impact. One of the ways of doing this is to compare change over time in a range of key indicators. Data is only available currently to compare South Tyneside between 2003 and 2005 but it is an illustration of the changes that can be measured;

[30] Measuring health inequalities is explored in more detail in the 'Background to Joint Strategic Needs Assessment' section



Source: North East PHO

It can be seen for example that for all indicators there were varying improvements between 2003 and 2005 with the following indicators worsening; education quality, income, lifestyle and health capital (includes obesity, blood pressure, cholesterol and low birth weight). The greatest improvement during this period was in relation to educational resourcing, local government resourcing, social care resourcing, effective primary care and quality of social care.

Gaps in knowledge

We do have a good range of indicators and data available to us to measure where we are in terms of the wider determinants of heath and addressing health inequalities. However what we need to move to is setting more precise goals or outcomes in terms of where we want to be and then identifying how we will measure these outcomes. What we don't therefore know or establish clearly is how far away we are from where we need to be.

There are therefore a number of actions that we can undertake to support us in identifying where we need to target our efforts most;

- setting precise local targets in relation to areas of health inequality which relate either to specific groups or sub groups in the population or to specific geographical areas;
- agreeing what exact data we need to collect to measure the progress in relation to specific local targets;
- closely linking our commissioning of services and investment to these local goals and targets rather than maintaining a broad 'one size fits all' approach - i.e. specifying exactly where services are delivered and how;
- understanding precisely and regularly whether commissioned services are actually meeting the desired goals that we have set ourselves;
- understanding the positive and potentially negative impact of particular developments, investment or strategies in terms of addressing health inequalities through more routine use of health impact assessment.

What is also needed is a more systematic process of tracking the targeted developments in terms of wider determinants in relation to measurable improvements in health through outcomes measures.

Risks of not delivering

The risk of not targeting our resources to where they are needed most is that we may raise the health and wellbeing of the whole population generally but that the gap between the most well off in terms of health experience and the least well off gets bigger.

Associated with this is the risk of the needs of the least well off continue to increase to a point where more crisis and complex interventions are required which draw funding away from targeted early interventions. At a time when there is going to be less funding available we need to be much more precise about how we target investment for **most gain**.

What is on the horizon?

In terms of future developments there are a number of developments and changes on the horizon with particular relevance in relation to the wider determinants of health. These have recently been highlighted in the Marmot Review[31]; With regard to championing local multi-sectoral work on social determinants the review recommends that;

> *'Local mechanisms need to be initiated to make multi-sectoral work on social determinants of health both easier and more effective. These include health and local authority leaders demonstrating the legitimacy and priority given to this kind of work by: agreement on common goals and targets between agencies focused on addressing inequalities in health and wellbeing; the setting up of joint appointments and joint operational units, the increasing use of joint funding mechanisms which are sustainable (moving away from reliance on short-term project funding); and the provision of long-term timescales for the processes of setting up and maintaining partnerships.'*

[31] Strategic Review of Health Inequalities in England Post 2010 The Marmot Review February 2010

And that;

> *'Local public agencies should be proactive in assessing how they can confront poverty, unemployment and disadvantage in their communities more directly. This includes using opportunities in health care settings to help patients get the social welfare benefits they are entitled to; contributing to rehabilitation of people with long term sickness to help them get fit for work; and using their organisation's employment and purchasing power for the benefit of the local communities that they serve.'*

With regard to the role of government and wider determinants, the Marmot Review recommends that;

> *'Government departments need to support rather than undermine local joint working on the social determents of health and inequalities. This includes demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place; through the setting of adequate timeframes for setting up the joint work and evaluating impact'.*

5. What should we be doing next?

In general health policies need to address two distinct issues; firstly, to tackle the many wider determinants, or factors which can cause ill health, and to which different groups face varying levels of exposure and secondly, in tackling the causes of health inequalities, to address the uneven distribution of health determinants[32]

Recommendations in relation to poverty and low income
Addressing poverty and low income has to be a multi-pronged approach which ensures that the most vulnerable in our community are able to sustain an adequate standard of living and participate in society. The key elements of the approach are to;

- increase employment opportunities - targeted for those from the most disadvantaged groups or areas;
- increase access to and uptake of welfare benefits;
- increase the level of educational attainment in most vulnerable and disadvantaged groups;
- increase the number of credit unions to support saving and safe borrowing;
- increase the provision of affordable housing particularly for vulnerable and low income groups;
- improve advice and support for people at risk of or experiencing poverty and/or debt.

Recommendations in relation to employment
Employment and working conditions make a significant contribution to the development of social inequalities in health in England. They are of critical importance to improve population health and redress health inequalities in several interrelated ways[33].

[32] Graham H (2004). Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings. The Milbank Quarterly 82[1], 101-24.
[33] Marmot Review Task Group **Employment Arrangements, Work Conditions and Health Inequalities 2010**

- increase the number of people in employment through providing support in developing skills, especially for those who have faced long term sickness, unemployment or disability;
- decrease the association between mental ill health and unemployment through the use of both targeted support and broader health promotion approaches;
- improve the working conditions for all workers to reduce their exposure to material hazards, work related stress, and health-damaging behaviours;
- introduce measures to increase job security;
- encourage participation at work to give employees greater say in working conditions;
- increase employees control over their health by providing occupational health services and 'healthy living' interventions;
- strengthen the work-life balance.

Recommendations in relation to housing and homelessness

As discussed earlier adequate housing has a major impact on health and is key to protecting the most vulnerable in the population in terms of their health and social circumstances. Key recommendations include;

- ensuring that the current housing stock in South Tyneside is of good quality and that new stock meets the needs and aspirations of current and future residents is key to improving resident's quality of life. recommendations to achieve these aims are;
- ensuring the completion of the decent homes programme for the council's housing stock;
- undertaking a stock condition survey of the local authority's private sector stock;
- using the information from the stock condition survey to target resources to achieve the greatest benefit for people's quality of life;
- continuing to facilitate the delivery of new housing, both affordable and market that meets the needs identified in the housing needs survey and provides choice for current and future residents;
- improving understanding of the housing and support needs of people with drug and alcohol problems, the frail older people and vulnerable young people.

Recommendations in relation to crime and disorder

The impact of crime and disorder on physical and mental health is very evident and in particular will affect those who are most vulnerable and who live in the most deprived areas in the borough. Key recommendations therefore include;

- facilitate early intervention in relation to crime 'hotspots' by mapping out trends and patterns from people coming into contact with the NHS;
- develop information sharing on crime and health issues, such as road accidents and violent attacks;
- develop integrated services at local level around issues such as reducing domestic violence, working with young offenders, supporting mentally disordered offenders, drug prevention and treatment and reducing alcohol misuse;

- develop joint approaches to reduce the fear of crime and sense of isolation particularly with vulnerable people;
- further explore the links between a range of preventative interventions for violent crime including school attendance;
- further work to consider the protective and preventative influences on antisocial behaviour perpetrated by children and adults.

Recommendations in relation to the environment, open spaces and urban design

The quality of the environment has a major impact on health and wellbeing – particularly in relation to vulnerable and more deprived groups in the community. Key recommendations include;

- ensure urban planning promotes healthy and safe behaviours equitably, through investment in active transport, retail planning to manage access to unhealthy foods, and through good environmental design and regulatory controls, including control of the number of alcohol outlets;
- assess the impact of open spaces on specific groups in the population who would benefit from enhanced wellbeing or exposure to green areas and nature;
- Ensure physical and mental health is given greater prominence in the Borough's Urban Design Framework.

Recommendations for education

There is good evidence that the following interventions will promote equity in health through the education system[34].

- Ensure expenditure on early years education, childcare and development is focused proportionately across the social gradient
- Identify and reduce economic, social and other barriers to gaining access to education at all levels, and provide life-long learning, to increase access to education and training for disadvantaged groups.
- Introduce comprehensive support programmes for children in less privileged families, to promote preschool development
- Ensure that schools in less privileged areas receive extra resources to meet the greater needs for special support to children from low-income and poor families
- Prevent children from becoming early dropouts from formal education and training, by early actions and support
- Provide extra support in the transition from school to work; in particular for those with a weak position in the labour market.
- Develop and secure comprehensive adult-education programmes for those with very limited basic education or vocational training.
- Maintain and develop Healthy Schools programmes, with a focus on equity.
- Increase attention to (and actions on) the physical and psychosocial work environment of schools
- Provide healthy school lunches, improve nutritional education and cooking skills

[34] Based on 'A synthesis of reviews of interventions to improve health and reduce health inequalities' Public Health Research Consortium August 2009

- Promote physical activities that also can attract obese children and that develop sound habits of exercise for life
- Provide equity-oriented injury prevention programmes, where students, teachers and parents are engaged to secure a safe school (including safe transport and walking to the school).

CHAPTER 4 Early Life

1. Introduction

Children and young people are now healthier than ever; as a direct result of social, economic, medical and technological advances that have reduced infant mortality rates. There is also a greater focus on health and wellbeing in schools and colleges with more support for parents, children and young people in promoting health and wellbeing.

Nevertheless, health inequality continues to affect children and young people. Evidence from birth and death registrations in England and Wales has been used to examine the links between social and biological factors and mortality in children. This has shown that many of the well-established risk factors for death in infancy persist into older ages, although the differential between these groups reduces in the older age-groups. These include the association between birth-weight and mortality, the differential between those children of fathers in manual occupations and those children of fathers in non-manual occupations, and the age, country of birth and marital status of the mother.

One of the national targets on health inequality is to reduce the gap in infant mortality between manual groups and the population as a whole by 10% by 2010. The main factors in reducing infant mortality include:[35]

- reducing maternal obesity
- reducing smoking prevalence in mothers in routine and manual groups
- reducing sudden unexpected deaths in infants
- reducing under 18 conceptions
- reducing child poverty
- housing overcrowding.

Recognising that many aspects of health begin early in life, giving every child a healthy start remains a high priority nationally and locally.

2. Where are we now?

Population profile

In 2007, the total population of South Tyneside was 151,000 with 23.8% of the population aged 19 years or under; this compares with 23.6% for the North East and 24.2% for England.[36] Biddick Hall is the ward with the highest percentage of children and young people aged 19 years and under (28.1% of the total population) whereas Westoe has the lowest percentage of children and young people (20.8%).

Of the population aged 0-19 years, 94.6% are White and the age structure of the BME population is considerably younger than the White British population; 29.7% of the

[35] Department of Health (2007) Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide
[36] Office for National Statistics (ONS)

BME population in South Tyneside is aged 0-19 years and 24.0% of the White British population of children and young people. The largest ethnic minority group of children and young people aged 0-19 is Asian or Asian British, with 3.2%.

Population projections by the ONS predict that the number of children and young adults is predicted to reduce by 12.9%; with the numbers of under 25 year olds reducing by 12.9% and 2.2% for under 20 year olds. This compares with only 2.4% for under 25 year olds in England. The percentage of the total population aged 0–4 years is currently 5.0% in South Tyneside compared to 5.4% in the North East and 5.82% in England. By 2020 this is expected to be 5.44% in South Tyneside, 5.68% in the North East and 6.10% in England.

Understanding the likely changes in birth rates is key to looking at population change and to anticipating the future need for maternity and child health services. Important factors for changes in the number of births in an area are the fertile female population and general fertility rates. For example, a fall in the number of women of childbearing age will, without increases in birth rates, reduce the number of births in future years.

Fertile female population: ONS data shows that in 2007 locally there were 30,138 women of child bearing age (15-44 years) representing 38.9% of the total female population. This compares to 39.5% in the North East and 40.8% in England. This is expected to fall over the next decade by 13.1% in South Tyneside compared to a fall of 7.1% in the North East and 2.29% in England.

General fertility rate (GFR) is the number of live births per 1,000 females aged 15-44 years. In 2006 the Borough had a general fertility rate of 56.9 live births per 1,000, a ranking of 118 in the country. This is compared to the national figure of 62.3 per 1000. The GFR for South Tyneside has been increasing over the past 4 years and the number of births per year is projected to increase by 6.3% from 2008 to 2016; this compares with a 2.7% increase in the North East and a 4.76% increase in England.[37]

The best start in life

Pregnancy and the first years of life are very important for future health and wellbeing. There are a number of factors which are key to giving a child the best start in life. These include;

- healthy pregnancy;
- healthy birthweight;
- breastfeeding for the first six months.

Antenatal and newborn screening

Over 95% of pregnancies result in the birth of a healthy baby. Screening is a way of assessing whether the unborn baby could develop or has developed an abnormality or other condition during pregnancy.

Smoking in pregnancy has a particular impact on low birth-weight babies and is also a major issue for South Tyneside as the prevalence of smoking in pregnancy is

[37] To estimate future numbers of births the projected GFR is multiplied by the projected fertile female population (and divided by 1,000) to give the number of births.

considerably higher than the national average. Low income and poor educational attainment are also associated with increased risk of low birth weight.

The National Priorities and Planning Framework contains a target of reducing the proportion of women continuing to smoke throughout pregnancy from 23% to 18% by 2005 and to 15% by 2010. The Framework focuses on smokers facing disadvantage as part of the national target to reduce, by at least 10%, the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year.

Guidance states that each PCT should deliver a 1% annual reduction in the proportion of women known to be smokers at the time of delivery. Each PCT has a plan that states how they intend to decrease the percentage of mother smoking at delivery year on year and this is how they are performance managed. (*Department of Health, Local Delivery Plan Healthcare Commission Indicator NHS Feedback as at Q4 2007/08)*

Breastfeeding: This is a very important start in life for all babies and protects them from infections and reduces the likelihood of becoming obese as children and adults. However, South Tyneside has a well embedded culture of bottle feeding and this is reflected in low rates of breast feeding at both when babies are born (initiation) and at 6-8 weeks (see performance section below).

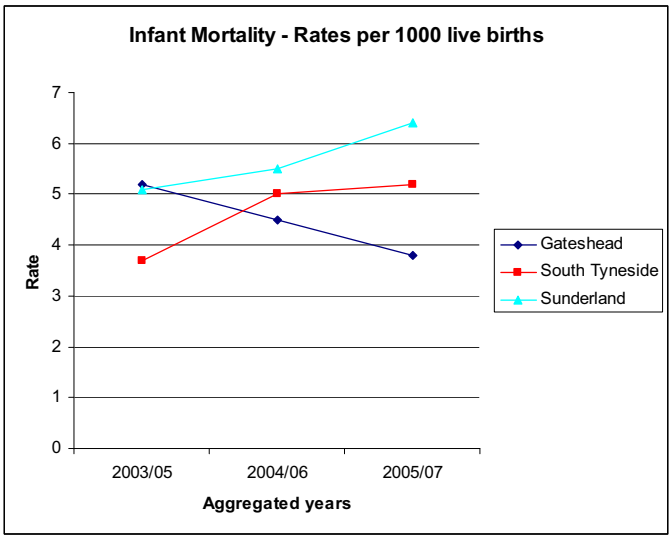
Low birth weight:[38] South Tyneside has a lower than average rate of low birth weight babies. Low birth weight is associated with the more deprived wards in South Tyneside with up to 13% of babies being classed as having a low birth weight in the most deprived wards compared with 3% of births as the lowest percentage in more affluent wards.

Why do children and young people die in South Tyneside?

Life expectancy at birth is a good marker for a range of health conditions and behaviours. Interventions that reduce deaths in the neonatal and post-neonatal period impact both on the infant mortality target and the life expectancy target, as younger deaths have a greater impact on life expectancy than older deaths. Deaths in children under 10 years of age are, after the first 12 months, largely due to unintentional injury, congenital anomalies, cancer and diseases of the nervous system.

Between 2005 and 2007 there were 25 infant deaths in South Tyneside, a rate of 5.2 per 1,000 live births. This was higher than in the North East and higher than in England. There were 5072 infant deaths in England in 2006 and the majority were attributed to events occurring in pregnancy. Around two-thirds of infant deaths occur in the first 28 days of life, with immaturity-related conditions accounting for around 46%.

[38] The World Health Organisation (WHO) defines low birth weight defined birth weight less than 2,500 grams



Sudden Infant Death Syndrome (SIDS) accounted for around 4.8%. The age of the mother is also a risk factor for infant mortality, the lowest rate being found in mothers aged between 30-34 years (4.1 per 1000 live births) compared to 6.5 per 1000 for mothers under 20 and 5.9 per 1000 in mothers aged 40 or over. However, rates in all age-groups have been falling.

Nationally, 57% of all deaths in children under 20 years in England (when?) were in infants aged under one year. After this, the highest rate of death among children and young people was in the 15-19 years age-group (21%) and the commonest causes of death were conditions arising in the perinatal period (39%), injuries (18%), congenital issues (12%), tumours or cancers (9%) and diseases of the nervous system (7%).

The most common cause of death among children aged 1-4 years is **unintentional injury**, which includes transport accidents, drowning, choking and suffocation, fire and flames. Children from the poorest families are at higher risk than children from more affluent families. Locally, the death rate in 1-4 year olds is higher when compared to the North East or England. In children aged 5-14 years there were 14 deaths in South Tyneside between 2003 to 2007; a mortality rate of 55.1 which is also higher than the North East and England. Among children aged 5-14 years nationally between 2003 and 2007 around one-half of all deaths were due to injuries (26%) or neoplasms (cancerous tumours) (25%) with about a half of all injury-related deaths due to transport accidents. The rates of death for both childhood cancers and road traffic injuries have fallen in recent years.

Over the period of 2003-2007 there were 16 deaths of 15-19 year olds in South Tyneside, a directly standardised rate of 106.7 compared with 84.3 in North East and 119.0 in England giving South Tyneside a higher mortality rate in the North East but a lower rate than England. Injuries accounted for 56% of all deaths in this age-group in 2007. The majority of these injuries are due to road traffic injuries (30% of all deaths). A further 18% of total deaths in this age range are due to intentional self-harm or where the cause of injury death was undetermined. The rate of suicide in young men aged 15-19 years increased by 72% between 1970 and 1990 in England and remained at a relatively high rate throughout the 1990s. 13% of deaths in the 15-19 years age-group locally are due to cancer.

What health problems do children and young people experience in South Tyneside?

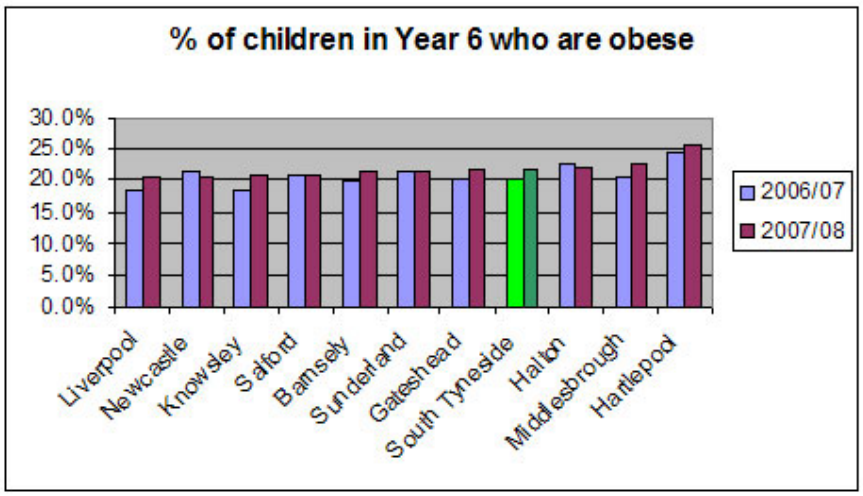
Respiratory disorders

The most commonly reported long-term illnesses in children and babies are conditions of the respiratory system. About 1 in 8 boys and 1 in 10 girls report a long-term respiratory disease[39] and the prevalence of respiratory disease in children is greater than that from all other chronic illnesses combined. One in four admissions to children's wards in the UK is because of a respiratory disease and one in five children seen in out-patient clinics has a respiratory illness as the main medical problem.[40] Among children, about a fifth of all GP consultations are classified as resulting from the respiratory system with another 2% registered as symptoms and signs involving respiratory disease.[41]

Among respiratory illnesses, acute viral upper respiratory infections and asthma are the commonest with asthma being the most chronic disease in children; about a fifth of children (21%) have a diagnosis of asthma.[42]

Childhood Obesity

In the UK, a third of children are either overweight or obese and it is predicted that without intervention this figure will rise to two-thirds by 2050. Most obesity in children and young people is a result of lifestyle and less than 1% is a consequence of underlying health problems. Research indicates that sedentary behaviour and a lack of physical activity in childhood and adolescence is a major contributor to the 'obesity epidemic'. In 2008/9, 13.1% of children starting school were overweight and 9.1% were obese, rising to 14.7% and 21% respectively for children in Year 6. The table below shows the levels of obesity in South Tyneside compared with similar councils (DCSF statistical neighbours) for 2006-7 and 2007-08.



[39] Burden of Lung Disease (2006) 2nd Edition British Thoracic Society
[40] British Lung Foundation (2003) Lung Report III
[41] http://www.laia.ac.uk/factsheets/20032.pdf
[42] British Lung Foundation (2003) Lung Report III

By 2010/11, we are aiming for only 20% of Year 6 children to be clinically obese.

Sexual Health

Inequalities in sexual health outcomes are an important public health priority. Sexual ill-health is clearly linked to deprivation and social exclusion and disproportionately affects particular groups. Sexually transmitted infections (STIs) have both short and longer term effects on the health and wellbeing of young people. The consequences of poor sexual health can also impact on an individual's social and economic well-being. It is estimated that sexual ill health costs the NHS more than £700 million a year.

Reducing the incidence of STIs requires effective primary prevention, timely access to appropriate services and treatment in order to prevent further onward transmission. While the incidence of STIs may be rising, this may be attributed to improved access to services and screening. NICE guidance[43] identifies a number of behavioural factors that affect the probability of STIs and include:

- misuse of alcohol and/or substances;
- early onset of sexual activity;
- unprotected sex / poor contraceptive use;
- frequent change of and / or multiple partners;
- low self-esteem;
- lack of skills (for example, in using condoms);
- lack of negotiation skills (for example, to say 'no' to sex without condoms);
- lack of knowledge about the risks of different sexual behaviours;
- availability of resources, such as condoms or sexual health services;
- availability of sex and relationship education (SRE)
- peer pressure;
- attitudes (and prejudices) of society which may affect access to services.

Chlamydia is the most common sexually transmitted infection in England and 15-24 years old are the age group most at risk of being diagnosed with a sexually transmitted infection with 65% of all Chlamydia being found in this age group. The health complications of Chlamydia include infertility, ectopic pregnancy and Pelvic Inflammatory Disease and its prevalence is increasing due to many factors including the fact that the majority of patients are asymptomatic. Data for April to December 2009 showed that 14% of the 15-24 year old population in South Tyneside had been tested and that 7.3% (209) were found to be positive for the infection. The equivalent figures for the North East were 13.8% and 6.6% respectively; and 13.8% and 6.5% for England.

Child and Adolescent Mental Health

From studies reported elsewhere it is estimated that in South Tyneside between 3,700 to 4,700 aged 0-19 years would be affected with some kind of mental health issue. The two most common conditions are emotional and conduct disorders. The following

[43] NICE (2007) One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups

lists the estimated numbers of specific child and adolescent mental health disorders for South Tyneside.

Table 12: Research based estimated prevalence of specific child and adolescent mental health disorders

Condition	Estimated Prevalence percentage rate		Expected number in South Tyneside
Autism	0.20%	0-18 yrs	74
ADHD (5-7%)	1.0% - 3.0%	0-18 yrs	369-1107
Anorexia	0.20% -	11-15 yr girls 16-18 yr girls	11 -
Bulimia	2.50%	13-18 yr girls	154
Conduct Disorder	4.00%	4-16 yrs	890
Emotional Disorders Phobias Anxiety Depression	 3.00% 1.00% 4.00%	 3-18 yrs 11 -15 yrs 16 -18 yrs	 963 107 233
Multiple Disorder	0.03% - 0.6%	5 - 18 yrs	9-171
Obsessive compulsive disorder	0.20% 1.90%	5-15 yrs 16-18 yrs	45 111
Psychosis	0.00% 0.15%	0-15 yrs 16-18 yrs	- 9
Substance Misuse (illegal)	2.00% 16.00%	11 yrs 16 yrs	41 328
Attempted suicide	2.0% - 4.0%	13-18 yrs	249-498
Suicide	0.0008%	15-18 yrs	1

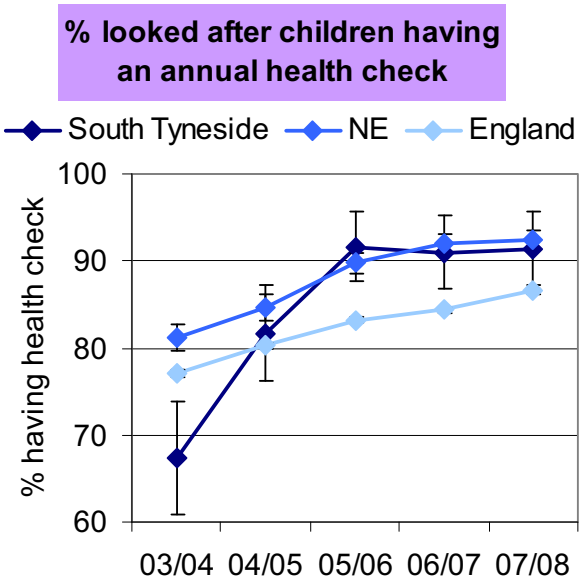
Source: Rutter 1994; Goodman & Scott 1997; Wallace et al 1995; Goodman 1998; Populations census 2001

A number of social and economic factors are associated with prevalence rates for child and adolescent mental health problems. These factors can have an effect on the frequency and seriousness of mental illness in children and young people. In South Tyneside, several characteristics have been identified which might have an impact on mental well-being of children and young people. These were[44]:

- 3,252 children in special school without statement of educational need and 754 children in all schools with a statement;
- 54 births where the mother was aged between 15-17 (about 50 per 1000 women aged 15-17 yrs);
- 5,929 (9.0% of the total) one parent households with dependent children;
- 5,236 (7.9% of the total) unemployed households with dependent children;
- 60% of all children in some parts of the Borough in families that are income deprived;
- 75 children on the Child Protection register;
- 270 looked after children;

[44] CAMHS Strategy in South Tyneside, 2006/2010

- 909 school exclusions (although the majority of these are fixed term of 1-2 days);
- 154 asylum seekers with more than 50% of those were children;
- on average, more than 200 children (16 and under) attended A&E per annum for drug, alcohol and deliberate self-harm.



Year	Gateshead % having annual health check	Gateshead children	South Tyneside % having annual health check	South Tyneside children	Sunderland % having annual health check	Sunderland children	NE % having annual health check	England % having annual health check
03/04	80.3	190	**67.4**	195	**88.2**	320	**81.2**	77.1
04/05	**97.7**	175	81.7	185	**88.4**	335	**84.6**	80.2
05/06	**92.1**	190	**91.6**	180	86.1	330	**89.7**	83.2
06/07	88.0	215	**91.0**	180	**92.0**	330	**92.0**	84.4
07/08	**91.3**	230	**91.4**	175	**93.7**	315	**92.4**	86.5

Source: Department for Children, Schools and Families (DCSF) at www.dcsf.gov.uk. Figures for year ending 30th Sept. 2009 will be published in April 2010

Childhood mental health problems are strongly socially patterned, being several times more common amongst low income groups, and amongst other marginalized groups such as children in care and young offenders. Evidence suggests that child and adolescent mental health services (CAMHS) users and their families are likely to be particularly vulnerable and disadvantaged, including limited personal and financial resources so services need to support children and young people at a range of levels.

There is also strong evidence that mental health problems can be prevented through the use of targeted interventions[45]. The cost-effectiveness of these interventions is high, with many more than paying for themselves in terms of reduced costs to society as a result of avoided health and social problems later in life[46].

[45] US Department of Health and Human Services (2007) Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience. Rockville, MD: DHHS.

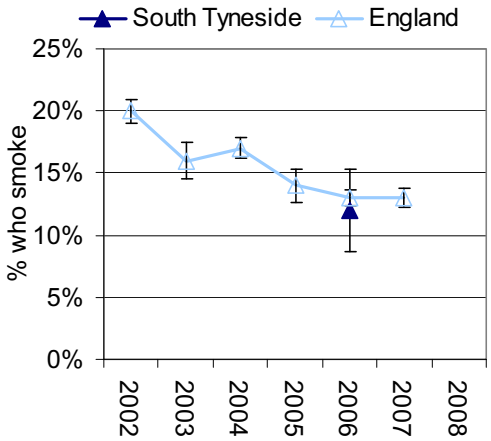
[46] Waddell, C., Peters, R., Hua, J., McKewan, K. and Garland, O. (2007) Preventing mental disorders in children: a systematic review to inform policy-making. *Canadian Journal of Public Health*, 98)3), 166-173.

Smoking

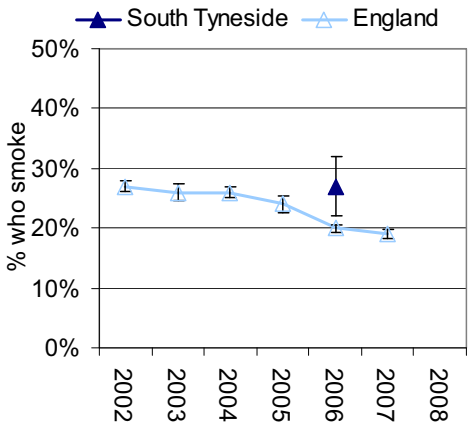
Nationally, between 1990 and 2000, girls were more likely to smoke than boys among those aged 11 to 15 years. In 2000, 12% of girls aged 11 to 15 years in England were regular smokers compared with 9% of boys. However, in this age group, consumption of cigarettes among regular smokers was higher for boys than girls with boys smoking an average of 50 cigarettes in a week compared with the 44 for girls. There was little variation in the prevalence of smoking among those aged 16 to 19 years.[47]

In South Tyneside, self reported data suggests that in 2006, 12% of boys and 27% of girls in year 10 indicate that they smoke; for boys this is slightly lower than England as a whole but for girls the South Tyneside figure was significantly higher than England. The comparative figures for year 8 students, aged 12-13 years, was 3% for boys (5% for England) and 9% for girls (6% for England).

Proportion of year 10 boys (14 or 15 years) who smoke



Proportion of year 10 girls (14 or 15 years) who smoke

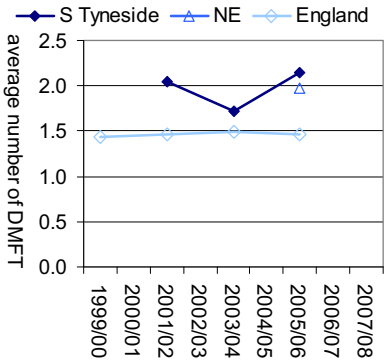


Dental health

Fluoridated water is associated with lower rates of dental decay but South Tyneside water is not artificially fluoridated. The British Association for the Study of Community Dentistry (BASCD) work with local community dentistry teams to carry out a survey of child dental health each year. This alternates between children aged 5 years and dental health among 12 and 14 year olds. The results for the five year olds are illustrated below:

[47] ONS, Health of Children and Young People 1990-2001

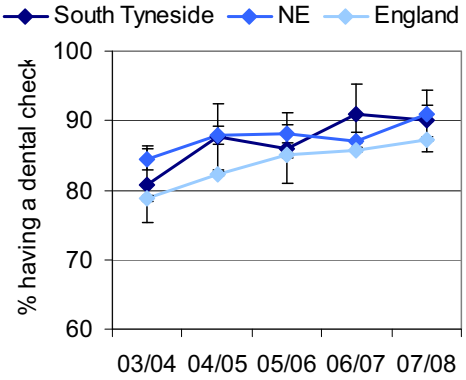
Average number of diseased, missing or filled teeth (DMFT) among five year olds



Average number of DMFT among 5 year olds

Year	South Tyneside	North East	England
2001/02	2.05		1.47
2003/04	1.72		1.49
2005/06	2.15	1.97	1.47

% looked after children who have had their teeth checked



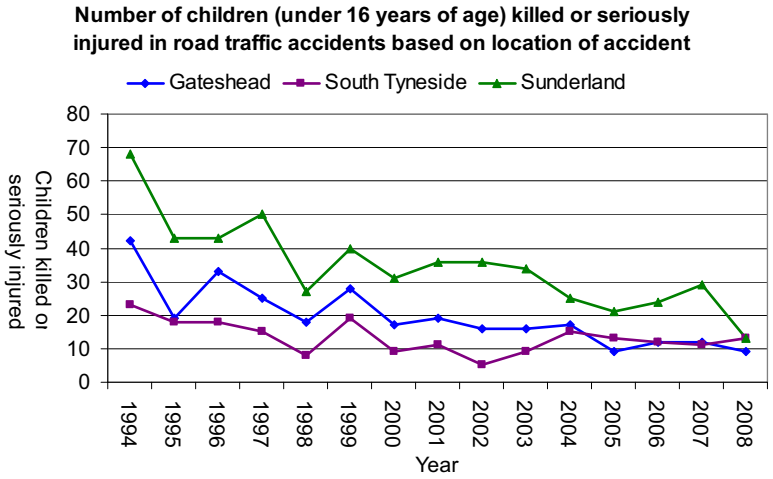
What type of accidents happen to children in South Tyneside?

The single major avoidable cause of death in the early years and beyond in England is unintentional injury – death in the home for under 5s and on the roads for over 5s. There are more deaths from unintentional injury than (for instance) leukaemia or meningitis and the social class gradient in child injury is steeper than for any other cause of death or long-term disability. Serious inequalities in injury deaths remain, particularly for pedestrians, cyclists and those involved in house fires[48].

Road accidents

By 2010, compared with the average for 1994-1998, we are expected to achieve a 50% reduction in the number of children (ages under 16 years) killed or seriously injured in road accidents.

[48] Edwards, P., Green, J., Roberts, I. & Lutchmun, S. (2006). Deaths from injury in children and employment status in family: Analysis of trends in class specific death rates. *BMJ*, doi:10.1136/bmj.38875.757488.4F.



