

South Tyneside Joint Strategic Needs Assessment

December 2007

Executive Summary

Demographics

- In line with the national trend South Tyneside has a growing older people population resulting in a major shift in the dependency ratio.
- There has been a small but significant increase in the proportion of the South Tyneside community from BME groups.

Wider determinants

- South Tyneside has the largest proportion of wards falling into the worst 20% for deprivation across Tyne and Wear.
- The proportion of the population claiming job seekers allowance is reducing in line with the national and regional picture. However South Tyneside still retains a higher level of unemployment than the national and regional average.
- Educational attainment appears to be improving across most schools.

Life expectancy

- Life expectancy in South Tyneside is improving for men and women.
- The gap between the national average and South Tyneside has increased for both men and women to 2.1 years for men and 1.2 years for women.
- National data suggests that while life expectancy has increased, healthy life expectancy has not seen the same improvement.
- There are variations in mortality rates by ward.
- Major causes of the life expectancy gap include:
 - Circulatory diseases
 - Cancer
 - Respiratory diseases
 - Digestive
 - External causes of injury
 - Mental and behavioural disorders
 - Infectious and parasitic diseases

Risk factors

- Smoking prevalence is higher than the national average and there is a particular issue with women smoking during pregnancy.
- There is a significant amount of unmet need in relation to smoking cessation provision.
- Obesity is higher than the national average.
- There is a significant amount of unmet need across all levels of overweight and obesity.
- Alcohol use is a major concern and is higher than the national average for all indicators.
- There is a significant amount of unmet need in relation to alcohol prevention and treatment provision.
- There is a higher level of mental ill-health in South Tyneside than the national average.
- There is significant unmet need in relation to mental ill-health and the broader well-being agenda.
- Teenage Pregnancies are reducing but are still at a higher rate than the national average. Teenage conceptions under 16 years have remained at a fairly static rate for the past five years.
- Sexual ill-health is rising across all key Sexually Transmitted Infections (STIs).

Disease specific

- South Tyneside has a higher level of Long Term Conditions than the national average (with the exception of asthma).
- At the 2001 census 23.6% of South Tyneside residents were living with a limiting long term illness.
- South Tyneside has a higher incidence of cancer than the national average.
- The gap between South Tyneside and the national average for cancer mortality rates is 26% which shows a small reduction of 1% since 1996.
- In line with the national picture there has been an increase in cancer incidence.
- There has been a corresponding decrease in cancer mortality.
- There is geographical variation in cancer mortality by ward in South Tyneside.
- Cervical and Breast screening rates show better coverage than the national average across all groups. However there is further geographical variation linked to deprivation identified.

Older people

- In parallel with the increase in the population of older people there is an increase in the burden of ill health
- Alongside the increase in ill-health there is an anticipated rise in demand for all aspects of social care and health service provision
- There is an anticipated increase in the number of people living with dementia

Predictive modelling for hospital admissions

- It is anticipated that there will be an increase in hospital admissions over the next ten years
- Older people are heavy users of hospital services for both elective and non-elective admissions.
- Children under four are higher users of health services than the rest of the population for both elective and non-elective admissions.
- It is estimated that a significant proportion of people requiring treatment have Long Term conditions.

Recommendations

Life Expectancy

- Identify and manage uncontrolled / unidentified hypertension with an identified high impact intervention, i.e. implementation of the NICE guidelines.
- Increase statin prescribing to patients without CVD
- Increase access to smoking cessation
- Increase access to the Choosing Health targeted comprehensive programme of prevention / risk factor management and reduction on those >50.
- Management of obesity through the use of a formal supported pathway of care adopting NICE guidelines.
- Develop preventative and treatment programmes related to alcohol use

Smoking

- Increase the number of intermediate SSS providers
- Increase the number of people accessing SSS
- Increase smoking cessation with pregnant women

Obesity

- Establish a whole systems approach to obesity prevention including universal campaign work alongside preventative activities in primary, secondary and tertiary care.
- Urgent attention must be given to further developing and increasing the capacity of preventative and treatment services in order to deal with the high prevalence of obesity in the region
- Establish a Maternity Lifestyle Post to facilitate signposting, referral and support for services in accessing maternity and early years health services.

- Develop a community based wellness service to improve access for vulnerable/hard to reach groups.
- Ensure Bariatric surgery must be made available to all patients who meet the NICE criteria.
- Workforce development is required to ensure relevant staff are provided with specific training in order that they can effectively provide and support interventions which prevent and manage obesity.

Alcohol

- Screening & Brief Interventions (SBI) ; Implement SBI in A&E, Primary Care & Criminal Justice System to provide training in SBI
- Access to effective alcohol services – Establish equity of current service provision, investment identified for alcohol treatment, commissioning in line with Models of Care for Alcohol
- Sustain the provision of targeted evidence based preventative interventions with young people to encourage responsible drinking and reduce antisocial behaviour
- Deliver effective public campaigns in relation to sensible drinking in conjunction with the Regional Alcohol Office
- Enforce the Licensing Act 2003 including action in relation to selling alcohol to under 18s and action where premises are selling alcohol to customers who are already intoxicated.

Drugs

- Further develop the Harm Reduction Strategy for drugs with a specific focus on preventing Drug Related Deaths
- Develop drugs Harm Reduction Service with a range of provision including alcohol SBI and sexual health services
- Reduce the risk of hidden harm to children and young people within the families of drug users, or with drug using parents
- Ensure active involvement of service users and carers in the development and delivery of services
- Provide the widest range of referral opportunities and minimise the time between referral and treatment
- Increase the range of services available, particularly those for stimulant users
- Improve supported community integration for substance misusers
- Develop systems that are responsive to the needs of BME communities

Sexual Health

- Increase access to sexual health screening (with a particular focus on vulnerable groups)
- Integrate the delivery of contraception and sexual health services and GUM.
- Implement a network model for sexual health across the NHS South of Tyne and Wear
- Implement the Chlamydia Screening Programme throughout PCTs and Local Authority Provider Services
- Increase access to postnatal and post TOP contraception
- Develop Local Enhanced Services within General Practice

Mental Health

- 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 (DOH)

Long Term Conditions

- Implement a whole systems approach to Long term Conditions
- Empower patients suffering with LTC to contribute to the management of their health concerns (e.g. Self-Care / Expert patient)
- Implement recommendations linked to life expectancy, smoking, obesity and alcohol

Cancer

- Improve early detection through increasing the uptake of screening with a particular focus on vulnerable groups
- Implement recommendations linked to risk factor prevention
- Ensure access to effective, timely treatment and rehabilitation services

Older people

- Implement the high impact changes related to life expectancy
- Target older people with risk factor prevention activities (e.g. preventing depression)
- Implement a whole systems approach to LTCs with a particular focus on developing the self-care model across a health and social care pathway.
- Identify and treat at risk of fracture.
- Develop a programme of self-care for osteoarthritis
- Develop additional capacity to support carers and volunteers working with older people.

Next Steps

- Analysis of current and projected activity for community based health care
- Analysis of current and projected activity Social Care and Health services
- Undertake the value for money and return on investment calculations (Annex A: Table 2)
- Patient and user involvement through engagement events in January and February

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Introduction

In March 2007 the DH published the framework 'Commissioning framework for health and well-being' which advocated the provision of services to meet needs further than merely the treatment of presenting conditions but also to enable people to maintain healthy and independent lives¹.

The framework outlined that historically commissioning has been too focused on volume and price rather than quality and outcomes with much service provision 'service led' rather 'needs led'; provided at the convenience of providers rather than patients. The needs of patients are now accepted as being central to the NHS.

The framework identifies eight steps to effective commissioning which include:

- Putting people at the centre
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers
- Recognising the interdependence between work, health and well-being
- Developing incentives for commissioning for health and well-being
- Making it happen – local accountability
- Making it happen – capability and leadership

The framework aspired to achieve:

- Services which are individually tailored, sensitive towards individual need and maintains independence and dignity.
- Strategic reorientation towards promoting health and well-being and reducing costs associated with future ill health
- Strengthen the focus on interventions with the greatest health impact promoting social inclusions and reducing health inequality

What is needs assessment?²

Health Needs Assessment is a systematic method for reviewing the health issues faced by a particular population or community of interest³ and making recommendations for changes to meet the needs identified. The assessment of the health of any given population (or group within that population) is imperative to both commissioning and delivery of high quality and effective services in order to secure health improvement at both a population and individual level.

Assessing the health and healthcare needs of the population is a complex, long-term and continuous process. It is the process of measuring health needs of the population so that health services can respond to them. The aim of a health needs assessment is to describe health problems in a population and differences within and between different groups in order to determine health priorities and unmet need. It should identify where people are able to benefit either from healthcare services or from wider determinants change and balance any potential change against clinical, ethical and economic considerations: that is, what should be done, what can be done and what can be afforded.

Underpinning the whole HNA process are three principles:

¹ Department of Health (2007) Commissioning Framework for Health and Well-being. DH. London

² Faisal, Al-Durrah (2003) South Tyneside Primary Care Trust. Health Needs Assessment Policy.

³ http://www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf

- **Improvement** of health and inequalities by making changes that improve the most significant conditions or factors affecting health, then targeting the population groups with the most to gain, and those services that can make the most difference to their needs.
- **Integration** of this improvement in health into the planning and commissioning process used by those services, so that the identified changes are implemented in their plans.
- **Involvement** of:
 - people who know the health issues in a community
 - people who care about those issues
 - people who can make changes happen

This aims to ensure the HNA results in effective actions being targeted at those with the most to gain, and engages those services that have most control over making these changes happen.

What is a Joint Strategic Needs Assessment?

Joint Strategic Needs Assessment (JSNA) is defined as a process of joint analysis of current and predicted health and well-being outcomes and community demands, alongside a process for identifying potential new or unmet need. The needs identified should then be used by the Local Strategic Partnership (LSP) to inform commissioning intentions. The process is dynamic and cyclical and aims to provide an iterative process whereby need fuels service design and performance review.

Process in South Tyneside

In August 2007 the Independent Healthy Lives and the Children and Young People's Alliance established processes to address the requirements for a JSNA. In response to this two working groups (Children and Adults) comprising the Local Authority and the PCT were established to undertake a four stage process:

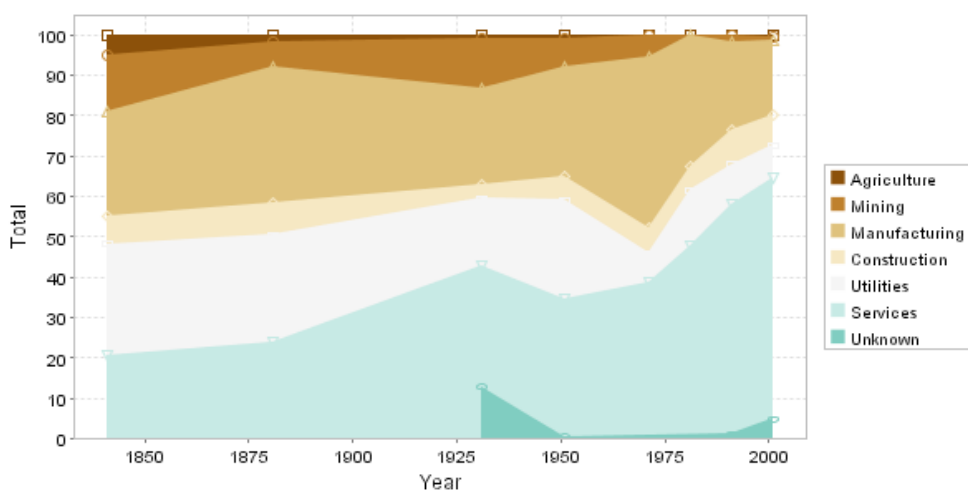
- Rapid assessment of social care, health and well-being needs identified in Annex A of the Commissioning Framework for Health and Well-Being led by the PCT
- Consultation with communities regarding the findings of the rapid assessment
- Identification of gaps in available information identified in Annex A
- Recommendations for the LSP

It is expected that this process will form the foundation for a regular cycle of JSNA which maintains the overarching goal of improving the health and well-being of the whole community with a particular focus on reducing inequality. The goal of health improvement advocates a shift from treatment towards prevention on avoidable ill-health.

South Tyneside profile

South Tyneside is situated on the South bank of the River Tyne on the North East Coast of England. It is the smallest of the five Tyne and Wear districts and covers an area of 64.43 square kilometres. There is a population estimate of 151,316 (ONS 2005). South Tyneside has one PCT and is the smallest metropolitan borough in England. It lies within the Northumberland, Tyne & Wear Strategic Health Authority (SHA) area.

South Tyneside is an area which has seen a decline in its traditional industry and suffers from significant socio-economic deprivation. South Tyneside's main industries historically were shipbuilding and coal mining,⁴ however the last shipbuilder (Redheads) closed in 1984 and the last coalmine (Westoe Colliery) closed in 1991. In 2001 the service industry was the largest sector of the local economy employing 63% of all workers. The table below outlines the proportion of workers within each of the industries re-organised to the categories used in the 2001 key statistics⁵.