Source: Great Britain - Department for Transport, Tyne and Wear - North East Traffic Accident Data Unit at www.northeast-tadu.gov.uk

Table 13: Number of children (under 16 years of age) killed or seriously injured in road accidents by location of accident

Year	South Tyneside	Gateshead	Sunderland	Tyne and Wear	Great Britain
1994	23	42	68	203	
1995	18	19	43	137	
1996	18	33	43	148	
1997	15	25	50	147	
1998	8	18	27	98	
1999	19	28	40	133	5699
2000	9	17	31	96	5202
2001	11	19	36	107	4988
2002	5	16	36	89	4596
2003	9	16	34	98	4100
2004	15	17	25	86	3905
2005	13	9	21	67	3472
2006	12	12	24	77	3294
2007	11	12	29	79	3090
2008	13	9	13	57	
1994-98 average	16	27	46	147	6860
% reduction 94-98 average to 2007	33%	56%	37%	46%	55%

Source: Great Britain - Department for Transport, Tyne and Wear - North East Traffic Accident Data Unit at www.northeast-tadu.gov.uk

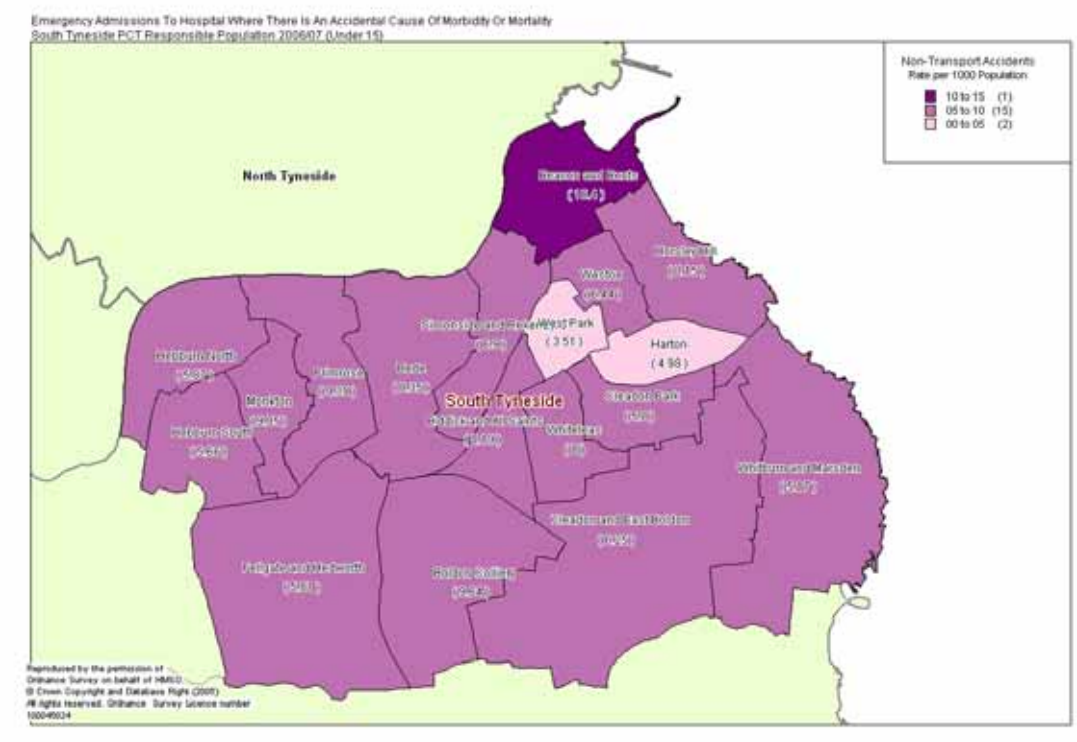
Accidents at home

Nationally in 2002, almost 900,000 children aged under 15 had an accident in the home with over 475,000 of these being under five. The largest number of non-fatal injuries happen when children fall. In 2002 390,000 children aged under 15 were taken

to UK hospitals after a fall at home. Most falls are either slips or trips on the same level. Babies and young children are also hurt after falling from one level to another (such as from a chair, bed or changing table) or on or from stairs. As with most home injuries, the under fives are most at risk. In 2002 230,000 children under five were taken to hospital after a fall. Nearly six in ten of these accidents involved boys.[49] Similarly, over 26,000 children under 5 years were taken to hospital after a suspected poisoning, the great majority being in the home. Fortunately the vast majority of cases of suspected poisoning require little or no further treatment.

Burns and scalds also happen in the home. In the UK in 2002 almost 37,000 children aged under 15 were taken to hospital after a burn or scald. Scalds happen more often than burns and the most frequent cause of injuries are hot drinks. House fires cause the most accidental deaths of children in the home. Eighteen children aged under 11 years died in house fires in 2005. Many of these deaths would have been caused by smoke inhalation.[50]

Work is being undertaken in South Tyneside to tackle and reduce accidental injury, avoidable admissions and self-harm by a range of individual organisations or task groups/boards. To maximise the impact and effectiveness of future work, a co-ordinated and targeted inter-agency strategy and action plan is being developed to provide an integrated approach to halt the increase in the number of avoidable admissions to Accident and Emergency.



- NI 47 People killed or seriously injured in road traffic accidents DfT DSO (average over 3 years)
- NI 48 Children killed or seriously injured in road traffic accidents DfT DSO

[49] http://www.capt.org.uk/FAQ/default.htm
[50] http://www.capt.org.uk/FAQ/default.htm

- NI 49 Number of primary fires and related fatalities and non-fatal casualties, excluding precautionary checks CLG DSO
- NI 70 Hospital admissions caused by unintentional and deliberate injuries to children and young people

Demand for health services

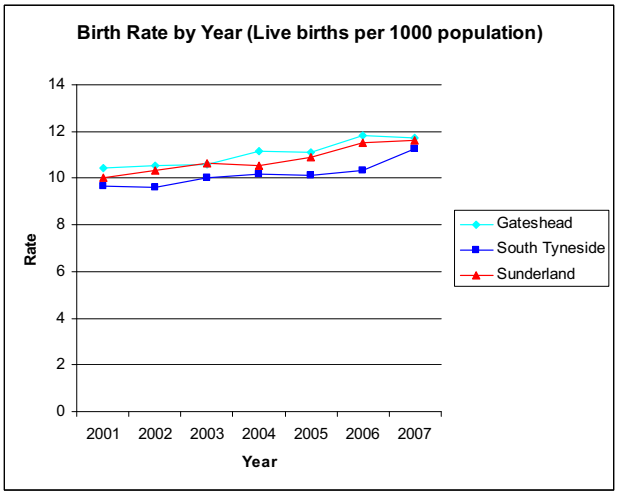
Maternity services

Birth data outlines an increase of 15% in the birth rate between 2001 and 2007 in South Tyneside. This rise has resulted in an actual increase in birth numbers of 219.

Table 14: South Tyneside births between 2001-2007

Year	No of live Births	Birth rate (live births / 1000 population	Number increase	% increase (2001)
2001	1479	9.68	Baseline	Baseline
2002	1467	9.62	- 12	- 1%
2003	1523	10.02	+ 44	+ 3%
2004	1540	10.18	+ 61	+ 4%
2005	1529	10.12	+ 50	+ 3%
2006	1560	10.33	+ 81	+ 5.5%
2007	1698	11.25	+ 219	+ 15%

Source: Maternal & Newborn Health Outline Strategy (draft 2009)



Source: Maternal & Newborn Health Outline Strategy (draft 2009)

Figures from Birth Choice UK suggest that home birth rates within the region have remained fairly static over the last 9 years. The combined Tyne and Wear area had a 1.50% home birth rate in 2006, whereas the figure for South Tyneside was 1.70%.

Table 15: Home birth rates in South Tyneside compared with neighbouring areas and Tyne and Wear

Local Authority	2006	2005	2004	2003	2002	2001	2000
South Tyneside	**1.70%**	**1.30%**	**1.10%**	**1.70%**	**1.10%**	**1.40%**	**1.10%**
Sunderland	1.20%	1.30%	0.90%	0.80%	0.80%	0.80%	0.90%
Gateshead	1.20%	1.30%	1.10%	1.20%	0.70%	1.10%	1.30%
Tyne and Wear	1.50%	1.30%	1.10%	1.20%	1.10%	1.20%	1%

Source: Home birth rates have been derived from information collected at birth registration Provided to BirthChoiceUK by the Office for National Statistics.
http://www.birthchoiceuk.com/Frame.htm

With regard to hospital admissions during pregnancy, there are a high number of women admitted as an emergency. This data indicates that South Tyneside had the fewest number of births but the greatest number of emergency admissions, as compared with Gateshead and Sunderland.

Table 16: Hospital admissions during pregnancy in South Tyneside, Gateshead and Sunderland

Admission Method	No. of admissions		
	South Tyneside	Gateshead	Sunderland
11 Elective – Waiting List	**3**	2	2
12 Elective – Booked	**284**	447	1030
13 Elective – Planned	**38**	244	24
21 Emergency - Accident and Emergency	**158**	140	189
22 Emergency - General Practitioner	**30**	45	37
24 Emergency - Consultant clinic	**68**	5	23
28 Emergency – Other	**204**	62	169
31 Maternity - Admitted ante-partum	**2155**	2871	4282
32 Maternity - Admitted post-partum	**7**	38	30
Grand Total	**2947**	**3854**	**5758**

Source: Maternal & Newborn Health Outline Strategy (draft 2009)

There are variations in the number of times different women have been admitted to hospital with one woman being admitted as many as eight times during the calendar year 2008/09.

Table 17: Frequency of admissions admitted ante-partum in South Tyneside

Number of admissions by patient	No.
1	1370
2	241
3	53
4	15
5	6
6	1
7	2
8	1
Unknown	26

Child health

In terms of planned care, the outlook is one of relative stability or modest growth. In relation to urgent care a significant proportion of paediatric Accident and Emergency attendances could be managed in different settings, and a significant proportion of emergency admissions could be prevented.

Analysis has identified that most emergency admissions for children related to minor infections, respiratory tract infections and gastro-intestinal disorders and that accidental injury accounted for 6.8% of all emergency admissions in the 0-19 years age range.

Table 18: Emergency admissions for children and young people 0-19 years

	Age in years						Total for 2006-7
	less than 1	1-4	5-9	10-14	15-19	Total	
Other Gastrointestinal or Metabolic Disorders	93	71	67	67	60	**358**	**296**
Upper Respiratory Tract Disorders	112	180	36	13	11	**352**	**414**
Minor Infections (including Immune Disorders)	89	152	39	36	22	**338**	**399**
Infectious and Non-Infectious Gastroenteritis	108	110	18	7	8	**251**	**223**
Accidental Injury without Brain Injury	8	28	35	59	23	**153**	**132**
Lower Respiratory Tract Disorders	31	61	21	9	7	**129**	**177**
Asthma or Wheezing	13	63	24	12	4	**116**	**125**
Acute Bronchiolitis	99	10	0	0	0	**109**	**89**
Ingestion Poisoning or Allergies	2	22	8	22	51	**105**	**102**
Skin, Musculoskeletal, or Connective Tissue Disorders	18	28	18	12	4	**80**	**73**
Neonates with one Minor Diagnosis	70	0	0	0	0	**70**	**60**
Fever Convulsions	5	34	6	9	3	**57**	**64**
Renal Disease	5	13	18	13	5	**54**	**48**
Appendicectomy	0	2	3	16	17	**38**	**29**
Fever	6	23	3	0	3	**35**	**20**
Total	**659**	**797**	**296**	**275**	**218**	**2,245**	**2,251**

Source: ONS report 'The mental health of children and young people in Great Britain, 2004, Green, H.

Alcohol

For alcohol related hospital admissions of children and young people in South Tyneside, there has been a consistent reduction between 2006/07 and 2008/09 in the under 18 age group for both males and females. However, admissions for young people aged 18-21 have increased over the same period. The most common health condition associated with alcohol was epilepsy, with more cases in the under 18 age group (131) compared to the 18-21 age group (31). Males were more likely than females to be admitted for mental and behavioural disorders due to alcohol misuse. 36 males aged under 18 years were diagnosed with oesophageal varices.[51]

Social and Environmental context

The 2007 Indices of Multiple Deprivation (IMD) indicate that South Tyneside is ranked 37 out of 152 local authorities in England compared with a ranking of 28 in 2004. The Income Deprivation Affecting Children Index (IDACI) relates to children aged 0-15 years and states how many children are income deprived[52] as a percentage of all children. In 2007 32 Super Output Areas ranked in the most deprived 20% in the country for children, with the worst areas clustered around the Town Centre and in Jarrow. This is a huge improvement compared with 2004, when 46 were in the worst 20%,

In February 2009, the Department for Communities and Local Government commissioned the creation of an Index of Child Well-being (CWI). This is an index of child well-being rather than an index of deprivation, because it contains variables that are not strictly related to deprivation. Child well-being is represented by how children are doing in a number of different domains of their life. These areas include:

- material well being;
- education;
- health and disability;
- environment;
- crime;
- housing;
- children in need.

Out of 354 local authorities South Tyneside performs well in relation to housing when considered against the indicators of overcrowding, shared accommodation, lack of central heating and homelessness. However, South Tyneside scores less well around material well-being (i.e., children living in households receiving in-work and out-of-work means-tested benefits) and children in need. Overall, taking into account of all the average scores in each of the domains, South Tyneside has a rank of 279.

[51] South Tyneside (2009) Young People's Needs Assessment: Tackling Drugs, Changing Lives

[52] Children living in households receiving benefits (e.g. Income Support or Job Seekers Allowance) and whose household income is below 60% of the national median income before housing costs are defined as income deprived.

Table 19: South Tyneside's ranking of Indices of Multiple Deprivation

Domain	Ranking
Material well being	309
Education	305
Health and disability	298
Environment	261
Crime	261
Housing	61
Children in need	318
Child Well-Being rank of average scores	279

Source: http://www.communities.gov.uk/publications/communities/childwellbeing2009

Teenage conceptions

This is strongly associated with young people from poor socio-economic groups and those who are socially excluded. There is also a direct correlation between poor sexual health and unintended teenage conceptions. Other risk factors include low self-esteem, low educational achievement and those with mental health problems. While many young people become very competent parents, there is strong evidence that having a baby at a young age can be harmful to both physical and mental health. Babies born to young parents are also at greater risk of experiencing negative health outcomes themselves.

In South Tyneside the rate fell by 20% between 1998 and 2004, ahead of a milestone to achieve a 15% reduction over this period. The rate continued to fall up to 2006 but has risen sharply in 2007. The local rise in teenage conceptions in 2007 has been reflected across both the North East region and, less markedly, England. In 2007 there were 164 conceptions among young women under the age of 18 years in South Tyneside.

Substance misuse

A range of factors influence substance misuse among children and young people including environmental factors such as the availability of drugs; family influences, individual experience (such as early sexual encounters and peer group pressure); mental health issues such as low self-esteem, depression and educational issues such as parental expectations. Although national research shows evidence of a decline in the prevalence of drug use, since 2001, among school pupils aged 11–15 years.

Illicit drugs use in the UK is most prevalent among young people aged between 16-24 years. The British Crime Survey (BCS) 2009 identified 42.9% of young people in this age group reporting having ever used illicit drugs. Class A drug use, whilst showing a slight reduction since 1996, increased by 1.2% between 2007/08 and 2008/09 (6.9% compared to 8.1%).

Recent drug users have an increased likelihood of having drunk alcohol in the last week. Recent drinking is also associated with experience of truancy or exclusion from school. Research evidence shows significantly higher levels of drug use among those who have a number of vulnerabilities and belong to more than one marginalised group.

The North East has the highest lifetime rate of amphetamine use amongst 10-25 year olds, with a higher percentage of females than males, aged under eighteen years, reporting lifetime amphetamine use (5% compared to 3.6%). The North East has the highest rate for 15-24 year old problem drug users in contact with structured drug treatment (39.3%). Problem drug use is defined as 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'.

In South Tyneside, it is estimated that for all 10-24 year olds, 17% (4,940) used 'any type of drug in the last 12 months. Of the 10-16 age group 16% are considered vulnerable, with an estimated 214 vulnerable young people considered potential drug users. Of that number, the estimated proportion using any type of drug in the last 12 months is 123, frequent use 66 and class A drug use is 25. For the 17-24 age group, 30% are considered vulnerable so giving 1,108 potential drug users. Of that number the estimated proportion of frequent drug use is 709 and estimated class a drug use is 576.[53]

Strategic Drivers

National

- Every Child Matters
  The Framework has five outcomes:
  Be Healthy
  Stay Safe
  Enjoy and Achieve
  Make a Positive Contribution
  Achieve Economic Well-being

- NSF for Children, Young People and Maternity Services
  This sets standards for children's health and social services and the interface of those services with education. It is a 10-year programme intended to stimulate long-term and sustained improvement in children's health by setting standards for health and social services that aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood. Standard 5 refers to Safeguarding and Promoting the Welfare of Children and Young People

- The Child Health Promotion Programme
  This offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

  Implementation of the Child Health Promotion Programme provides an invaluable opportunity to identify families in need of additional support and children at risk of poor outcomes.

- Saving Lives: Our Healthier Nation (1999)
  This advocated the target of reducing the death rates from accidents by at least a fifth and to reduce the rate of serious injury from accidents by at least a tenth by 2010 (with children being one of the key groups selected).

[53] South Tyneside (2009) Young People's Needs Assessment: Tackling Drugs, Changing Lives

- Tomorrow's Roads – Safer for Everyone (2002)
  This set the national target of a 50% reduction in the number of children (under 16 years of age) killed or seriously injured by 2010. In addition a target of a 10% reduction was set with respect to slight casualty rate, expressed as the number of people slightly injured.
- Safe as Houses Community Fire Safety Task Force (1997)
  This sets out a co-coordinated strategy for fire safety and awareness with a target of a 20% reduction in accidental fire-related deaths in the home by 2010.
- Department of Health guide to Maternal and Infant Nutrition
- "Better Safe than Sorry," Health Care Commission
- Better Prevention, Better Services, Better Sexual Health, The national strategy for sexual health and HIV (2001)
- CMO's letter of January 2009 relating to the Humanpapilloma Virus vaccination catch-up Programme

Local

- Infant feeding and weaning guidelines 2008, North East Strategic Health Authority
- South Tyneside Breast Feeding Action Plan

How are we performing?

Smoking in Pregnancy: The prevalence of smoking in pregnancy is considerably higher in South Tyneside than the national average with an estimated prevalence of approximately 28% in South Tyneside compared to a national average of 17%. For 2008/09 South Tyneside was the fourth worst PCT for women smoking at the time of delivery.

Table 20: Percentage of mothers smoking at delivery

PCT	2004/05	2005/06	2006/07	2007/08	2008/09
South Tyneside	**25.6**	**28.6**	**28.4**	**28.8**	**27.4**
Gateshead	24.2	24.6	20.0	18.5	19.6
Sunderland	34.9	-	21.9	24.1	23.4

Source: Department of Health, "Local Data on Pregnant Women Smoking at Time of Delivery"

Breastfeeding: Evidence from breastfeeding research undertaken at Government Office North East shows that for the majority of women a crucial point for stopping breastfeeding is in the early weeks after pregnancy. The targets around breastfeeding are listed below.

Table 21: Breastfeeding Targets for 2009-10

	Breastfeeding in first 48 hours (Initiation)	Breastfeeding at 6-8 weeks (Continuation)	
	Prevalence	Coverage	Prevalence
South Tyneside	**52.8%**	**90%**	**24.3%**
Gateshead	61.6%	90%	26.7%
Sunderland	42.3%	90%	24.4%

Immunisation is the most effective public health intervention for saving lives and promoting good health. Childhood immunisation has been effective in wiping out key infectious diseases. Unimmunised people are at risk from catching the disease and rely on other people being immunised to avoid becoming infected.

The National Immunisation Programme aims to prevent illness and death caused by vaccine preventable diseases; many diseases that used to be commonplace are now rare or not seen at all. Vaccinations now include diphtheria, tetanus, pertussis, polio, and Haemophilus influenzae type b (DTaP/IPV/Hib), meningitis C, and measles, mumps and rubella (MMR) vaccines. Boosters are offered for diphtheria, tetanus, pertussis and polio and a second dose of MMR at 3 years. The Health Protection Agency recommends vaccination coverage levels of 95% for the first year and age two; and 90% for age groups 5 and more. These recommended immunisation coverage levels are necessary to confer the wider health benefits of immunisation ('Herd' Immunity).

In September 2006 new vaccine against pneumococcal infection was introduced and the Human Papilloma Virus (HPV) vaccination was introduced for girls aged 12-13 years in 2008. In July 2008 the Department of Health extended the programme to include girls aged 17 years to 18 years of age.

Childhood Obesity

Tackling overweight and obese people is a government priority and is focused on children. The national vision states that, 'by 2020 we will not only have reversed the trend in rising obesity and overweight among children but also reduce it back to the 2000 levels.' This ambition forms part of the Government's public service agreement on child health:

> PSA 12: to improve the health and wellbeing of children and young people under 11.

Regionally Government Office North East (GONE) and the Strategic Health Authority (SHA) has led on the identification of priorities for the development of a regional care pathway framework. To date the North East now has standard referral criteria:

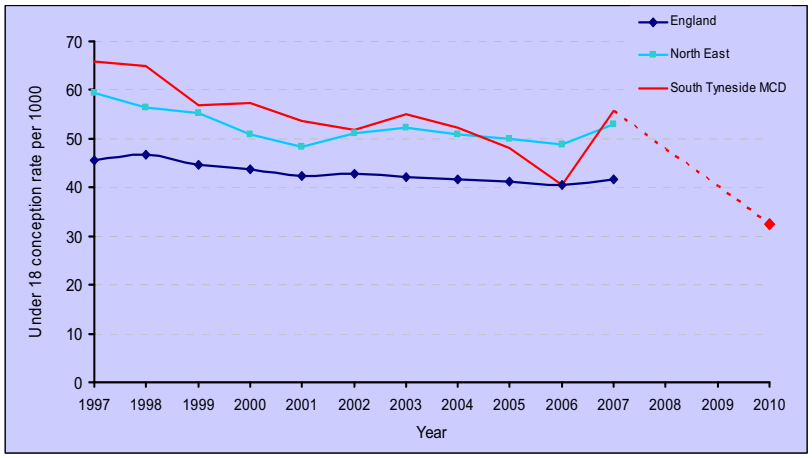
- 99.6th centile for clinical interventions (or 98th with co-morbidities)
- 98th centile for focused individual interventions
- 95th centile standard material and access to universal services

In South Tyneside reducing health inequalities through reducing smoking, alcohol and obesity is one of the top ten priorities for Children and Young People's Plan. To support the obesity element two indicators that have been agreed:

NI 53 – prevalence of breastfeeding at 6-8 weeks from birth
NI 56 - obesity among primary school age children in Year 6

Teenage Conceptions

In order to meet the 2010 target of a 50% reduction, the table below provides detail of targets needed for 2008, 09 and 2010.



Sexual Health

For 2009-10 the target is to screen 25% of the 15-24 year old population for Chlamydia, with the target increasing to 35% in 2010-2011. This is based on the following populations:

Table 22: Chlamydia targets

	2008-09	***2009-10***
The population aged 15 - 24 years	19,935	20,500
The number of 15 - 24 year old persons screened or tested for chlamydia	3,390	5,125
Percentage of the population aged 15 - 24 screened or tested for chlamydia	17.0%	25.0%

Emergency hospital admissions

PSA Delivery Agreement 13: Improve children and young people's safety has included Indicator 3 which is Hospital admissions caused by unintentional and deliberate injuries to children and young people.

Child and Adolescent Mental Health Services (CAMHS)

CAMHS refers to all services whose aim is to meet the mental health and emotional wellbeing needs of children and young people. This ranges from health promotion and primary prevention and specialist community-based services, through to specialist

care, outlined in tier four of the framework set out in the Children's National Services Framework (NSF).

NI 51 - Effectiveness of child and adolescent mental health (CAMHS) services
NI 50 - Emotional health of children (drawn from the TellUs survey)

3. What progress are we making?

Children and Young People's Plan Must Shifts for 2010-11 in relation to health have been identified as;

Smoking in pregnancy: The percentage of women smoking at time of delivery in South Tyneside during 2008 / 09 is considerably higher (28%) than the national average of 17% (based on data from the 2005 Infant Feeding Survey) and higher than neighbouring PCTs of Gateshead and Sunderland.

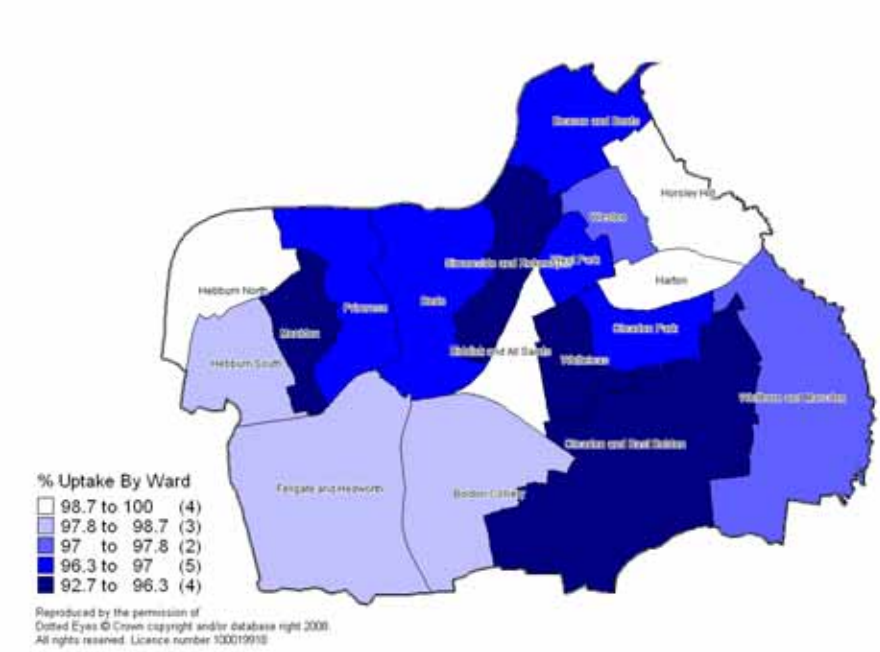
Breastfeeding initiation is significantly lower in South Tyneside than the national average of 69% for England (Health Profile 2008). Breastfeeding initiation rates during 2008/09 were 48.5% but this still remained lower than the North East average of 54.4%. Breastfeeding continuation in South Tyneside at 6–8 weeks is recorded as being below 25% but as this feeding status is not always recorded, this figure should be regarded with some caution.

Immunisations: With regard to achieving immunisation coverage targets, South Tyneside PCT ranks amongst the best regionally and nationally although there remains some variation between practices and geographical areas in the Borough.

Table 23: Uptake of Childhood Immunisation for the year 2007/08 (%)

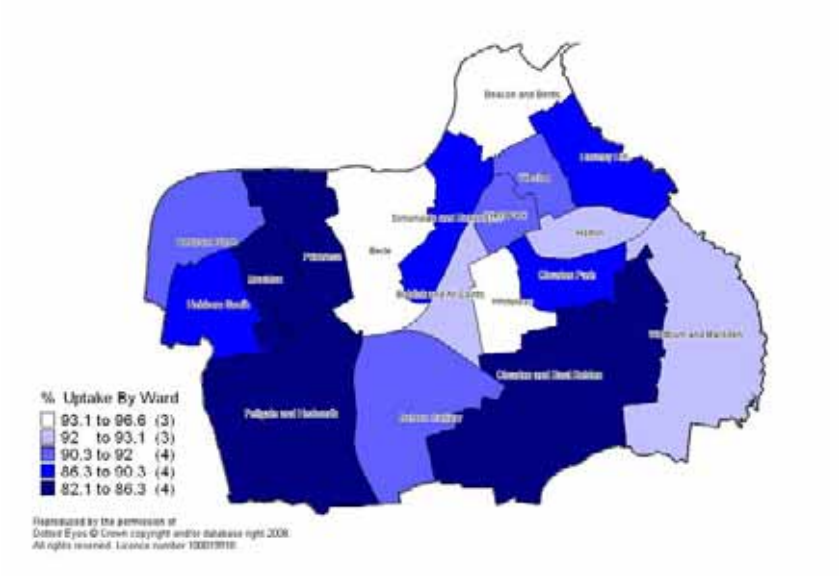
Immunisation	South Tyneside	North East	England
Children aged 1 who have been immunised for diphtheria, tetanus, polio, pertussis, haemophilus influenza type b	97	94	91
Children aged 2 who have been immunised against meningitis and haemophilus influenza type b	95	96	93
Children aged 2 who have been immunised for measles, mumps and rubella (1st dose)	90	88	85
Children aged 5 who have been immunised for diphtheria, polio, tetanus, pertussis, haemophilus influenza type b	89	86	78
Children aged 5 who have been immunised for measles, mumps and rubella (1st + 2nd dose)	85	82	74

Uptake of Diphtheria, Tetanus, Polio, Pertussis and Haemophilus influenzae B Immunisation at 12 Months in 2007/08



In recent years the uptake of the MMR vaccination has declined both in South Tyneside and nationally, most likely due to adverse publicity about the vaccine. Although the uptake of MMR vaccination among five year olds was not optimum in the Borough, the coverage has slowly and steadily increased in the last year.

Uptake of MMR Immunisation 1st and 2nd dose at 5 Years in 2007/08



The implementation of the HPV Vaccination Programme in South Tyneside is a success story. Although the Programme is logistically challenging as three doses are needed, in South Tyneside we achieved an uptake 78% of the vaccine among 12 -13 year olds; the target set was 50%. With the extended programme for girls aged 17-18

years the uptake shows that with this age group indicates that there is still a lot to be done: from a cohort of 740 girls only 26% have received two full doses of the vaccine.

Childhood Obesity

The most recent data available from the National Child Measurement Programme (NCMP) found that 20.2% of reception age children and 35.7% of Year 6 children are overweight or obese (see table below).

Table 24: National Child Measurement Programme data for 2008/9

	Reception			Year 6		
	% with height and weight recorded	% obese	% overweight	% with height and weight recorded	% obese	% overweight
South Tyneside	**97.3**	**9.1**	**13.1**	**95.6**	**21.0**	**14.7**
North East	94.6	10.2	14.4	93.5	20.4	14.7
England	91.2	9.6	13.2	89.1	18.3	14.3

Teenage Conceptions

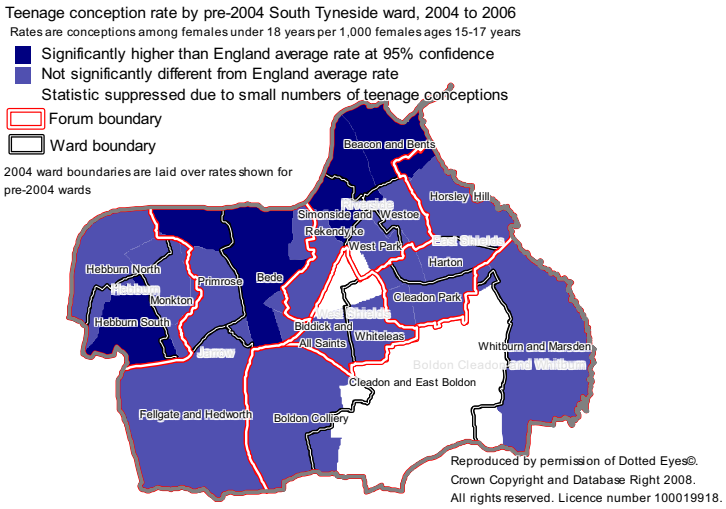
Before 2007, the rates had seen a significant reduction since the baseline was set in 1998. Disappointingly the confirmed data for 2007 showed a reversal in this trend. The under 18 conception rate for South Tyneside increased from 40.5 per 1000 young women aged 15 – 17 years in 2006 to 55.7 in 2007. While this demonstrates a significant increase having moved from a reduction of 37.6% to a reduction of 14% in 2007 since the 1998 baseline, South Tyneside is the best performing area in the region. Whilst the reduction remains greater than both the national and the North East reduction, data released in February 2009 demonstrated an increase in South Tyneside during 2007, a rise that was reflected nationally and regionally. The increase was a sharp reversal of a previously positive downward trend with 164 under 18 conceptions in South Tyneside during 2007.

The table below outlines the rate in South Tyneside against the England average and the reduction since the 1998 baseline. South Tyneside had had a rate consistently above the national average with the exception of 2006.

Table 25: Teenage conceptions

Area	Number	Rate	Reduction
South Tyneside	**164**	**55.7**	**- 14.2%**
North East	2,598	52.9	- 6.4%
England	40,298	41.7	- 10.7%

There are variations in the under 18 conception rate between wards in South Tyneside with the forum areas alongside the riverside showing rate that is significantly higher than the national average. In contrast there are only two areas in South Tyneside that have a rate significantly lower than the national average.



Sexual Health

We are currently underperforming around obtaining the number of screens required to meet the 25% Chlamydia target. At the end of December we had achieved only 58% of the target with only three months left in the year. In view of this the PCT have developed a recovery plan which is being monitored weekly.

Substance Misuse

Over the last few years there has been significant development of the Drug and Alcohol Services for young people in South Tyneside in the form of the Matrix Service. During the period from April 2004 to the end of December 2004 the Matrix has received 289 referrals; 30% of which could be identified with a need to access specialist CAMHS services.

Emergency hospital admissions

Understanding emergency admission rates to hospital is a 'must shift' priority identified in the Children and Young People's Plan in 2009-10. Most emergency admissions for children relate to minor infections, respiratory tract infections and gastro-intestinal disorders. However, accidental injury accounted for 6.8% of all emergency admissions in the 0-19 years age range and is an area where hospital admissions could be prevented.

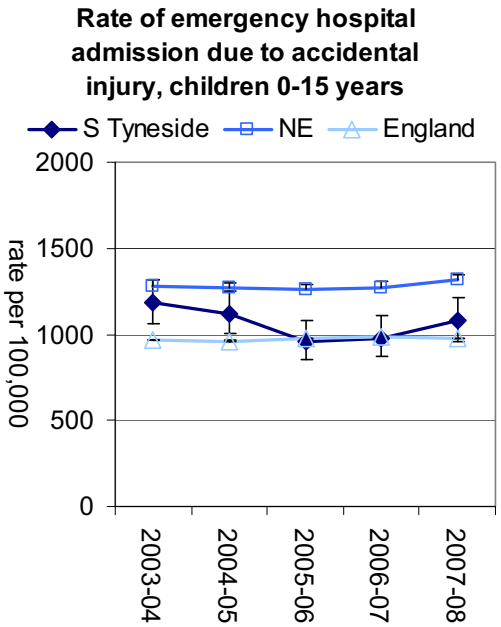


Table 26: Rate of emergency admission to hospital due to accidental injury among children and young people under 16 years

Year	Gateshead Rate	Gateshead Admissions	S Tyneside Rate	S Tyneside Admissions	Sunderland Rate	Sunderland Admissions	NE Rate	England Rate
2003-04	**1440**	518	**1184**	347	**1357**	738	**1282**	970
2004-05	**1477**	524	**1119**	321	**1225**	652	**1268**	962
2005-06	**1323**	461	960	270	**1295**	677	**1261**	977
2006-07	**1337**	461	980	270	**1317**	677	**1274**	981
2007-08	**1253**	427	1078	291	**1252**	634	**1315**	979

Source: North East Public Health Observatory based on Hospital Episode Statistics extract.
Figures in bold are significantly higher or lower than England rate at 95% confidence.

Healthy schools

The National Healthy Schools Programme (NHSP) is a joint initiative between Department for Children, Schools and Families (DCSF) and the Department of Health (DH) which promotes a whole school / whole child approach to health. The Programme has existed since 1999 and is recognised as a key delivery mechanism in the Children's Plan (DCSF 2007) and in Healthy Weight, Healthy Lives (DH 2008) – 21st Century White Paper reference.

NHSP aims to have all children and young people to be healthy and achieve at school and in life, believing that by providing opportunities at school for enhancing emotional and physical health and well-being, this will improve long term health and well-being, reduce health inequalities, increase social inclusion and raise achievement for all. NHSP aims to deliver real benefits for children and young people, specifically:

- To help reduce health inequalities
- To help promote social inclusion
- To help raise the achievement of children and young people
- To support children and young people in developing healthy behaviours

By December 2009, the Government expected that 100% of schools be engaged with the National Healthy School programme, with 75% having achieved National Healthy School Status.

Currently in South Tyneside there has been a 100% engagement onto the programme for the last 3 years, with 83% of schools registered on the National Database. Although this exceeds targets, there is still significant work to be done due to the rollout of the new Enhanced Healthy Schools Model All schools in South Tyneside are working towards Healthy Schools accreditation and over 70% of schools have already achieved Healthy Schools accreditation.

Local consultation and engagement

Health-related behaviours: To monitor trends in health-related behaviours among young people, every two to three years NHS South of Tyne and Wear commissions a health and lifestyle survey carried out in a sample of local primary and secondary schools. The questionnaire is organised by the School Health Education Unit (SHEU) at the University of Exeter. This questionnaire has standard questions as it is used across England, so local responses can be compared to the average response across England. All responses are anonymous and completed questionnaires are sent directly to the university for analysis. Responses are gathered from pupils in primary Years 5 and 6 and secondary Years 8 and 10 and aggregate results are sent to participating schools and to NHS South of Tyne and Wear. In this way, findings can influence health policy and strategy at both school and district level.

Immunisations: Local parents' views were researched in 2007 and revealed that parents would like to:

- to receive/access to timely information prior to immunisation appointment
- to have face-to-face, in-depth engagement/discussion with health professionals to enable informed decision making

Current activity and service provision

Maternity services: The SoTW Maternal and Newborn Health Network is developing a strategy to ensure that the best possible outcomes for women and their infants are achieved through the development of an integrated maternity and neonatal care pathway. This pathway will support the delivery of flexible and accessible services for all women and babies, including at risk groups. The vision is achieving first class maternity and neonatal services that are innovative in delivering continuity of safe care, based around the needs of women, their babies and families.

Maternity Services in South Tyneside meet the required National Choice Guarantee commitments. All women are able to book directly with a midwife or, if they wish may be referred via a GP receptionist to a community midwife. Information is displayed in GP practices, some Children's Centres, community venues and pharmacies to inform women that they can book directly with a midwife. NHS Direct website provides a telephone number for direct booking with South Tyneside District General Hospital and local alternatives.

Women are also offered, depending on their circumstances, a risk assessment at booking, either midwifery led antenatal care or care provided by midwives and obstetricians. Information in relation to types of midwifery care is communicated across a range of outlets including the hospital website in South Tyneside General Hospital.

Choice of place is discussed at time of booking by midwives with delivery options being dependent on risk assessment. These include hospital birth, hospital water birth, home birth and home water birth. Home birth is part of the 'core offer' of place of birth and the Foundation Trust provides 24/7 midwifery cover. In relation to postnatal care, whilst the majority of women choose to be seen at home, other alternative venues available include, hospital, and in some areas, Children Centre drop in clinics.

Across South Tyneside women have either a lead professional or named midwife who coordinates their care, and care plans in place for all women during the maternal period. There is flexibility of midwifery teams across community and hospital services and contingency plans in place to address any shortfall in staffing.

Smoking in pregnancy: In line with DH Guidance, there is a dedicated Smoking in Pregnancy Service across NHS South of Tyne and Wear. The service:

- is delivered in a number of community and hospital settings (ante-natal settings);
- provides a home visiting service
- offers a full range of support including contact by phone/text during pregnancy and post delivery to pregnant women and their families.

Specialist Stop Smoking advisers have increased their presence in ante-natal settings working with midwives to encourage pregnant women and their families to access the service. In addition, the pathway for Maternity services is being changed to ensure that advice about stop smoking is a routine part of care and monitors that show the amount of Carbon Monoxide reaching the foetus will be used at time of booking to encourage pregnant women and their families to access the stop smoking services.

NHS South of Tyne and Wear has an established Smoking in Pregnancy Group (Public Health, Heads of Midwifery, Specialist Service and Information Department) which meets regularly to monitor performance, identify potential improvements in the pathway, implement changes and evaluate the impact.

Breastfeeding: In 2009 a Breastfeeding Co-ordinator was appointed in South Tyneside to increase breastfeeding initiation and continuation rates. The co-ordinator will take a lead in the preparation of South Tyneside NHS Foundation Trust achievement of UNICEF Baby Friendly Initiative; the Foundation Trust has already applied for a certificate for commitment. This achievement would directly impact on the breast feeding rates in South Tyneside by providing best practice standards and ensuring parents get the best advice and support around feeding their baby.

A breastfeeding policy and action plan are in place which are monitored through the Breastfeeding Operational Group which reports to the Maternity Services Liaison Committee locally and the Maternity Network. The Breast Feeding Operational Group

oversees the work around breastfeeding and links with the regional infant feeding coordinator to ensure consistency.

Breast feeding training is commissioned from La Leche and is offered to all frontline staff in the Borough including NHS, children centres and voluntary agencies. Since June 2009 breast feeding workshops have been held in Children's Centres for the local community and messages continue to normalise breastfeeding as a way of combating the dominant culture of bottle feeding. Peer support is in place through 'Breast Friends' and to improve support and co ordination of 'Breast Friends' public health funding has been identified to advertise a post to coordinate their work and strengthening community activities. South Tyneside also hosted a Breast Feeding action planning event in June 2009 to consult and update the action plan.

Immunisations: An integrated NHS South of Tyne and Wear Immunisation and Vaccination Strategy Group was established in September 2007 and serves three PCT's including South Tyneside PCT. The key focus of this integrated strategy group is to improve, develop and oversee the delivery of national immunisation programmes to more than 200,000 residents: various age groups and via various settings across the three PCT's.

An MMR catch-up programme was implemented in October 2008 to cover MMR vaccine to those aged 13 months to 18 years who have not received any MMR vaccine or have been partially immunised in the past. MMR vaccine was offered to those who had received no MMR followed by those who were partially immunised. The public health team responsible for health protection has worked collaboratively with GP practices to address the need to improve MMR coverage.

Waiting lists were first identified as a problem in July, 2007 when four practices in South Tyneside had several children waiting to be immunised. The Childhood Immunisation Waiting List Initiative Task Group agreed to monitor routinely practices with 20 children or less and target practices with more than 20 waiting. The number of children on the waiting list has been reduced by more than 90% and from the four practices with waiting lists of over 20, there are now only two practices with waiting lists of over 20 children. All practices are now aware that they are responsible for immunising their practice population.

A rolling programme of training is being delivered to ensure that all health professionals who become involved in immunisation in any context receive training in immunisation. This includes practice nurses, health visitors, school nurses, community nurses, specialist nurses, GPs and occupational health professionals.

Childhood obesity: In 2009 the Childhood Obesity National Support Team visited the three PCTs and their partners across South of Tyne and Wear and an action plan was subsequently drafted. In October 2009 there was a multidisciplinary innovation day to explore further the action points from the NST and this was been agreed at the Childhood Obesity Task Group. There are also a range of services and initiatives working towards a reduction in obesity and these include:

- Supporting Toddlers in Attainment and Relationship (STAR) is aimed at families with children aged between 2-4 years where the toddler or member of the

child's family is overweight or obese. It is focussed on promoting healthy eating, active play and behaviour change;

- the PCT has funded an Early Years dietician (0.3 wte) to provide preventative services for 0-5 years via training to mainly childcare providers and input into nursery menus. There is also an element of targeted service provision to deliver the dietetic element of the STAR programme including sessions with families involved in the Programme;
- MEND is holistic, multidisciplinary, family based activities addressing healthy eating and physical activity as a lifestyle choice. Fun is an important part of this initiative and is aimed at 7- 13 year olds;
- Food in Schools programme ensures healthy school meals and education on nutrition and resources for school staff. It also promotes school meal uptake;
- National Child Measurement Programme measures the height and weight of children in reception and year 6 classes and is used to calculate the Body Mass Index (BMI) of children measured. This data is further analysed locally and at school level and is used as a benchmark and to target activities and programmes. This is overseen by the local Childhood Obesity Task Group;
- Regional Weaning programme involves training multidisciplinary staff including early years practitioners from Children's centres to roll out this programme to families. By Dec 2009 16 courses had taken place with 110 participants and a further six courses planned to be delivered in the new year;
- the initiatives to increase breastfeeding, including 'Breast Friends,' is a key approach to controlling the rising incidence of childhood obesity. Evidence suggests that mothers who breastfeed their babies end up with far fewer overweight and obese children and the longer babies are breastfed the greater the benefits, suggesting that those breast-fed for a year or longer are more than five times less likely to become obese.

The Healthy Schools Programme is the main way of engaging with children around the health agenda. The Healthy Schools team is co-ordinated by a Council lead (Educational Psychologist) and Health lead (Public Health Practitioner). All areas related to health are covered in the Personal, Social and Health Education (PSHE) curriculum. Other initiatives include:

- Smoke Free School Awards contribute to educating and encouraging the whole school community to be smoke free;
- Headliners UK were commissioned to create a SAYS (South Tyneside against Youth Smoking) DVD which is a piece of consultation work with young people to understand the issue of smoking from their perspective;
- South Tyneside Tobacco Alliance and FRESH North East funded, "Gibber - The Truth" performances in all secondary schools which highlighted how the tobacco industries manipulate young people to smoke. It was well received and the evaluation was positive;
- South Tyneside secured government funding for the second phase of Targeted Mental Health in Schools programme (TaMHS) and is involved in the National Evaluation, "Me and my school" which aims to:
    - improve mental health outcomes for children and young people through school based interventions;

- test 'effective' models of early intervention work in school based settings that have a clear impact on improving mental health outcomes for children and young people at risk of and experiencing mental health problems;
- integrate effective early intervention models into Local Authority and PCT systems of assessment, referral and intervention work in targeted support services and specialist CAMHS;
- understand the factors and barriers (structural, cultural, financial and professional) to successful implementation of programme in schools at strategic and operational levels.

Sexual Health: South Tyneside's vision is to embed Chlamydia screening within the Borough in line with the Risk and Resilience Plan. This is being achieved by developing, delivering and monitoring Chlamydia screening services throughout the Borough and building on current services commissioned via the Chlamydia Screening Programme with a particular focus in areas of greater need. The Northumberland Tyne and Wear Chlamydia Screening Programme was originally rolled out in 2007. As part of this there are Health Advisors appointed to cover each area to screen young people, treat positive patients and pursue partner notification.

Child and Adolescent Mental Health: The Child and Adolescent Mental Health Service (CAMHS) is provided in a tiered approach, namely:

Tier 1 – health promotion in a range of settings;
Tier 2 – clinical psychology in primary care;
Tier 3 – specialist services in the Child and Family Unit at the acute trust;
Tier 4 – very specialist services provided in Newcastle.

A number of services have been established including the development of a comprehensive Adolescent Service, providing for all 16 and 17 year olds in the Borough. Funding was also secured to refurbish and expand the Child and Family Unit facilities and the successful recruitment of a second consultant psychiatrist in the Child and Family Unit. For Looked After Children, their health assessment has been improved to ensure that both their physical and mental health needs are met and a training programme is now in place to ensure primary care workers are aware of, and confident in, dealing with child mental health issues.

The Tier 2 Primary Care Clinical Psychology service offers early, brief interventions for children and young people with more acute mental health problems. The service also offers consultation, training, sign-posting and mental health promotion and this service covers all GP practices and Children's Centres in the Borough. Clinical Psychology and the Looked After Children's clinical psychology service both operate a successful "no waiting list" policy.

The tier 3 service is delivered by a multidisciplinary team and includes the following services:

- Autistic Spectrum Disorder;
- Neuro-developmental Disorder;
- Deliberate Self-harm;
- Parent Infant Counselling Clinic;
- School Refusal Clinic.

The very specialist tier 4 CAMHS service is based in Newcastle – the Fleming Nuffield Unit (for younger children), the Young People's Unit (for adolescents) and the Kolvin and Roycroft Units for forensic services. Currently, there is a needs assessment for CAMHS and a review of Tier 3 provision being undertaken.

Young People's Drug and Alcohol Service (The Matrix): This is a multi-agency, multi-disciplinary team, which aims to ensure young people under 19, families and carers whose lives have been affected by substance use or those who are at risk of developing substance use issues have access to appropriate intervention and support. The service consists of an Operational Manager managed by the Drug Action Team (DAT) and ten workers, which include a Substance Misuse Looked After Children (LAC)/CAMHS post; this is a joint funded by DAT and CAMHS with a specific remit providing a service to Looked After Children. There is a protocol in place, which indicates that all Looked After Children are referred to the service as soon as they come into that system. This ensures that all of these children are screened for substance abuse. There are well-established links with the LAC psychologist regarding referrals and consultation, as there are with the CAMHS Tier 3 Child and Family Unit (CFU).

Other services provided by Matrix include:

- Advice and information
- Drug/alcohol awareness
- Assessment/treatment options
- Housing issues
- Family support
- Health issues
- One to one or group work
- Comprehensive care plan

A needs assessment in relation to young people's substance misuse has been undertaken in 2009 and a review of the Matrix Service has been completed.

Emergency Hospital Admissions: South Tyneside Safeguarding Children's Board (LSCB) has a statutory duty to safeguard and promote the welfare of children, which includes keeping children safe from accidental and avoidable injury and death. A multi-agency strategy **has been produced** based on a needs analysis including performance measures and indicators. The group are identifying gaps in the available data and will make recommendations for improving data systems, including exploring emergency rates within GP practices as a priority.

Accidents at Home: The Safe at Home scheme is a national programme to prevent accidents in under fives through training to families and fitting of safety equipment at home. The Programme is delivered locally by the WHOOPS team. In addition, a consultation was undertaken with sample GP practices in South Tyneside to review reasons and solutions for reducing Emergency Admissions practices.

Children with Disabilities: There are currently 2,280 children and young people in the locality who have been identified as having some degree of disability that causes them some form of special educational need. This equates to 8.1% of the children and

young in the locality and is slightly above the national estimate that 7% of the population has some form of disability.

The Aiming High for Disabled Children programme is increasing the number of services and opportunities available for children and young people in the locality. It is also funding a 4 bedded short break residential facility within the locality for young people with complex care needs.

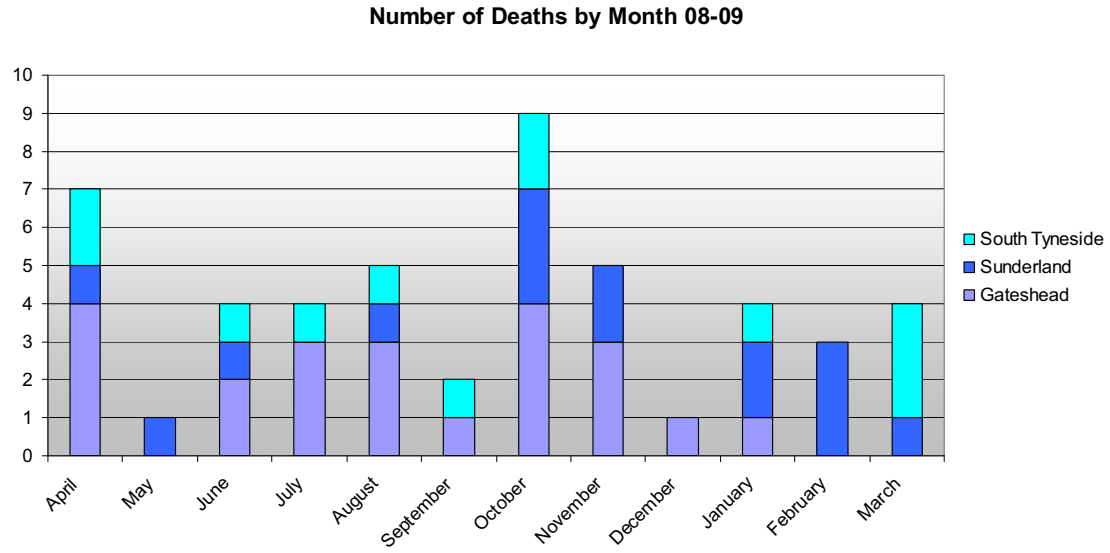
Consultation with parents identified a number of areas for improvement. The main areas being: access to short breaks including residential and better information and support and information prior to and during transitions between services.

Transitions packs are being created for all children identified as having some form of disability. These packs provide relevant information, for the individual and their carer, about the changes in health, education and social care services that will be experienced as the child or young person passes through the transition.

4. What is this telling us?

Life Expectancy

A formal process for assessing and monitoring all child deaths in South Tyneside was established in April 2008. In South Tyneside, for the period 2008-9, there were 12 case reviews. Across South of Tyne and Wear, there were 49 deaths of which 12 cases (24%) were potentially preventable. Of the 49 cases, 66% were children under 1 year old and 22% occurred within 24 hours of birth. No cases were completed where the death was felt to be due to deliberate injury, abuse or neglect.



Source: South of Tyne and Wearside Child Death Overview Panel

Key health inequalities

In order to improve the health of children and young people in South Tyneside we need to target services and support to those who need it most and are most likely to experience ill health.

Breastfeeding: Women from low socio-economic backgrounds and those with low educational attainment are less likely to breastfeed.

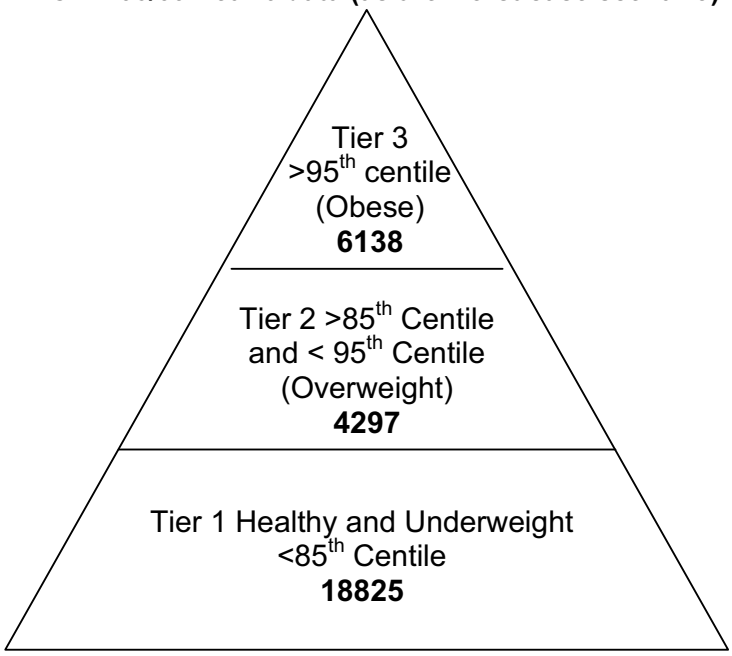
Smoking in pregnancy is a critical area of health improvement as babies born to mothers who smoke have greater risk of a range of poor health outcomes including low birth weight and perinatal death. In South Tyneside the proportion of women smoking at time of delivery has remained well above the national average over the previous five years. The percentage of women smoking at time of delivery for 2008/09 was 27% which is higher than the national average of 17% (based on data from the 2005 Infant Feeding Survey) and higher than neighbouring PCTs of Gateshead and Sunderland.

Immunisations: Following a decade of relatively low MMR vaccination uptake across the UK, there are now a large number of children and young people who are unvaccinated or partially vaccinated. The potential exposure of large numbers of unprotected individuals to the measles virus means that there is a real risk of a large measles epidemic and there have been outbreaks of measles across the UK. Immunisation uptake can be affected not only by the efficiency of the programme but also by different socio-economic and cultural reasons why parents do or do not take advantage of the programme.

Locally, although the uptake among five year olds was not optimum, evidence suggests that the vaccination of some children is delayed rather than avoided. This may be caused by problems with child health information systems or problems in service delivery, for example, infrastructure and/or capacity, as well as issues around the attitudes and beliefs of parents. Research shows that about 20-30% of those children who were unvaccinated at 24 months of age, go on to receive their vaccines before their third birthday. Such evidence suggests that following up children who are not vaccinated on time is a worthwhile and important intervention.

Obesity: Childhood obesity is a health inequalities issue because children from low socio-economic backgrounds are more likely to be overweight or obese. It is clear from data that as children get older the chances of being overweight and obese increases. The trend for children to be overweight and obese across year groups is also still increasing. As can be seen in figure 1 by year 6 there are more obese than overweight pupils meaning increased demand on targeted services.

Estimate of need: Tier based estimate of need extrapolated from NCMP 08/09 Year 6 data (as the worst case scenario)



What impact are we making?

Smoking in Pregnancy: We are not currently making sufficient progress in relation to smoking in pregnancy in South Tyneside and this is a key priority for 2010-11.

Breastfeeding: We are currently not making sufficient progress in relation to breastfeeding in South Tyneside although work is underway to ensure that information in relation to all women who are breastfeeding is captured accurately.

Good links have been established with GONE, the Regional Infant feeding Co-ordinator and the Early Years Regional Advisory Group. The South Tyneside Breastfeeding Co-ordinator is likely to have a positive impact on improving breastfeeding rates. However post has only recently been filled so the impact of the establishment of the post needs to be evaluated.

Childhood Obesity: There is good progress in relation to recording of Body Mass Index however efforts need to continue to halt the increase in overweight and obese children, in particular, by the time they leave primary school.

A Childhood Obesity Strategy has been produced and a well motivated multidisciplinary task group is in place. Links have been established with adult obesity services to ensure services are aligned and the National Support Team action plan has been updated with local actions.

Teenage Conceptions: We are not making sufficient progress in relation to under 18 conceptions. A review of local actions has been undertaken by the Department of Health during 2009-10. A detailed action plan has been produced. Research is

underway with young women to understand more about the reasons why they are becoming pregnant.

Sexual Health: We are currently not meeting targets for Chlamydia screening although intensive work is underway and is hoped that the target of screening 25% of 15-24 years olds during 2009-10 will be achieved. If targets are to be met, we need to embed screening in core services. For 2008-9 the chlamydia positivity rate was 6.7 which is considered low. This is due to targeting of educational establishments where positivity tends to be low and consideration needs to be given to how we target those who may be at higher risk of having Chlamydia.

Child and adolescent mental health: At Tier 1 there are a good range of universal services to identify children and young people with emotional and behavioural problems and either provide interventions or refer to more specialised services. The Targeted Mental Health in Schools initiative operates at Tier 2 to identify children and young people with mental health problems at an early stage and provide targeted interventions. There is a need to strengthen Tier 2 provision in particular to prevent some children and young people requiring more specialist services.

Results of the needs assessment will support further service improvements and inform commissioning.

The reprovison of Tier 3 services is going ahead across NHS South of Tyne and Wear with the aim of improving services.

Tier 4 contracts for child and adolescent in-patient provision continue to be under review.

Emergency hospital admissions: An audit was undertaken in relation to emergency admissions and data shows that the top three causes of emergency admissions are Upper Respiratory Tract Infections (URTI), Minor Infections (including Immune Disorders) and Other Gastrointestinal or Metabolic Disorders. However, there is a wide variation in the emergency admission rates between GP practices, ranging from 11.6 to 56.1 for URTIs. This could be due to a range of factors including arrangements in place for triaging, out of hours advice and local prevention activities. Further analysis is being undertaken during 2009-2010 to understand the reasons for the variation and whether there is a link with families on low income or other factors. This will be used to suggest interventions to prevent or reduce the number of admissions.

Health related behaviour: Evidence suggests that children and young people continue to be exposed to a range of lifestyle issues including access to alcohol and illicit drugs. The 2006 Exeter survey for South Tyneside reported that:

- 14% of girls had nothing to eat or drink for breakfast on the day of the survey;
- 11% of pupils had a chocolate bar or sweets for breakfast;
- 7% of pupils had nothing to eat for lunch on the day before the survey;
- 16% of pupils reported that they had taken an illegal drug at some point in the past year;
- of Year 8 pupils, 4% of boys and 8% of girls had bought alcohol from an off-licence during the seven days before the survey;

- 19% of pupils had drunk alcohol at home in the seven days before the survey;
- 43% of pupils reported that their parents always knew if they drank at home;
- 13% of pupils smoked at least one cigarette during the last seven days. Of these;
    - 46% smoked between 1-15 cigarettes;
    - 23% smoked between 16-45 cigarettes;
    - 31% smoked over 46 cigarettes.

Gaps in knowledge and services

Breast feeding:

- no in-house breast feeding training;
- no breast feeding strategic group locally or across South of Tyne and Wear;
- a need to strengthen the Breast Friends provision;
- identify funding to ensure that the Foundation Trust and PCT Provider Services work towards reaching Baby Friendly Initiative status.

Childhood Obesity:

- a lack of a single referral pathway for obesity services;
- a lack of a comprehensive childhood obesity service;
- provision of targeted services for overweight and obese children is variable and fragmented, for example, existing multi-disciplinary family based interventions are limited to children aged 2–4 years with the STAR programme and 7–13 years with MEND. However, all ages have access to one to one services via their GP, e.g. dietician or paediatrician.

Teenage Conceptions:

- lack of a dedicated Teenage Pregnancy Co-ordinator to drive the local strategy;
- insufficient engagement of all local partners;
- co-ordination and delivery of Sex and Relationships Education (SRE) in schools has not been consistent or to the standard of previous years;
- insufficient targeting and support for young people most at risk of pregnancy.

Chlamydia:

- GP practices need to be encouraged to undertake Chlamydia screening as part of their core services;
- Closer working relationships between local services, including formal agreements, need to be in place to encourage more screening activity if we are to meet the performance targets.

Child and adolescent mental health services:

- services at Tier 2 level are not sufficiently resourced and co-ordinated to meet the needs of children and young people at the early intervention stage;
- issues in terms of capacity at Tier 3 to meet current demand. A Workforce and Service Planning Review of Tier 3 services has been undertaken and identified the need for a CAMHS Therapist, an additional Social Worker and additional nursing capacity to work with the neuro-developmental disorder service.

Emergency Hospital Admissions:

- need to identify the reasons for high levels of emergency admissions in some areas of the Borough;
- need to strengthen work with GP practices where emergency admissions are high.

Health related behaviour:

- a lack of quality data available so we need to commission a Young People's Health Behaviour survey for 2010**.**

What is on the horizon?

Smoking in Pregnancy: From January 2010, the Foundation Trust will start using foetal CO monitors to encourage pregnant women and their families to access Stop Smoking services, funded through Choosing Health. Also, NHS South of Tyne and Wear will be working with Fresh (Smoke Free North East) and the Strategic Health Authority to reduce the rates of Smoking at Time of Delivery (SaToD) by trying to change the culture amongst midwives and other professionals working with pregnant women and their families to integrate stop smoking messages into mainstream health services.

Breast feeding: The possibility to apply for Health Inequalities funding in 2010 to support the development of the Baby Friendly Initiative and a willingness of the PCT and Foundation Trust to consider funding for this.

A regional breastfeeding framework will be published to support and encourage a consistent approach across the area. IN addition, a breast feeding education curriculum for the North East is likely to be agreed.

Sexual Health: We know that the Chlamydia target for 2010/11 will be 35% and so need a robust plan that ensures that all the screening providers work consistently throughout the year.

Health related behaviour: The Targeted Mental Health in Schools evaluation will be available in 2010.

5. What should we be doing next?

Ante-natal care

- high quality ante-natal care that identifies and addresses risks early;
- a full assessment of needs and risks by 12 weeks of pregnancy;
- advice during pregnancy on a variety of lifestyle factors including nutrition, smoking, alcohol as well as breastfeeding.

Maternal and child wellbeing

- identify pregnant women at risk of postnatal depression and provide specialist intervention;

- carry out routine enquiry to identify women at risk of or experiencing domestic violence;
- identify unborn/newborn babies at risk of abuse and work with parents to prevent or minimise abuse;
- improve the quality of interaction between parents or carers and children in the very early years, including the implementation of the Family Nurse Partnership Programme.

Smoking in Pregnancy

- adapt the Maternity Pathway to ensure stop smoking is included in the pathway as routine;
- use monitors which show the amount of Carbon Monoxide reaching the foetus will be used at time of booking to encourage pregnant women and their families to access the stop smoking services;
- reduce the length of time between booking and first appointment with the Stop Smoking Service.

Maternal nutrition/obesity during pregnancy

- information around maternal obesity needs to be collated and analysed to see how South Tyneside compares with other similar areas, the region and nationally;
- develop maternal nutrition pathway to ensure that issues around poor nutrition and/or obesity are addressed at an early stage.

Breast feeding

- deliver breast feeding education in schools to change the attitude of the next generation towards breast feeding and improve breast feeding uptake;
- analyse breast feeding rates for babies in children centres so as to target local support in low prevalence areas;
- appoint breast friends co-ordinator to ensure continuation and support to strengthen peer support;
- breast feeding in house training to be planned and implemented;
- ensure that all staff adhere to the infant feeding and weaning guidelines;
- progress with the UNICEF Baby Friendly Initiative application for foundation trust and community;
- implement action plan to ensure implementation being taken forward.

Children at particularly high risk

- provide targeted interventions and programmes;
- implement Child Health Promotion Programme.

Emotional wellbeing in children & young people

- expand targeted mental health support in universal settings;
- evaluate Emotional Resilience Programme
- strengthen targeted emotional/mental health support services for young people in the community
- ensure specialist services are accessible and young person friendly

Immunisation

- continue to promote the National Immunisation Programme in order to maintain a high vaccination uptake;
- ensure that children who have missed their routine vaccinations are followed up and invited back for vaccination;
- use the routine pre-school booster vaccination visit as an opportunity to review the vaccination records of children to ensure that all of their immunisations are up to date. Additional vaccines should be offered where appropriate;
- use the teenage vaccination visit as an opportunity to review the vaccination status of children and ensure that the appropriate vaccines, including any missed doses of any vaccines are offered;
- develop an information system to monitor the uptake of the different training programmes and ensure the provision of immunisation training is seen as a priority.

Childhood Obesity

- establish a dedicated multidisciplinary team including psychology, dietician and sports covering all age bands;
- establish one referral pathway and gateway for parents and practitioners so as to improve clarity and efficiency of services;
- provide childhood obesity training for staff.

Dental Health

- reduce the number of children who have decayed, missing or filled teeth.

Teenage conceptions

- ensure dedicated time for the teenage pregnancy co-ordinator role;
- strengthen Sex and Relationships Education in schools and targeted settings with high risk young people;
- ensure high risk young people have access to services (outreach wherever possible).

Sexual Health

- maintain a robust plan that ensures coverage of programme and achievement of the chlamydia target;
- ensure high risk and hard to reach young people are targeted.

Emergency Hospital Admissions

- undertake further analysis to explore the factors leading to high emergency admission rates in South Tyneside and to identify priorities to curtail the rates

Health related behaviour

- carry out the Young People's Health Behaviour in 2010 to capture and compare data to identify priority areas;
- use South Tyneside Against Youth Smoking DVD to promote de-normalisation of smoking amongst young people;

- evaluation findings of the Targeted Mental Health in Schools programme to be used to strengthen further action and formulate a plan to roll out TaMHS to all schools in South Tyneside;
- investigate the lack of referrals from health services into specialist substance misuse services;
- running a workshop for health practitioners on substance misuse issues affecting young people, the screening and referral process and brief interventions;
- continue to penetrate universal services, to encourage use of the substance misuse screening tool amongst professionals, as well as target potential service users/ parent /carers.

Children with Disabilities

- prioritise the needs of children with disabilities and to ease the transition from children's to adult services.

High quality centre-based pre-school provision and school education

- improve attainment of children and young people at all key stages in the most deprived wards;
- improve educational outcomes for looked after children;
- reduce the number of permanent and fixed period exclusions;
- reduce the percentage of young people Not in Education, Employment or Training (NEETS).

Alleviate poverty in families with young children

- implement and evaluate Tyne Gateway Poverty Pilot.

Reduce environmental hazards

- evaluate Safe at Home project to assess the impact and to identify areas that need to be strengthened to prevent accidents in 0-5 year olds;
- extend 20mph maximum speed zones especially in residential and urban areas.

CHAPTER 5 Working Age & Later Life

1. Introduction

Everyone has the right to good health, regardless of personal circumstance. Although it may not be possible to prevent every single occurrence of cancer, heart disease, stroke or respiratory problem there are certain risk factors that make these diseases much more likely to occur. However, many of these risk factors are preventable and if they changed on a large enough scale across the population, the health experience of South Tyneside's population could be improved greatly. Moreover, many of the diseases that cause the greatest burden of ill health share common preventable factors, offering the added advantage of reducing several diseases simultaneously. We must, therefore, ensure that our interventions are as powerful, effective and accessible as possible.

2. Where are we now?

Life expectancy

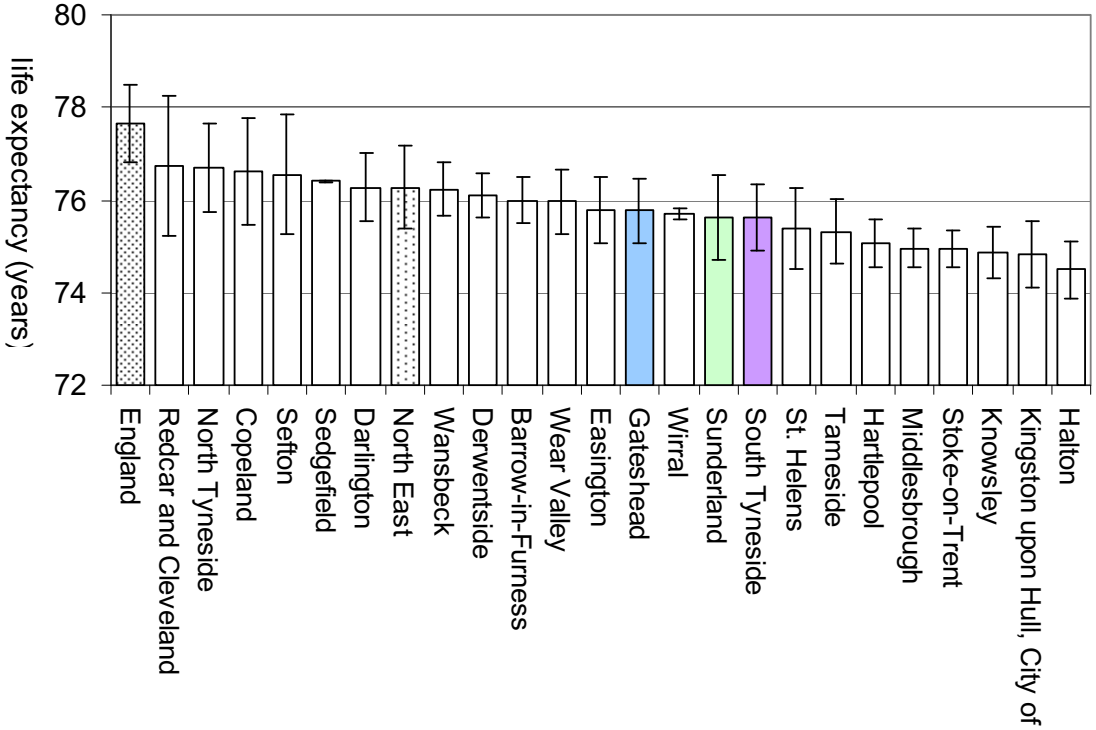
International comparisons: Life expectancy at birth in the United Kingdom in 2005 (76.9 years among men, 81.1 years among women) is slightly above the Organisation for Economic Co-operation and Development (OECD) average among men (75.7 years) but slightly below the average among women (81.4 years). Countries with high life expectancy include Japan (78.6 years for men, 85.5 years for women) and Switzerland (78.7 years for men, 83.9 years for women). Countries with low life expectancy are Turkey (68.9 years for men, 73.8 years for women) and Mexico (73.0 years for men, 77.9 years for women).[54]

The gap between life expectancy in South Tyneside and nationally is increasing and continues to be greater for men than women. The mortality rate due to all causes (age standardised) is falling although in 2005-7 it was higher (692 per 100,000 population) compared to the North East (671) and England (595).