The Index of Multiple Deprivation 2004 outlines 103 Super Output Areas (SOA) within 20 Wards in South Tyneside. The IMD 2004 highlights that for overall deprivation South Tyneside has over 19.4% of SOA's in the worst 10% category and over 52% in the worst 20% for England. This is the largest proportion of areas falling into these categories in Tyne and Wear. 5 SOA's are in the 5% worst deprived category nationally including:

| | |
|--------------------|----------------------------|
| Rekennyke | ranked 546 (out of 32,482) |
| Jarrow Town Centre | ranked 547 |
| Horsley Hill | ranked 600 |
| Cleadon Park | ranked 636 |
| The Woodbine | ranked 795 |

A further 15 SOA's are in the 10% worst deprived including Fellgate and Boldon Colliery.

In relation to life expectancy the health profile (2006)⁶ for South Tyneside indicates 13 of the 20 wards were significantly lower than the national average. Furthermore 15 of the 20 wards were shown in the most deprived 25% with 4 in the second most deprived 25%. Thus 19 of the 20 wards (95%) in South Tyneside feature in the worst 50% for life expectancy nationally.

⁴ <http://en.wikipedia.org.uk>

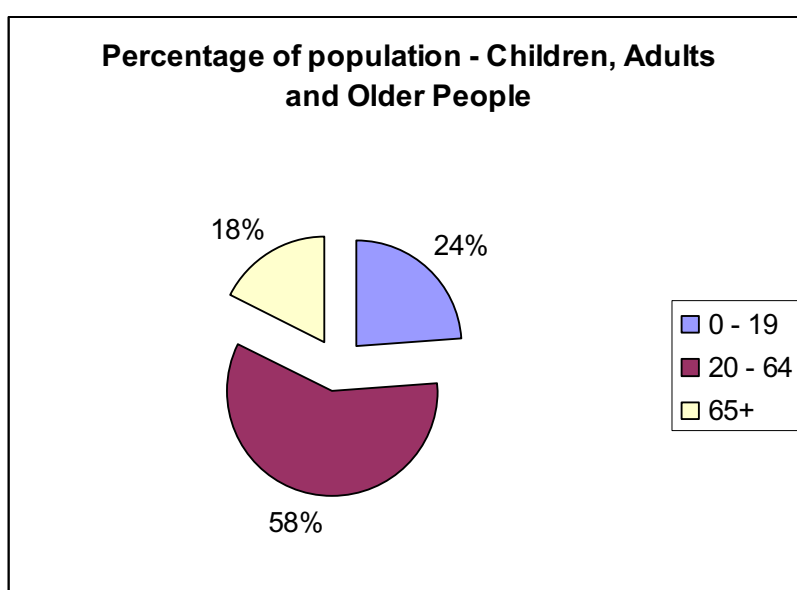
⁵ www.visionofbritain.org.uk

⁶ Association of Public Health Observatories (APHO) Health Profile for South Tyneside 2006. Department of Health

South Tyneside residents are serviced by one Metropolitan Borough Council, one Primary Care Trust, 29 GP practices, one Acute Trust (South Tyneside Foundation NHS Trust), and one specialist mental health NHS Trust. Services are also provided by voluntary sector organisations.

Demographic Profile

The demographic profile for South Tyneside is shifting, with fewer births than the national average and an elderly (75+) population that is higher than the English average. The total population of South Tyneside has reduced from approximately 158,000 in 1984 to approximately 151,300 in mid 2005. The population of childbearing age (women aged 15 – 44) includes approximately 30, 372 women. The proportion of the population falling into the three age groups, Children and Young People (19 years and under), Adults (20 – 64 years) and Older People (Over 65 years) can be broadly categorised. It is important to note that 8.7% of the total people falling within the older people category are over 75 years of age.



Births

The General Fertility Rate is lower in the North East at 54.10 (per 1000) than the rest of England (58.51) and lower again in South Tyneside (50.34). The Total Period Fertility Rate (average number of children) also highlights South Tyneside as lower than both the North East and the rest of England with 1.64 in South Tyneside, 1.71 in the North east and 1.79 in the rest of England.

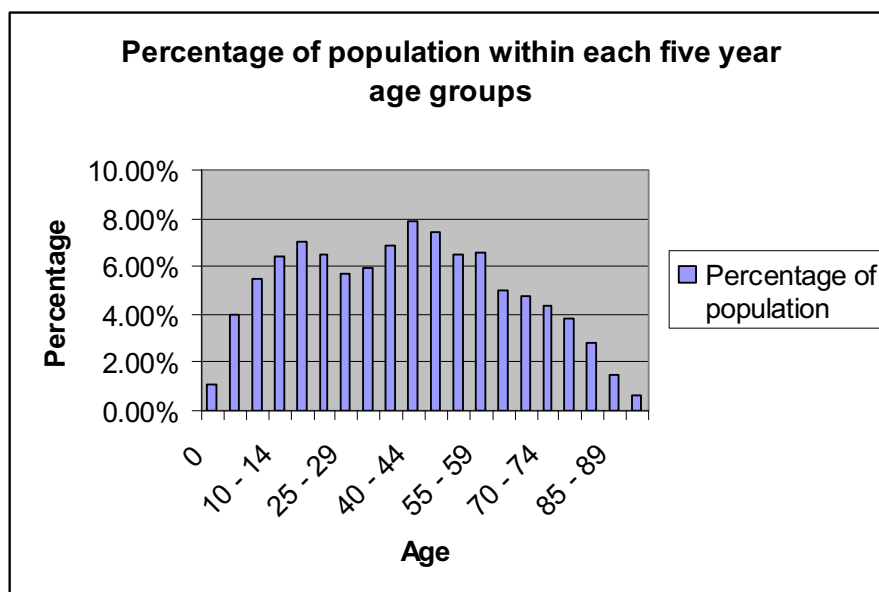
By applying these rates to South Tyneside's resident population estimates for women of childbearing age (30, 372 number of female aged 15 - 44) shows approximately 1528 births. Birth data from South Tyneside District Hospital reflects this figure showing that the large majority of these births occur within South Tyneside.

Number of maternities at South Tyneside Foundation Trust for 2004/2005 and 2005/2006 (Hospital IT System)

| Year | Number of maternities |
|--------------------|-----------------------|
| 2004 / 2005 | 1427 |
| 2005/2006 | 1468 |

Age profile

The percentage of people within each five year age group across South Tyneside shows a peak in the 40 – 44 age group. This group comprise nearly 8% of the total population. The smallest age group as a proportion of the total population is unsurprisingly within the 90+ age group. However analysis of the data from the peak within the 40 – 44 age group shows a reducing ratio through the young age groups with the proportion of children within the 1 – 4 age group only comprising 4% of the total population almost half the number within the 40 – 44 age group.



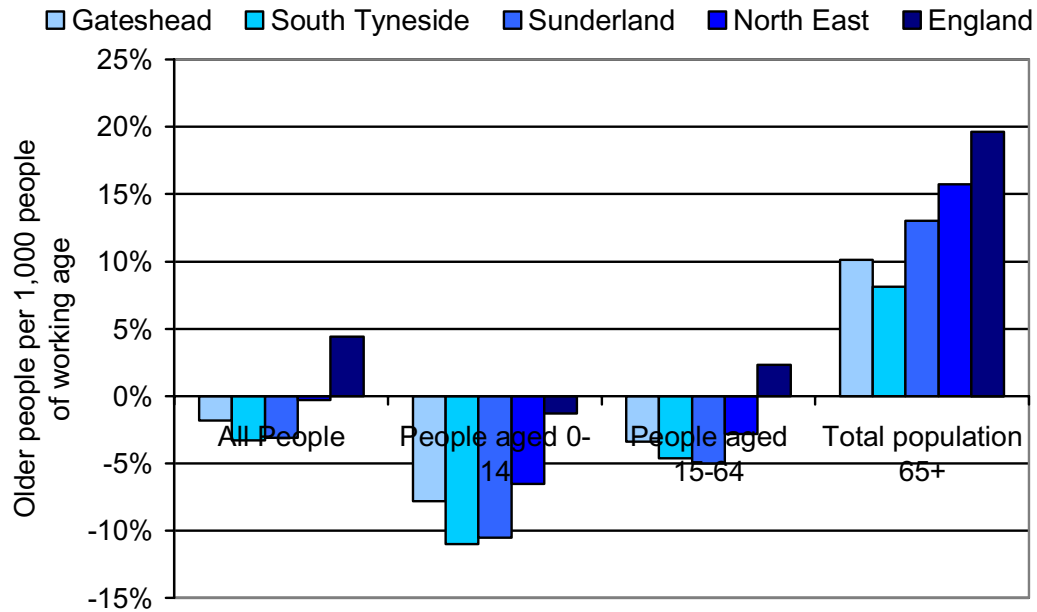
Evidence relating to this population shift has been used to project the population changes within each age group over the next eight years. Across the total population it is expected that South Tyneside will show a 3.3% reduction by 2015 with variations within each age group. The population over 85 is expected to see the largest growth with a massive 35.5% increase. Furthermore the second largest increase is within the 65 – 69 age group with 17.8%. This is accompanied with an 11% decrease in the 0 – 14 age group and a 4.6% reduction in the 15 – 64 age group.

| | 2006 | 2008 | change 2006-08 | 2010 | change 2006-10 | 2015 | change 2006-15 |
|----------------------|---------|---------|-------------------|---------|-------------------|---------|-------------------|
| All People | 151,000 | 149,200 | -1.2% | 148,200 | -1.9% | 146,000 | -3.3% |
| People aged 0-14 | 25,500 | 24,500 | -3.9% | 23,600 | -7.5% | 22,700 | -11.0% |
| People aged 15-64 | 98,500 | 97,400 | -1.1% | 97,100 | -1.4% | 94,000 | -4.6% |
| People aged 65-69 | 7,300 | 6,900 | -5.5% | 6,900 | -5.5% | 8,600 | 17.8% |
| People aged 70-74 | 6,700 | 6,800 | 1.5% | 6,800 | 1.5% | 6,300 | -6.0% |
| People aged 75-79 | 5,800 | 5,900 | 1.7% | 5,800 | 0.0% | 5,800 | 0.0% |
| People aged 80-84 | 4,200 | 4,200 | 0.0% | 4,300 | 2.4% | 4,400 | 4.8% |
| People aged 85+ | 3,100 | 3,500 | 12.9% | 3,700 | 19.4% | 4,200 | 35.5% |
| Total population 65+ | 27,100 | 27,300 | 0.7% | 27,500 | 1.5% | 29,300 | 8.1% |

Source: Office for National Statistics, 2004-based subnational population estimates

This data reflects the changing age related demography across the North East of England with a shrinking prevalence of working age accompanied by a growing older population. South Tyneside shows the greatest decrease in the population under 14 years with a smaller increase over 65 years.

Percentage change in the population 2006 to 2015 by age band

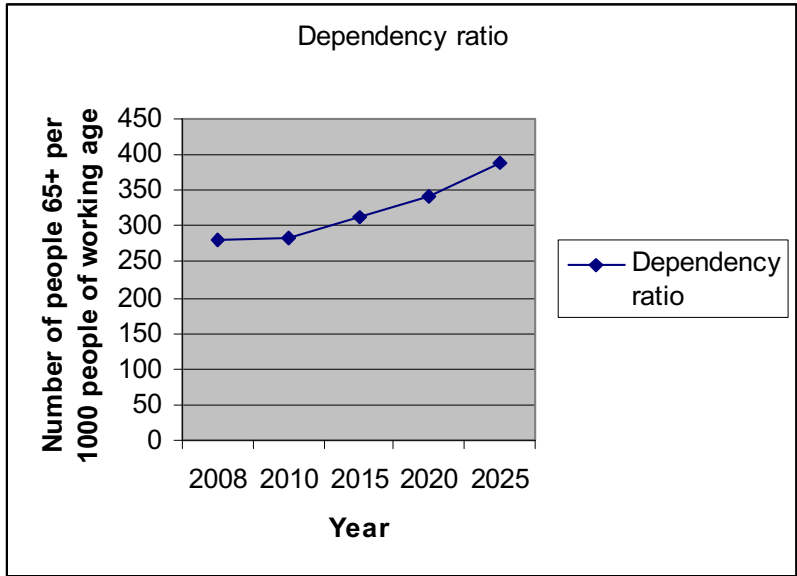


The changing age profile is particularly significant when considering the issues related to a growing older population, a reducing younger population and the potential issues associated with a variation in the age prevalence particularly related to the dependency ratio for a growing older population alongside a smaller population of working age able to provide this.

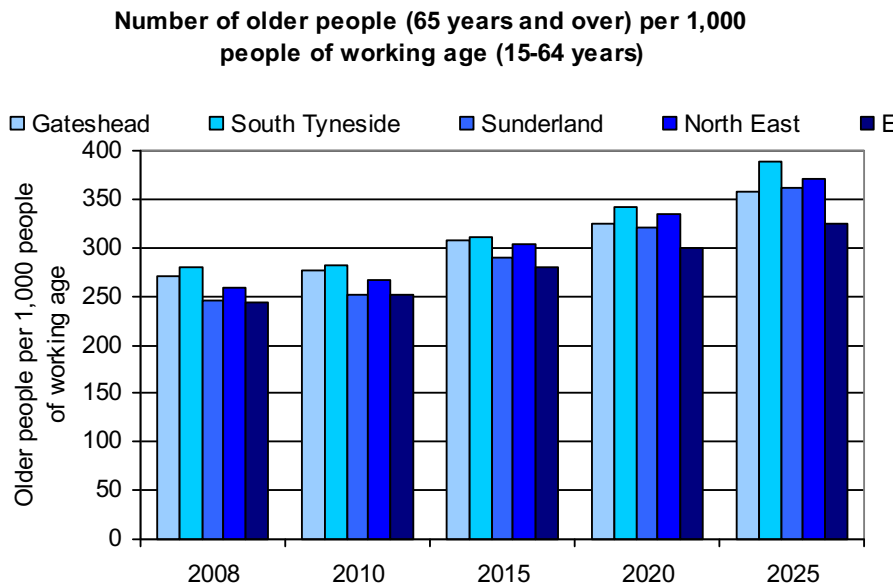
The dependency ratio is a calculation of the economically dependent proportion of the population against the productive part. Exact definitions vary, but the measure is typically defined as either the ratio of both young and old people to people of working age or simply the ratio of older people to people of working age. As the population of older people place the greatest demand on health and social care services this section adopts the latter definition.