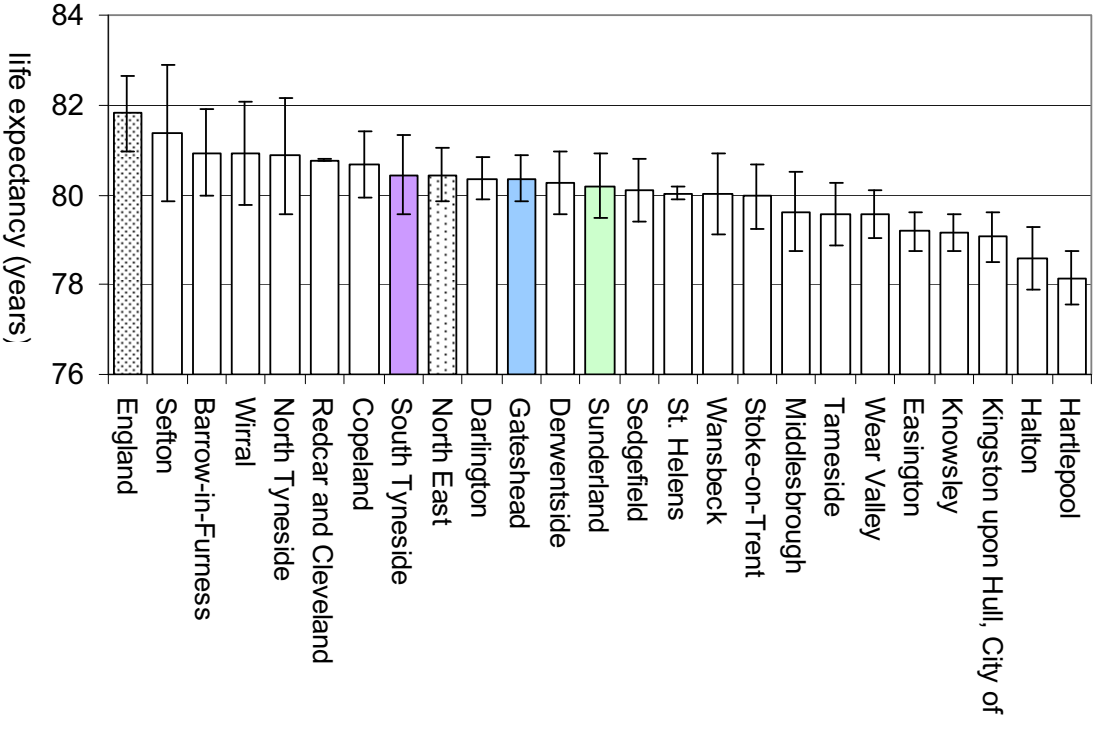
The graphs below show the life expectancy for men and women in South Tyneside in relation to comparable districts in England.

[54] OECD

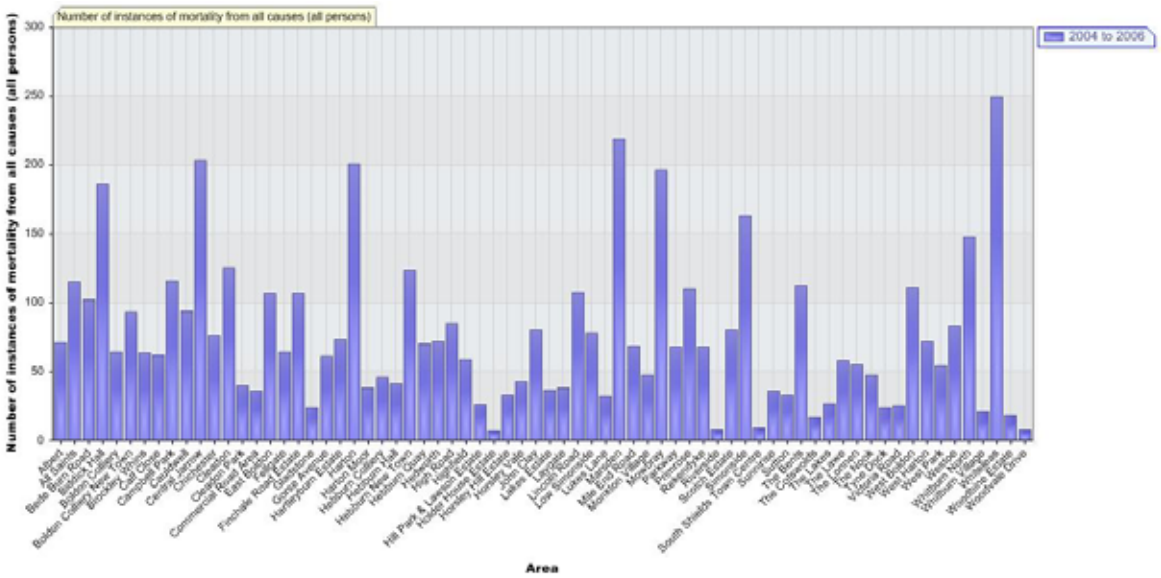
Male life expectancy at birth by "Industrial and Hinterlands" Local Authority 2005-2007 showing 95% confidence limits



Female life expectancy at birth by "Industrial and Hinterlands" Local Authority 2005-2007 showing 95% confidence limits



As suggested earlier inequality in health is closely linked to deprivation and for all causes of mortality it is clear that a greater number of premature deaths occur in the most deprived wards in the Borough. The chart below shows neighbourhood level data that has been calculated in relation to mortality across all causes within the population under 75 years.



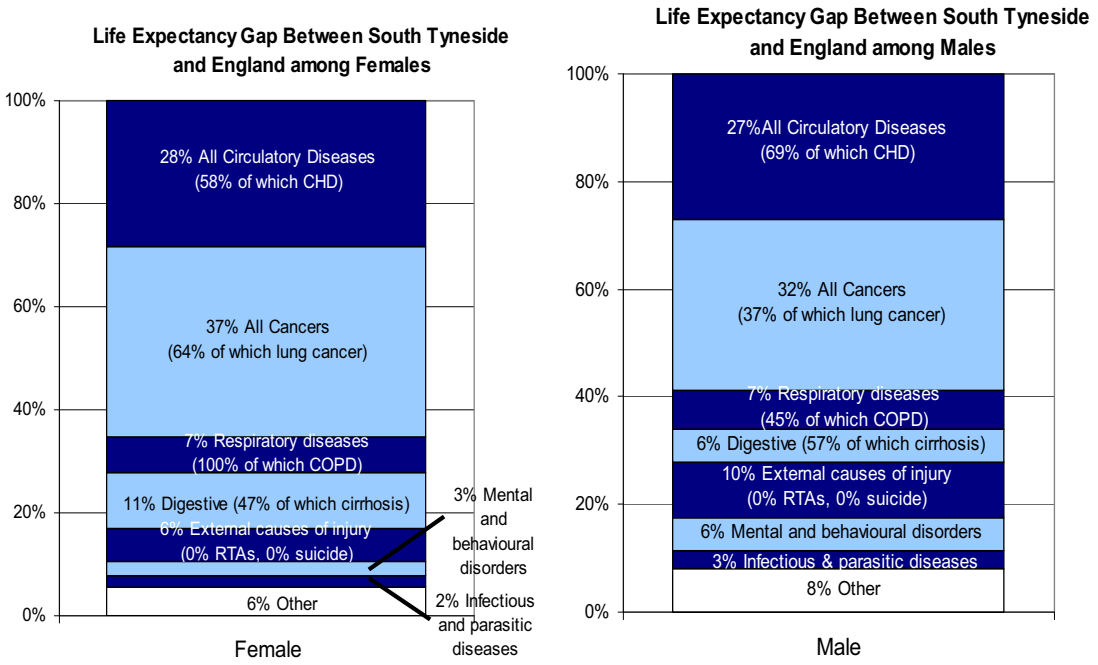
Source: South Tyneside Council Intelligence Online

Which diseases are reducing life expectancy?

Over the last ten years, death rates from all causes have decreased for men and women at a similar rate to the England average. The early death rate from heart disease and stroke has decreased markedly. The early death rate from cancer has decreased faster than the England average in recent years.

Mortality and morbidity from cardiovascular disease and cancer are unevenly distributed across society particularly in low-income groups, minority ethnic groups and people living in the north of England. Mortality and morbidity from cardiovascular disease and cancer are also higher amongst people with poor mental health. Socioeconomic status has been shown to be related to lung cancer incidence, with people with low levels of education having a higher incidence of cancer.

Cardiovascular disease and cancers remain the main causes of premature mortality in South Tyneside. Understanding which diseases make up the life expectancy gap for men and women allows us to focus our efforts on making a large impact on tackling these diseases. The charts below outline which diseases contributed most to the Life Expectancy gap for men and women in South Tyneside compared to England for the years 2003-2005.



Source: Health Inequalities Tool Department of Health 2007

Circulatory diseases

In South Tyneside, premature mortality under the age of 75 years due to circulatory diseases has seen a reduction of 40% between 1995-7 and 2005-7 from a rate of 167.3 per 100,000 per population to 100.3. The rate reduction over the same period for England was even greater, 44%, resulting in an increasing gap between local and national figures. There are also considerable differences in rates between men and women with 135.2 for men compared to 68.3 for women (2005-7 figures). In addition, there are wide variations across the Borough with Cleadon and East Boldon and Whitburn and Marsden having significantly lower rates than the Borough as a whole.

Circulatory diseases include:

Coronary heart disease - 7,700 (6%) people from the Borough have a diagnosis of coronary heart disease although the true prevalence is estimated to be closer to 6.5% equating to 8,300 people on GP lists.

Acute myocardial infarction - between 2003 and 2005 the standardised mortality ratio (SMR) for all persons aged 35 to 64 years was 151.6 (where the SMR for the North East was 124.7 and England was 100).

Hypertension – in 2008-9 although 18.4% (23,700 people) had a diagnosis of hypertension the true prevalence was estimated to be about 32% (41,500 people). This means that a large number of people have hypertension in South Tyneside but have not been diagnosed.

Stroke – In 2008-9, 3,600 (2.8%) of the population of in South Tyneside aged 16+ were known to have suffered a stroke.

By estimating prevalence for GP Practice populations and comparing this with actual Practice prevalence published within the Quality and Outcomes Framework, it will be possible to identify those communities where the gap between actual and expected prevalence is widest. This will help to focus case finding work.

Mortality due to cardiovascular disease - International comparisons of rates of mortality due to coronary (or ischaemic) heart disease in the UK in 2004 were close to the OECD average. Rates in the UK in 2004 were 154 per 100,000 among males and 73 among females. Countries with high rates of CHD mortality include Hungary (292 for men, 170 for women) and New Zealand (179 for men, 97 for women). Countries with low CHD mortality rates are Japan (42 for men, 20 for women) and France (64 for men, 26 for women).[55]

Diabetes – Diabetes mellitus is a condition where the amount of glucose in the blood is too high, because the body cannot use it properly. There are two main types of diabetes, Type 1 and Type 2. Type 1 diabetes cannot be avoided and accounts for approximately 15% of cases, Type 2 is mostly linked to being overweight and accounts for 85% of cases. There are currently 2.5 million people who have diabetes in the UK, and there are more than half a million people who have the condition and don't know it (Diabetes UK, 2009).

In 2008-9 7,000 people in South Tyneside were diagnosed with diabetes (4.5%) with the true prevalence closer to 5.3% (8,200 people). This is higher than our neighbouring PCTs and the North East and England as a whole (see table below).

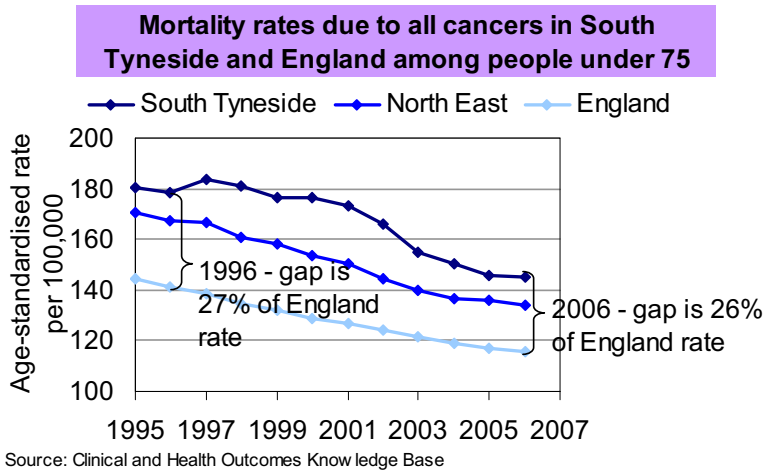
Table 27: Percentage prevalence of diabetes (based on numbers on GP registers)

Year	South Tyneside	Gateshead	Sunderland	North East	England
04/05	**4.0**	3.3	3.5	3.6	3.3
05/06	**4.2**	3.5	3.6	3.8	3.6
06/07	**4.3**	3.8	3.7	3.8	3.7
07/08	**4.5**	4.2	4.0	4.1	3.9
08/09	**4.8**	4.5	4.3	4.3	4.1

Cancer

Premature mortality due to all cancers in South Tyneside has decreased between 2005-7 from 178.7 per 100,000 to 145.1. The inequality gap between these figures and those of England has reduced from 27% to 26%.

[55] OECD



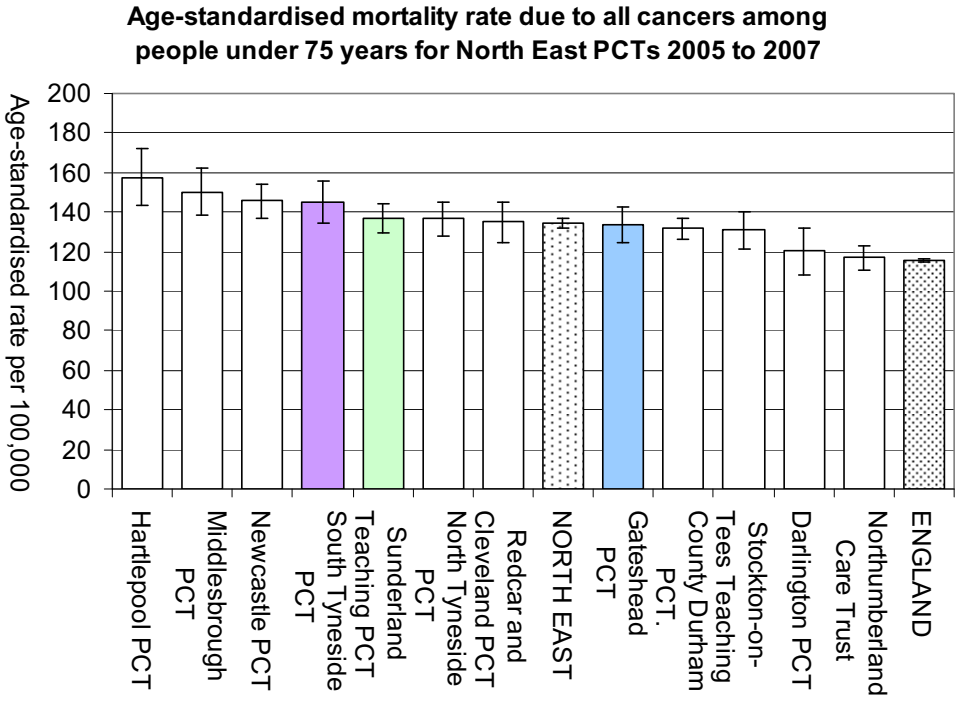
Source: Clinical and Health Outcomes Know ledge Base

In 2004-6, there were around 500 deaths each year due to cancer, which represents 28.9% of all deaths. This is higher than for England (26.7%). During this time in South Tyneside, 27.7% of cancer deaths were caused by lung cancer, followed by 10.5% due to colorectal cancer.

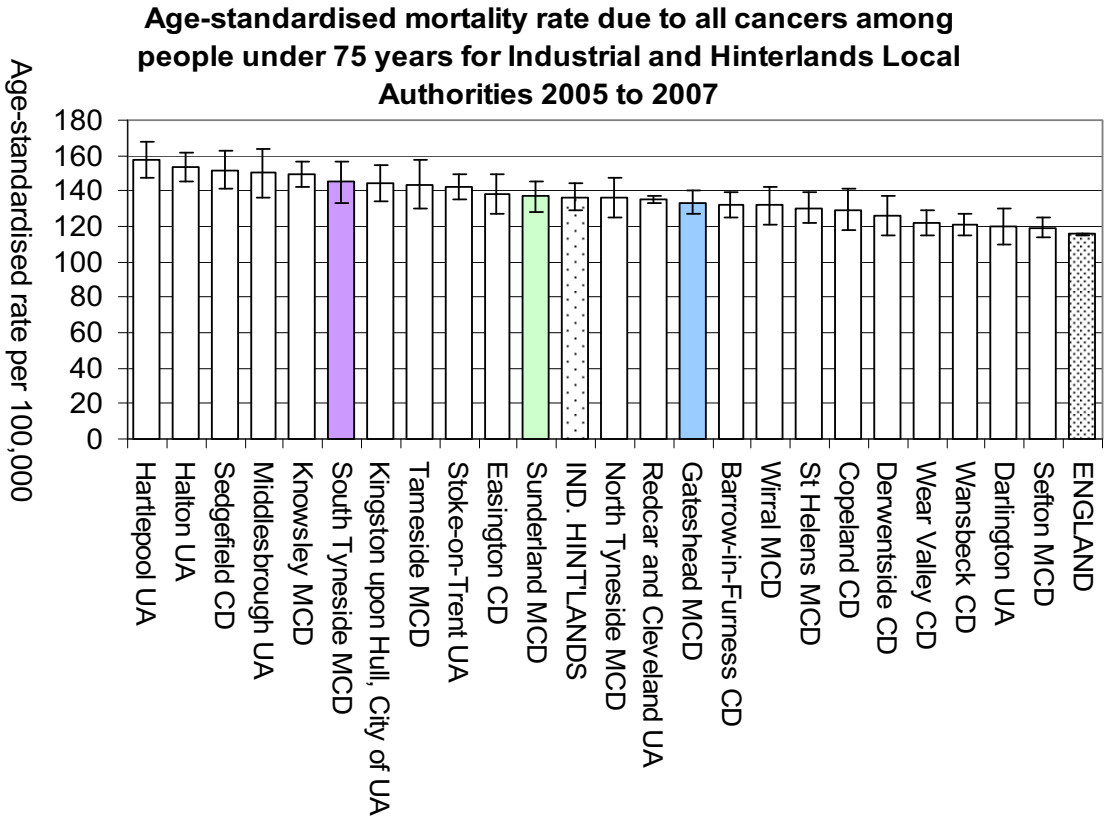
Table 28: Deaths due to Cancer, 2004-6 (pooled data)

	South Tyneside		England	
	Deaths	**%**	**Deaths**	**%**
Lung	428	27.7	80,615	21.3
Colorectal	162	10.5	40,201	10.6
Breast	86	5.6	30,828	8.1
Prostate	90	5.8	25,529	6.7
Oesophageal	63	4.1	18,021	4.8
Stomach	65	4.2	13,493	3.6
Malignant Melanoma	7	0.5	4,545	1.2
Cervical	8	0.5	2,505	0.7
Other cancers	636	41.2	163,305	43.1
Total	**1545**	**100**	**379,042**	**100**

The graph below shows that the South Tyneside cancer mortality rate for all cancers is higher than more than half of North East PCTs.



In relation to comparable districts in England the graphs below show cancer mortality for men and women between 2005 and 2007:

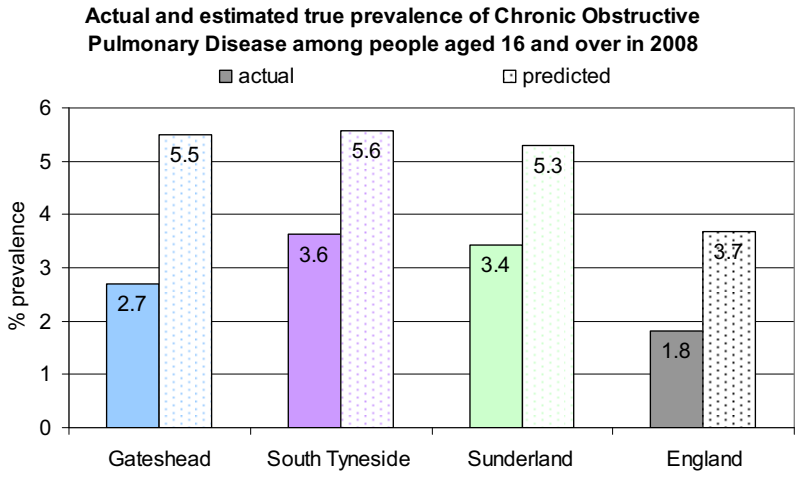


It can be seen that South Tyneside cancer mortality rates are significantly higher than the majority of comparable districts.

Cancer mortality - International comparisons of mortality rates due to all cancers among people of all ages in the United Kingdom were 214 per 100,000 among males and 149 among females in 2004. OECD countries with particularly low rates are Sweden (177 for men, 130 for women) and Australia (196 for men, 123 for women). OECD countries with high rates include Denmark (245 for men, 186 for women) and Hungary (346 for men, 178 for women).[56]

Chronic Obstructive Pulmonary Disease (COPD)

The prevalence of chronic obstructive pulmonary disease is high and rising in South Tyneside, being strongly linked to the high levels of smoking in the Borough. In 2008-9 there were 4,700 people aged 16+ with COPD (3.6%) although the true prevalence was more likely to be 5.6% (7,200 people on GP lists). The graph below shows the actual and estimated prevalence of COPD in South Tyneside compared with Gateshead, Sunderland and England.



Chronic kidney disease (CKD)

In 2008-9, 2,400 people in South Tyneside had a diagnosis of chronic kidney disease (CKD) – 2.0% of all people ages 18 and over. True prevalence was more likely to be 9.6% – 11,500 residents or 11,900 people on GP lists.

Which lifestyle factors contribute to reducing life expectancy?

Smoking: This is the biggest risk factor for circulatory diseases and cancer. The proportion of smokers, both men (26.7%) and women (24.6%) was higher in 2008 than the national projections in England (24.5% and 22.2% respectively). The South of Tyne and Wear Lifestyle Survey showed that the largest proportion of smokers (31%) in South Tyneside are from the 31-44 age group. However, the highest percentage of male smokers was in the 25-35 age range, whereas the highest proportion of females were in the 45-54 age range.

[56] OECD

- people from a BME community are much more likely to smoke: 29.5% compared to 25.8% of the white population;
- the greater proportion of residents living in areas of ST classed as living within the 20% most disadvantaged areas of England are smokers (32%). This contrasts with just over 12% of people being smokers living in areas classed as within the most advantaged areas of England;
- the highest rates of smoking are found in the wards of Biddick Hall and All Saints (38.5%) and Rekendyke (36.1%). Cleadon and East Bolden ward has the lowest proportion of smokers (12.3%);
- the highest percentage of smokers (30%) are found within the 'lower supervisory and technical' group. 'Small employers and own account workers' and 'semi-routine/routine workers' have slightly lower rates, at 29%. The lowest percentage of smokers (21.8%) is the 'managers and professional' group;
- Mosaic group data shows that the lowest percentage of smokers in South Tyneside is among career professionals living in sought after locations (12%) and the highest rates are in those living in social housing with uncertain employment in deprived areas (39.1%) and low income families living in estate based social housing (34.5%).

Alcohol

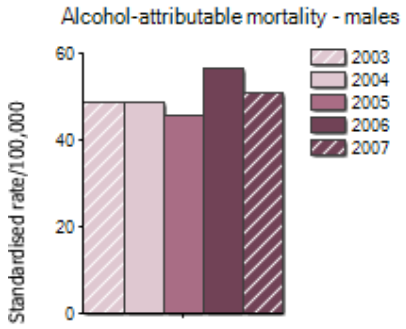
Alcohol contributes to a wide range of health conditions and alcohol misuse was estimated to cost the NHS £1.5 billion in 2000/01 (Prime Minister's strategy unit, 2003). Data on mortality from alcohol-related conditions are collated by ONS. The table below lists the categories included in the ONS definition of alcohol-related deaths:

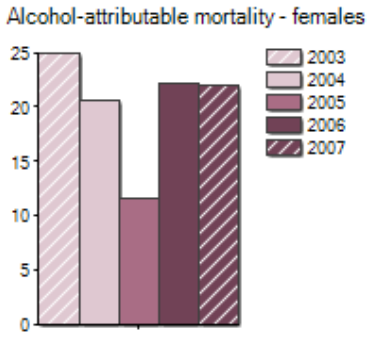
Table 29: Definition of alcohol-related deaths

Description	ICD10 Code
Methanol poisoning	T51.1
Mental and behavioural disorders due to the use of alcohol	F10
Ethanol poisoning	T51.0
Degeneration of nervous system due to alcohol	G31.2
Alcohol-induced pseudo-Cushing's syndrome	E24.4
Alcoholic polyneuropathy (disease of the nerves)	G62.1
Alcoholic myopathy (disease of the muscles)	G72.1
Alcoholic liver disease	K70
Alcoholic gastritis (disease of the digestive system)	K29.2
Alcoholic cardiomyopathy (disease of the heart muscle)	I42.6
Accidental poisoning by and exposure to alcohol	X45

Source: APHO Indications of Public Health in the English Regions 8: Alcohol Appendix 1

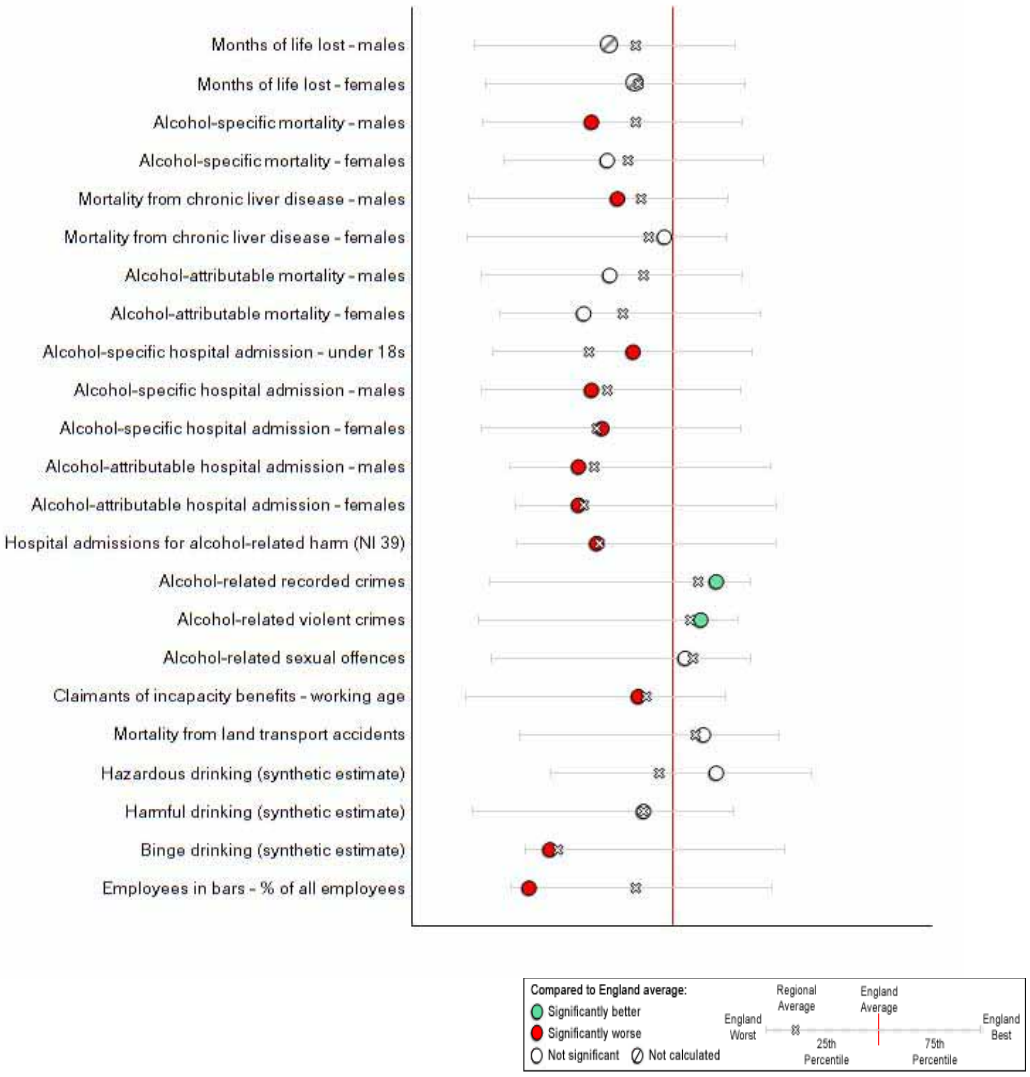
Death rates in South Tyneside are higher than those for the North East and the years of life lost rates are higher than the national average. Locally, on average there have been 28 alcohol-related deaths per year since 2001. Mortality rates for chronic liver disease are increasing for females. The charts below show the standardised rate of alcohol-attributable mortality rates in South Tyneside for men and women.





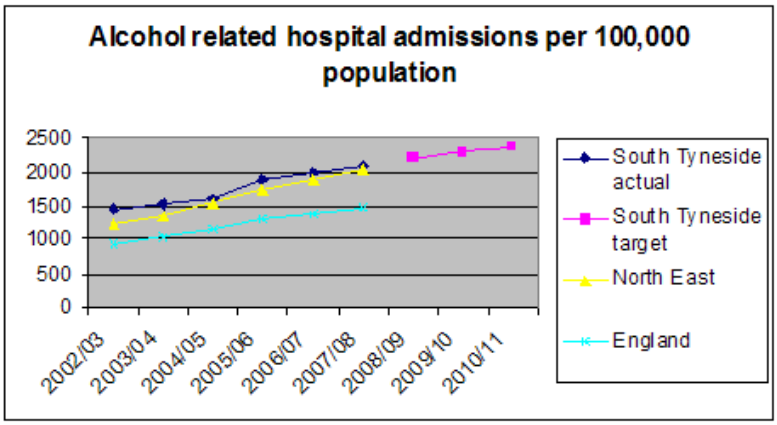
Alcohol related harm: There are a range of indicators that are considered when considering the profile of alcohol-related harm. Alcohol specific conditions are those that are wholly related to alcohol, such as alcoholic liver disease or alcohol overdose. Alcohol attributable conditions include the alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). The chart below shows how South Tyneside compares for each indicator, as well as the regional and England averages.

Profile of alcohol related harm



Source: Local Alcohol Profiles for England, http://www.nwph.net/alcohol/lape/pctProfile.aspx?reg=q30

Alcohol related illness: In 2006-7, the number of hospital admissions for alcohol related harm was 3,508 people per 100,000. In 2007/08, we had a rate of 2,085 people per 100,000 being admitted to hospital for alcohol related harm. Local and national trends indicate that this rate will increase. By 2011, we are aiming to have a rate of 2,345 per 100,000, which is lower than the amount admissions are predicted to rise by. The graph above shows that we expect the rate of hospital admissions to increase initially over the next couple of years at least before a decrease is experienced.



Approximately half of all digestive disease - which contributes to, on average, about 8% of the life expectancy gap - is due to liver cirrhosis.

Locally, there was a reported increase in unsafe drinking from the lowest rates in those living in the most disadvantaged areas (26.1%) to those living in the 4th most disadvantaged 20% areas (34.8%), with a slight decrease in the most advantaged areas (28.6%). Those living in the 60% most disadvantaged areas are most likely to drink alcohol at very unsafe levels and patterns for excessive ('binge') drinking reflect these patterns.

Self reported figures from the South of Tyne and Wear Lifestyle Survey suggested that:

- the 18-24 years age group were more likely to consume alcohol above the recommended safe weekly limits (21 units: males, 14 units: females) than other age groups: 45.2%, compared with over 8.5% of over 75 year olds;
- Men reported to be much more likely to drink more than recommended at all ages when compared with women (40% of men and 18% of women);
- figures for those reporting to drink alcohol at very unsafe levels (>50 units per week for men, >35 units per week for women) reflect the above demographics, with young men being most likely to do so (16%), and decreasing numbers with increasing age;
- men were considerably more likely to drink very unsafely than women (10.7% compared with 3.2%);
- young men are most likely to binge drink (67.3% compared to 32.5% of the whole population), and men generally are much more likely to do so than women (45.3% compared to 21.6%);
- BME communities are much less likely than the white population to drink unsafely: 11.5% compared to 29.2%.

Obesity

There are some differences in rates of people who are overweight across socio-economic areas, with the lowest rates being found in the middle of the range. There is a slight gradient in obesity, with higher levels being found in the most disadvantaged areas. Data shows that career professionals living in sought after areas and older families living in suburban area have the lowest rates of obesity.[57]

[57] Mosaic data

Rates of obesity[58] were lower (17.4%) than in England (26.1% projected figure) in 2007. From the ages of 25-64, women were less likely to be obese than men (18.1% compared to 21.75%). The pattern reverses from 65 years onwards, with 20.4% females being obese, compared to 9.1% of men. Further, the white population are more likely to be overweight[59] (37.8%) or obese (17.7%) than the BME population (30.7% and 14.7% respectively).

Healthy eating: Projected figures for the proportion of adults eating five or more portions of fruit and vegetables each day were 28.2% in 2008, compared to 31.3% in England. Women are more likely to eat five or more portions of fruit and vegetables a day than men: 31.6% of women compared to 24.5% of men and people from BME groups are less likely (24.7%) than white groups (28.4%). Those living in the 29% most advantaged areas are more likely to eat five or more portions of fruit and vegetables each day (40%) than those living in the 20% most disadvantaged areas (23.7%). Again, career professionals living in sought after locations, older families living in suburban areas and independent older people with relatively active lifestyles eat more fruit and vegetables.

Physical activity

The South Tyne and Wear Lifestyle Survey showed that 45.5% of males and 42.4% of women in South Tyneside reported doing 5 or more 30 minute sessions of physical activity per week. Both are well above the forecasted figures for men and women across England which are 42.4% for men and 31% for women. Those most likely to report to exercise at least five times per week were males aged 18-24 years (58.4%). The largest percentage of women exercising at this level were those aged 55-64 (51.5%), though only 38.2% of men in this age range do so. Women over 75 years were least likely to report exercising (33.3%).

Fewer people from a BME background (35.9%) report doing 5 x 30 minutes of physical activity a week, compared to those who are white (44.8%). Interestingly, the highest numbers of respondents who report doing 5 x 30 minutes exercise a week (46.8%) live in the 20% most disadvantaged areas in England, in contrast to those living in the 20% most advantageous areas (31.7%). This is supported by the mosaic data, which identified that the least physically active are career professionals living in sought after locations (37.4%) and older people living in social housing with high care needs (33.6%). Those reporting to be the most physically active were identified as being low income families living in estate based social housing (50.1%).

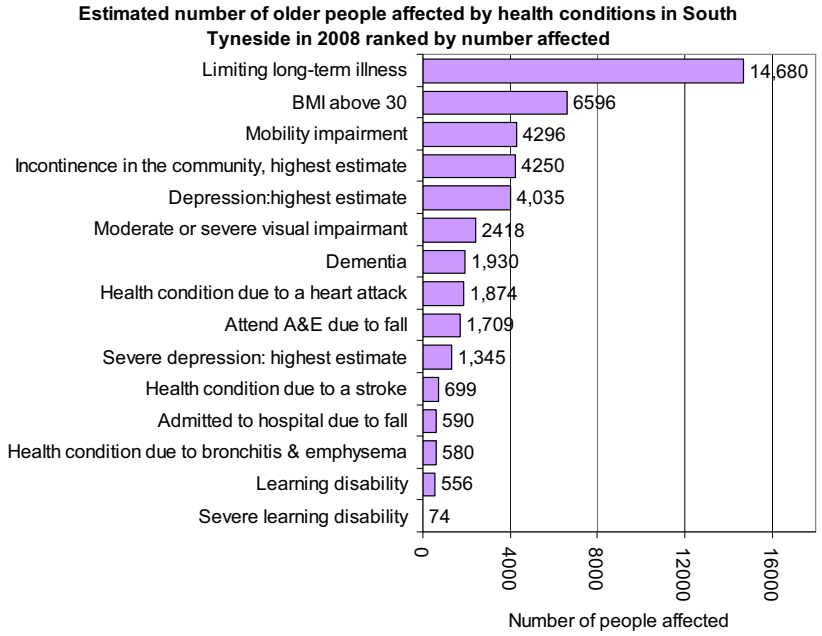
There are slightly lower levels of people taking part in sports and active recreation in South Tyneside (19.8%) than in England (21.3%)

[58] Defined as a Body Mass Index (BMI) of more than 30, calculated by a person's weigh in kilograms divided by their height in metres squared
[59] Overweight is defined as having a BMI between 25 and 30

Which conditions are having an impact on quality of life?

Drug misuse: The estimated prevalence of opiate and/or crack misuse among persons aged 15-64 years was 947 in 2004/5, dropping to 648 in 2006/7: a rate of 6.3 per 1,000 people, considerably lower than the rate for the North East, which was 9.4.

Older people: Of the estimated number of older people affected by health conditions in 2008, limiting long-term illness was the most prevalent (14.680), followed by obesity (6,596), mobility impairment (4,296), incontinence (4,250) and depression (4,035).



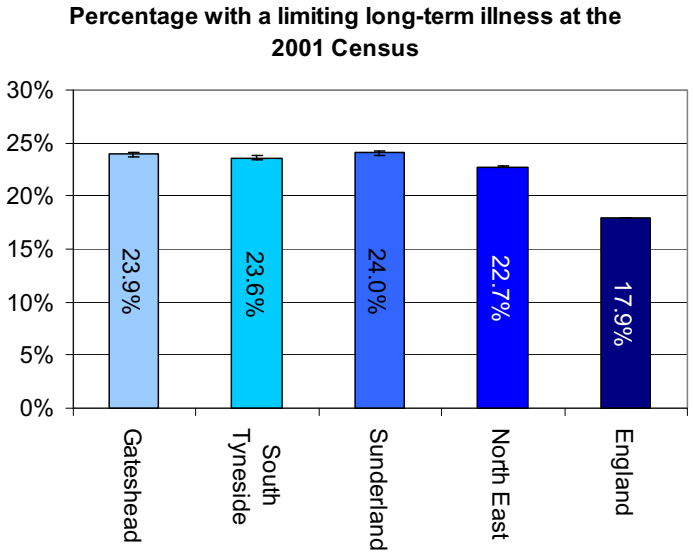
Emergency admission for falls, patients aged 65+: Falls are common critical incidents in hospitals and community settings and pose a major risk both to the individual who falls and to health and social care providers. Falls are most common in older people, particularly in the frail and those with dementia and whilst not an inevitable result of ageing, older people have a higher risk of accidental injury resulting in hospitalisation or death than any other age group.

The National Service Framework for Older People [DOH 2001] is a key Government target aiming to reduce morbidity and mortality by *'reducing the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen'.*

In 2006/7, the admission rate for falls was 2,302 per 100,000 population, higher than the rate for England (1,920). South Tyneside has the highest rate of hospital admission for fractured femur (hip fracture) at 98.3 per 100,000 population compared with England at 77.7.

Limiting long-term illness: South Tyneside has high levels of ill health. The 2001 Census showed 16,851 people (18.6% of adults of working age) had a limiting long-term illness, compared with 13.3% nationally. There are also wide variations between

wards in the Borough. Rekendyke had 23.5% of adults with a limiting long-term illness whereas in Cleadon and East Boldon it fell to 10.9%. Self reported limiting long-term illness is also higher with 23.9% of South Tyneside's population self-reporting poor health compared to 22.7% in the North East and 17.9% for England.



Statistics for the number of people who receive Incapacity Benefit or SDA helps give an indication of the level of ill-health in the Borough. Between 2005 and 2007, approximately 11.8% of people in South Tyneside were in receipt of one of these benefits. Other measures of limiting long-term limiting illness in South Tyneside include:

- highest rate of people of working age claiming disability living allowance (1.19%) than any other area in the North East (1.06% as a whole), which is in itself higher than that of England (0.95%). All these figures are on the increase: in South Tyneside the rate has risen from 0.97% in 1997;
- highest number of people registered as blind (0.3%) in the North East, which is similar to England as a whole. In contrast, it has lower rates of people registered as partially sighted than the North East;
- low levels of people registered deaf or hard of hearing (0.1%) when compared with Gateshead (1.1%), Sunderland (0.8%) and England (0.4%);
- the numbers of people registered with GPs as having a learning disability (0.36%) is lower than the numbers estimated by the Department of Health. South Tyneside has a slightly higher rate than England, but lower than the North East as a whole;
- the rate of incapacity benefits claimed for mental illness and hospital stays for alcohol related harm are worse than the England average;
- blue badge parking permits are issued to disabled people. They are issued to a smaller proportion of the population (48 per 1,000 population in 2007) than the North East (53), and to a higher proportion in England (45.1).

Road traffic accidents
The number of people of all ages killed or seriously injured in road traffic accidents has dropped from 81 in 1994 to 41 in 2008.

Sexual Health
The number of cases of **gonorrhoea** reported annually in the North East has continued to fall since 2005. This is also reflected in data locally for South Tyneside with the annual number of cases since 2005 declining from 27 (2005) to 18 (2008).

The number of cases reported for quarter 3 in 2008 has increased slightly for females while reducing for males in the Borough from the same period in 2007. While the numbers during this period are low the incidence if highest in the 25 – 34 age group in males.

Table 30: Incidence of gonorrhoea in South Tyneside

Year	North East rate per 100,000 population all ages	New diagnoses		
		Expected number	Actual number at GUM Clinic	% difference compared to expected rate
2004	23	35	13	-63%
2005	22	33	27	-18%
2006	19	28	8	-72%
2007	18	26	19	-28%
2008	18	28	23	-21%

The Health Protection Agency notes that the global **HIV** epidemic continues to have an impact on communities in the UK which originate from countries with current high prevalence. This is particularly true of individuals from sub-Saharan Africa where an estimated two thirds of the 33 million people living with HIV worldwide reside. It is recognised that the total number of people infected with HIV is higher than the number receiving care. However, the number of HIV-infected people receiving care is readily available and is a good guide to relative levels of infection.

- in 2008, 1,086 HIV-infected people received care in the North East. The rate of people diagnosed with HIV/AIDS receiving care in the North East is below the England average;
- the number of HIV-infected people accessing services was 30 in 2007: a crude rate per 100,000 population of 20, low when compared with the North East (39), England (102) and London (333), the region with the highest rates of HIV-infection.

In 2006 there were 27 people living with HIV in South Tyneside. This forms part of an undulating trend across the previous five years and is the only area South of Tyne and Wear to see a reduction from the previous year.

South Tyneside also shows a disparity in the age of people living with HIV with a peak in the 35–44 age group. Diagnosis of HIV within the under 25 group is deemed an indicator of recent transmission. There are currently no people under 25 living with

HIV; South Tyneside is the only area South of Tyne with no people in this category. This is deemed to be attributable to two potential factors:

- Screening availability and take up within this population group (under 25);
- Less members of population groups deemed at greater risk (e.g. MSM and BME).

In South Tyneside 80% of people with HIV accessing care are white and 20% are from black African ethnic groups. As the Black African population is much smaller than the white population in South Tyneside, the rate of prevalence among the black African population is much higher. This is reflected in national statistics. In 2007 around three quarters of people accessing care diagnosed with HIV or AIDS in South Tyneside were male and one quarter female.

Table 31: Incidence of HIV in South Tyneside

Year	North East rate per 100,000 population all ages	New diagnoses		
		Expected number	Actual number at GUM Clinic	% difference compared to expected rate
2004	24	15.8	20.8	66.6
2005	35	23.1	24.9	75.8
2006	32	21.2	29.4	85.4
2007	27	17.9	33.8	94.0
2008	30	19.9	39.2	101.8

Syphilis is an infection which can be transmitted between partners during sexual intercourse and from an infected pregnant woman across the placenta to a developing baby. Although the data from 2004 onwards suggests that the incidence across the North East has been quite stable in recent years, fluctuating around 4 diagnoses per 100,000 population, there was a regional outbreak which commenced in 2002. Between 2004 and 2008 the number of diagnoses at South Tyneside GUM Clinic has been less than the number that would be expected if the regional average rate of incidence is applied to the local population. This may be due to the true rate of incidence in South Tyneside being lower than the regional rate, or it may be due to a larger number of South Tyneside residents with syphilis seeking treatment outside the area compared to the number of people living outside who present with syphilis in South Tyneside.

Table 32: Incidence of syphilis in South Tyneside

Year	North East rate per 100,000 population all ages	New diagnoses		
		Expected number	Actual number at GUM Clinic	% difference compared to expected rate
2004	4	5	<5	*
2005	3	5	<5	*
2006	3	5	<5	*
2007	5	7	<5	*
2008	4	6	5	-10%

Genital herpes simplex virus (HSV) infection is the most common ulcerative sexually transmitted disease in the UK. Symptoms can start with mild soreness and groups of small painful blisters appearing on the genitals and surrounding areas. Further episodes of these symptoms can occur from time to time as recurrent episodes. The virus can cause severe disease in newborn infants and the immunosuppressed and it may facilitate HIV transmission. Many HSV infections are not detectable, as there are no signs or symptoms.

Incidence of genital herpes has been rising both nationally and regionally in the North East since 2004. The trend in the number of new diagnoses at South Tyneside GUM clinic has been rising between 2004 and 2008. In 2004 the number of new diagnoses was one third less than the number that would be expected if the average regional rate of incidence is applied to the local population. By 2008 the number was only 16% less than that suggested by regional incidence.

Table 33: Incidence of HSV in South Tyneside

Year	North East rate per 100,000 population all ages	New diagnoses		
		Expected number	Actual number at GUM Clinic	% difference compared to expected rate
2004	19	28	18	-36%
2005	24	37	16	-56%
2006	29	43	13	-70%
2007	39	59	46	-22%
2008	39	59	50	-16%

Genital warts are caused by certain types of the human papillomavirus (HPV). Warts are the most common viral STI diagnosed in the UK. Rates of new cases are highest among 20-24 year old men and 16-19 year old women. Warts are found on or around the penis, anus or vagina. Low risk HPV types 6 and 11 cause the majority of genital warts. The number of genital warts diagnosed in the UK population has risen continuously since records began in 1971.

Locally, the number of new diagnoses at South Tyneside GUM clinic has fluctuated around the expected number of diagnoses suggested by regional rates of incidence. The number of new diagnoses in South Tyneside increased in 2007, reflecting the increase in the rate of incidence regionally in this year.

Table 34: Incidence of syphilis in South Tyneside

Year	North East rate per 100,000 population all ages	New diagnoses		
		Expected number	Actual number at GUM Clinic	% difference compared to expected rate
2004	150	228	215	-6%
2005	152	230	231	0%
2006	164	248	196	-21%
2007	185	279	310	11%
2008	183	277	275	-1%

Mental health

In July 2009 a Mental Health Needs Assessment (MHNA) was undertaken across South of Tyne and Wear. This outlined that a range of factors including deprivation, employment, education, social networks, housing, the environment and lifestyle factors all had an impact on mental health. *Choosing Health* (DH 2004) identifies life events as being important and natural times for people to review their health and lifestyles and some health issues do have particular relevance to some ages. Pregnancy and childbirth bring particular issues relevant to mental health, as does ill health and advancing age.

There is little reliable and readily available information on the number of people with mental illness. The predicted prevalence of anxiety and depression in South Tyneside is 18% of the population aged 16 – 64 years in 2000. Many common mental health problems such as depression and anxiety are managed entirely within primary care and many people with these conditions may not even present to a health professional. The rate of hospital admissions due to mental health problems is, therefore, not a good indicator of the prevalence of mental illness.

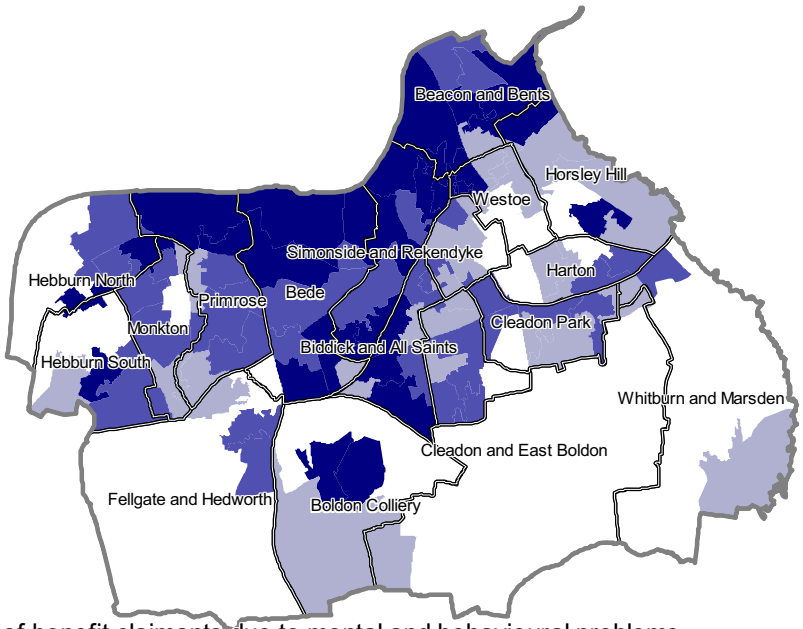
The number of claimants of Incapacity Benefit or Severe Disablement Allowance due to mental or behavioural problems of working age, in February 2009, is outlined in the table below. South Tyneside has less than neighbouring areas but higher than the regional or national rate.

Table 35: **Number of working age people claiming benefits for mental or behavioural problems**

	Number of claimants	Population of working age, mid-year 2008	Crude rate claimants per 1,000
South Tyneside	**3400**	**93,300**	**36.4**
Gateshead	4690	117,200	40.0
Sunderland	7050	175,900	40.1
North East	56610	1597500	35.4
England	838320	31937600	26.2

Source: Numbers of people claiming benefits, Department for Work and Pensions published by NOMIS, Office for National Statistics.

The map below shows the rate of claiming benefits due to mental or behavioural problems per 1,000 people of working age in South Tyneside at November 2008.



Rate of benefit claimants due to mental and behavioural problems per 1,000 adults of working age, November 2008

- Signif. higher than PCT average (95% confidence, 55 to <130 per 1,000 adults)
- Higher than PCT average (40 to <55 per 1,000 adults)
- Lower than PCT average (27 to <40 per 1,000 adults)
- Signif. lower than PCT average (95% confidence, 0 to <27 per 1,000 adults)

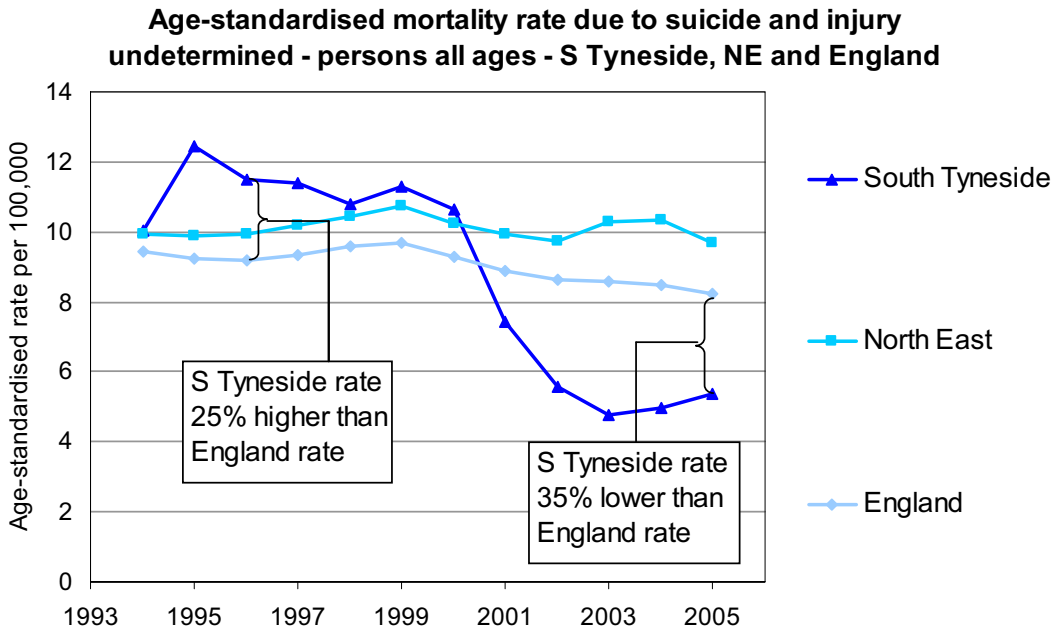
Source: Number of claimants by lower tier super output area, Department of Work and Pensions, available at www.nomisweb.co.uk, population by LSOA, Office for National Statistics.

Rates of prescribing antidepressants are higher in South Tyneside than in the North East, in themselves higher than national rates. However, prescribing rates need to be treated with caution, because there are multiple reasons for the differing rates. For example, poor access to psychological services may mean higher prescription rates.

Suicide

The North East has the highest age-standardised mortality rate directly due to suicide and injury undetermined among people of all ages (2004-2006), of all the English regions. However, the South Tyneside rate is lower compared to the Sunderland rate which is higher. However, it is worth bearing in mind that the all age three year pooled mortality rate is based on only a small number of observations or deaths. As this rate fluctuates considerably from one three-year period to the next.

Common to all national, regional and local populations, the suicide mortality rate among men is higher than that of women. From 2000 onwards there was a sharp drop in suicide mortality rates among men in South Tyneside. Since 2003, the rate has been increasing. The analysis below considers both the most recent mortality rates and trends over time.



Strategic drivers

National

- Choosing health: Making healthy choices easier. (DH 2004)
- NICE Guidelines
- Alcohol Harm Reduction Strategy for England (2004)
- Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy (2009)
- NSF for Children Young People and Maternity Services (2005)
- Every Child Matters (2004)
- Emergency Admissions: A journey in the right direction? (2007)
- Foresight: Tackling Obesity: Future Choices Report (2007)
- Smoking Kills (2006)
- New Horizons: Towards a shared vision for mental health: Consultation (DH 2009)

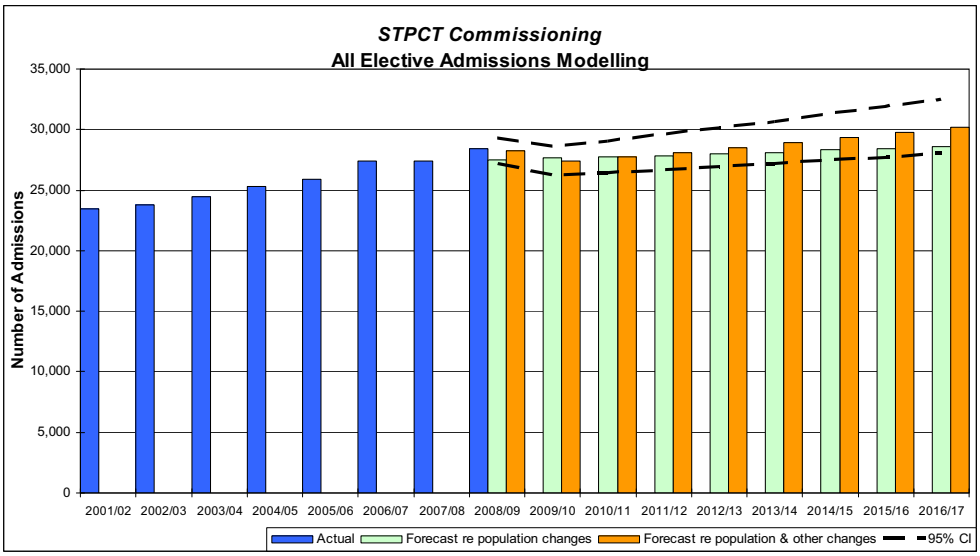
Local

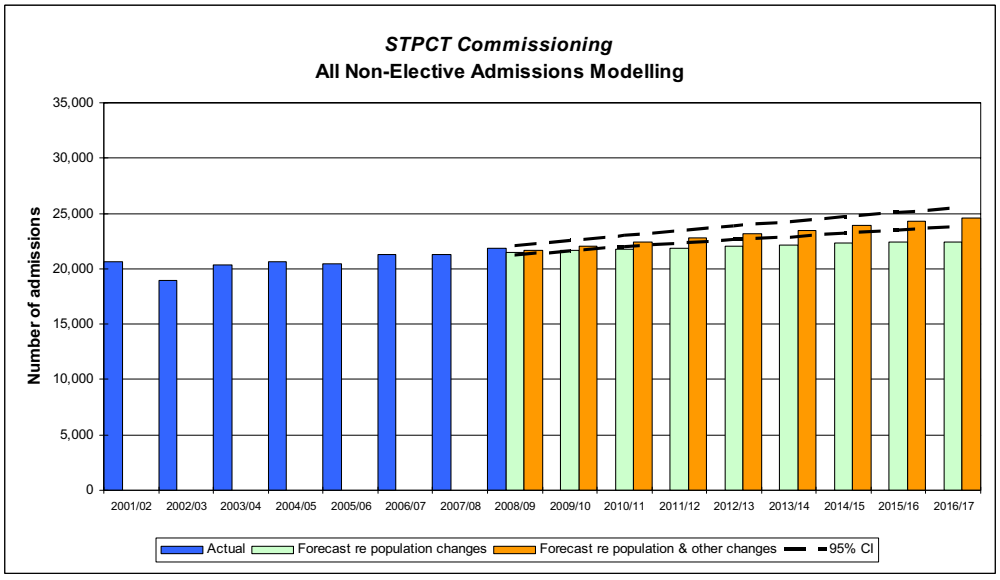
- Better Health Fairer Health (GONE 2008)
- Alcohol Harm Reduction Strategy 2007-12
- Crime and Disorder Partnership Plan 2009-12
- National Support Team visit recommendations (January 2009)
- South of Tyne and Wear Overweight and Obesity Strategy *(draft 2009)*
- Mental Health Needs Assessment
- BME Mental Health Needs Assessment
- Emotional Health and Well-being Strategy (forthcoming Dec 2009)
- Maternal Mental Health Needs Assessment (forthcoming Jan 2010)

Current and future trends and trajectories

As part of the South of Tyne & Wear's Strategic Plan, a number of predictive activity models were developed with clinicians across the health economy to forecast future activity based on a range of scenarios. These took into account the likely impact of a range of factors, including predicted changes in disease prevalence (in particular obesity, dementia, diabetes and alcohol harm) and expected clinical and technological changes. Consideration was also made of the impact of high and repeated users of services. The model uses ONS population forecasts. These impacts have been built into the baseline model which shows likely future activity if no significant changes are made.

The following graphs show total elective and non-elective hospital activity since 2001/02, forecast forwards to 2016/17, without effective action by the PCT.





The very strong message from the initial iterations of the model was that if NHS South of Tyne and Wear did not take effective action, in less than ten years, there would be hospital shortages equivalent to a small general hospital and a financial cost which the PCT would not be able to meet. This is due to a number of factors including the increasing elderly population with their high use of health services, coupled with the inevitable developments in clinical practice, technology and patient expectations. The annual update and refinement of the model continues to confirm this message.

Life expectancy and mortality: Life expectancy is continuing to rise and the gap between local and national figures increasing.

Cancer: Cancer mortality is likely to be higher among population groups with lower uptake of health screening programmes. In medium to long term (10 to 20 years) hospital admissions will be reduced if uptake of cervical, breast and bowel cancer screening can be increased now.

Coronary Heart Disease: The prevalence is likely to rise to 7.2% in South Tyneside by 2020. Between 9,100 and 9.400 people will be affected. The Eastern Region Public Health Observatory is planning to publish predicted prevalence of CHD for all GP Practices in England and using this data it will be possible to identify those communities in South Tyneside where the gap between actual and predicted CHD prevalence is widest.

Stroke: The prevalence is likely to rise to 3.1% in South Tyneside by 2020. Between 3,900 and 4,000 people will be affected.

Hypertension: The prevalence is likely to rise to 34.4% in South Tyneside by 2020. Between 43,300 and 44,800 people will be affected.

COPD: The prevalence is likely to rise to 6.0% in South Tyneside by 2020. Between 7,500 and 7,800 people will be affected.

Diabetes: The prevalence is likely to rise to 6.6% in South Tyneside by 2020. Between 9,600 and 9,900 people will be affected.

Smoking: Although there was an increase in numbers of smokers in England in 2005, the numbers are now on a downward trend. However, South Tyneside rates have increased quite dramatically since the last measurements were taken in 2003.

Alcohol: The South Tyneside figures do not show the sudden increase in excessive ('binge') drinking since 2006 that the England figures show. The age-standardised hospital admission rate per 100,000 people in South Tyneside increased from 1,856 in 2005/6 to 1,967 in 2006/7.

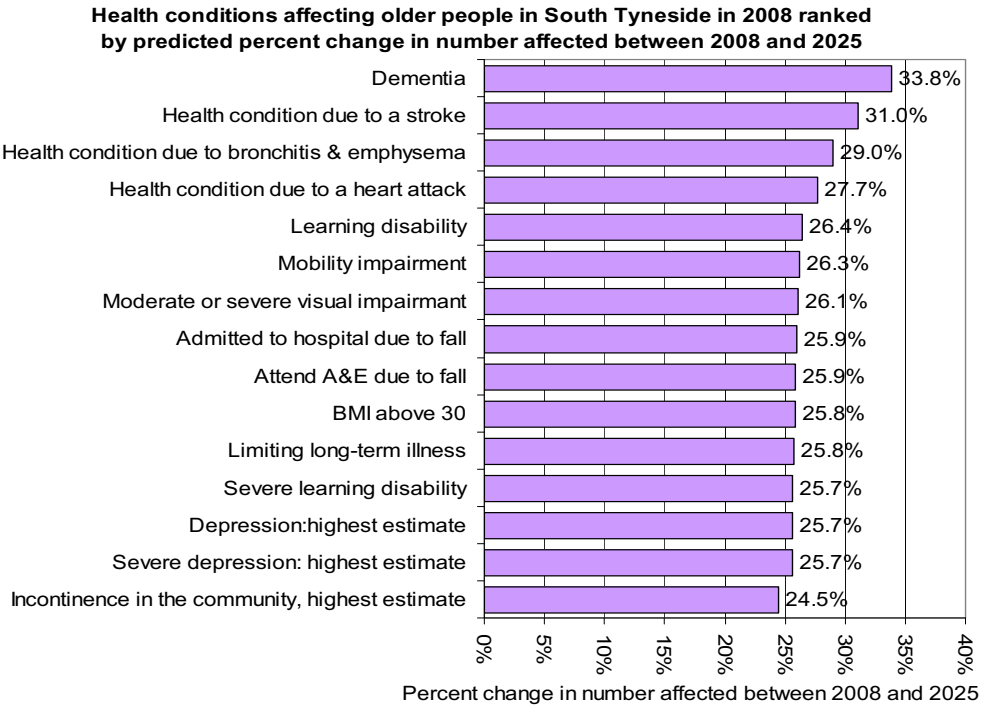
Excess Winter Deaths: Excess winter deaths in South Tyneside mirrored the rates in the North East and England from 2002 -5/6, being lower in some periods. However, the latest figures for 2006/7 show an increase to 117, from 88 in 2002/3.

Sexual Health: The percentage increase in HIV-infected people receiving care between 2002 and 2008 was higher in the North East (172%) than either England 100%) or London (61%).

Obesity: Obesity rates are increasing across England, with the percentage of men being obese being 13.2% in 1993 and 23.6% in 2007, and of women being 16.4% in 1993 and 24.4% in 2007. In South Tyneside the rates have risen from 11% for both males and females in 2003 to 17.2% and 17.6% respectively in 2008.

Physical activity: The rates of people exercising for 5 x 30 minutes per week have increased from 26.1% in 1997 to 33.8% in 2006. Projected activity rates for men and women for 2008 were 45.5% for men and 42.4% for women.

Older people: Of health conditions affecting older people in South Tyneside in 2008 ranked by predicted percent change in number affected between 2008 and 2025, dementia shows the greatest increase (33.8%), followed by a health condition due to a stroke (31%).



Targets and performance

National

Life expectancy and mortality

South Tyneside is on schedule to meet the *Our Healthier Nation* target of a 20% reduction in the premature mortality rate due to cancers between 1996 and 2010.

Local

- NIS 120 All-age all cause mortality – PSA 18
- NIS 121 Mortality rate from all circulatory diseases at ages under 75 – DH DSO/PSA 18
- NIS Mortality from all cancers at ages under 75 – DH DSO/PSA 18
- NIS119 Self reported measure of people's overall health – DH DSO

Table 36: PCT Performance indicators

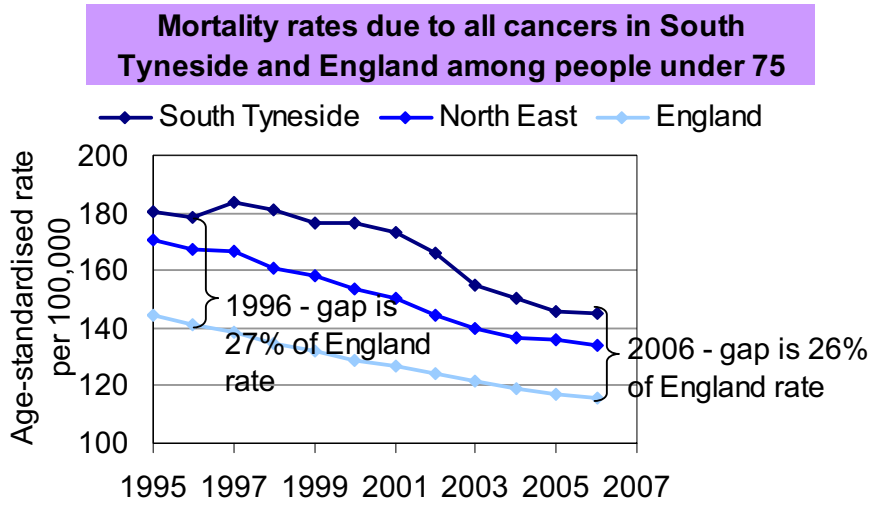
	2009/10 Trajectory	Performance at December 2009
All-age all cause mortality rate per 100,000 population (Females)	517	593.77
All-age all cause mortality rate per 100,000 population (Males)	746	791.33
Breast cancer screening - ages 53-64	>=65%	78.7%
Breast cancer screening - ages 65-70	>=65%	74.1%
Cervical Screening for women aged 25-49	80.0%	80.1%
Cervical Screening for women aged 50-64	80.0%	78.0%
Reduction in <75 Cancer mortality rate	123.6	143.92
Reduction in <75 Cardiovascular disease mortality rate	75.1	91.91
Implementation of the stroke strategy - % of higher risk TIA cases who are treated within 24 hours	45.0%	NA
Patients with a BP of 150/90 or less in last 9 months	89%	83.3%

Long-term limiting illness

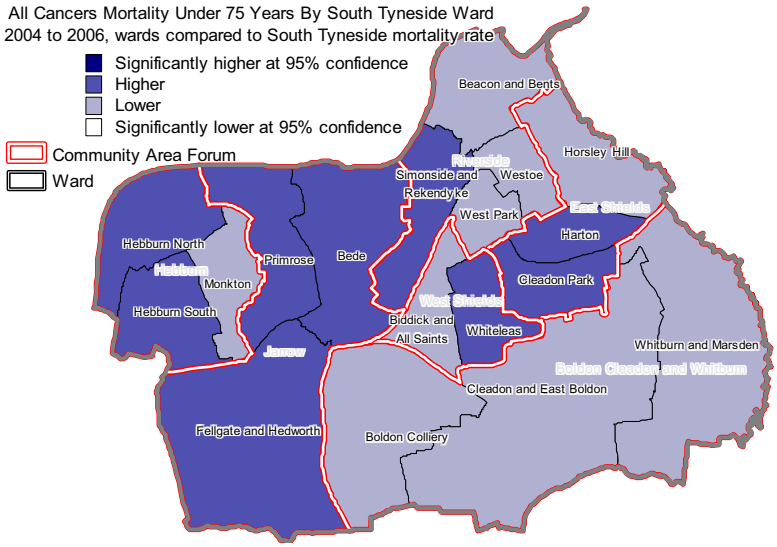
NI 124 Proportion of people with long-term conditions supported to be independent and in control of their condition – PSA 19

Cancer: The "Our Healthier Nation" target is a 20% reduction in the premature mortality rate due to all cancers between 1996 and 2010. The graph below shows the contribution from premature mortality due to all cancers towards reducing the life expectancy gap and that South Tyneside is on schedule to meet this target.