The dependency ratio here will be defined as: $1000 * (\text{Population } 65+ \text{ years} / \text{Population } 15-64 \text{ years})$. The unit of measure is number of older people per 1,000 people of working age⁷.

⁷ Population forecasts are taken from the Office for National Statistics 2004-based sub national population projections and both the dependency ratio and the proportion of the total population aged 65 and over is shown



By 2025 the dependency ratio is expected to have grown from 18.3% in 2008 to 23.7% in 2025 showing almost a 40% increase in dependence.



Ethnicity

Population estimates (2001) outline that 2.8% of the total population in South Tyneside are from minority ethnic groups equating to around 4300 people. Estimates of population change by ethnic group suggest that there has been 52.7% increase in non -'White: British' prevalence between 2001 and 2005 in South Tyneside. This increase has resulted in BME groups comprising 4.4% of the total population equating to 6,700 people in total.

| | | |
|-------------------------|--------|-------|
| Total population | 152785 | |
| White (British) | 147466 | 96.5% |
| White (Irish and other) | 1172 | 0.8% |
| Indian | 970 | 0.6% |
| Bangladeshi | 812 | 0.5% |
| Pakistani | 306 | 0.2% |
| Chinese | 185 | 0.1% |

The BME communities reside primarily in two main wards which are Beacon and Bents and Rekendyke. This population largely comprises established communities living in South Tyneside. The known minority ethnic communities living in South Tyneside include the Arab, Bangladeshi, Indian, Black – African, Black - Caribbean, Chinese and Pakistani communities. The Arab community is one of the most established in the country; its origins can be traced back to 1890s with the arrival of Yemeni seamen. The Bangladeshi community is the largest minority ethnic group represented in South Tyneside.

South Tyneside is a National Asylum Seeker support (NASS) area as a result of unused housing stock and available school places. The number of available properties was kept at 50 resulting in a small asylum seeker population (EMTRAS report, 22.01.07).

| | |
|----------------|--|
| asylum seekers | TOTAL OF 167 - 147 registered with LA (asylum seekers team) - 17 registered with Kimberley Housing Group - 3 families registered with Angel Housing Group |
| refugees | - Estimate from LA: 108 (50 families) |
| other migrants | - 110 ¹ - LA does not count migrants - Lots of Poles in South Shields area |

These figures are the most accurate estimates available; however it is thought anecdotally by frontline staff that the true numbers are much higher.

Total number and percentage of asylum seekers and refugees at November 2007 highlights that refugees and asylum seekers comprise a small but significant element of the overall South Tyneside population. :

| | Gateshead | South Tyneside | Sunderland |
|-----------------------------------|---------------|----------------|---------------|
| Total population at mid-year 2006 | 190,500 | 151,000 | 280,600 |
| Total number of asylum seekers | 465 | 167 | 431 |
| Percentage of asylum seekers | 0.2% | 0.1% | 0.2% |
| Total number of refugees | not available | 108 | not available |
| Percentage of refugees | - | 0.1% | - |
| Total number of other migrants | 338 | 110 | 316 |
| Percentage of migrants | 0.2% | 0.1% | 0.1% |

Wider determinants

The causes of health inequalities are complex, multifaceted and inter-related. Wider determinants are acknowledged to present a major impact in health outcomes. Evidence suggests that enduring solutions to address health inequality will only be achieved when poverty, education, housing and employment are addressed⁸. Adults aged 45 – 65 in routine and manual occupational groups are much more likely to have a limiting long-standing illness or disability than those from non-manual groups (45% versus 19%)⁹. Health inequalities extend during retirement. People from the lowest socio-economic groups are more likely to become disabled earlier in life¹⁰. Furthermore adults in the poorest fifth are twice as likely to be at risk of developing a mental illness as those on average incomes¹¹. Government initiatives which aim to tackle this inequality have been implemented including:

- The national minimum wage
- Working Families Tax Credit
- Minimum Income Guarantee for pensioners
- Winter fuel payments
- The New Deal
- Sure Start
- Increased investment in health services

Multiple Deprivation

The 2004 Index of Multiple Deprivation measures socioeconomic disadvantage across seven domains; income, employment, health, education, barriers to housing and services, crime and the living environment. The overall Index of Multiple Deprivation is a weighted average of the indices for the seven domains.

Deprivation is a major issue for South Tyneside with almost two thirds of the total population living in areas ranked in the worst 25% nationally for deprivation. This is a higher proportion than any other district in Tyne and Wear and above the regional average of 45.3%. However the proportion of South Tyneside residents living in areas classified in the worst 10% for deprivation nationally is slightly lower than both the national average (19.7% compared to 21.4%) and the regional averages (with the exception of North Tyneside).

The overall deprivation picture has remained static since 2000 with many deprived areas positioned along the riverside although outer neighbourhoods such as Biddick Hall, Whiteleas, Hedworth and Cleadon Park badly affected.

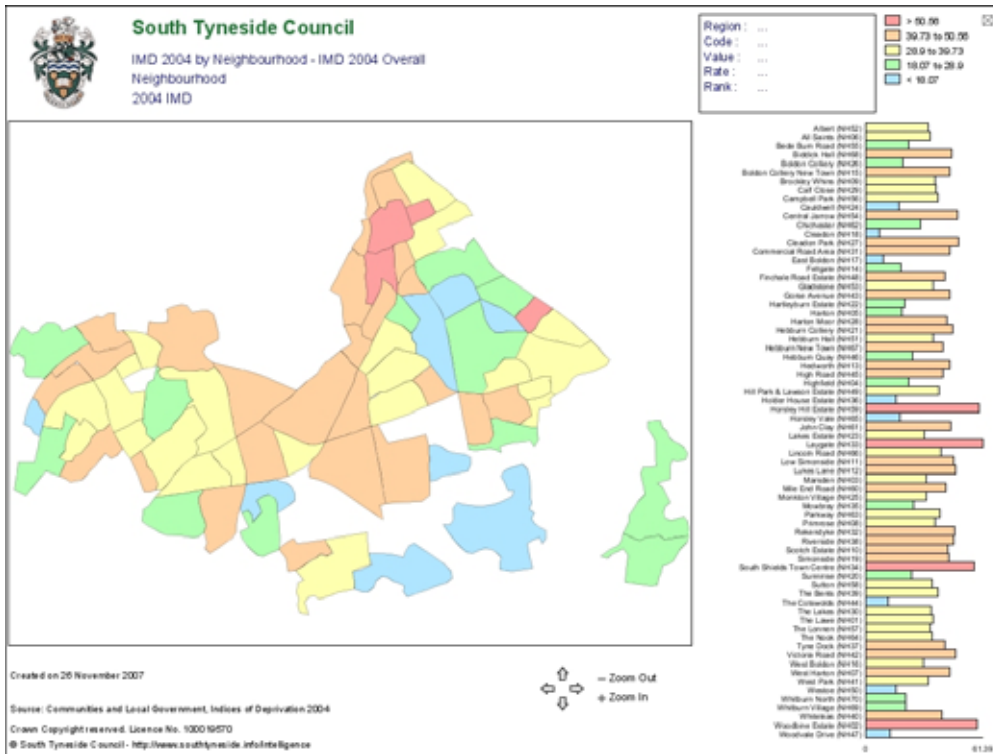
| IMD 2004 Overall Deprivation – Population in worst 10% and 25% Super Output Area | | | | | |
|--|-------------------------|----------------|-------------------------|----------------|------------------|
| Area | Population in worst 10% | % in worst 10% | Population in worst 25% | % in worst 25% | Total population |
| Gateshead | 52,026 | 27.2% | 103,237 | 54% | 191,109 |
| Newcastle | 81,529 | 31.4% | 133,243 | 51.3% | 259,508 |
| North Tyneside | 20,265 | 10.6% | 75,246 | 39.2% | 191,711 |
| South Tyneside | 30,046 | 19.7% | 93,908 | 61.5% | 152,785 |
| Sunderland | 75,696 | 27% | 155,643 | 55.4% | 280,749 |
| Tyne and Wear | 259,562 | 24.1% | 561,277 | 52.2% | 1,075,850 |
| North East | 538,774 | 21.4% | 1,138,306 | 45.3% | 2,515,234 |

⁸ NHS Confederation (2007) In Sickness and In Health. NHS Confederation Publications. London

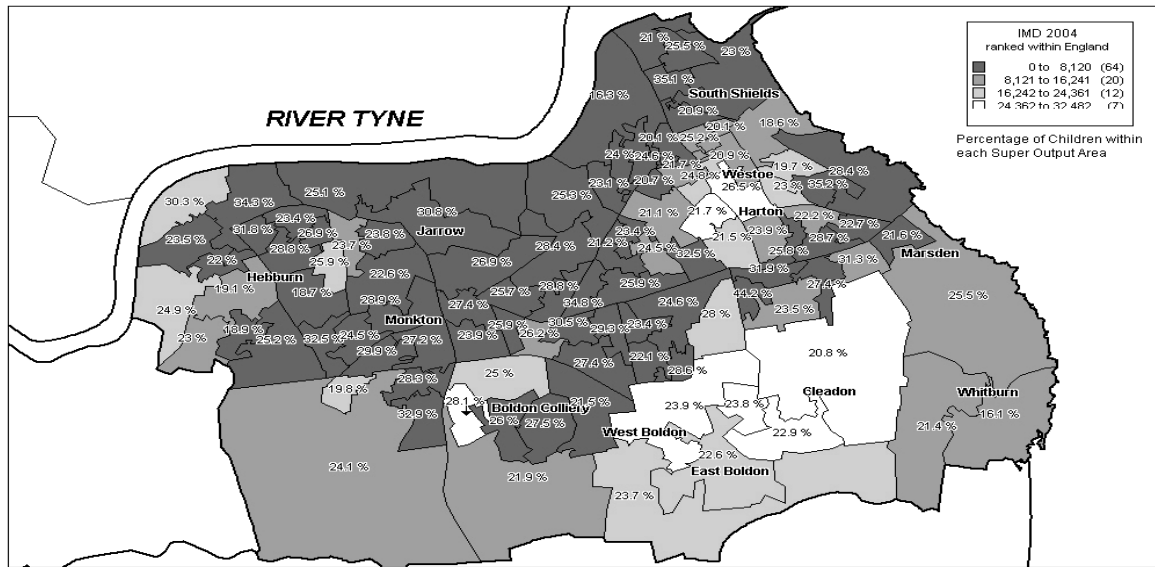
⁹ General Household Survey, ONS Updated March 2007

¹⁰ Office for National Statistics (2001) Health expectancies at birth for the 2001 census wards in England and Wales

¹¹ Health Survey for England. DH. Updated July 2007



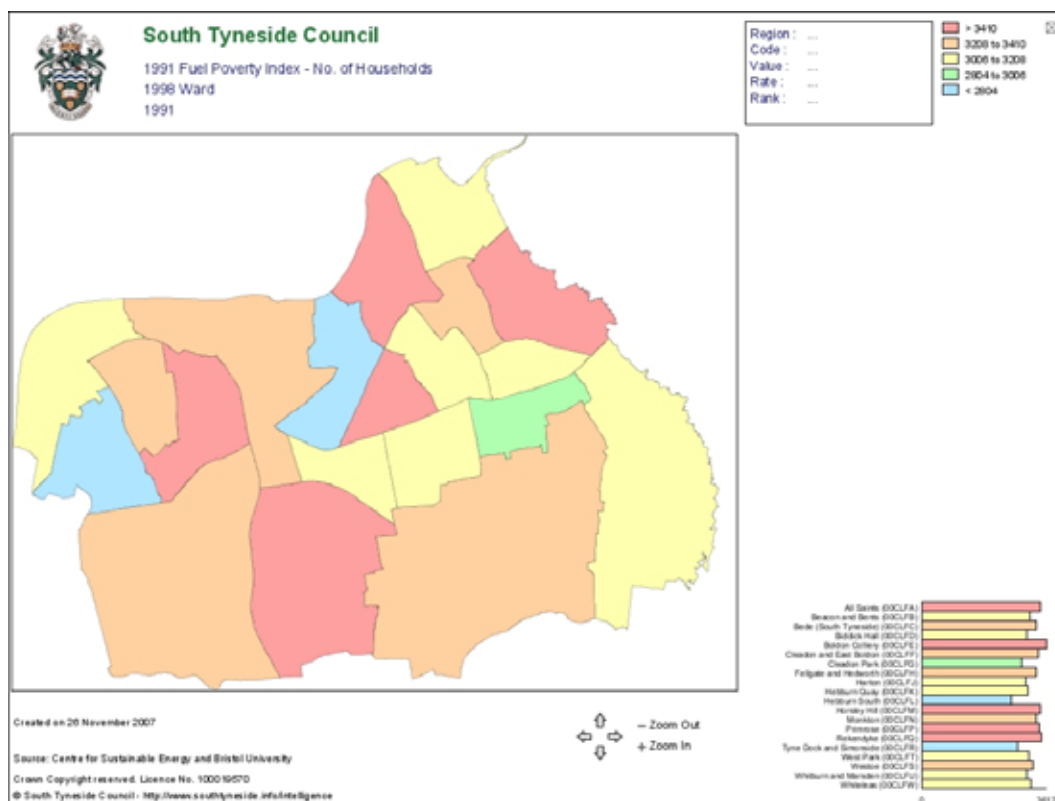
The map below shows those areas in South of Tyne and Wear that are among the most disadvantaged fifth of all areas across England.



© Crown Copyright
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 Source: Indices of Deprivation 2004, DETR.

Fuel Poverty

Fuel poverty occurs when a household needs to spend 10% or more of its income on fuel to maintain satisfactory heating and other energy sources.



Fuel poverty is caused by the interaction of a number of factors¹². However there are three key influences which stand out including:

- The energy efficiency statuses of the property
- The cost of energy
- Household income

People with lower incomes are more susceptible for fuel poverty as they are more likely to pay a greater proportion of their total household income on fuel. In November 2001 the Government published the UK fuel Poverty Strategy which aimed to end fuel poverty for vulnerable households defined by houses containing people who are children, elderly, sick or disabled.

According to the latest Fuel Poverty Survey (2005) the North East has the highest rate of fuel poverty in England, at 11.5% of households, compared with the national average of 7.2%. The survey also shows that older people are more prone to fuel poverty with the over 60s accounting for 40% of all households living with fuel poverty.¹³

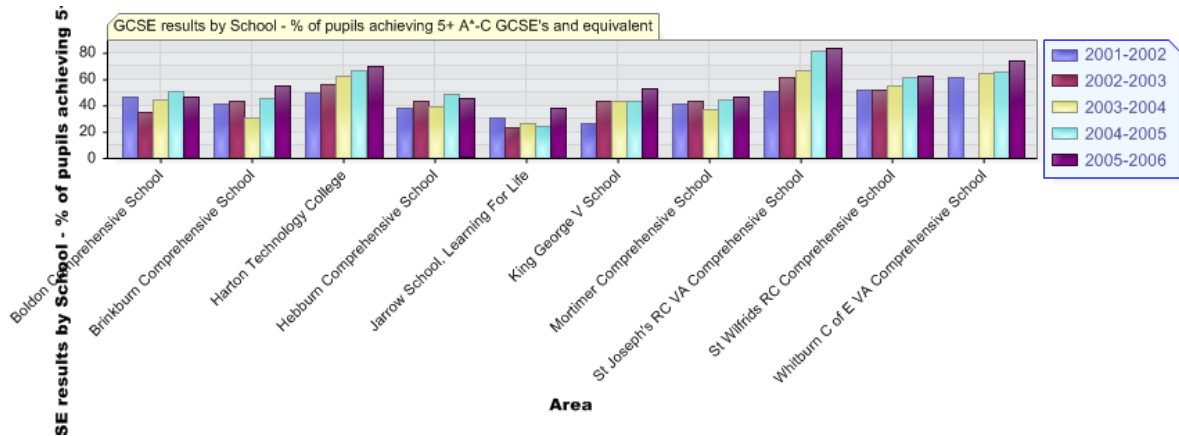
Education

There is a strong association between education and health. People with lower levels of educational achievement are much more likely to have poor health as adults across a range of indicators. Education also has an important effect on future employment, working conditions and in turn income levels which are also wider determinants of health status. The table below

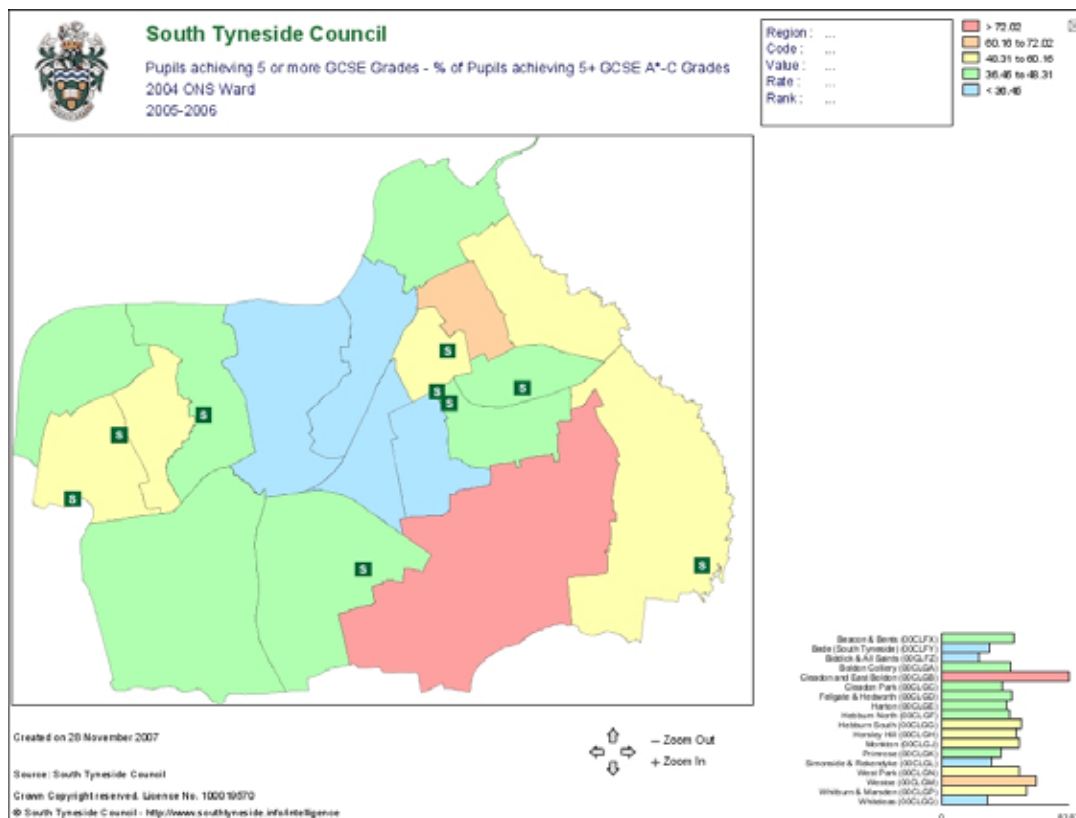
¹² www.dti.gov.uk/energy/fuel-poverty/index.html Accessed 26th November 2007

¹³ <http://www.berr.gov.uk/files/file42705.pdf>, detailed tables, 2007.

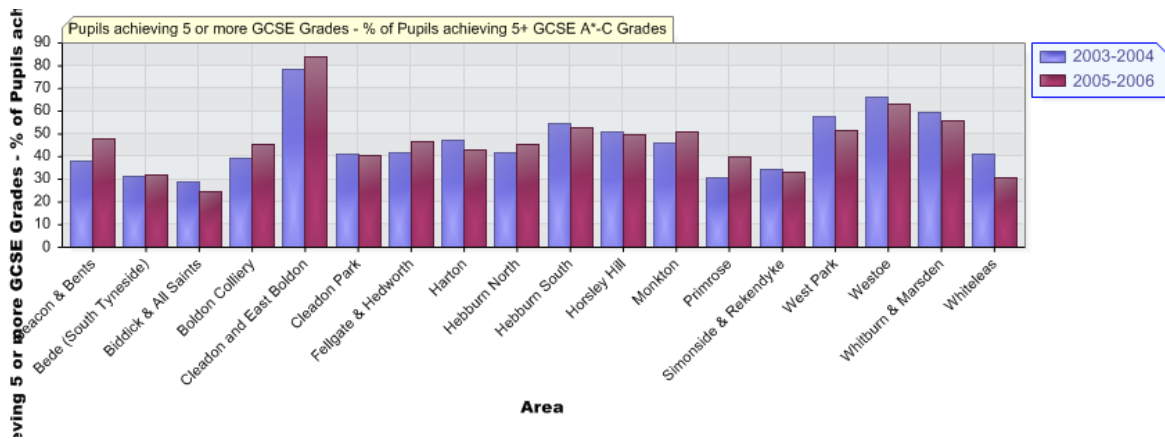
highlights GCSE attainment by year for each school in South Tyneside and illustrates a fairly positive picture with the percentage of young people achieving five or more A to C GCSEs rising for most schools.



One of the Government's key national targets is to increase to 60% the percentage of those aged 16 achieving the equivalent of five GCSE's at grades A* – C. However attainment mapped across the borough highlights pockets of lower attainment in relation to GCSE's based on the results from 2005-2006.



Data at ward level for comparison years 2003-4 and 2005-6 outlines an increase in attainment for some wards but a corresponding decrease in others.



Employment

Unemployment is known to be a potential risk factor for ill health. In relation to mortality there is an estimated 20% excess risk of death for both men actively seeking work and their wives, with the possibility that this is even higher in areas of high unemployment¹⁴. There is also a link between unemployment and acceleration of cardiovascular mortality accelerating after two or three years¹⁴. In addition to the more obvious effects of poverty and low income those people unemployed for long periods are also more likely to suffer from poor mental health such as depression, anxiety, self harm and suicide¹⁴.

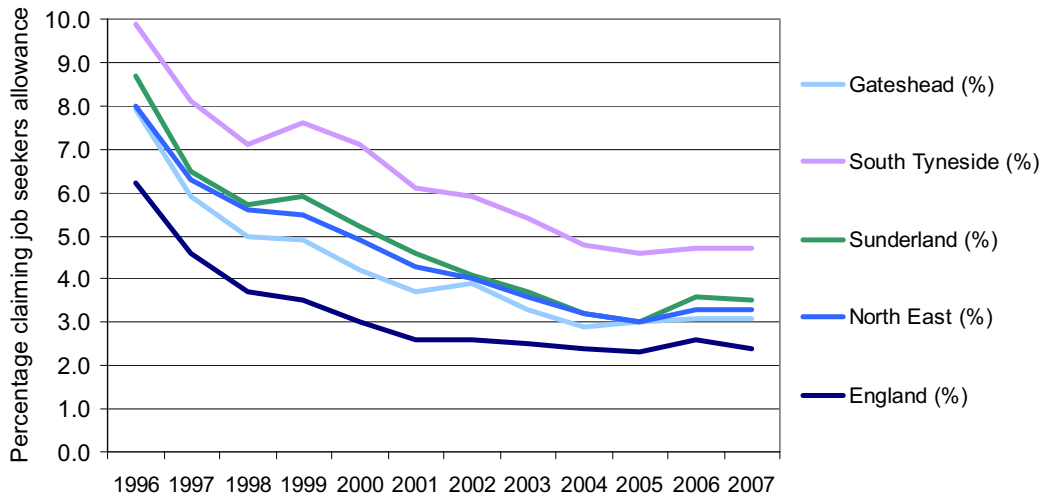
The five largest sectors for employment are:

- 18.9% manufacturing
- 15.2% wholesale trade and repair of motor vehicles
- 12.3 health and social work
- 7.4% transport and storage
- 7.2% construction

Unemployment in South Tyneside is significantly higher than the national average with 4.7% of the working age population claiming Job Seekers Allowance compared to a national average of 2.4%. This percentage equates to around 4,700 people across the borough. Whilst this percentage is high there has been a significant reduction in unemployment over the past ten years from a high of 9.9% in 1996.