We have seen an increase in urgent two week referrals for all cancer sites. Both suspect bowel cancer and suspect lung cancer show increases of 25%. Across the three cancer types, the increase in urgent two week referrals is 18%. Data also shows a corresponding increase in the number of people diagnosed with those cancers through a fast track referral as opposed to presenting at A & E, or diagnosed through screening. The overall proportion of cancers diagnosed through the urgent two week route for breast, bowel and lung cancers has increased from 43% to 51%. Bowel cancer and lung cancer show the largest improvement of over 25%. In line with the success in referrals and diagnosis, there is an improvement in the number of people diagnosed with no spread of disease for every cancer type, with lung cancer showing the biggest change over a quarter in 2008-9.



Source: Clinical and Health Outcomes Know ledge Base



Obesity

Targets for adult obesity are:

Table 37: Adult obesity targets

	2009/10 Trajectory	Performance at December 2009
GP recording of body mass index (BMI) status	35.0%	41.6%
GP recording of body mass index % with a status recorded, recorded as being obese	30.0%	32.2%

Road Traffic accidents

Target: by 2010, that, compared to the average for 1994-1998, to achieve a 40% reduction in the number of people killed or seriously injured in road accidents.

In South Tyneside, the reduction to 2007 has been 35%, compared to 32% in Tyne and Wear, and 36% in Great Britain

Table 38: Smoking targets

	2009/10 Trajectory	Performance at December 2009
Smoking status among the population aged 16 and over	71.0%	75.2%
% of population smoking status recorded as smoking	21.0%	21.5%
Infant health & inequalities: smoking during pregnancy	27.8%	23.9%
Smoking prevalence among people with chronic conditions	25%	
Smoking During Pregnancy		

3. What are we doing?

Cardiovascular disease (including stroke, diabetes, hypertension and chronic kidney disease)

NHS South of Tyne and Wear has undertaken a social marketing exercise to support the design and delivery of a high-risk patient pathway for Cardiovascular Disease (CVD). Working closely with Explain, the exercise seeks to reduce health inequalities in the area by using preventative measures to assess those at risk of CVD and implement appropriate interventions.

As part of a range of local cardio vascular disease (CVD) programmes, South Tyneside Primary Care Trust has developed new plans aimed at both increasing awareness of the importance of quick treatment for strokes and introducing new services to help those affected by strokes. Patients will be at the centre of the new measures being proposed and will be given the opportunity to discuss and raise awareness of their experiences of local stroke services with health professionals. This will be part of process to identify priorities for future service development and for everyone involved to give their opinion on proposed stroke service changes.

NHS South of Tyne and Wear ran a general awareness Change 4 Life campaign in 2009 by focusing on positive health and lifestyle messages aimed specifically at local men in the 40-plus age bracket. The football-related theme of the campaign aimed to encourage more men to understand that an unhealthy diet and inactive lifestyle can lead to more serious illnesses such as heart disease and cancer – cutting years off their life expectancy.

Chronic Obstructive Pulmonary Disease (COPD)

South Tyneside PCT has been working in partnership with the British Lung Foundation to provide spirometry sessions and COPD awareness for the public in community settings. Sessions took place in four venues in early 2009 and will be repeated in early 2010.

Diabetes

The prevalence of diagnosed diabetes among people aged 17 years and older in South Tyneside PCT is 4.5% compared to 3.8% in all PCTs with similar diabetes risk factors (Diabetes Community Health Profile, YHPHO, 2009). This means in reality that there are around 7,500 people aged 17 years and older with diabetes in South Tyneside and the indications are that the numbers of those being diagnosed with diabetes are increasing.

Despite these high prevalence levels, research carried out by Diabetes UK in 2008 identified South Tyneside as an area where the public are the least aware of the risk factors of diabetes and/or signs and symptoms.

In view of this, a campaign was undertaken to raise awareness of the risk factors, signs and symptoms of diabetes and the availability of NHS Health Checks (which could include a test for diabetes) to the population of South Tyneside. This was done by:

1. Using the media to raise awareness of the risk factors, and signs and symptoms of diabetes to the population of South Tyneside;
2. Carrying out extra awareness raising in areas of South Tyneside where there is already high incidence of diabetes and other chronic diseases, and providing information for at risk groups at community events/locations;
3. Promoting local opportunities to have an NHS Health Check, which may have included a test for diabetes;
4. Potentially identifying those people with undiagnosed diabetes via NHS Health Checks carried out by Community Pharmacists.

The Target groups were 40-74 year olds, as identified in the NHS Health Checks criteria and people from Black, Asian, BME communities over the age of 25 years. The numbers reached by the campaign were:

Table 39 NHS Health Checks undertaken in South Tyneside

Number who attended events	Number of specific contacts made	Number of mini health checks done	Number of NHS Health checks done
2,249	784	66	60

Obesity and Diet

Obesity is the second most common preventable cause of death after smoking in Britain today and is responsible for more than 9,000 premature deaths per year in England. At present, more than half of the British adult population is overweight and obesity has trebled in the last 20 years to 22% of men and 23% of women. The same scale of problem is true for children also. There has been a 22% increase in overweight (including obese) and a 38% increase in childhood obesity since 1995. *Forecasting Obesity to 2010* warns that if current trends continue more than a quarter of British adults will be obese by 2010.

Annual Operating Funding was made available in 2008-2009 as part of the 'Bridging the Gap' programme to begin to establish 'high impact' treatment services for adults identified as being obese in each locality, including South Tyneside. Further funding was also allocated for 2009-2010 to ensure that adult services were also commissioned which would prevent those 'at risk' from becoming overweight or obese. In addition, the local authority has undertaken a mapping of services across the Borough.

Tackling obesity needs to be delivered as part of an overall plan to improve the health of the local population and create thriving, socially inclusive communities. It is recognised that obesity prevention and treatment initiatives need to be firmly embedded in other related strategies e.g. those that impact on planning, transport, food, physical activity, mental well-being and education. Other organisations therefore have a key role to play in addressing obesity.

A new draft NHS South of Tyne and Wear Overweight and Obesity Strategy has been written to support local targets and outcomes including the (PSA) 'Childhood Obesity Indicator' and (LAA) 'Local Indicator Sets' as well as the NHS Operational Framework. This ten year strategy, which reflects the scale of the problem and the challenge to be tackled by partners, is a life-course strategy and encompasses maternity, early years, school age children, families, adults and older adults. The strategy places a particular emphasis on health inequalities and targeted populations in order to effectively prevent, treat and manage obesity.

A consultation day was held in December 2008 which was attended by a wide variety of partners and stakeholders who feedback on the strategy, whilst local delivery plans will be begun to be developed in readiness for the new financial year.

Locally the prevalence of BMI ≥30 in adults over the age of 16 years is collected by General Practice as part of their Quality Outcomes Framework. This data is monitored annually by the Healthcare Commission as part of the annual health check carried out with Gateshead, South Tyneside and Sunderland PCT's. Detailed below is the end of year performance for each PCT along with the recording of BMI per quarter.

Table 40: GP performance around recording BMI of patients

	South Tyneside PCT		Gateshead PCT		Sunderland TPCT	
	Target	08/09	Target	08/09	Target	08/09
GP recording of BMI status	35%	40.8%	40%	42.19%	39%	38.7%
GP recording of BMI % with a status recorded as obese	30%	31.9%	30%	31.05%	30%	32.3%

The number of clients being referred on to the weight management pathway of care and being supported by service providers is rapidly increasing, as most services are now well established within localities and delivering at full capacity. Indeed the commissioning of these weight management services has also had a significant impact on the number of patients whose BMI is being recorded within General Practice as part of the Quality Outcomes Framework (QOF). Performance significantly

improved in the second half of the financial year 2008-2009 in each locality due to the fact that primary care practitioners could refer patients to weight management services if a BMI reading was above the recommended level, whilst performance in Quarter 1 and Quarter 2 exceeded targets.

Alcohol

'Total Place' is a pilot to explore how a "whole area" approach to public services might lead to better services at reduced cost through collaboration, introducing new ways of working and local leadership. The pilot had as a focus minimising harm from alcohol misuse and was set within the context of constrained resources and public expectations of higher quality services and builds on a background of efficiency work already in progress. South Tyneside, Gateshead and Sunderland are working together as one of 13 pilot areas participating in the scheme.

Alcohol and drug misuse has been chosen for the first 'deep dive' analysis exercise. The area was chosen because the three areas perform strongly on these priorities, but key challenges remain. There are significant issues with lifestyle choices and a third of respondents to the Place Survey think drug and alcohol issues are problems in the area.

In addition, the local authority has mapped local alcohol services and from this a commissioning action plan has been developed.

Emergency admission for falls, patients aged 65+

There are gaps in the provision of falls services in South Tyneside because services currently provided are not 24/7 and do not have contingency plans for cross cover in times of pressure and staff absence. Services and care pathways are also presently fragmented and are not in line with the best clinical evidence for multi disciplinary and inter-professional working, to ensure that care provided is based on a comprehensive assessment and includes individual patient and carer involvement and care planning.

A strategy to tackle falls has been developed across South of Tyne and Wear. As part of this the South Tyneside Falls Prevention and Management Strategy Group have developed an integrated and coherent multi disciplinary/multi agency care pathway approach to address this issue across various settings. The key aspect of this strategy is establishing and developing a Community Falls Team within SoTW provider, which will be complimentary to the specialist falls clinic ran by a Geriatrician at the local hospital. The Community Falls Team would be the Co-ordinating Centre of Falls Care programme for the people of South Tyneside, so that they can expect access to the same care wherever they live and however they access the service. A business plan for the development of a community falls team in South Tyneside has been submitted.

Smoking

The local authority has mapped stop smoking services across the Borough and there has been concerted effort to improve the number of people giving up smoking. Over 100 advisors have been trained to deliver tier two services and mentors have provided support to these services. A wide variety of drop-in services have been provided and stop smoking services have been promoted alongside other events, such as Chlamydia screening at local venues, including employers. Local press advertising is

another important part of the service with targeted press advertising on local radio and pharmacies. Opening hours of some clinics have also been extended.

Emotional Wellbeing & Mental health
There is a wide range of activities involving statutory and non-statutory agencies and a Local Action Plan is being developed to implement the Emotional Health and Well-being Strategy locally. In addition the mental health directory is being updated to provide information for professionals and local people.

Demand for local health services

Planned care

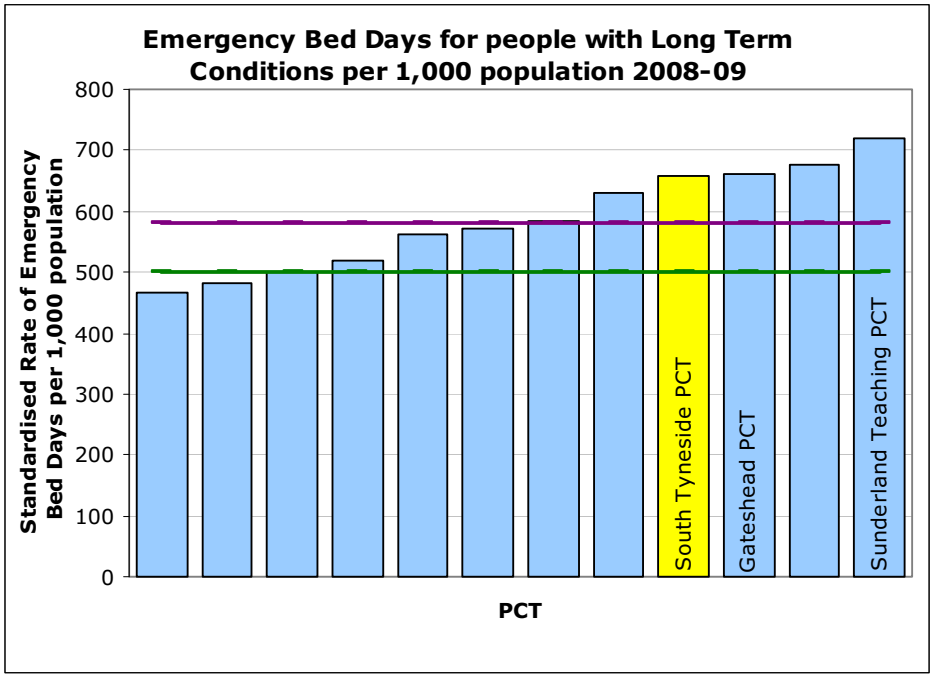
It is expected that there will be an increase in planned care (inpatients and outpatients) activity over the next couple of years in relation to meeting the 18 weeks target. This reflects a modest growth in referrals, but also the reduction of maximum and average waits. Within five years, it is expected that maximum waiting will be in the 14–16 weeks range, with average waits in the 9–11 weeks range (except for the most complex of conditions).

Plans include an allowance for growth in planned care for the rising numbers of older patients. There will be greater efficiency in planned care, with a continuing shift towards day cases and shorter lengths of stay. NHS capacity will be supported by planned care being delivered by NHS contracts with independent sector suppliers.

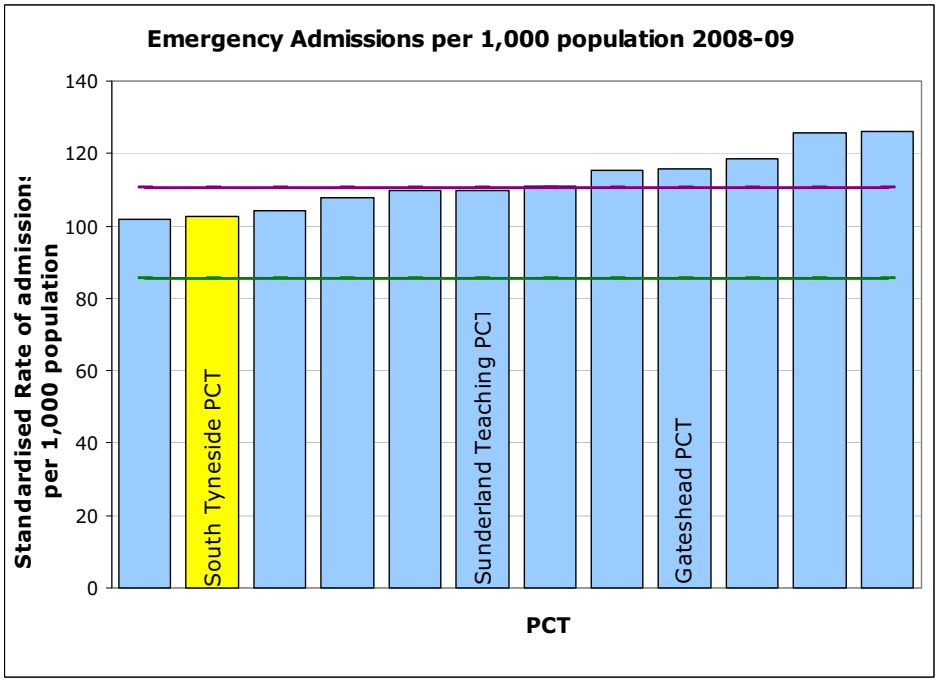
Urgent Care

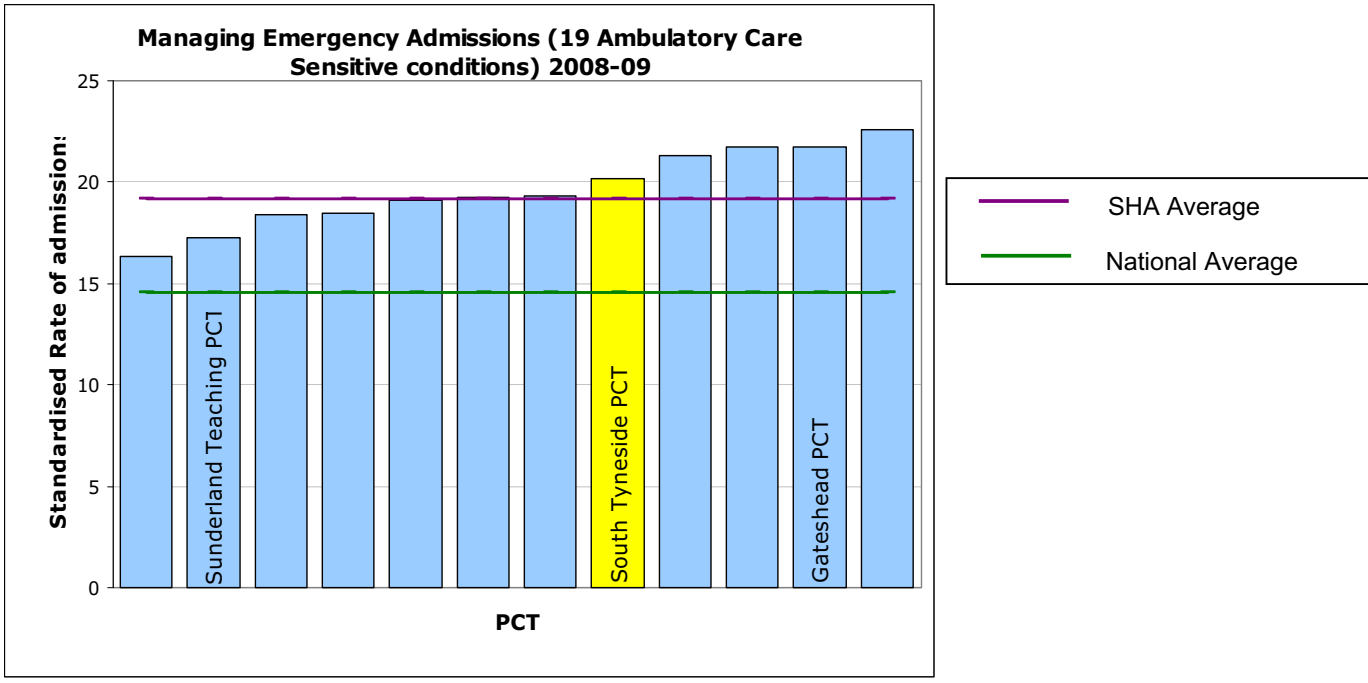
A review of urgent care was undertaken to consider the higher than average emergency admissions to hospital compared to England. In addition, data suggested that there are also very high rates of hospital admissions for Ambulatory Care Sensitive conditions compared to England. Ambulatory Care Sensitive Conditions (ACSC) are those where timely and effective ambulatory care and good case-management can help to prevent the need for hospitalisation. These conditions include:

- Chronic conditions where effective care can prevent flare-ups (asthma, COPD, diabetes, congestive heart disease, etc);
- Acute conditions where early intervention can prevent more serious progression (ENT infections, cellulitis, pneumonia, etc);
- Preventable conditions where immunisation can prevent illness.



Non-elective admissions and Accident and Emergency attendances





Foundation Trust Coronary Care Unit. A broad range of heart conditions are treated including high risk patients presenting with acute myocardial infarction, unstable angina, severe heart failure or significant arrhythmias.

Cardiac Rehabilitation

A health needs assessment carried out in 2009 to identify and describe current rehabilitation services within Gateshead, South Tyneside and Sunderland for people with heart disease found that:

- The burden of coronary heart disease (CHD) and heart failure (HF) in terms of health inequalities, mortally, morbidity and costs to the NHS are well documented.
- Cardiac rehabilitation (CR) services are an essential component of the contemporary management of patients with all aspects of heart disease.
- An exercise-based rehabilitation programme could result in:
    - An estimated reduction in all cause mortality of 20%
    - A 26% reduction in cardiac mortality at 2 – 5 years
    - A reduction in hospital re-admissions
    - Improved confidence and self care

A 26% reduction in mortality equates to 260 lives per year saved in a cardiac rehabilitation programme of 1000 patients per year. The estimated numbers for each service across South of Tyne and Wear has been calculated using local cardiology inpatient activity for 2008/09 for specific diagnostic groups. Future service demands are presented in the table below according to which rehabilitation service they would access.

Table 41 : Summary of numbers requiring rehabilitation for specific services

	GATESHEAD	SOUTH TYNESIDE	SUNDERLAND
Prehab	323	339	827
Cardiac Rehab	561	548	1681
HF	157	125	224

Source: NHS South of Tyne and Wear cardiology inpatient activity for 2008/09, and for Heart Failure, NICE Commissioning toolkit

Evidence suggests that 50% of people accessing rehabilitation will access the group programmes, 30% will require a home programme and 20% will not be interested (NI). A total of 956 people across South of Tyne and Wear will potentially decline rehabilitation due to not being interested in current programme options.

Adult Social Care

Adult Social Care (formerly Adult Services) provides social care support for people who are aged 18 and over. There are a wide range of services available to help people to live as independently as possible in their own homes and in the community. Many of these are provided by voluntary and private organisations in partnership with South Tyneside Council.

Adult social care - number of people helped to live at home 18-64 years by client group in South Tyneside

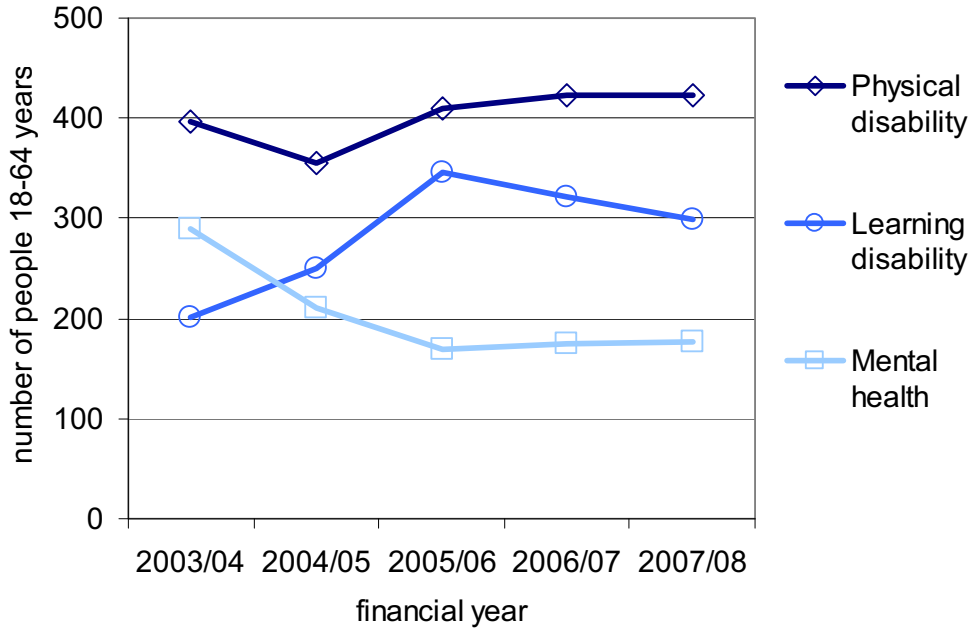


Table 42: Number of people supported to live at home by client group and rate per 1,000 people 18 to 64 years

	Population 18-64 years	Physical disability number	Physical disability rate (C29)	Learning disabilty number	Learning disability rate (C30)	Mental health number	Mental health rate (C31)
2003/04	90,441	396	4.4	202	2.2	290	3.2
2004/05	90,434	356	3.9	250	2.8	210	2.3
2005/06	90,934	410	4.5	346	3.8	170	1.9
2006/07	91,588	422	4.6	321	3.5	175	1.9
2007/08	92,132	423	4.6	298	3.2	176	1.9

Source: South Tyneside Metropolitan Borough Council

Table 43: Adults Receiving Commissioned Services in South Tyneside

		2004/05		2005/06		2006/07		2007/08	
Service	**Age**	Number	%	Number	%	Number	%	Number	%
Community-based Services	**18-64**	1604	92%	1706	92%	1669	93%	1659	93%
	65+	3302	74%	3539	77%	3715	81%	3768	81%
Independent Residential	**18-64**	230-234	*	290-294	*	173	10%	164	9%
	65+	1633	37%	1187	26%	768	17%	717	15%
Local Authority Residential	**18-64**	<5	*	<5	*	7	0%	10	1%
	65+	12	0%	178	4%	336	7%	334	7%
Nursing Homes	**18-64**	9	1%	29	2%	35	2%	31	2%
	65+	26	1%	314	7%	230	5%	233	5%
Total Residential	**18-64**	234	13%	295	16%	180	10%	174	10%
	65+	1645	37%	1365	30%	1104	24%	1051	23%
Total	**18-64**	1744		1854		1799		1783	
	65+	4445		4609		4571		4628	

Source: South Tyneside Metropolitan Borough Council - Adults' Services

This contrasts with the number of older people 65 years and over admitted to permanent care. In 2005-6 this increased from 261 (rate per 10,000 of 95.0) to 305 (rate 111.4) in 2006-7. However, for 2007/8 this fell to 250 (rate 91.8).

4. What is this telling us?

Key inequalities

It is accepted that wider health determinants play a significant role in tackling health inequalities, including access to food, transport, green space and the built environment, and these are all factors which can narrow or widen the health gap between rich and poor communities. We need to create a better environment and healthier people at the same time. At the same time as improving individual behaviours around lifestyles to reduce cancers, heart disease and strokes we need to ensure that current services do not widen existing inequalities.

Projections suggest that there will be an increase in the number of older people remaining in their community regardless of their condition which will impact on the

health of people in South Tyneside and the services that will need to be provided. To reduce health inequalities for working age people more effort needs to be directed at the wider determinants of health, including employment, transport, housing and the wider environment.

What is on the horizon?

The development of NHS Health Checks in South Tyneside will provide early identification of people at risk of vascular diseases (including stroke, kidney disease and diabetes). By focusing on 40-74 year olds to identify their risk of vascular diseases, ensuring they have access to pharmacological interventions to reduce hypertension or cholesterol, or referring them into lifestyle interventions including stop smoking and or weight management services this will impact on current services. This is also likely to shift resources from secondary care into the community setting, including the development of services within Primary Care Centres.

A recently published White Paper commits the Government to building a new National Care Service which is likely to lead to a fundamental reform of the care and support system in England. This will significantly impact on the provision of health and social care services in South Tyneside.

5. What should we be doing next?

Cardiovascular disease

- carry out health equity audit to assess uptake of NHS Health checks in deprived areas;
- robust service specifications for cardiac and heart failure rehabilitation against national standards;
- increased choice – a menu based approach to Phase III and Phase IV integrated with current services;
- investing in workforce development to increase skill mix, providing appropriately qualified, skilled and competent staff;
- systematic identification of all those eligible for rehabilitation;
- developing innovative approaches to engaging service users;
- ensuring robust audit / evaluation of rehabilitation services.

Cancer

- develop communication and public engagement plan in relation to early identification of cancer.

Emotional Wellbeing and Mental Health Recommendations

- develop further the wellbeing strategy led by the Local Authority in South Tyneside with a specific focus on identifying vulnerability early and developing programmes (learned optimism) and resilience taking account of the differing needs of children, young people, adults and older people;

- establish a population based audit of suicides and undetermined injury in the South of Tyne and Wear Primary Care Trust localities and implement local suicide prevention action plans;
- develop a local action plan to implement measures outlined in the Mental Health and Social Exclusion Report, with delivery arrangements mainstreamed through Local Strategic Partnerships;
- develop a co-ordinated media anti-stigma campaign to raise public awareness of mental health issues to support the strategic approach linking with the regional approach;
- develop a model of preventative and physical healthcare for people with mental health problems across South Tyneside;
- continue to work with the black and minority ethnic communities in South Tyneside to support their mental health needs and implement the programmes of work currently being developed to take forward the recommendations in Delivering Race Equality: A Framework for Action (DH);
- wellbeing checks in deprived areas should identify people with depression and anxiety and make sure they get treatment and support.

Maximise Independence (decrease hospital stays / increase services in communities)

The strategic direction of services is to provide more care in the community, closer to people's home to give people greater choice over where and how they receive care when needed.

- further analyse hospital admissions data to focus on service areas to reduce unnecessary admissions;
- extend access to community matrons, particularly to those with long term health conditions;
- provide local and accessible services, and more inter-agency working to ensure cohesive delivery;
- promote self and supportive care and to implement the falls prevention strategy;
- work with the third sector to encourage volunteering in the community;
- commission alternatives to long-term care, including extra-care housing and assistive technology;
- further analyse programme budgeting information.

CHAPTER 6 Vulnerability

1. Introduction

It remains a challenge to balance the health needs of the most vulnerable in our community with improving the health of the wider population. “Vulnerable groups” are usually defined as those that are likely to have additional needs compared with the general population and experience poorer outcomes if these needs are not met. This tends not to recognise the combined effect of multiple risk factors on the health of vulnerable individuals or groups. Despite there being no definitive list of “vulnerable groups” populations such as Black and Minority Ethnic (BME) communities or disabled people have, traditionally, been singled out for interventions or specialist services, so perpetuating stigma and marginalisation.

An alternative approach acknowledges that vulnerability is not static. In this approach, vulnerability occurs when risk factors (threats) to an individual or community from either the environment or from personal circumstances become greater than their ability to cope with those threats (resilience). When this happens, health outcomes will most likely suffer. To improve the health and wellbeing of individuals and communities, threats should decrease or resilience to these threats should increase. Importantly, sections of the community, either groups or individuals, will face vulnerabilities at different times of their lives and not everyone who is exposed to threats will be vulnerable to poor health.

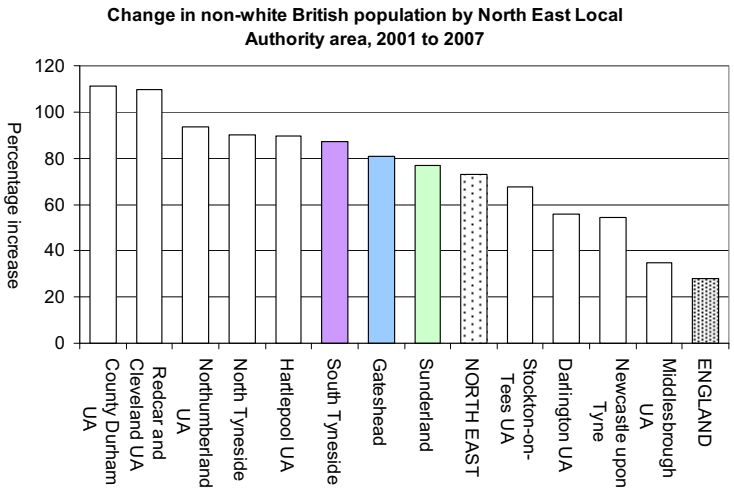
Although this chapter considers the needs of particular groups it will take account of the clustering of multiple threats for vulnerability to poor health so that we may begin to move away from a hierarchy of least to most vulnerable groups. It contains quantitative information relating to the needs of some groups and qualitative data from surveys and consultations, both local and national. This can often help to fill gaps caused by the unavailability of local quantitative data.

2. Where are we now?

Demographics, social and environmental context

BME communities: There is a rapidly increasing BME population in the Borough that can largely be attributed to the influx of Eastern European migrants in recent years, as opposed to an increase in people of Asian and African-Caribbean ethnicity, who have tended to make up the BME population in the Borough. The Bangladeshi community is the largest minority ethnic group but other communities include Arab, Indian, Black African, Black Caribbean, Chinese and Pakistani. BME communities live primarily in two main wards: Beacon and Bents and Rekendyke.

In April 2009, the ONS published population estimates for Local Authority areas at mid-year 2007. It estimated that there are roughly 10,300 people in South Tyneside not classified as White British, equating to 6.8% of the total population of South Tyneside. This is almost double the BME population of South Tyneside in 2001 and a much steeper increase than seen nationally, as illustrated by the graph below:



Extensive research suggests that many people from BME communities experience social inequalities, such as poverty, poor housing and unemployment, which contribute to health inequality. Despite progress, minority ethnic communities still suffer disproportionately from certain health conditions. People from BME communities and, in particular, those who do not speak English are at risk of poor access to healthcare.

The 2004 *Health Survey for England* [60]found that Bangladeshi and Pakistani men and women and Black Caribbean women were particularly likely to report bad or very bad health. Other findings included:

- HEART DISEASE: South Asians experience significantly higher rates of coronary heart disease. Pakistani men, in particular, are twice as likely as men in the general population to report this condition. There is also evidence of higher rates of heart disease among Irish men and women;
- DIABETES: The prevalence of diabetes among South Asians can be up to five times that of the general population. Rates of diabetes among Black Caribbeans are also higher than the general population;
- SMOKING: Smoking rates are higher among Bangladeshi men (40%), Pakistani men (29%) and White Irish men (30%) compared to the general population (24%).

As there is a relatively substantial Bangladeshi and Pakistani population in South Tyneside, it is likely that our local populations will have similar risk factors.

In addition, the 2008 national *'Count Me In' Census (NIMHE)* of mental health inpatients showed that:

- Black people and 'white/black' people have significantly higher than average admission rates and are more likely to be compulsorily admitted under the Mental Health Act 1983;

[60] Department of Health (2004), *Health Survey for England: Health of Ethnic Minorities*

- inpatients with learning disabilities admission rates were two to three times higher than average for Black Caribbean, white/black Caribbean and Other Black groups.

Asylum Seekers: South Tyneside is a National Asylum Seeker support area. As of March 2008, there were estimated to be 171 asylum seekers in the Borough, though this number can fluctuate and is difficult to monitor due to the fluidity of the population. There are fifty properties available to house asylum seekers in South Tyneside. People from as many as twenty-seven countries reside in the Borough, speaking a wide range of languages.

Table 44: Total numbers of asylum seekers in South Tyneside at March 2008

	Gateshead	**S Tyneside**	Sunderland
Total population at mid-year 2007	190,500	**151,000**	280,300
Total number of asylum seekers at March 2008	355	**171**	354
Percentage of asylum seekers	0.2%	**0.1%**	0.1%

Source: ONS 2007 mid-year estimate of resident population by Local Authority, asylum seeker, – North of England Refugee Service (2009)

Since the arrival of the first asylum seekers in 2000, over thirty families have been given leave to remain in the Borough as refugees. The more pronounced health needs of asylum seekers and refugees can usually be attributed to previous experiences in their country of origin and their travel to the UK. Many asylum seekers have experienced torture in their country of origin and are likely to have suffered rape and sexual abuse. Furthermore, asylum seekers and refugees commonly experience mental health problems such as stress and depression as a direct consequence of torture, a traumatic journey to the UK and concerns about the asylum application process.

The detrimental impact of the asylum process on the health of asylum seekers is a recognised concern and can cause stress and depression. The separation of asylum seekers and refugees from their families can also cause similar distress and mental health problems. Their health can also be affected by health care provision in their country of origin, such as incomplete immunisation programmes or poor dental care facilities.

Gypsies and Travellers: Gypsies and travellers have poorer health and more self-reported symptoms of ill health than other UK residents. Reported chest pain, respiratory problems and arthritis, in particular, are more prevalent. The mortality rate of gypsies and travellers is between one and one and a half times that of the housed population. Life expectancy in the gypsy/traveller population tends to be below that of the general population. Research highlights high smoking prevalence and levels of coronary heart disease as the main factors for this low life expectancy. Studies have also found that maternal mortality is higher for gypsies and travellers than for any other ethnic group. They experience exceptionally high rates of miscarriage, stillbirth, perinatal death and infant mortality as well as high child accident rates.