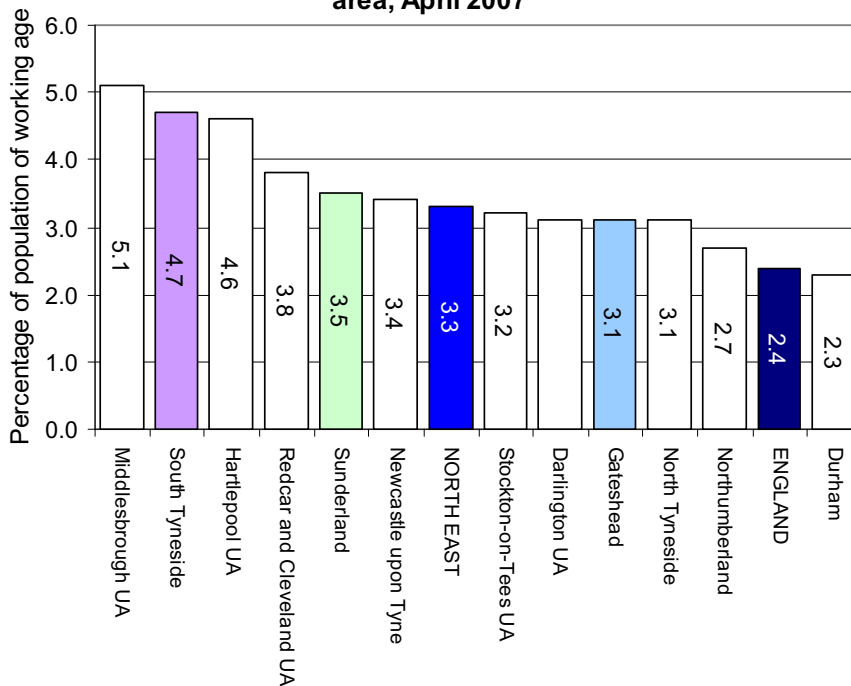
¹⁴ Health Development Agency (2005) Worklessness and health – what do we know about the causal relationship? (1st Edition). Available online at www.hda.nhs.uk

Proportion of the population of working age claiming Job Seekers Allowance



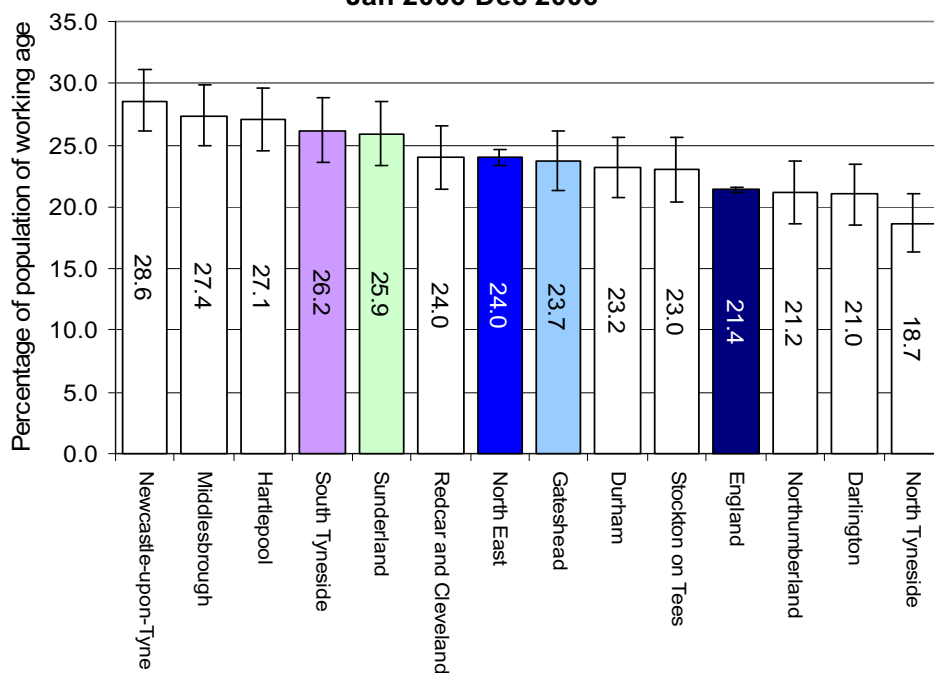
Despite the overall reduction in unemployment South Tyneside retains a larger percentage unemployed than other areas across South of Tyne. Furthermore South Tyneside has the second highest percentage falling into this category across the North East region.

Proportion of the population of working age claiming Job Seekers Allowance by North East Local Authority area, April 2007



Data analysed further explores the total number of economically inactive members of the population. People of working age can be economically inactive for a variety of reasons. They may be seeking work (the proportion claiming Jobseekers' Allowance as measured in the previous data item). However they may also be looking after a home, have caring responsibilities or they may have retired early. This data suggests over a quarter of the working age population in South Tyneside fit this category (26.2%) which equates to approximately 23,700 people. Again this figure is higher than the national and North East average as well as our neighbouring districts across South of Tyne and Wear.

**Proportion of the population of working age who are economically inactive with 95% confidence limits
Jan 2006-Dec 2006**



Income

Between 2002 and 2006 (latest figures) gross weekly pay in South Tyneside increased by 6.1%, from £358.6 per week to £380.6 per week.

This was less than half the national average (14.5%), and regional averages (14.7%).

Between 2002 and 2006 full time gross pay in Great Britain rose from £392.7 to £449.6 per week, the North East saw wages rise from £343.2 to £393.6 per week.

The average part time pay is less than half that for the average weekly wage for all employees, so in 2006 the average part-time weekly wage for South Tyneside was £126 per week compared to £306.6 per week for all employees.

However the data for part-time workers is subject to an even greater level of error and should be treated with caution.

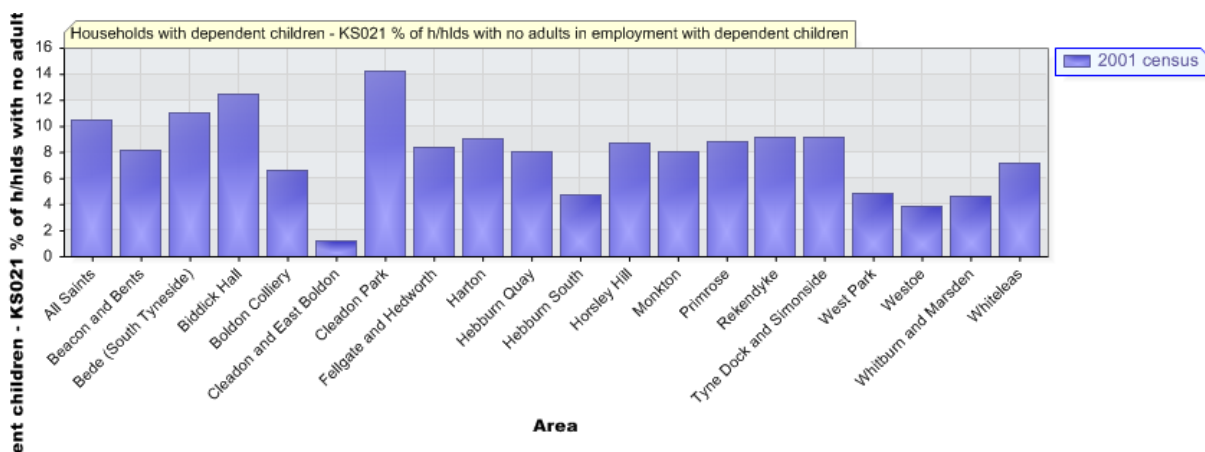
Deprivation Affecting Children

The Index of Deprivation 2004 includes income deprivation affecting children (i.e. figures on children living in low income households). Almost one third (32.6%) of South Tyneside's children are in families that are income deprived (i.e. in receipt of benefits like Job Seekers Allowance). This places South Tyneside in the second worst position in Tyne and Wear (behind Newcastle) and below the average performance for Tyne and Wear (30.1%) and the North East Region (27.9%).

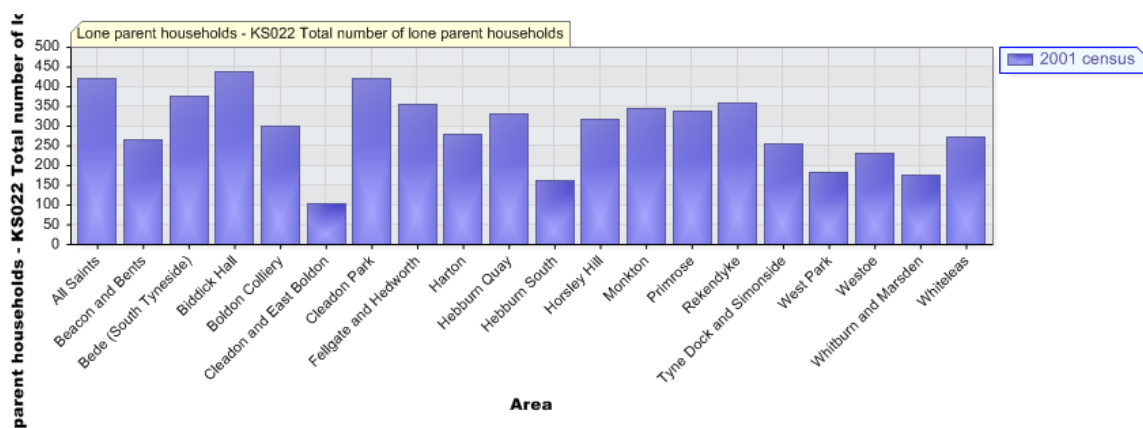
Children living in deprivation are more likely to smoke, drink, use drugs, practice unsafe sex and become teenage parents than their counterparts. They are more at risk of developing mental health problems and more likely to have contact with the Youth Offending Service.

| IMD 2004 - Income Deprivation Affecting Children | | | |
|--|--------------------------|----------------------|-------------------|
| Area | Children Income Deprived | Total Children 0 -15 | % Income Deprived |
| Gateshead | 10,565 | 36,904 | 28.6% |
| Newcastle | 17,125 | 48,720 | 35.1% |
| North Tyneside | 8,936 | 36,776 | 24.3% |
| South Tyneside | 10,123 | 31,064 | 32.6% |
| Sunderland | 16,445 | 56,182 | 29.3% |
| Tyne & Wear | 63,194 | 209,646 | |

Deprivation affecting children shows variation within the borough for example in the north Jarrow area 70% of children are in families that are income deprived. The table below outlines the percentage of households with no adults in employment with dependent children. There is clear disparity between wards with specific issues identified.



The table below identifies the number of lone parent households in each ward. Whilst all areas are affected there are some similarities with the table above with wards affected by parental unemployment being the same wards with a greater number of lone parent households.



Domestic Violence

Domestic Violence is an issue which affects victims, children and other family members. Nationally, it is estimated that one in eight women in long term relationships are affected by domestic violence. In South Tyneside, one in seven women in long term relationships are affected. Between April 2000 and March 2001 there were 1634 cases of domestic violence in South Tyneside. This is an average of 4.5 incidents per day and just over 30 incidents per week. Offences were most likely to be reported in December of January (160 and 159 respectively), with the first week in January seeing the most reports (65 incidents; nearly 10 women per day).

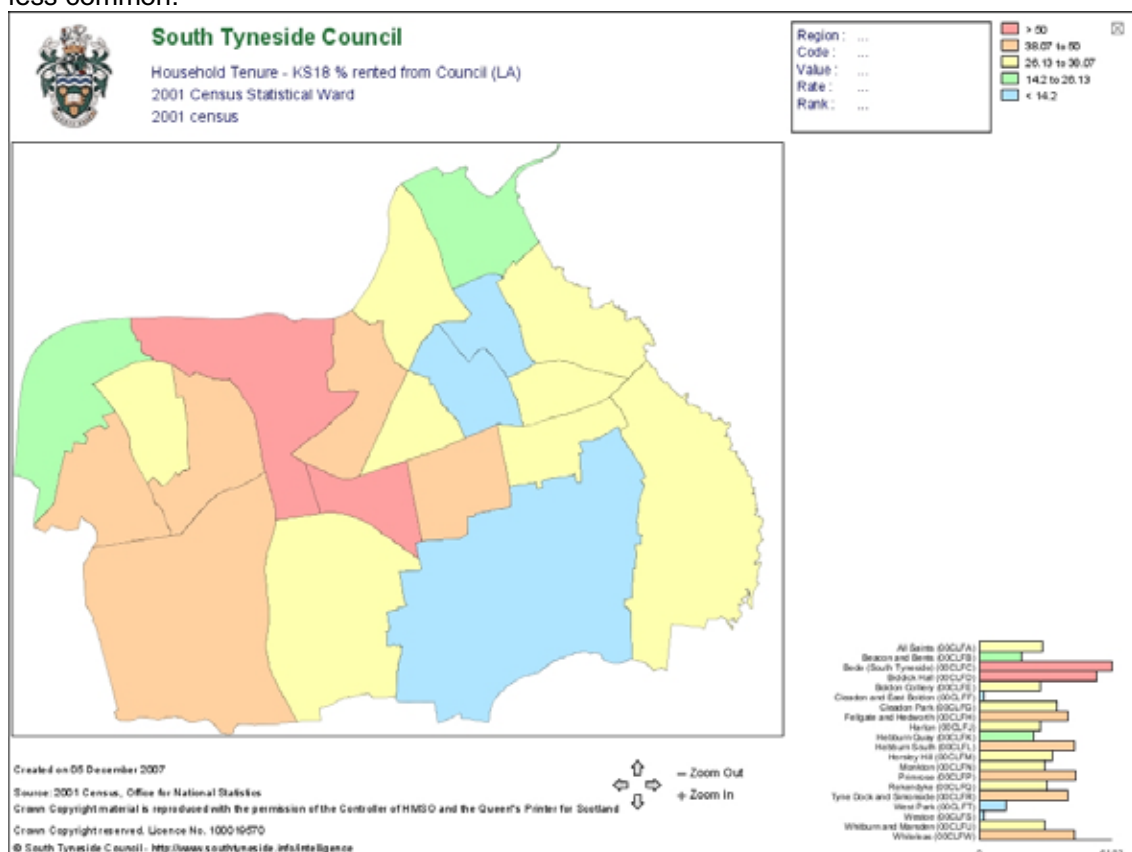
Much work has been undertaken to understand the needs of this group, needs analyses (*Domestic Violence in South Tyneside: Incidence, Provision and Good Practice* and *Service Provision and Needs: Children Living with Domestic Violence in South Tyneside* - by Professor Marianne Hester) are available separately and will be incorporated into the next edition of the Joint Strategic Needs Assessment, a list of services which support children who are the victims of or who have witnessed domestic violence is included at Appendix three.

Housing

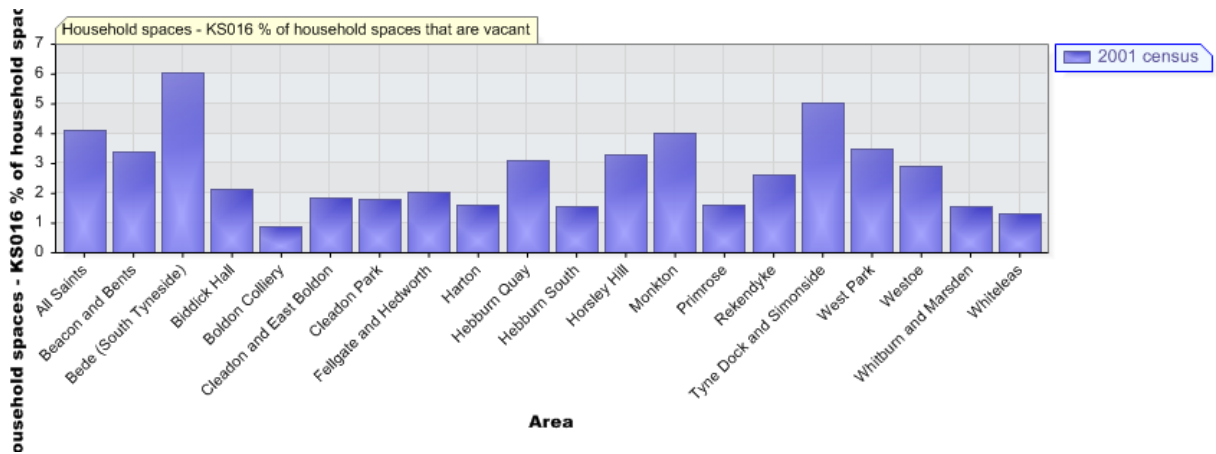
There are 66,097 households in South Tyneside, with an average occupancy of 2.29 people, of which:

- 31.8% are rented from the Local Authority
- 6.0% are rented from Housing Associations
- 4.2% are rented from Private landlords
- 1.8% are rented from "other"
- 30.2% have dependant children
- 10.7% have dependant children <4 years old
- 7.9% of homes with dependant children have no employed adult in the home
- 9% are lone parents living with dependant children
- 3.3% are co-habiting with dependant children

The map below presents data regarding houses rented as a percentage of the total. All rented properties were included in this data regardless of who they were rented from. There are areas where more than 50% of people rent their housing with corresponding areas where renting is less common.



The table below provides data regarding the percentage of houses within each ward that are vacant. This data highlights specific wards with an issue with vacant housing.



At April 2007 60% of Council dwellings did not meet the Government's Decent Homes standards. This is a total of over 11,000 homes, the majority of which were not in a reasonable state of repair.¹⁵

Access to car/van

A further indication of deprivation and a barrier to finding employment is access to a car or van. In South Tyneside over two thirds of all households (44.3%) have no access to a car or van (June 2007).

¹⁵ Draft South Tyneside Housing Strategy, 2007-2011.

Physical disability

The number of people claiming Incapacity Benefit and Severe Disablement Allowance by North East local authority area over the past five years is provided in the table below. These figures include people with a physical disability, learning difficulties or sensory impairment and are thus only a proxy indicator. In addition, figures for claimants 65 years and over show that only a small number of people continue to claim these benefits above retirement age.

The number of people 16 years and over claiming Incapacity Benefit or Severe Disablement Allowance by North East Local Authority area is:

| Area | persons 16 | persons 16 | persons 16 | persons 16 | persons 16 | persons 65 |
|-------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| | years and over May 2003 | years and over May 2004 | years and over May 2005 | years and over May 2006 | years and over May 2007 | years and over May 2007 |
| uacounty:Darlington | 5,760 | 5,730 | 5,710 | 5,560 | 5,450 | 80 |
| uacounty:Durham | 41,470 | 40,950 | 39,700 | 37,900 | 36,760 | 390 |
| uacounty:Gateshead | 15,670 | 15,100 | 14,070 | 13,450 | 12,840 | 140 |
| uacounty:Hartlepool | 8,130 | 7,910 | 7,750 | 7,380 | 7,220 | 60 |
| uacounty:Middlesbrough | 11,050 | 10,960 | 10,920 | 10,510 | 10,010 | 70 |
| uacounty:Newcastle-upon-Tyne | 19,640 | 18,960 | 18,340 | 17,590 | 16,860 | 190 |
| uacounty:North Tyneside | 12,330 | 11,910 | 11,440 | 11,040 | 10,480 | 130 |
| uacounty:Northumberland | 17,980 | 17,880 | 17,200 | 16,290 | 15,310 | 240 |
| uacounty:Redcar and Cleveland | 10,250 | 10,020 | 9,820 | 9,280 | 8,960 | 90 |
| uacounty:South Tyneside | 11,470 | 11,170 | 10,700 | 10,390 | 10,030 | 100 |
| uacounty:Stockton on Tees | 10,770 | 10,620 | 10,500 | 10,100 | 9,850 | 80 |
| uacounty:Sunderland | 23,290 | 22,790 | 22,130 | 21,490 | 20,730 | 200 |
| gor:North East | 187,800 | 184,020 | 178,290 | 170,970 | 164,520 | 1,770 |
| country:England | 2,248,170 | 2,254,100 | 2,235,070 | 2,197,720 | 2,166,470 | 24,160 |

Source: NOMIS, Office for National Statistics at www.nomisweb.co.uk

For South Tyneside this outlines very small variation in the numbers between 2003 and 2007. Furthermore this number of claimants equates approximately to between 6.6% and 7.5% of the total population.

South Tyneside is an area of high levels of disability. According to the last census 18.6% of adults of working age had a long term illness, compared with 13.3% nationally.

| Ward | % Adults with a Limiting Long Term Illness |
|-------------------------|--|
| All Saints | 19.3 |
| Beacon and Bents | 20.7 |
| Bede (South Tyneside) | 23.3 |
| Biddick Hall | 20.7 |
| Boldon Colliery | 16.6 |
| Cleadon and East Boldon | 10.9 |
| Cleadon Park | 20.2 |
| Fellgate and Hedworth | 19.3 |
| Harton | 19.1 |
| Hebburn Quay | 18.7 |
| Hebburn South | 19.5 |
| Horsley Hill | 17.9 |
| Monkton | 20.2 |
| Primrose | 20.0 |
| Rekedyke | 23.5 |
| Tyne Dock and Simonside | 21.4 |
| Westoe | 13.6 |
| West Park | 14.4 |
| Whitburn and Marsden | 17.8 |
| Whiteleas | 19.2 |
| South Tyneside | 18.6 |
| England | 13.3 |

Learning Disability

In 2007, Learning Difficulty was included in the Quality Outcomes Framework. Results from a census carried in February each year are published down to GP practice level in October of the same year on the Information Centre's website at www.ic.nhs.uk.

The data highlights the number of people with a learning difficulty and the average prevalence for South Tyneside. The data below also presents the estimated number of people calculated using the prevalence figures published in the national report "Valuing People"¹⁶.

| | South | | | | |
|---|-----------|----------|------------|------------|------------|
| | Gateshead | Tyneside | Sunderland | North East | England |
| Total people registered with a GP (2006/07 QOF) | 204,513 | 155,449 | 284,898 | 2,654,901 | 53,681,098 |
| Total people registered with a GP aged under 18 years (2006/07 QOF) | 40,544 | 26,013 | 48,946 | 516,567 | 11,210,168 |
| Total people registered with a GP aged 18 and over (2006/07 QOF) | 163,969 | 129,436 | 235,952 | 2,138,334 | 42,470,930 |
| Number of people with a learning difficulty aged 18 years and over | 453 | 373 | 1,097 | 9,247 | 139,321 |
| Average percentage prevalence | 0.28% | 0.29% | 0.46% | 0.43% | 0.33% |
| Number with learning difficulties aged 18-64 supported within a community care setting | 590 | 205 | 1,305 | 8,835 | 136,755 |
| Estimated prevalence of severe learning disability among children and young people (0-19 years) per 100,000 population | 0.52% | 0.52% | 0.52% | 0.52% | 0.52% |
| Suggested number of people ages under 18 years with a severe learning disability based on number of people registered with a GP | 212 | 136 | 256 | 2707 | 58741 |
| Estimated prevalence of severe learning disability among adults (20 years and over) per 1,00,000 population | 0.40% | 0.40% | 0.40% | 0.40% | 0.40% |
| Suggested number of people ages 18 and over with a severe learning disability based on number of people registered with a GP | 649 | 513 | 934 | 8468 | 168185 |
| Estimated prevalence of mild to moderate learning disability among people of all ages | 2.50% | 2.50% | 2.50% | 2.50% | 2.50% |
| Suggested number of people with a mild to moderate learning difficulty | 5,113 | 3,886 | 7,122 | 66,373 | 1,342,027 |

Sources: number and average prevalence, NHS Information Centre at www.ic.nhs.uk, estimates of prevalence from "Valuing People: A New Strategy for Learning Disability for the 21st Century"

Children with disabilities

Children with disabilities service is an integrated service including both Social Workers and Community Learning Disabilities Nurses for children. It is a specialist service in that the Social Work team provides a service to children with permanent and substantial impairments, whilst the nursing service is open to all children with learning disabilities - although differentiated responses are made according to the level of severity.

| | 05/06 | 06/07 | 07/08 |
|-----------------|-------|-------|--------------------|
| New Assessments | 71 | 66 | 21 |
| Open cases | | | 105 Social Worker |
| | | | 58 Nursing Service |
| | | | Including 10 LAC |

¹⁶ * "Valuing People: A New Strategy for Learning Disability for the 21st Century", Department of Health, 2001 - People with severe learning disabilities are those who need significant help with daily living.

The increase in activity can be explained by:

- Increase in the numbers of children born and surviving with multiple and complex needs.
- Decline in numbers of referrals to team associated with the introduction of Common Assessment Framework, whereby initial assessments of Need are screened through the CAF process and panel

The service does not have waiting lists as such, as people who are referred are offered an assessment that is completed within 7 days. Neither is there a waiting list to access services as services are commissioned. However, as referral is in most cases are voluntary, from families who are seeking additional support it is difficult to say why other families don't ask for support from this service.

At this time we cannot predict the impact of the injection of **Aiming High** resources that is likely to involve a "core offer" of service availability to families with children with severe disabilities. For some families, the provision of the core offer might be sufficient for their needs, and so not require other services

Unmet needs

National estimates suggest 7% of the population of children have a disability- based upon the widest definition of disabilities. In South Tyneside this would equate to 2,675 children and young people. Local work to estimate numbers of children with disabilities are based upon:

- Number of children and young people with statements for SEN (Number 826)
- Number of children registered with South Tyneside Active Network (Number 350)
- Estimates from Connexions of young people with learning and other disabilities who have left school in yr 11
- Pre-school children with complex needs who are heavily involved with health services.

The total is estimated to be approx 1150, which is 43% of the estimate based upon national figures. Currently 163 are receiving services from the specialist disabilities service which may demonstrate a level of unmet need. Of the 163, the majority of young people with the most severe needs are known or have been to the Children with Disabilities Service.

The highest area of unmet need is with those families who don't meet the criteria for the CWD Social work service, but whose children have needs that are not able to be appropriately met within universal services

Recommendations

- Further work is required to explain both the gap in figures nationally and local estimates.
- The impact of CAF will need to be monitored, to ascertain if the drop in assessment is a temporary, or if more families are able to receive the support they need through the CAF process.
- Preventative measures which could be taken or developed to reduce demands on the service and/or make more effective use of the service include more work with mainstream providers to improve access to social and leisure and childcare related services for children with complex needs
- Explore the feasibility of locating services closer to home and improving integration of service in response to the parent survey detailed in Appendix 2.
- Improve recording of preventative work undertaken with children with disabilities and their families / carers

Life Expectancy

Background

Inequality in life expectancy is linked to many different factors. Life expectancy is affected by geographical variation, socio-economic grouping, ethnicity and gender amongst others. Furthermore a complex range of interacting factors are associated with poor health outcomes. For example, life expectancy is influenced by individual choices, lifestyles and familial factors and risk factors associated with life expectancy - smoking, low physical activity, heavy alcohol consumption, high blood pressure, unhealthy diet and obesity, are also unevenly distributed in the population, with the least well off exposed to the highest risks.

It is widely accepted that many other conditions and circumstances, including income, poverty, housing, employment, the environment, transport, education and access to services and facilities, influence inequalities in life expectancy. Within this context many of the wider influences and determinants of health fall outside the direct remit of the NHS, but are very much part of the broader health, social and economic infrastructure influenced by local government, the voluntary sector, community groups, business and commercial enterprise.

Inequities in access

Further inequality has been linked to the issue of 'equity of access to health care'¹⁷. This encompasses the concept of 'individualised' care based on need. However it has been suggested that healthcare is often delivered to the populations that need it least, which is known as the Inverse Care Law (Hart 1971)¹⁸. The inverse care law is not inevitable but rather can be reversed by targeting care based on disadvantage.