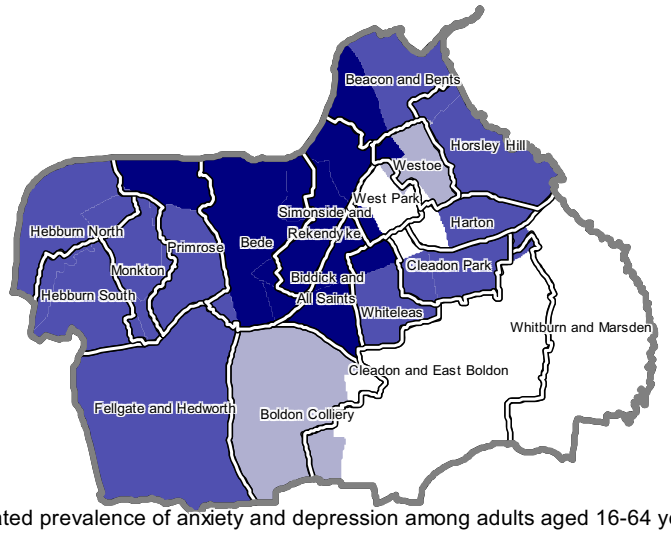
In South Tyneside, a site in Boldon is a site dedicated to the gypsy/traveller population. The site is home to approximately ten adults and five children, though this number is very fluid and changes frequently.

People with mental health problems: There is currently little reliable data on the prevalence of common mental health problems at local authority level.

In 2000, a national survey of psychiatric morbidity among adults aged 16-64, living in private households was undertaken across England[61]. Heady and Ruddock[62] used this data to estimate the prevalence of common mental health problems for small areas by correlating the likelihood of experience mental illness with a range of population characteristics, such as poverty, unemployment, and social isolation. Using mid-year population estimates, the total number of people within South Tyneside that are expected to suffer from mental health problems is 16,617, equating to roughly 18% of the total population.

There is a strong correlation between deprivation and poor mental health; those on the lowest incomes tend to experience much higher rates of mental illness. Indeed, significant mental health inequalities are apparent in the poorer areas of the Borough with higher rates of depression and anxiety. High levels of depression are prevalent in particular wards in the Borough that experience significant deprivation: Bede, Simonside and Rekendyke, and Biddick and All Saints.

The prevalence of these estimated mental health problems is disaggregated into specific Borough wards below.



Estimated prevalence of anxiety and depression among adults aged 16-64 years by pre-2004 ward, based on data from 2000 National Psychiatric Morbidity Survey

19% to <22%
17% to <19%
16% to <17%
13% to <16%

People with serious mental illness have a reduced life expectancy of ten years compared to the general population. This difference is more marked for men than

[61] Singleton N. et al. (2000) "Psychiatric morbidity among adults living in private households, 2000", The Stationery Office, London
[62] Heady P. & Ruddock V. (1996) "Report on a Project to Estimate the Incidence of Psychiatric Morbidity in Small Areas", Office for National Statistics

women and is largely due to physical health problems, such as coronary heart disease, respiratory and infectious disorders.

BME groups are more likely than the general population to experience mental health difficulties. This is due directly to the discrimination that they may suffer, which can affect self-esteem, ability to cope, and can lead to people feeling isolated, intimidated and fearful. Poor outcomes for mental health problems can be due to their lack of access to appropriate services, either because they are unavailable or because they are not recognised as being in need of such services.

Victims of domestic violence, in addition to suffering physical injuries, are likely to suffer mental health problems, such as depression. Women experiencing domestic violence have been found to be 15 times more likely to abuse alcohol, 9 times more likely to abuse drugs, 5 times more likely to attempt suicide and 3 times more likely to be diagnosed with depression or psychosis[63].

People with learning disabilities experience a higher rate of mental illness. For instance, those with a learning disability are three times more likely to suffer from schizophrenia than the general population.

Disabled people: The term 'Disabled' covers people who are wheelchair-reliant, people who are wheelchair users, blind people, deaf people, people with long-term progressive conditions such as Multiple Sclerosis, HIV /AIDS or cancer from the point at which adverse effects emerge, as well as people with impairments such as back pain and mental heath problems. However many do not claim disability-related benefits or use services aimed specifically at disabled people.

In the UK an estimated 11 million adults, using the widest survey definition, are 'disabled'; this is equivalent to more than one-in-five adults. Evidence suggests that disabled people are more likely to achieve lower outcomes in terms of employment, income and education and are more likely to face discrimination and negative attitudes, and often experience problems with housing and transport. Disabled people still earn 30% less than non-disabled people. Individuals of Indian, Pakistani, Bangladeshi and Chinese origin remain less likely to report that they are disabled than people from other ethnic origins.

People with learning disabilities: People with learning disabilities are a particularly vulnerable group within society. They experience considerable stigma, often have complex needs and experience significantly poorer health than the rest of the population. Life expectancy has been increasing in people with learning disabilities but is still lower than in the general population. Some studies suggest that reduced life expectancy is confined to people with more severe learning disabilities, which is also frequently associated with marked physical health problems.

The recent *Independent inquiry into access to healthcare for people with learning disabilities*[64] found evidence that this group had higher levels of unmet need and

[63] Stark et al (1981) *Wife Abuse in the Medical Setting: An Introduction for Health Personnel*, US Department of Health, Office of Child Abuse and Neglect
[64] Department of Health (2008), *Independent inquiry into access to healthcare for people with learning disabilities*

received less effective care. Many reasons for this were identified, including a lack of awareness of the health needs of this group, lack of knowledge and information, poor training and education of clinical staff, and negative attitudes of staff.

As of October 2009, there were 780 people in South Tyneside known to the adult social care service as having a learning disability.

Carers: The 2001 Census showed that, nationally, there are almost six million carers in the UK. Moreover, women are more likely than men to be carers; 3.4 million (58%) of the six million carers in the UK are women. Most carers are over-18 and the peak age for caring is 50-59 years of age. The prevalence of caring in the UK varies between ethnic groups but it can be seen that nationally Bangladeshi and Pakistani men and women are three times more likely than those of White British ethnicity to be carers.

These trends are replicated in South Tyneside, with 15,871 people in South Tyneside shown to be carers, according to the 2001 Census. It is also estimated that the majority of carers in the Borough are female and over the age of 50 though there are still significant numbers of carers who are male and under that age group. There are also many 'hidden' carers – those who do not identify themselves as carers and, therefore, do not receive the support that they may need.

As a consequence of caring, many carers can experience ill health, poverty and discrimination. Carers are often family members or friends who have health needs themselves that are often unmet. The health needs of carers are very personal and vary from person to person. However, it is recognised that carers do have health needs that are often neglected as a result of the focus on the person that is cared for.

A report[65] found that those caring for 50 hours a week or more are twice as likely to be in poor health as those not caring. Caring for a friend or family member is often a long-standing commitment and those providing care over a long period of time are at particular risk of poor health. Moreover, both mental and physical health are likely to deteriorate the longer the carer has been caring. Many carers are forced to ignore their own health because of a lack of alternative care and the absence of emergency planning.

A 2002 study[66] found that carers are twice as likely to have mental health problems if they provide substantial care. Factors contributing to poor mental health include: the inevitable stress of providing care, often 24 hours a day; social isolation as a result of the demands of providing care; and, the financial burden of caring – the vast majority of carers are unemployed, have additional costs due to disability services and do not always receive correct or substantial benefits.

In South Tyneside carers receive support from the local authority through Adult Social Care and there has been a steady increase in the number of carers receiving services from 221 in 2004-5 to 502 in 2007-8.

[65] *In Poor Health: the impact of caring on health* (2004), Carers UK
[66] Singleton, N. et al (2002), *Mental Health of Carers*

Table 45: Carers Receiving Services in South Tyneside as a Proportion of All People Receiving Services

Financial year	Number of carers receiving services	Total number of people receiving services	Percentage of people receiving services that are carers (C72)
2003/04	No data	No data	No data
2004/05	221	4,906	4.5
2005/06	478	5,245	9.1
2006/07	441	5,384	8.2
2007/08	502	5,427	9.3

Source: South Tyneside Metropolitan Borough Council - Adults' Services

People facing Domestic Violence: Nationally, it is estimated that one in eight women in long term relationships are affected by domestic violence. Domestic violence is an issue that affects victims, children and other family members. Women account for 80% of all reported victims of domestic violence in the UK. One in four women and one in five men are reported to have experienced domestic violence.[67]

There were 2,549 reported incidents in 2008 up to and including September. In that same time period in 2009, there were 2,415 reported incidents. Although the number has slightly decreased in 2009, it is still an issue of concern. Moreover, it is difficult to measure the actual number of victims of domestic violence, as it is often a hidden crime. Therefore, an apparent higher prevalence of domestic violence could be more as a result of increased reporting of the crime.

Homeless People: Monitoring the prevalence of homelessness is particularly difficult, given the nature of the problem. However, in the first two quarters of 2009/2010, South Tyneside Council received 240 homelessness applications and by October 2009 had made 181 decisions. Of those 181 decisions, 95 cases were accepted as statutorily homeless and, therefore, eligible for Council accommodation.

The 95 statutorily homeless in the Borough included:

- 79 dependent children / pregnant women
- 9 suffering from physical or mental illness or alcohol or drug dependent
- 2 minors (aged 16/17)
- 4 victims of domestic violence
- 1 homeless as a result of an emergency (fire).

Homeless people have multiple health needs and are among the most vulnerable group in society. In addition to ever-present health concerns, they are faced with ongoing difficulties related to poverty and discrimination. Persistent health problems include severe psychiatric conditions, ongoing substance abuse issues, and learning disabilities. These often occur alongside an array of physical health difficulties that

[67] British Medical Association (2007) The BMA's submission to the Home Affairs Select Committee outlining findings from the BMA Board of Science's report on Domestic Abuse, http://www.bma.org.uk/health_promotion_ethics/domestic_abuse/InqDomVio.jsp

are frequently under-diagnosed and untreated. As a result, they experience considerable difficulties in accessing appropriate services.

While poor mental or physical health can sometimes be the primary cause of homelessness, more often it is homelessness that causes or contributes to health problems. Chronic and acute health problems often result from poor living conditions and contribute to the inability of an individual or family to break the cycle of homelessness. The more basic needs of food and shelter can result in neglect of general health. This can allow minor health problems to progress until they become life-threatening illness. The first encounter with the healthcare system will occur only when the problem has finally become so serious that it no longer can be ignored.

Housebound people

There is a considerable amount of evidence to suggest that people who are housebound are more likely to suffer poorer physical health (in addition to their primary reason for becoming housebound), higher levels of depression and are less likely to access health services[68].

In 2005/06, a housebound survey was undertaken in South Tyneside to determine the health needs of housebound patients to ensure they all receive an effective health services. The analysis of the gathered information from practices revealed that there were about 1500 patients identified in a GP record as a housebound with one or more with a major chronic disease (e.g. diabetes, CHD, etc.) The survey also showed that there were significant shortages in the provision of primary care services to those housebound people.

Strategic Drivers

National

- Choosing health: Making healthy choices easier (DH, 2004)
- Putting people first: a shared vision and commitment to the transformation of adult social care (DH, 2007)
- National Service Framework for mental health (DH, 1999)
- Making it happen. A guide to delivering mental health promotion (DH, 2001)
- Our health, our care, our say,(DH, 2006)
  Making it possible: Improving mental health and wellbeing in England (NIMHE 2005) is the
- Foresight Mental Capital and Wellbeing Project (2008) Final Project report – Executive summary, www.foresight.gov.uk
- Improving the Life Chances of Disabled People", January 2005

Local

- Better Health, Fairer Health (NESHA, 2008)
- Spirit of South Tyneside. Our new Sustainable Community Regeneration Strategy and Local Area Agreement

[68] Economic and Social Research Council

Targets & Indicators

General

NI119: Self-reported measure of people's overall health and wellbeing
NI140: Fair treatment by local services
NI141: Number of vulnerable people achieving independent living
NI142: Number of vulnerable people who are supported to maintain independent living

Disabled people

NI124: People with a long-term condition supported to be independent and in control of their condition
NI127: Self reported experience of social care users
NI128: User reported measure of respect and dignity in their treatment
NI130: Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)
NI132 Timeliness of social care assessment
NI133 Timeliness of social care packages
NI136 People supported to live independently through social services (all ages)

Learning Disabilities

The impact of provision for people with learning difficulties is measured against a number of key targets and indicators. Key national-level indicators include:
NI145: Adults with learning disabilities in settled accommodation
NI146: Adults with learning disabilities in employment
NI145: Adults with learning disabilities in settled accommodation

Older people

NI129: End of life care - access to appropriate care enabling people to choose to die at home
NI139 The extent to which older people receive the support they need to live independently at home

Carers

NI135 - Carers receiving needs assessment or review and a specific carer's service, or advice and information
NI136 and Vital Sign VSC03 - People supported to live independently through social services

Domestic Violence

Historically the emphasis was largely placed on partnerships and local authorities to set their own priorities. More recently, in 2008/09 government introduced Public Service Agreements (PSAs) which are measurable through the National Indicator Set (NIS) and Assessment of Policing and Community Safety (APACS) and this has increased the priority of tackling domestic violence.

Homeless people

- NI141 - Number of vulnerable people achieving independent living (measures the number of people making a planned move to independence

from an accommodation-based supported housing that is intended to provide short term support)
- NI142 - Number of vulnerable people who are supported to maintain independent living (measures the number of people sustaining independence as a result of Supporting People funded long-term services or floating support)

The Department for Communities and Local Government (DCLG) also provide Best Value Performance Indicators (BVPIs)
- BV213 - Number (%) of households who considered themselves as homeless, who approached the authority's housing advice service(s), and for whom housing advice casework intervention resolved their situation

Offenders
- PSA 16 - increase the proportion of socially excluded adults in settled accommodation and employment, education and training
- The National Offender Management Service (NOMS) aims to reduce re-offending by 10% by the end of the decade

3. What are we doing?

Mental Health Needs Assessment: South Tyneside Council, in partnership with the PCT, recently carried out a Mental Health Needs Assessment for the Borough. This identified a number of groups of people who face the risk of poor mental health at particular life stages, including ante and post natal women, older people, people with dementia, people with long term conditions, BME communities, LGBT people, victims of domestic violence and offenders.

Learning Disability Health Assessment Framework: In order to fully understand the needs of people in the Borough with learning disabilities, South Tyneside Council, in partnership with the PCT, carries out an annual Health Assessment for people with learning disabilities. As a result of this annual health assessment, any areas of concern are highlighted and addressed.

The Learning Disability Partnership Board (LDPB) comprises members of the PCT, the local authority and voluntary organisations, and works to address the health inequalities faced by people with learning disabilities. 'Valuing People' – the government's strategy for people with learning disabilities – is a key focus of the LDPB. We are making services better and creating more opportunities for people with a learning disability. There is a comprehensive range of specialist learning disabilities services available to sustain and support people in their local community.

Carers Association in South Tyneside (CAST): CAST is a voluntary organisation in South Tyneside that works with carers of all ages. There are roughly 1300 people registered with CAST. The majority of people registered are female and caring for elderly people. The needs of carers vary; therefore, the service CAST provides is very personalised. Their services includes providing courses for carers, therapy sessions and short-breaks.

Annual Reports into health needs of asylum seekers: The Specialist Health Visitor responsible for Asylum Seekers within the PCT produces an annual report into the health needs of asylum seekers in the Borough and the most common minor health problems of asylum seekers are generally associated with conditions of overcrowding, as a result of hostel accommodation and people smuggling into the UK and can usually be treated prior to referral to the primary healthcare team. These have been found to include scabies, fungal skin infections and tooth decay. More serious health problems include tuberculosis, HIV, haemophilia, malaria and sickle cell anaemia.

Although access to free medical treatment is available to asylum seekers and refugees, many are not aware of appropriate uses of healthcare in the UK. Evidence also suggests that difficulties in accessing healthcare can be exacerbated by language barriers. The requirement of a translator can be difficult and time-consuming to arrange. This is a particular difficulty when taking into account the wide range of nationalities and languages of asylum seekers in the Borough.

Victims of domestic violence: There are a number of initiatives addressing this issue, such as the Freedom Programme, a group approach to helping women understand domestic violence and to promoting self-esteem and confidence. There are also perpetrator programmes, addressing the causes of violence and abuse and supporting people in finding more appropriate strategies for dealing with anger.

Health checks for homeless people: When people apply for homelessness status, their health needs are assessed with the Health and Housing Team within the Council.

Consultation with Gypsies and Travellers: A member of the Council visits the dedicated site for gypsies and travellers in the Borough on a weekly basis.

In July 2008, the Public Involvement Locality Lead for South Tyneside met with two representatives of the traveller community to discuss the procurement of GP services and took verbal comments about the health centre; no comments were made about the GP surgeries, as the travellers do not know the areas. The range of services highlighted as a priority for the gypsy/traveller community were:

- Dental services;
- Services for children;
- Emergency services;
- Practice nurses;
- Advice and information service.

4. What is this telling us?

Vulnerable groups face a number and wide range of significant health needs compared to the general population. Socio-economic disadvantage is a key indicator of groups who may face particular health inequalities. Indeed, many of the vulnerable groups identified live in areas with widespread deprivation. Many issues of vulnerability are cross-cutting. For instance, a number of the vulnerable groups identified have been found to be at high risk of facing mental health problems. The nature of some sections of the community, for example - instance gypsies/travellers

and homeless people - makes it particularly challenging to gather information on their specific health needs.

The level of health inequality of BME groups varies, as does the level of need across and between different ethnic groups. This is often compounded by a complex multiplicity of social and environmental factors. Moreover, the increase in the BME population in the Borough is something that needs to be considered, given their likely health needs. Asylum seekers have significant and numerous health needs that are related to experiences in their country of origin and on arrival to the UK.

Lack of awareness of available healthcare is a common trend amongst vulnerable groups, particularly asylum seekers and refugees. Foreign nationals, be it asylum seekers, refugees or parts of the BME community, have specific difficulties in accessing healthcare due to language barriers. The requirement of a translator can pose a considerable challenge in accessing appropriate healthcare.

The Learning Disability Health Assessment found that:

- people from BME groups, older family carers and parents with learning disabilities need to be better identified;
- there needs to be further strengthened partnership working between GP practices, the local authority and Primary Care Commissioning to establish precise data relating to people with learning disabilities;
- we need to ensure that learning disability and mental health services are working closely and positively together to enhance care delivery for people with learning disabilities;
- plans need to be put in place to meet the particular needs of people with learning disabilities who are ageing.

On the whole, knowledge of learning disabilities needs to be further embedded across the health community.

Gaps

There are significant gaps in both knowledge and services available for people facing vulnerabilities which makes it a challenge to comprehensively assess the health needs of all those considered vulnerable. For example, a lack of data on the prevalence of depression and anxiety in women in the ante and post-natal period needs to be addressed. The South of Tyne and Wear Maternity Network has recognised this and has commissioned a Maternal Mental Health Needs Assessment to explore this.

Offenders and ex-offenders: There is no prison within South Tyneside but the health needs of offenders and ex-offenders residing in the Borough is still a concern. In the financial year 2008/2009, there were 89 prison leavers from South Tyneside, of which 83 were male. Although this figure is lower than other authorities in the North-East, the health of prison leavers is still a matter of concern.

Literature suggests that a high proportion of prison leavers have alcohol and drug misuse issues. A report by the Partnership for Access to Health (PATH) Project[69]

[69] Partnership for Access to Health (PATH) Project, *'Prison Leavers and Families Affected by Imprisonment'*, http://www.pathproject.scot.nhs.uk/

found that 48% of prisoners have an alcohol or drug misuse problem. Prison leavers are also likely to suffer from mental health problems, which can be attributed to their substance misuse issues, traumatic childhoods or experiences in prison. Over 70% of ex-prisoners suffer from at least two mental disorders. Research has also found that there are limited opportunities for ex-offenders to address mental health issues. Access to appropriate healthcare is a key issue for prison leavers. Many reported to the PATH Project that they were reluctant to visit GPs and other healthcare providers due to a lack of trust and reluctance to be seen as 'weak'.

Foreign Students: The presence of marine students at South Tyneside College also means there is always a large, international student population in the Borough, primarily located in South Shields. During a typical year, there will be up to 2,500 students from around 30 countries worldwide.

Migrants: Nationals from the Accession 8 (East European) countries can come to the UK to work but have limited access to social provisions and benefits. Between May 2004 and February 2006, 110 migrants from the A8 countries had registered in South Tyneside, equating to 0.1% of the population.

Table 46: Total number of A8 Migrants in South Tyneside, May 2004- February 2006

	Gateshead	**S Tyneside**	Sunderland
Total number of EU migrants registered May 2004 to Feb 2006 from newly acceded states	338	**110**	316
Percentage of migrants	0.2%	**0.1%**	0.1%

Source: ONS 2007

The health needs of this particular group in South Tyneside are not yet known and more research needs to be carried out to have a better understanding.

Bereaved: The bereaved have been identified as a vulnerable group who may have special health needs. As yet, however, there is a lack of information regarding their population within South Tyneside and the specific health needs they face. National information highlights social isolation as a significant problem for bereaved. In addition and as a result of this isolation, mental health issues and, in particular, depression can result. Furthermore, long periods of mourning can lead to neglect of health and minor health issues that could have been resolved if dealt with early. These issues can then lead to more serous illness. Further research needs to be carried out to better understand the health needs of the bereaved.

5. What should we be doing next?

- further consultation and strengthen links with organisations across the Borough to improve understanding of the needs of vulnerable groups. There are a plethora of voluntary organisations in the Borough that work with vulnerable people and understand their health needs; it is crucial that the Council and PCT further develop working partnerships with these groups to share knowledge and information and, ultimately, improve the health of people facing vulnerabilities in South Tyneside;

- develop further the wellbeing strategy led by the Local Authority in South Tyneside with a specific focus on identifying vulnerability early and developing programmes

(learned optimism) and resilience taking account of the differing needs of children, young people, adults and older people.

Mental Health
The influences on mental health and wellbeing are extremely wide and varied. We are aware that certain groups, for example those seeking asylum, are at particular risk of facing mental health problems. Therefore, we can target support at these groups. For older people should focus on reducing social isolation through:

- providing social and educational group activities aimed at:
    - Improving self-esteem
    - Developing self-help networks
    - Promoting volunteering
- increasing physical activity levels
- improve screening in primary care settings and provision of psychological interventions such as cognitive behavioural therapy.

Violence and Abuse
In relation to preventing and dealing with the consequences of violence and abuse priorities include establishing and strengthening local initiatives to:

- support people who experience domestic violence;
- reduce levels of alcohol related violence;
- empower communities to reduce the acceptability of violent behaviour;
- support parents in adopting non-physical approaches to disciplining children.

Homeless People
The main issues in South Tyneside at the moment are the lack of affordable housing options in a Borough with a high dependency on benefits and the culture of entitlement to social assistance. There is a lack of adequate supported accommodation in the Borough and people from South Tyneside often do not wish to move out of the Borough to places like Sunderland and Newcastle where there is more supported housing.

- explore ways of developing affordable housing options in the Borough, including supported accommodation.

Learning Disability
The PCT is working with the Partnership Board and other local partners to address health inequalities faced by people with learning disabilities. The wider primary care community is to a certain extent addressing and promoting the better health of people with learning disabilities but more needs to be done. PCTs and their local partners need to agree a long term 'across system' strategy to address services to people with learning disabilities from ethnic minority groups and their carers.

- closer partnership working to ensure that people with learning disabilities access disease prevention, screening, and health promoting activities in their practice and locality, to the same extent as the rest of the population.

Disabled people

- support people with long term health needs by delivering care pathways;
- set up a system of systematically collecting and analysing data for people with long term health conditions;
- support disabled people to choose and control their own services through personal budgets;
- prioritise the implementation of the disability action plans;
- continue to involve disabled people in service planning and commissioning of services

Housebound people

- Establish a register of housebound people which identifies current health n needs and how these are being met

CHAPTER 7 Community Engagement

1. Introduction

Without citizen participation and community engagement fostered by public service organisations, it will be difficult to improve penetration of interventions and to impact on health inequalities[70]. To achieve this goal community engagement practices need to move beyond what are often routine, brief consultations, to involving individuals in partnerships to define problems and develop local solutions to address those problems. Community interventions should be about building active and sustainable communities based on principles of social justice. This is about changing power structures to remove barriers that prevent people from participating in the issues that affect their lives[71].

South Tyneside is a Borough with stark health inequalities. It is clear from the Vitality Index[72] that some neighbourhoods in South Tyneside remain extremely difficult to improve. There still remains a legacy of mass unemployment from the traditional industries. However, local employment opportunities are often not filled by local people. Financial exclusion remains a barrier within many of our communities who find access to services restricted due to not being able to afford to either travel or attend.

By having a real understanding of the needs of communities and neighbourhoods and what is important to them we can tackle health inequalities. This means undertaking genuine and meaningful involvement that will empower our residents and give them the opportunity to help design and improve the services they receive.

2. Where are we now?

Community engagement is an important element of the JSNA, as it puts people at the centre of commissioning and helps us to understand the needs of populations and individuals. As part of the JSNA process this includes actively engaging with communities, patients, service users, carers and providers including the third and private sectors to develop a full understanding of needs with a particular focus on the views of vulnerable groups. JSNA is linked to a number of key national strategic drivers.

Strategic drivers

National

Health and Social Care Act 2001: Section 11 of this Act made it a duty for Health Authorities, Primary Care Trusts and NHS Trusts to make arrangements to involve the

[70] Russell H, Johnston L and Jones D (2009) Long term evaluation of local area agreements and local strategic partnerships. Volume 1. London: Department of Communities and Local Government.
[71] Bentley C (2009) Presentation to The King's Fund Seminar on Partnerships and Health Inequalities. 15 October.
[72] http://www.southtyneside.info/search/document_view.asp?cls=1742

public and consult on services covered by the Act on the planning and provision of services and the development and consideration of proposals for changes in the way those services are provided.

Local Government and Public Involvement in Health Act 2007: This Act came into force on 1 April 2009. It requires local authorities in England to involve local people in the delivery of services. Local authorities must consider, as a matter of course, the possible information provision, consultation and involvement opportunities they need to provide people across all authority services. This act included a requirement that a Local Involvement Network (LINk) be established in every local authority area that has social services responsibility. The primary role of LINks is to provide a stronger voice for local people in the planning, design or redesign, commissioning and provision of health and social care services.

High Quality Care for All 2008 ("Darzi Report"): The Darzi review identified the need to improve access to GPs and stipulated every Primary Care Trust in England is to have at least one new "GP led health centre". These centres will provide GP and other specialist services. It also stated that in GP under-resourced areas PCTs are to procure new GP practices.

Comprehensive Area Assessment (CAA): in April 2009 CAA replaced the Comprehensive Performance Assessment. CAA looks at the public services in an area delivered by Councils and their partners including the private and voluntary sectors. It aims to be more relevant to local people by focussing on issues that are important to their community. CAA includes evaluation of the quality of public involvement.

Key strengths and challenges outlined through the 2009 CAA are summarised below:

Key Strengths
Restoration, regeneration and investment in cultural attractions
Good opportunities for local people to influence how public money is spent
Good children and young people's services management with clear leadership and a good capacity to improve
Educational attainment is improving for young people
Outstanding actions to improve the health and well-being of children and young people
Crime levels are lower than in other similar areas. Focus on specific neighbourhoods has significantly reduced crime and anti-social behaviour in those areas
Good progress in tackling the cause and effects of domestic violence
Progress in reducing gaps in employment and benefit claimant rates between the worst performing neighbourhoods and national average
Partners have got local businesses working together for the benefit of the area
Good use of social clauses in legal contracts with external suppliers to increase the value of Council spending

Source: Performing Together: Once Team, One Plan 151,600 lives (draft 2009)

Neighbourhood Agenda: the Government believes that working directly with people at neighbourhood level should be at the heart of how councils and other service providers conduct their business. It wants all councils, in partnership with other service providers to make sure they give every neighbourhood the right opportunities and support for them to say what they want and to be heard.

Place Survey 2008: this is the new biennial statutory survey which all local authorities in England are required to carry out. The survey collects the 18 perception based national indicators. The survey was first conducted in the last quarter of 2008. The survey included a number of questions relating to health and wellbeing, satisfaction with health services and support for older people.

Local

The following strategies and plans are interlinked:

Spirit of South Tyneside: this is the combined Sustainable Community Regeneration Strategy and Local Area Agreement (LAA). This strategy sets out our vision of a "Better Future for South Tyneside's People" and how South Tyneside's Local Strategic Partnership will deliver this vision. Involving people to have a greater voice and influence over decision making and the delivery of local services is one of the top ten priority objectives within the Spirit of South Tyneside.

Performing Together 2009-2012: is one of the local authority's three major plans. It is the overarching document that sets out how we will work towards achieving the LAA and National Indicators and sets the scene for service plans.

Community Involvement Strategy: this sets out how key public sector partners, including the Council, NHS Foundation Trust, PCT, Fire, Police and South Tyneside Homes communicate, consult with and empower communities to get involved in decision-making. One of the themes in the strategy is 'Independent and Healthy Lives' and within that is a priority objective to increase service user involvement to help people live independent and healthy lives. This is important as increasingly public services are becoming more personalised. Services need to be flexible to the individual needs of citizens, families and communities.

The NHS in South Tyneside – Involving Patients Strategy: sets out a broad strategic framework for the development of our work to involve people effectively in the work of Northumberland, Tyne and Wear Trust. It focuses on the ways that people who use health services; their families, carers and the wider public will be involved.

Housing Plan for People with Learning Disabilities 2009–2012: outlines our approach to meeting the needs of people with learning disabilities. It brings together social care, health and housing to work in a more focused way to improve opportunities for independence. The strategy sets the overall vision for the housing needs of people with learning disabilities.

Working Together - South Tyneside Homes Involvement Strategy and Compact puts involvement at the heart of the organisation and sets out how they involve, engage and empower tenants, leaseholders and residents in decisions about housing.

Reaching Out – South Tyneside Homes Hard to Reach Strategy aims to improve the quality of services provided.

Third Sector Compact is an agreement between the Council and the Third Sector in South Tyneside. It aims to ensure the sector's activity is central to developing and sustaining a democratic, socially inclusive South Tyneside.

Area and Neighbourhood Working Strategy sets out the vision for delivering services at an area and neighbourhood level, together with the objectives and priorities.

Neighbourhood Action Plans have been prepared for a number of our priority neighbourhoods; they set out detailed actions for improving the quality of life for residents. They are based on extensive work with residents and other stakeholders to identify community issues and solutions to neighbourhood problems.

Targets, Indicators and Performance

National

The new National Indicator Set includes a number of perception indicators in respect of civic participation and the extent to which people feel able to influence decisions affecting their local area. The table below outlines the indicators, targets and our performance in respect of these. All performance shown below is measured through the Place Survey 2008. The 2010 Place Survey will provide the data for our targets.

Table 47: National Indicator set for civic participation

National Indicator	Description of Indicator	Target	Current Performance
NI 3	Civic participation in the local area	13% (end of March 2011)	11.2% of respondents had taken part in a range of activities that affect the local area in the last 12 months
NI 4	% of people who feel they can influence decisions affecting their locality.	32.87% (End of March 2011)	30% of residents agreed that they are able to influence decisions affecting their local area.
NI 119	Self reported measure of people's overall health and wellbeing.	This is numeric but has no target. Only priority indicators in the LAA have set targets for 2011.	70% of residents report their health as good.
NI 139	The extent to which older people receive the support they need to live independently.	40.23 % (end of March 2011)	38% of people agreed that older people in their local area get the help and support they need to continue to live at home for as long as they want to.

Local

The following list details the local actions within Performing Together 2009-2012 that underpin the achievement of our targets.

- S2/1/1 – deliver a coordinated programme of consultation and engagement;
- S2/1/4 – raise awareness within communities of how to engage in the local democratic process;
- S2/2/1 – deliver a programme of community events and festivals to build a sense of place and contribute toward area wellbeing;
- S2/2/2 – work with residents in regeneration areas to increase confidence, capacity and involvement in activities that build mutually supportive networks that hold communities together.

3. What are we doing?

Performance and achievements

During the last year we have focussed on working towards our LAA targets and delivering the local actions detailed above. As part of this we have seen some notable achievements and some examples are outlined below:

- developed and agreed a joint Community Involvement Strategy ('A Stronger Voice through Opportunity and Choice') with the key public sector partners in the Local Strategic Partnership. Practical outcomes so far include the agreement of a Community Involvement Charter and the Council and the PCT Involvement Teams working together on a programme of consultation events;
- PCT established an effective Local Engagement Board. The objectives of the Local Engagement Board (LEB) are to assist the statutory PCT boards in maintaining and enhancing their local accountability, along with providing opportunities for the local community to interact with board members. At their inception the LEBs averaged 40-50 attendees, now the average attendance is 70-80;
- PCT developed a Junior Engagement Board. A Junior Engagement Board was held in July 2009 at St Josephs RC Comprehensive School with the Year 9 students;
- completed a comprehensive community involvement exercise in relation to a GP led Health Centre and GP Practices. The PCT's Public Involvement Team engaged a range of people representing different sections of the community. A detailed report on the consultation process is on the PCT website ;
- South Tyneside's Local Involvement Network (LINk) was established in December 2008 and in the last year has involved local people in a number of important health issues, e.g. the Department of Health acknowledged the work of South Tyneside LINk, from 150 LINks Nationally. We were notified that we have received national recognition for the work demonstrated over the 'Specialist Orthodontic' service in the Borough. The piece of work was recognised as a 'Best Practice' example or work by a LINk;

- the Council and PCT have undertaken a major mapping exercise of services to help inform partnership work aimed at developing a joint approach to improving health at the neighbourhood level. The project focused on the Local Area Agreement for tackling health inequalities through reducing obesity, smoking and alcohol consumption. This was reported jointly in the Local Government Chronicle and Health Services Journal as an example of best practice in involving local communities in health;
- completed and analysed the 2008 Place Survey, which included questions on health and wellbeing and health services. The survey was completed by over 2200 residents;
- developed an innovative participatory approach to neighbourhood appraisal and action planning, which has been identified as best practice nationally. A number of Neighbourhood Action Plans now include detailed actions in respect of improving community health;
- satisfaction amongst older people's service users increased from 67% in 2002 to 82% in 2006.

Local consultation and engagement

The Local Authority and the PCT are committed to making sure that everyone has the opportunity to influence the design and delivery of health and social care services. So our framework for involving people provides a variety of methods to make sure that we include all sections of our diverse community and take account of local needs. At a Borough wide level, for example, representative household surveys are undertaken (e.g. Ipsos MORI Residents Survey, Place Survey 2008 etc). The Local Authority also uses their Citizens Panel and Local Engagement Board to consult local residents.

At the Community Area Forum (CAF) level the Consultation Roadshow visits all six CAF areas every year. At the neighbourhood level our approach is more intensive and is focussed on the priority neighbourhoods that have the highest levels of deprivation. One of the main ways of engaging local people in these neighbourhoods is through participatory appraisal and a number of Neighbourhood Management Partnerships have been created to deliver the Neighbourhood Action Plans for these areas.

In addition our framework takes account of cross cutting issues such as equality and diversity are addressed by involving people through a range of different methods including:

- **CREST** (Compact for Racial Equality in South Tyneside) - acts as a forum for consulting Black and Minority Ethnic groups;
- The **Young People's Parliament** - gathers views from young people;
- **Forum 50** - gives older people in South Tyneside a stronger voice in the community. Membership stands at just over 100;
- **South Tyneside Council on Disability** – gathers views from our disabled communities.