Prevalence

The life expectancy gap between South Tyneside and England

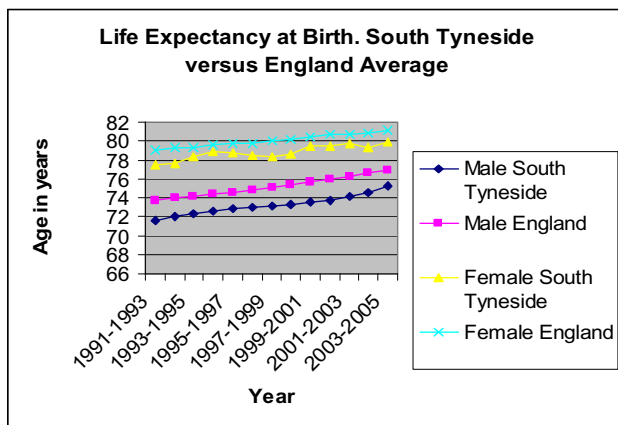
The average life expectancy for men in South Tyneside is 75.2 years compared with 77.3 years for England. The average life expectancy for women is 80.1 years compared with the England average of 81.6 years¹⁹. The difference in life expectancy between men and women in South Tyneside is approximately 5 years. Further variation is apparent between wards from 80.3 years for men in Cleadon and East Boldon to 72.2 years in Simonside and Rekendyke. The following graph illustrates the gap in life expectancy between South Tyneside and England as a whole for both men and women.

Life expectancy at birth

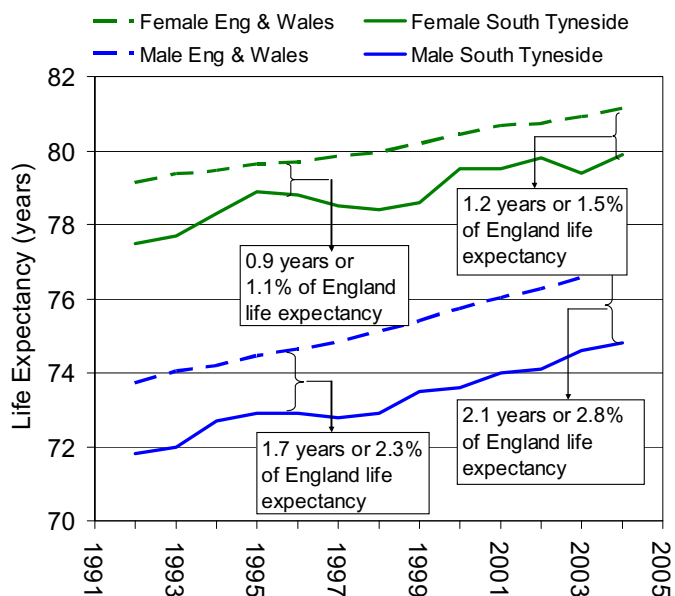
¹⁷ Hart, A., Lockey, R., (2002) 'Inequalities in health care provision: the relationship between contemporary policy and contemporary practice in maternity services in England': *Health and nursing policy issues* Blackwell Science Ltd

¹⁸ Hart, J.T. (1971) 'The Inverse Care Law'. *Lancet*: 1 405 – 412

¹⁹ ONS Pooled data 2004 – 2006



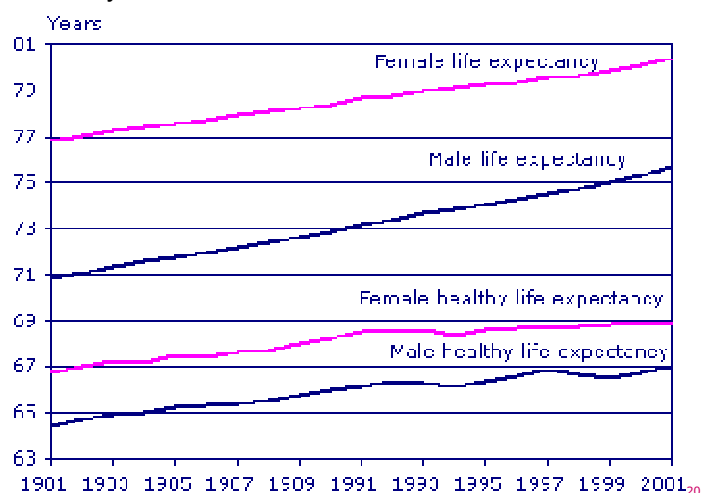
| Year | Aggregated Life Expectancy (years) | | | |
|-----------|------------------------------------|--------------|-----------------------|----------------|
| | Male South Tyneside | Male England | Female South Tyneside | Female England |
| 1991-1993 | 71.6 | 73.7 | 77.5 | 79.1 |
| 1992-1994 | 72 | 74 | 77.7 | 79.4 |
| 1993-1995 | 72.3 | 74.2 | 78.3 | 79.4 |
| 1994-1996 | 72.6 | 74.4 | 78.9 | 79.6 |
| 1995-1997 | 72.9 | 74.6 | 78.8 | 79.7 |
| 1996-1998 | 73 | 74.8 | 78.5 | 79.8 |
| 1997-1999 | 73.2 | 75.1 | 78.4 | 80 |
| 1998-2000 | 73.3 | 75.4 | 78.6 | 80.2 |
| 1999-2001 | 73.6 | 75.7 | 79.5 | 80.4 |
| 2000-2002 | 73.7 | 76 | 79.5 | 80.7 |
| 2001-2003 | 74.1 | 76.2 | 79.8 | 80.7 |
| 2002-2004 | 74.6 | 76.6 | 79.4 | 80.9 |
| 2003-2005 | 75.3 | 76.9 | 79.9 | 81.1 |
| 2004-2006 | 75.2 | 77.3 | 80.1 | 81.6 |



The table above highlights that despite an overall increase in age of 3.7 years for men and 2.4 years for women their appears to be widening gap in life expectancy between South Tyneside

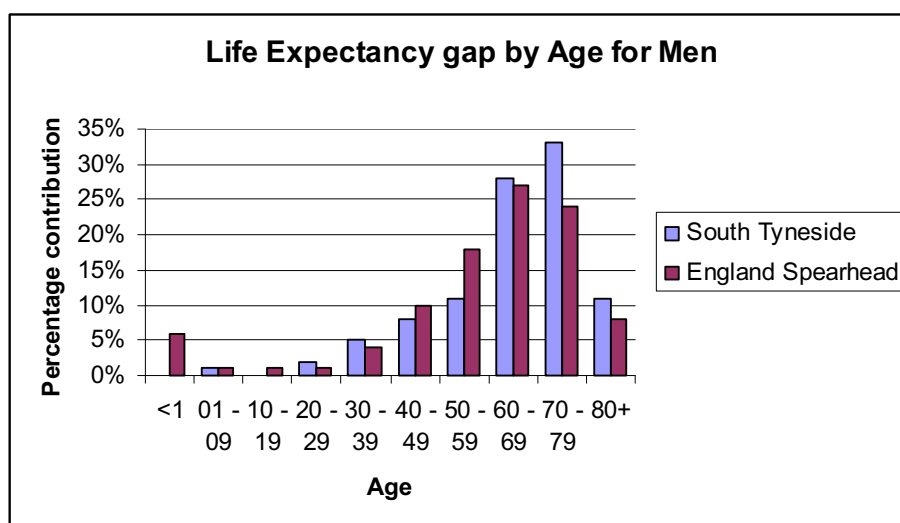
and the national average. This inequality shows a difference of life expectancy of 1.5% (1.2 years) for women and 2.8% (2.1 years) for men.

It is also possible to measure Healthy Life Expectancy²⁰. Healthy Life Expectancy combines life expectancy and population data on the health of the population to present an index of the expected remaining years of healthy life. This provides an indication of how long people will live in generally good health. Recent national figures show that while life expectancy is improving, Healthy Life Expectancy is not keeping pace. In 1981 the expected time lived in poor health was 6.5 for men and 10.1 for women. By 2001 this has risen to 8.7 years for men and 11.6 years for women. Estimates also suggest that the North East's Healthy Life Expectancy is around 4 years less than the national average. Furthermore data suggests that the percentage of the South Tyneside population living with a long term limiting illness is around 40% higher than the national average. This rate impacts on healthy life expectancy suggesting further inequality in South Tyneside.



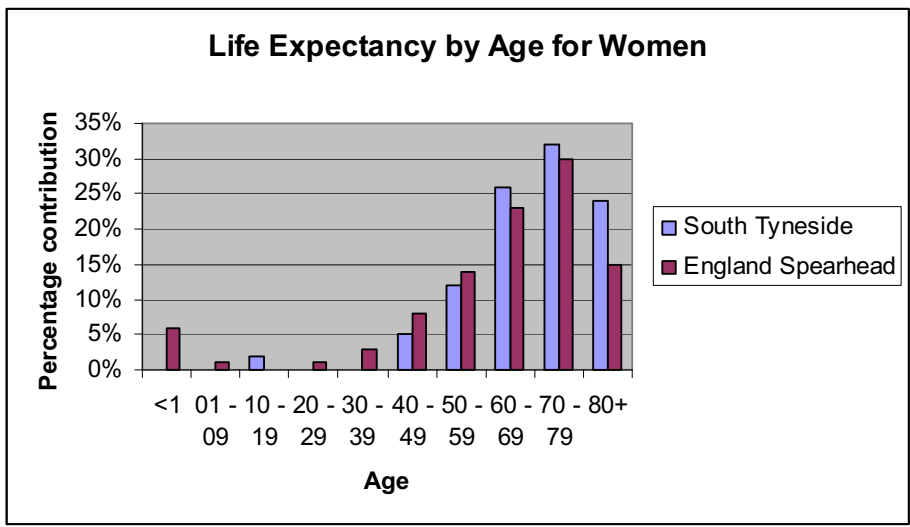
Life Expectancy gap by Gender

There is variation in the implications for different ages in relation to the life expectancy gap by gender. In South Tyneside the Health Inequalities Tool²² outlines that the inequality gap is a specific issue for men aged above 60 years and the percentage contribution to the overall inequality gap is greatest within these age groups when compared to the England Spearhead average.



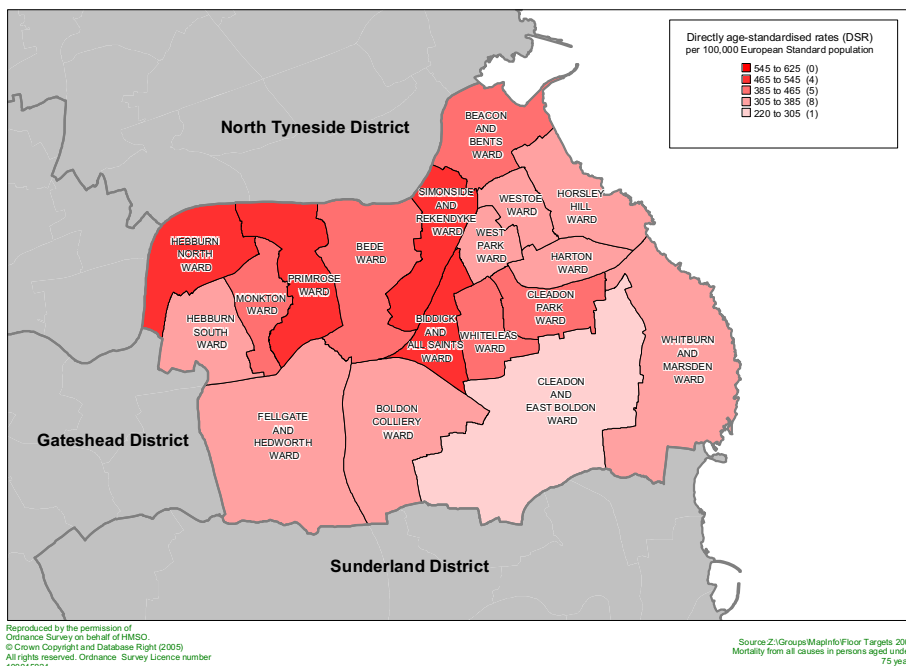
²⁰ <http://www.statistics.gov.uk/cci/nugget.asp?id=934>

For women the evidence suggests that females over 60 years present the greatest percentage contribution to the overall inequality gap when compared to the England Spearhead average.



Mortality by Area of residence

Mortality from all causes in persons aged under 75 years 2003 to 2005 (Pooled)



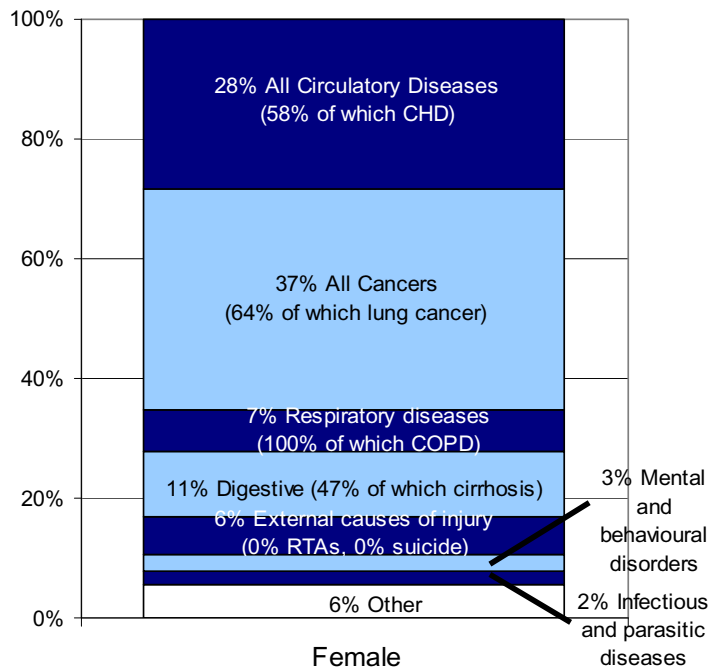
Data presented on the map above highlights pockets of higher mortality across all causes with the population under 75.