Local views are also gathered through:

- Stakeholder and service user groups;
- Focus groups;
- Local surveys;
- Web site and residents' newsletters.

To supplement routine data sources on patient and service users experiences we involve our communities through active dialogue with local people, service users and their carers including:

- **HealthNet** - a monthly forum with an interest in social care and health issues with a membership of over 100 groups. The group is involved in the strategic planning of health improvement and is chaired by the community and voluntary sector
- **South Tyneside Local Involvement Network (LINk)** – this has consulted local groups on a range of issues including:
    - Specialist orthodontic service for children
    - Chronic pain management services
    - Speech and language therapy services
    - Council tendering protocols
    - Quality of private home care provision commissioned by the Council
    - Direct payments
    - Support for people with learning disabilities while accessing ambulance services
    - Support for people with learning disabilities while accessing South Tyneside Foundation Hospital Trust

- **The Community Health and Wellbeing Officers** (each responsible for two Community Area Forums areas) within the Area Teams. They play an active role in addressing solutions to local health need including understanding health needs and how this matches health data and services available.

Current activity

Once a year we take **consultation roadshows** into the community to meet people and ask their views. The roadshows give people the opportunity to ask questions, tell us what we are doing well and what we can do better. They are an opportunity to meet people who may not usually get involved in the decision making process. In 2009 the consultation roadshow was used to ask local people about their views on health priorities using the 'Health of the Community in South Tyneside' questionnaire.

The Local Authority have been analysing the **Place Survey 2008** data and report received from Ipsos MORI to see what implications this has for health and social care services. The 2009 Interim Place Survey has been undertaken and these results will be used to inform next year's JSNA.

The **Local Engagement Board (LEB)** has consulted with members of the public on six occasions through the year. There have been presentations on the LINk, a 'flu pandemic update, the Dementia Strategy and the NHS Constitution. There have also been presentations and round table discussions on the Urgent Care reforms, reducing

alcohol related harm in South Tyneside, the JSNA, an update on the Strategic Plan and the re-provisioning of Mental Health Services for older people in South Tyneside. Responses from the round table discussions are used to inform the commissioning process and decisions. Engagement through the LEBs is used to demonstrate World Class Commissioning Competencies.

The local authority has a programme to develop **Neighbourhood Action Plans** in priority neighbourhoods. A key element of developing these plans has been the use of participatory appraisal involving residents and local workers. The process enables residents to talk freely about where they live. Their views help to shape the Plans in the areas where there are big challenges. The feedback from the Neighbourhood Action Plans is shared with the community so that residents understand what the issues are and how we are working together to make improvements.

The **Community Services Mapping** exercise has identified existing health provision operating within South Tyneside with a particular focus on the priority neighbourhoods. The analysis includes identifying gaps and opportunities for increasing health provision. The Community Health and Wellbeing Officers are using the findings of the mapping exercise to support development of local health plans.

The **Junior Local Engagement Board** – St Josephs RC Comprehensive School facilitated the involvement of year 9 students to gain a wide view of children's opinions of healthcare, what issues matter to them, what would make them access available services more readily and the ways they felt were appropriate to engage young people.

South Tyneside Against Youth Smoking – this project was run by Headliners, a youth journalism organisation. It aimed to survey young people across South Tyneside to identify what tobacco services they would use and what stops them using existing services. During the consultation this grew to encompass why these vulnerable young people started smoking, their attitudes and where they get tobacco. A DVD illustrating the key themes was produced.

4. What is this telling us?

In July and August 2009 six consultation road-shows were held - one in each of the six Community Area Forum areas - to meet people and ask for their views. The road-shows give people the opportunity to ask questions, tell us what we are doing well or what we can do better. They are an opportunity to meet with people who may not usually get involved in the decision making process and this year the road-shows were used to ask local people about their views on health priorities.

A total of 465 questionnaires were completed. Residents were asked to identify their top 3 priorities from a list including:

- reduce smoking;
- promote healthy eating;
- increase physical activity;
- promote responsible drinking;
- promote emotional health and well being (and reduce stress);

- reduce teenage pregnancies;
- reduce accidents;
- reduce cardio vascular disease (heart problems);
- reduce chronic obstructive pulmonary disease (chest problems);
- reduce cancer.

The top 3 priorities identified were:

1. increasing physical activity;
2. reducing cancer;
3. reducing smoking.

The main reasons for choosing these were that they were considered important because of personal or family experience. There was also recognition of the cost to the NHS of treating illness.

People were also asked if any key health issues were missing and although the majority thought that the list reflective their priorities, some additional areas they suggested included:

- screening services;
- drugs / substance misuse;
- mental health;
- Alzheimer's / dementia;
- infectious diseases;
- sexually transmitted diseases;
- arthritis;
- diabetes;
- prostate cancer;
- women's health / men's health;
- epilepsy;
- asthma.

The **Area Teams / Community Health and Wellbeing Officers** have highlighted that people don't naturally talk about health or identify health issues in our priority neighbourhoods. Health is not seen as a priority by local people and they don't always see the link between the wider determinants e.g. housing and how this impacts on their health. There is also the perception that it is difficult to engage with health services at a local level and that other services need to understand the role they have to play in health improvement. The Health of the Community in South Tyneside questionnaire identified that resident's top 3 health priorities were increasing physical activity, reducing cancer and reducing smoking.

The **Place Survey 2008** indicates that the majority of South Tyneside residents (70%) see their overall health as good. Only 7% of respondents reported their health as bad or very bad. Good health is more likely to be reported amongst those aged 18 – 34, in fulltime work and not in social rented accommodation.

Residents were also asked whether older people in South Tyneside are getting the support and services they need to live independently, to inform a new national indicator (NI 139). South Tyneside is performing well with an NI score of 38 which is

higher than the National Place Survey average. Agreement is higher amongst white people, those aged over 55 and disabled people.

Self reported wellbeing: In South Tyneside an additional question was added to find out how satisfied people are with their life. Nearly three quarter (74%) of respondents said they were satisfied, while only 9% expressed dissatisfaction. Satisfaction was highest among the over 55s.

Satisfaction with health and other public services: Residents were satisfied with their GP (86%), local hospital (78%) and dentist (79%). South Tyneside is also performing better than Tyne and Wear overall in terms of satisfaction levels across public services. Most residents (55%) agreed that local services were helping people lead healthier lives, but just under one third (29%) were undecided on the issue.

GP practices and health centres: the Riverside practice closed in 2008 and relocated into Flagg Court Primary Care Centre. There was support for a new GP practice in Hebburn so The Glen Primary Care Centre opened in 2008. The main alternative location suggested for GP services was Biddick and All Saints. Other areas suggested included Jarrow and West Shields. There was general support for the services proposed by the PCT. Additional services requested included mental health and counselling; stress management, Lymphoedema/tissue viability clinics; minor surgery; Warfarin monitoring clinics; joint injection clinics and rheumatology services. In addition to the above a number of respondents asked for complementary therapies such as aromatherapy, acupuncture and reflexology, which are non-traditional GP services. A number of support services and those traditionally provided within secondary care were also requested.

It is clear from consultation that the public holds strong views on the location / relocation of GP practices and the services they provide. Consultation revealed there was insufficient support for a health centre to be located at the proposed site of Cleadon Park. The main concerns were based on the proximity of the site to the hospital. Alternative sites are being considered.

Local Engagement Board - Some key points which have come from the consultation are the provision of accessible services, with easily accessible transport and a general coming together of public and health professionals' views around health issues that need to be prioritised.

The **Junior Local Engagement Board** identified that smoking, illegal drugs, alcohol, sex and exercise were important health issues to them. They also identified what barriers they encounter to using services, namely:

- medical staff;
- environment;
- appointment availability, waiting times and GP location;
- confidentiality;
- information availability / advertising.

They also gave some suggestions for ways of getting information and messages across to their peers including:

- use new technology (internet, text, social networking);
- use imagery (pictures, cartoons);
- use TV shows and television advertising;
- young approach with young staff members to get message across;
- speakers with experience such as ex-addicts and NHS staff;
- short, simple messages with no jargon.

South Tyneside Against Youth Smoking raised the following issues:

- normalising smoking; the majority of friends and family of most of the young people smoke and it is seen as the norm. First experiences of smoking tend to come from tobacco provided by family (knowingly or unknowingly) or peers;
- "Tab houses" – which are a major source of tobacco;
- peer support – participants saw their friends quitting successfully as a positive impetus for quitting smoking.

3. Is what we are doing working?

Taking a community development approach and using participatory appraisal techniques works in priority neighbourhoods and have helped to shape local vision and direction. However such methods are resource intensive and we are considering how we can support this with different ways of engaging people in priority neighbourhoods. It is also clear that change takes time to embed and the continued support of elected members is critical to success.

Gaps in knowledge

The **community mapping exercise** achieved a response rate of 39.5% so there are gaps in respect of those organisations that did not respond. These gaps in knowledge are across services provided by both the public sector and community and voluntary sector. The Community Health and Wellbeing Officers are focusing on improving this intelligence within the priority neighbourhoods.

In the **Neighbourhood Action Plans** health is an area where data, perceptions and other service providers information is lacking in detail at a neighbourhood level. Anecdotal information from residents is often used to inform the action plans. Understanding how we can improve health in our priority neighbourhoods is an on-going challenge given that residents are often reluctant to prioritise this as an issue.

Gaps in services

Community engagement is ongoing to ensure that services meet needs and expectations of residents. The information gathered through **the community mapping exercise** indicates there are gaps in services in the priority neighbourhoods particularly in relation to stop smoking support and alcohol services. The mapping exercise suggests that the priority neighbourhoods of Tyne Dock, Horsley Hill, Sutton and The Lonnen appear to have limited service provision on key risk factors.

However, there are also challenges about residents identifying health services as important and accessing them. Residents living in priority neighbourhoods where the health inequalities gaps are widest rarely identify health as being a priority. Raising health as an issue is often sensitive. Residents in priority neighbourhoods tend to not want to engage as they do not see that engaging will not change anything for them. Therefore, there are gaps in knowledge about services in terms of what the public want to be provided.

In the Neighbourhood Action Plans the health theme has identified gaps in provision for example, linking local people to local jobs.

Barriers and risks

One of the biggest challenges is getting people to engage with us on health issues, especially in priority neighbourhoods. On the other hand there is a related risk of consultation fatigue where several organisations are consulting small communities (e.g. neighbourhoods, communities of interest such as BME). Community organisations may be wary and reluctant to engage in any mapping exercises and for organisations with very limited resources (time and finance), they may not have the capacity to engage in consultations.

There is also a challenge about ensuring that communities understand their role in helping to shape and influence the delivery of health provision. Therefore, consultation needs to be timely and appropriate to avoid unrealistic expectations.

In summary:

- residents do not naturally talk about health or identify health as a local priority, especially in our priority neighbourhoods. However, when they do they tend to match our key priority areas, i.e. reducing obesity, smoking and alcohol
- residents are generally satisfied with their health and the provision of health services but access is a recurring issue
- taking a community development approach and using participatory appraisal techniques in our priority neighbourhoods works but it takes time to embed and is resource intensive.
- we still do not have a full understanding of all the organisations and services being provided at a neighbourhood level. Also understanding how we can improve health in our priority neighbourhoods is an on going challenge given residents reluctance to raise health as an issue.
- the mapping exercise suggests that there are gaps in service provision in the priority neighbourhoods particularly on smoking and alcohol. However as previously mentioned we do not have a complete understanding of all service providers.

What is on the horizon?

The results of the Interim Place Survey 2009 are expected in early 2010. The next statutory Place Survey will be carried out between September to December 2010.

The Community Health and Wellbeing Officers are currently undergoing an assessment matching their local knowledge of services for alcohol, obesity and smoking in the priority neighbourhoods with what residents in these areas are telling us.

It is aimed to refresh and update Neighbourhood Action Plans on an annual basis in a number of areas.

South Tyneside Tobacco Control Programme: The Improvement and Development Agency (IDeA), Local Government Association (LGA) and Local Authorities Coordinators of Regulatory Services (LACORS) have negotiated a programme of central support with the Department of Health (DH), to address health inequalities through tobacco control. The programme is targeted at the 25 local authorities with the highest smoking prevalence - South Tyneside is ranked 5th worst in England. South Tyneside has been given a grant of £100K with the suggestion of further financial support until March 2011. This grant is to be used to support the implementation of tobacco control activity in local communities to reduce the inequalities gap. The focus will include smoking cessation and regulatory enforcement activity.

5. What should we be doing next?

- continue to coordinate / align the Council's and the PCT's community involvement arrangements to make sure they are as effective as possible and avoid consultation fatigue
- use the Joint Community Involvement Strategy Steering Group to plan and deliver a community involvement programme which will give us a real and shared understanding of health needs
- develop a more systematic approach to gathering community intelligence as part of the JSNA process. So, for example, use the gaps in our knowledge (e.g. why views on health vary by socio-economic group) to plan the consultation programme for next year.
- use our community health intelligence to help implement the Tobacco Control Programme
- promote health and deliver services in a range of settings particularly at a neighbourhood level
- Community Health and Wellbeing Officers to follow up key known non respondents to the Community Services mapping exercise and maintain the database.
- continue to work closely with the Neighbourhood Action Teams to develop effective, community led health interventions.

CHAPTER 8 Key Findings, Priorities & Recommendations

Our aim is that South Tyneside's JSNA will become a tool to inform effective commissioning, through an iterative process to ensure that all stakeholders are able to view the data, and contribute to our understanding of local priorities and issues. However, the JSNA must be considered alongside other key policy and strategy documents relating to our population in South Tyneside.

This JSNA has re-stated our view that work to reduce health inequalities and tackle the wider determinants of ill health must take a life-course approach; work needs to be undertaken at all stages from pre-conception and birth right through adult life and later life. The JSNA recommendations have a critical role to play in moving this forward and will only be achieved through consistent work between partnerships and communities. No one agency, organisation or group can achieve this in isolation and the work of the Local Strategic Partnerships and the Children's Alliance will be key to meeting our outcomes.

The key recommendations for each chapter is summarised below:

Chapter 2: Population and Demography

Recommendations in relation to population changes

- further, more detailed analysis is carried out on predicted population change and impact on services;
- commissioning plans for services to take account of population changes, and to develop new models of preventative and rehabilitative services;
- use small are analysis to identify top priorities in key neighbourhoods.

Chapter 3: Wider Determinants of Health

Recommendations in relation to poverty and low income

Addressing poverty and low income has to be a multi-pronged approach which ensures that the most vulnerable in our community are able to sustain an adequate standard of living and participate in society. The key elements of the approach are to;

- increase employment opportunities - targeted for those from most disadvantage groups or areas;
- increase access to and uptake of welfare benefits;
- increase the level of educational attainment in most vulnerable and disadvantaged groups;
- increase the number of credit unions to support saving and safe borrowing;
- increase the provision of affordable housing particularly for vulnerable and low income groups;
- improve advice and support for people at risk of or experiencing poverty and/or debt.

Recommendations in relation to employment

Employment and working conditions make a significant contribution to the development of social inequalities in health in England. They are of critical importance to improve population health and redress health inequalities in several interrelated ways[73].

- increase the number of people in employment through providing support in developing skills, especially for those who have faced long term sickness, unemployment or disability;
- decrease the association between mental ill health and unemployment through the use of both targeted support and broader health promotion approaches;
- improve the working conditions for all workers to reduce their exposure to material hazards, work related stress, and health-damaging behaviours;
- introduce measures to increase job security;
- encourage participation at work to give employees greater say in working conditions;
- increase employees control over their health by providing occupational health services and 'healthy living' interventions;
- strengthen the work-life balance.

Recommendations in relation to housing and homelessness
As discussed earlier adequate housing has a major impact on health and is key to protecting the most vulnerable in the population in terms of their health and social circumstances. Key recommendations include;

- ensure that the current housing stock in South Tyneside is of good quality and that new stock meets the needs and aspirations of current and future residents is key to improving resident's quality of life. recommendations to achieve these aims are;
- ensure the completion of the decent homes programme for the council's housing stock;
- undertake a stock condition survey of the local authority's private sector stock;
- use the information from the stock condition survey to target resources to achieve the greatest benefit for people's quality of life;
- continue to facilitate the delivery of new housing, both affordable and market that meets the needs identified in the housing needs survey and provides choice for current and future residents;
- improve understanding of the housing and support needs of people with drug and alcohol problems, the frail older people and vulnerable young people.

Recommendations in relation to crime and disorder
The impact of crime and disorder on physical and mental health is very evident and in particular will affect those who are most vulnerable and who live in the most deprived areas in the borough. Key recommendations therefore include;

- facilitate early intervention in relation to crime 'hotspots' by mapping out trends and patterns from people coming into contact with the NHS;
- develop information sharing on crime and health issues, such as road accidents and violent attacks;

[73] Marmot Review Task Group **Employment Arrangements, Work Conditions and Health Inequalities 2010**

- develop integrated services at local level around issues such as reducing domestic violence, working with young offenders, supporting mentally disordered offenders, drug prevention and treatment and reducing alcohol misuse;
- develop joint approaches to reduce the fear of crime and sense of isolation particularly with vulnerable people;
- further explore the links between a range of preventative interventions for violent crime including school attendance;
- further work to consider the protective and preventative influences on antisocial behaviour perpetrated by children and adults.

Recommendations in relation to the environment, open spaces and urban design

The quality of the environment has a major impact on health and wellbeing – particularly in relation to vulnerable and more deprived groups in the community. Key recommendations include:

- ensure urban planning promotes healthy and safe behaviours equitably, through investment in active transport, retail planning to manage access to unhealthy foods, and through good environmental design and regulatory controls, including control of the number of alcohol outlets;
- assess the impact of open spaces on specific groups in the population who would benefit from enhanced wellbeing or exposure to green areas and nature;
- Ensure physical and mental health is given greater prominence in the Borough's Urban Design Framework.

Recommendations for education

There is good evidence that the following interventions will promote equity in health through the education system[74].

- Ensure expenditure on early years education, childcare and development is focused proportionately across the social gradient
- Identify and reduce economic, social and other barriers to gaining access to education at all levels, and provide life-long learning, to increase access to education and training for disadvantaged groups.
- Introduce comprehensive support programmes for children in less privileged families, to promote preschool development
- Ensure that schools in less privileged areas receive extra resources to meet the greater needs for special support to children from low-income and poor families
- Prevent children from becoming early dropouts from formal education and training, by early actions and support
- Provide extra support in the transition from school to work; in particular for those with a weak position in the labour market.
- Develop and secure comprehensive adult-education programmes for those with very limited basic education or vocational training.
- Maintain and develop Healthy Schools programmes, with a focus on equity.
- Increase attention to (and actions on) the physical and psychosocial work environment of schools,
- Provide healthy school lunches, improve nutritional education and cooking skills

[74] Based on 'A synthesis of reviews of interventions to improve health and reduce health inequalities' Public Health Research Consortium August 2009

- Promote physical activities that also can attract obese children and that develop sound habits of exercise for life
- Provide equity-oriented injury prevention programmes, where students, teachers and parents are engaged to secure a safe school (including safe transport and walking to the school).

Chapter 4: Early Life

Ante-natal care

- high quality ante-natal care that identifies and addresses risks early;
- a full assessment of needs and risks by 12 weeks of pregnancy;
- advice during pregnancy on a variety of lifestyle factors including nutrition, smoking, alcohol as well as breastfeeding.

Maternal and child wellbeing

- identify pregnant women at risk of postnatal depression and provide specialist intervention;
- carry out routine enquiry to identify women at risk of or experiencing domestic violence;
- identify unborn/newborn babies at risk of abuse and work with parents to prevent or minimise abuse;
- improve the quality of interaction between parents or carers and children in the very early years, including the implementation of the Family Nurse Partnership Programme.

Smoking in Pregnancy

- adapt the Maternity Pathway to ensure stop smoking is included in the pathway as routine;
- monitors which show the amount of Carbon Monoxide reaching the foetus will be used at time of booking to encourage pregnant women and their families to access the stop smoking services;
- reduce the length of time between booking and first appointment with the Stop Smoking Service.

Maternal nutrition/obesity during pregnancy

- information around maternal obesity needs to be collated and analysed to see how South Tyneside compares with other similar areas, the region and nationally;
- develop maternal nutrition pathway to ensure that issues around poor nutrition and/or obesity are addressed at an early stage.

Breast feeding

- deliver breast feeding education in schools to change the attitude of the next generation towards breast feeding and improve breast feeding uptake;
- analyse breast feeding rates for babies in children centres so as to target local support in low prevalence areas;
- appoint Breast Friends Co-ordinator to ensure continuation and support to strengthen peer support;

- breast feeding in house training to be planned and implemented;
- ensure that all staff adhere to the Infant feeding and weaning guidelines;
- progress with the UNICEF baby friendly application for foundation trust and community;
- implement action plan to ensure implementation being taken forward.

Children at particularly high risk

- provide targeted interventions and programmes;
- implement Child Health Promotion Programme.

Emotional wellbeing in children & young people

- expand targeted mental health support in universal settings;
- evaluate Emotional Resilience Programme
- strengthen targeted emotional/mental health support services for young people in the community
- ensure specialist services are accessible and young person friendly

Immunisation

- continue to promote the National Immunisation Programme in order to maintain a high vaccination uptake;
- ensure that children who have missed their routine vaccinations are followed up and invited back for vaccination;
- use the routine pre-school booster vaccination visit as an opportunity to review the vaccination records of children to ensure that all of their immunisations are up to date. Additional vaccines should be offered where appropriate;
- use the teenage vaccination visit as an opportunity to review the vaccination status of children and ensure that the appropriate vaccines, including any missed doses of any vaccines are offered;
- develop an information system to monitor the uptake of the different training programmes and ensure the provision of immunisation training is seen as a priority.

Childhood Obesity

- establish a dedicated multidisciplinary team including psychology, dietician and sports covering all age bands;
- establish one referral pathway and gateway for parents and practitioners so as to improve clarity and efficiency of services;
- provide childhood obesity training for staff.

Dental Health

- reduce the number of children who have decayed, missing or filled teeth

Teenage conceptions

- ensure dedicated time for the teenage pregnancy co-ordinator role;
- strengthen Sex and Relationships Education in schools and targeted settings with high risk young people;
- ensure high risk young people have access to services (outreach wherever possible).

Sexual Health

- maintain a robust plan that ensures coverage of programme and achievement of the Chlamydia target;
- ensure high risk and hard to reach young people targeted.

Emergency Hospital Admissions

- undertake further analysis to explore the factors leading to high emergency admission rates in South Tyneside and to identify priorities to curtail the rates.

Health related behaviour

- carry out the Young People's Health Behaviour in 2010 to capture and compare data to identify priority areas;
- use South Tyneside Against Youth Smoking DVD to promote de-normalisation of smoking amongst young people;
- evaluation findings of the Targeted Mental Health in Schools programme to be used to strengthen further action and formulate a plan to roll out TaMHS to all schools in South Tyneside;
- investigate the lack of referrals from health services into specialist substance misuse services;
- running a workshop for health practitioners on substance misuse issues affecting young people, the screening and referral process and brief interventions;
- continue to penetrate universal services, to encourage use of the substance misuse screening tool amongst professionals, as well as target potential service users/ parent /carers.

Children with Disabilities

- prioritise the needs of children with disabilities and to ease the transition from children's to adult services.

High quality centre-based pre-school provision and school education

- improve attainment of children and young people at all key stages in the most deprived wards;
- improve educational outcomes for looked after children;
- reduce the number of permanent and fixed period exclusions;
- reduce the percentage of young people Not in Education, Employment or Training (NEETS).

Alleviate poverty in families with young children

- implement and evaluate Tyne Gateway Poverty Pilot.

Reduce environmental hazards

- evaluate Safe at Home project to assess the impact and to identify areas that need to be strengthened to prevent accidents in 0-5 year olds
- extend 20mph maximum speed zones especially in residential and urban areas

Chapter 5: Working Age and Later Life

Cardiovascular disease

- carry out health equity audit to assess uptake of NHS Health checks in deprived areas;
- robust service specifications for cardiac and heart failure rehabilitation against national standards;
- increased choice – a menu based approach to Phase III and Phase IV integrated with current services;
- investing in workforce development to increase skill mix, providing appropriately qualified, skilled and competent staff;
- systematic identification of all those eligible for rehabilitation;
- developing innovative approaches to engaging service users;
- ensuring robust audit / evaluation of rehabilitation services.

Cancer

- develop communication and public engagement plan in relation to early identification of cancer.

Emotional Wellbeing and Mental Health Recommendations

- develop further the wellbeing strategy led by the Local Authority in South Tyneside with a specific focus on identifying vulnerability early and developing programmes (learned optimism) and resilience taking account of the differing needs of children, young people, adults and older people;
- establish a population based audit of suicides and undetermined injury in the South of Tyne and Wear Primary Care Trust localities and implement local suicide prevention action plans;
- develop a local action plan to implement measures outlined in the Mental Health and Social Exclusion Report, with delivery arrangements mainstreamed through Local Strategic Partnerships;
- develop a co-ordinated media anti-stigma campaign to raise public awareness of mental health issues to support the strategic approach linking with the regional approach;
- develop a model of preventative and physical healthcare for people with mental health problems across South Tyneside;
- continue to work with the black and minority ethnic communities in South Tyneside to support their mental health needs and implement the programmes of work currently being developed to take forward the recommendations in Delivering Race Equality: A Framework for Action (DH);
- wellbeing checks in deprived areas should identify people with depression and anxiety and make sure they get treatment and support.

Maximise Independence (decrease hospital stays / increase services in communities)

The strategic direction of services is to provide more care in the community, closer to people's home to give people greater choice over where and how they receive care when needed.

- further analyse hospital admissions data to focus on service areas to reduce unnecessary admissions;
- extend access to community matrons, particularly to those with long term health conditions;
- provide local and accessible services, and more inter-agency working to ensure cohesive delivery;
- promote self and supportive care and to implement the falls prevention strategy;
- work with the third sector to encourage volunteering in the community;
- commission alternatives to long-term care, including extra-care housing and assistive technology;
- further analyse programme budgeting information.

Chapter 6: Vulnerability

Mental Health

- providing social and educational group activities aimed at:
    - improving self-esteem;
    - developing self-help networks;
    - promoting volunteering.
- Increasing physical activity levels;
- Improve screening in primary care settings and provision of psychological interventions such as cognitive behavioural therapy.

Violence and Abuse

- support people who experience domestic violence;
- reduce levels of alcohol related violence;
- empower communities to reduce the acceptability of violent behaviour;
- support parents in adopting non-physical approaches to disciplining children.

Homeless People

- explore ways of developing affordable housing options in the Borough, including supported accommodation.

Learning Disability

- closer partnership working to ensure that people with learning disabilities access disease prevention, screening, and health promoting activities in their practice and locality, to the same extent as the rest of the population.

Disabled people

- support people with long term health needs by delivering care pathways;
- set up a system of systematically collecting and analysing data for people with long term health conditions;
- support disabled people to choose and control their own services through personal budgets;
- prioritise the implementation of the Disability Action Plans;
- continue to involve disabled people in service planning and commissioning of services/

Housebound people

- Establish a register of housebound people which identifies current health n needs and how these are being met

Chapter 7: Engaging with Communities

- continue to coordinate / align the Council's and the PCT's community involvement arrangements to make sure they are as effective as possible and avoid consultation fatigue;
- use the Joint Community Involvement Strategy Steering Group to plan and deliver a community involvement programme which will give us a real and shared understanding of health needs;
- develop a more systematic approach to gathering community intelligence as part of the JSNA process. So, for example, use the gaps in our knowledge (e.g. why views on health vary by socio-economic group) to plan the consultation programme for next year;
- use our community health intelligence to help implement the Tobacco Control Programme;
- promote health and deliver services in a range of settings particularly at a neighbourhood level;
- Community Health and Wellbeing Officers to follow up key known non respondents to the Community Services mapping exercise and maintain the database;
- continue to work closely with the Neighbourhood Action Teams to develop effective, community led health interventions.

Next steps

The purpose of the Joint Strategic Needs Assessment is largely to inform commissioning and service development issues and a number of recommendations have been made. However, it is recognised that not all these recommendations may be translated into outcomes in the short term and some will need a number of years to affect change in the population.

In South Tyneside we are using a health equity approach. The JSNA identifies needs, and priorities and gaps in terms of population health and methods including Health Impact Assessment and Health Equity Audit will assist in undertaking this task more effectively. We now need to develop high impact local actions based on quality evidence to address and narrow these gaps and make changes in the way we commission services to do this. This commissioning must be clear about the outcomes needed from investment.

A 10 year health inequalities strategy and framework will be developed based on the key priorities identified in the JSNA and will bring together key priorities, gaps in health experience, evidence base, high impact changes and key actions and measurable outcomes. This framework will complement and support the existing commissioning which as a rule does not focus on addressing specific health inequalities in the borough.

The priorities and actions will be very specific to those groups or neighbourhoods for example where we know that inequalities are greatest.

There will be short, medium and long term actions in the framework and outcomes will be linked to these actions appropriately. The work to address these inequalities will be the responsibility of the PCT, Local Authority and other partners and progress will be monitored via the LSP theme groups.

In addition to developing the framework for partners it will also be shared with local people - in particular those groups or neighbourhood where we are aiming to reduce specific health inequalities. Local people will be engaged to understand what the specific health inequalities are in their area and what is being done to address these.

Sign up to this strategy and framework from all partners and stakeholders is essential so that the specific actions and outcomes are understood alongside the timescales that are involved to achieve changes.

Appendix 1: Shared Priorities

Action	NHS SOTW Strategic Plan priority	Better Health Fairer Health	LAA Target	National Indicators
Wider Determinants				
Increase housing, especially affordable and social housing			✓	✓ NI154, NI155, NI159
Increase the proportion of homes that meet the Decent Homes Standard			✓	✓ NI158, NI187
Ensure working age population have relevant skills for employment		✓	✓	✓NI163, NI164, NI165, NI174
Create conditions for employment including supporting local businesses and attracting investment		✓	✓	✓ NI151, NI152, NI153, NI166, NI171, NI172
Reduce carbon footprint and prepare climate change impacts, including minimising waste			✓	✓ NI185, NI186, NI187, NI188, NI191, NI192, NI193
Develop integrated transport that promotes health and well being and reduces local car travel			✓	✓ NI 75, NI167, NI176, NI177, NI178
Implement the requirements of the Equality Bill				
Early Life				
Improve child health (e.g. increasing breastfeeding; reducing tooth decay)	✓	✓	✓	✓ NI53

Reduce the numbers of women smoking in pregnancy	✓			
Reduce childhood obesity	✓	✓	✓	✓ NI55, NI56, NI57
Reduce teenage conceptions	✓	✓	✓	✓ NI112
Increase Chlamydia screening for under 25s	✓		✓	✓ NI113
Improve mental and emotional health in children and young people	✓	✓	✓	✓NI50, NI58
Increase the proportion of children feeling safe		✓	✓	✓NI69, NI71
Improve support to families and looked after children and young people			✓	✓ NI64, NI68, NI59, NI60
Narrow the gap in attainment levels		✓	✓	✓ NI81, NI82, NI87, NI92, NI101, NI92,NI102
Raise standards at all Key Stages			✓	✓ NI73, NI75
Improve school provision, including early years			✓	✓ NI72
Improve support for disabled children	✓		✓	✓ NI54, NI104, NI105
Address anti-social behaviour			✓	✓ NI22, NI110
Increase number of 16-18 year olds in education, employment and training			✓	✓ NI45, NI90, NI91, NI106, NI117, NI148
Reduce child poverty levels		✓		✓ NI46, NI116, NI118
Improve mental health services for children and young people	✓		✓	
Working Age Adults and Older People				

Strengthen safeguarding adults arrangements				
Reducing adult obesity	✓		✓	✓ NI8
Reduce alcohol consumption and alcohol related injury	✓	✓	✓	✓ NI39
Improve services for drug users	✓		✓	✓ NI40
Reduce the numbers of people who smoke	✓	✓	✓	✓ NI123
Reduce the number of people dying early due to cancer	✓	✓		
Reduce the number of excess winter deaths	✓	✓		
Reduce the number of falls in older people	✓			
Repeat incidents of domestic violence			✓	
Reduce prevalence of depression	✓			
Increase identification of CVD and Diabetes	✓			
Vulnerability				
Reduce the number of households living in temporary accommodation				✓ NI156
Priorities from Crime and Disorder strategic analysis including the reduction in:			✓	

- anti-social behaviour and perceptions - hate crime - youth related crime				
Ensure local housing and support meets local need, especially older people			✓	✓ NI141, NI142
Support for older people with learning disabilities				
Increase and promote self directed support and support for carers			✓	✓ NI130, NI135
Promote independent living, including use of assistive technology			✓	✓ NI125, NI181, NI141, NI142
New BME Communities, e.g. need for services & engagement				
Engaging with Communities			✓	
Provide and promote clear information and advice to users and carers	✓		✓	✓ NI139
Opportunities for local people to influence decisions in their local area				✓ NI3, NI4
Strengthen commissioning arrangements in health and social care, especially with the third sector	✓			
Support opportunities for regular volunteering				✓ NI6

Appendix 2: Programme budget categories

	Description	Expanded description
1	Infectious Diseases	All disease caused by infectious organisms, excluding Tuberculosis and Sexually transmitted disease
2	Cancers & Tumours	All cancers and tumours, malignant and benign. Including those with suspected or at risk of developing cancer
3	Blood Disorders	Disorders of the blood and blood forming systems
4	Endocrine, Nutritional and Metabolic Problems	Disorders of internal metabolism and its regulation
5	Mental Health Problems	Problems of mental health including patients with Alzheimer's syndrome
6	Learning Disability Problems	Patients where the primary issue is the problem of learning disability
7	Neurological System Problems	Problems relating to the Neurological system
8	Eye/Vision Problems	Problems relating to the eye and vision
9	Hearing Problems	Problems relating to the ear and hearing and balance
10	Circulation Problems	Problems relating to the heart, and the circulation of blood in central and peripheral vessels
11	Respiratory System Problems	Problems of respiration, including tuberculosis and sleep apnoea
12	Dental Problems	Problems due to the teeth, including preventive checks and community surveys
13	Gastro Intestinal System Problems	Problems of the gastro intestinal systems
14	Skin Problems	Problems of the skin, including breast.
15	Musculo Skeletal System Problems (excluding Trauma)	Problems of the Musculo Skeletal system, excluding trauma
16	Trauma & Injuries	Problems of Trauma & Injuries
17	Genito Urinary System Disorders (except infertility)	All Genito urinary problems except for those relating to infertility
18	Maternity & Reproductive Health	Maternity and problems associated with reproduction
19	Neonates	Conditions of babies in the neonatal period.
20	Poisoning	Poisoning, toxic effects and other adverse events, whether accidental or deliberate
21	Healthy Individuals	Individuals who have no current problems but who are involved in programs for prevention of illness and promotion of good health
22	Social Care Needs	Problems related to life-management difficulty and problems related to care-provider dependency
23	Other	Other conditions and other congenital malformations