Life Expectancy Gap by Disease Group

The charts below outlines which diseases contribute most to the Life Expectancy Gap by gender for South Tyneside when compared to England for the years 2003-2005.

Females

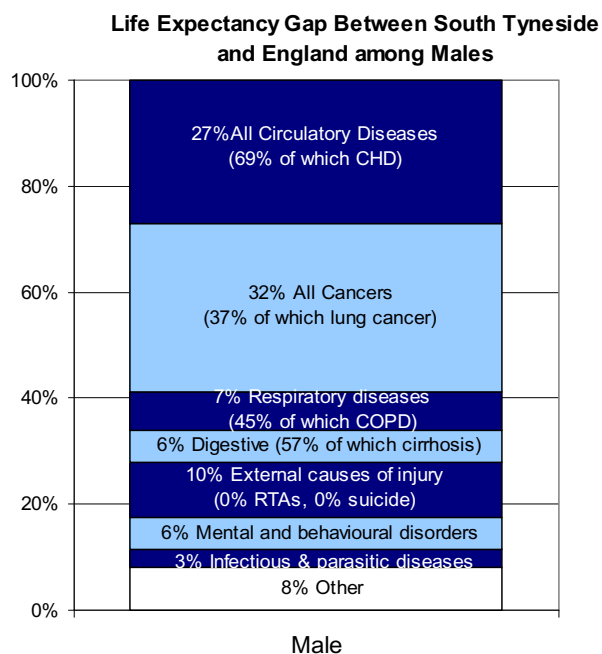
Life Expectancy Gap Between South Tyneside and England among Females



The table above²¹ highlights considerable inequality in life expectancy for females linked to both circulatory diseases and cancer. These two conditions account for 65% of the total inequality in life expectancy for women. For women 64% of all cancers contributing to the variation in life expectancy are lung cancer with 58% of circulatory diseases attributed to CHD. Within the category of digestive diseases (11% of inequality gap) 47% is cirrhosis.

²¹ Life expectancy gap for South Tyneside from London Health Observatory, 2007, "Health Inequalities Intervention Tool", LHO, London ; Effective Interventions from Dept. of Health, 2007, "Commissioning Framework for Health and Well-being", Dept. of Health, London

Males



The table above²¹ outlines a similar picture of inequality in relation to life expectancy for men with some variation in the disease groups. For men circulatory diseases and cancer account for 59% of the total inequality. The variation in life expectancy due to cancer is different for men with lung cancer accounting for 37% of all cancers. Within the category of digestive diseases (6% of inequality gap) 57% is cirrhosis.

Unmet need

Using evidence provided by the Health Inequalities Tool²² it is possible to identify unmet need impacting on the inequality gap in relation to specific interventions. By applying these estimates to the South Tyneside population it is suggested that there are approximately 26, 815 people living in South Tyneside with undiagnosed or uncontrolled hypertension. This estimate equates to 13,376 men and 13,439 women. Furthermore it is estimated that there are approximately 40,632 smokers in the borough and the Stop Smoking Service provides services to between 6 and 8.3% of this population with an average 3.4% of the total smoking population quitting based on figures over the past three years.

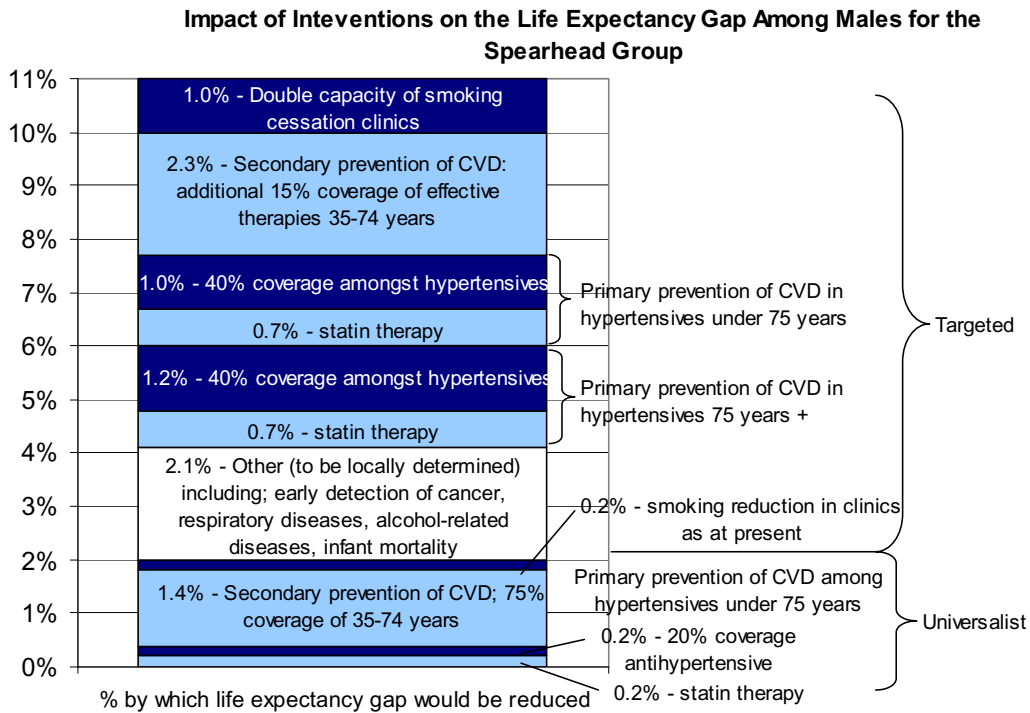
Linked performance indicators

- NI 119 Self reported measure of people's overall health and well-being DH DSO
- NI 120 All-age all cause mortality rate PSA 18
- NI 121 Mortality from all circulatory diseases at ages under 75 DH DSO
- NI 122 Mortality from all cancers at ages under 75 DH DSO
- NI 123 16+ current smoking rate prevalence PSA 18
- NI 126 Early access for women to maternity services PSA 19
- NI 129 End of life palliative care enabling people to choose to dies at home DH DSO
- NI 134 The number of emergency bed days per head of weighted population DH DSO
- NI 137 Healthy Life Expectancy at age 65

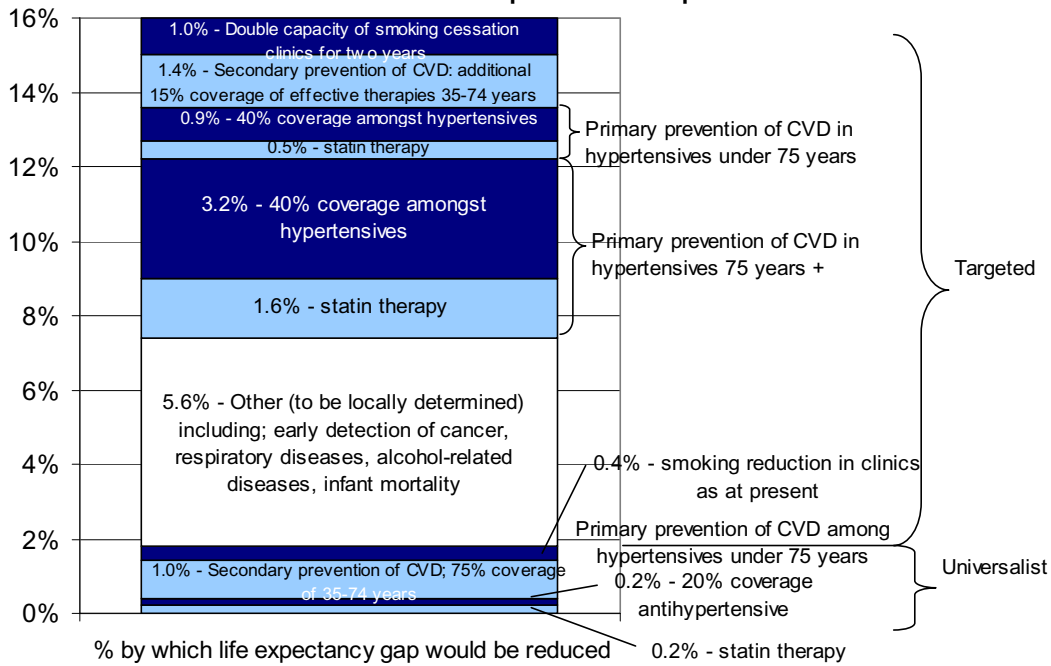
²² Association of Public Health Observatories – Health Inequalities Tool – Working in partnership with the Department of Health. Accessed online at www.lho.org.uk on 15th November 2007

High Impact Changes

Using the evidence highlighting which diseases contribute most to the Life Expectancy Gap for South Tyneside specific evidence based interventions are identified. Realising the benefit of evidence based interventions comes from the identification and effective management of patients with chronic disease and /or the key risk factors (e.g. hypertension). Evidence suggests an increase in these interventions will have the greatest impact on reducing the life expectancy gap. A range of sources suggests that disease prevalence may be significantly higher indicating a high level of unidentified disease and unmet need. The tables presented below outline the high impact changes required for each Spearhead PCT (of which South Tyneside is one) in order to impact on the life expectancy gap.



Impact of Interventions on the Life Expectancy Gap Among Females for the Spearhead Group



Recommendations

Evidence suggests we adopt the following high impact changes:

- Identify and manage uncontrolled / unidentified hypertension with an identified high impact intervention, i.e. implementation of the NICE guidelines.
- Increase Statin prescribing to patients without CVD
- Increase access to smoking cessation
- Increase access to the Choosing Health targeted comprehensive programme of prevention / risk factor management and reduction on those >50.
- Management of obesity through the use of a formal supported pathway of care adopting NICE guidelines.
- Develop preventative programmes related to alcohol use

Based on the evidence from the Health Inequalities Tool²² to reduce the life expectancy gap by 10% it would be necessary during the next year to:

- Double the number of smoking quitters to 3,060
- Identify and treat hypertension in 9,500 people (6,500 men and 3,000 women) with an additional/first treatment
- Provide Statin treatment to 5,700 people (3,300 men and 2,000 women) with undiagnosed or uncontrolled hypertension

Smoking

Background

Smoking remains the single most preventable cause of death and ill-health in England. Half of all smokers will die prematurely as a result of smoking and treatment of smoking related diseases has been estimated to cost the NHS between £1.4 and £1.7 billion each year²³.

Smoking is a major cause of death from coronary heart disease, strokes and cancers amongst other health morbidity. Nationally, 19% of deaths (120,000 per year) are caused by smoking. Half of all regular smokers die from smoking related with one in two of these people losing an average of 20 years of life and the other half losing an average of eight years. It has been estimated that smoking causes²⁴:

- 80% of chronic obstructive pulmonary disease
- 80% of all cases of lung cancer
- 30% of all deaths from cancer, including cancer of the mouth, lip, tongue, stomach, lung, liver, pancreas, kidney, bladder, cervix and leukaemia
- 90% of peripheral vascular disease
- 17% of all cases of coronary heart disease
- 50% of all Sudden Infant deaths

Smoking prevalence is significantly higher within the most deprived communities and thus further exacerbates inequality²⁵. A reduction in smoking prevalence will have a major impact on health inequalities as measured by infant mortality and life expectancy at birth and a priority within the Government's white paper *Choosing Health: Making Healthy Choices Easier*²⁶. The Commissioning framework for health and well-being cites reduced smoking levels as one of three key factors which will make the most difference in reducing health inequalities.²⁷

Targets have been set to reduce the prevalence of smoking by 2010 to 21% for adult smokers with a reduction among routine manual groups (from 31% in 2002) to 26% or less (Data source: ONS general Household Survey). In addition a national target is set to reduce the prevalence of smoking in pregnancy to 15%. The plan for this is through a national Public Service Agreement to reduce levels of smoking during pregnancy by 1 percentage point each year in order to secure the overall national prevalence of 15% by 2010²⁸. Indicators for these targets include smoking status recorded by primary care and the four week quit rate of smokers accessing NHS cessation services.

Prevalence

Over the past five years the PCT in South Tyneside has been working to encourage the systematic and accurate recording of smoking status within General Practice. Currently, around 57.4% of adults aged between 16 and 74 years of age have had their smoking status recorded within the past 15 months. Estimates of prevalence from this source will be skewed as the sample is biased towards the less healthy population as it is made up of those people presenting at their GP. However, the data source offers the potential for analysis of variations in prevalence. This could allow a much greater understanding of those population groups where prevalence is highest and thus it will allow the effective targeting of services aimed at reducing prevalence.

²³ British Medical Journal(2004)Economics of Smoking Cessation (Parrot S, Godfrey C 328:947-949)

²⁴ Association of Public Health Observatories – Health Inequalities Tool – Working in partnership with the Department of Health. Accessed online at www.lho.org.uk on 15th November 2007

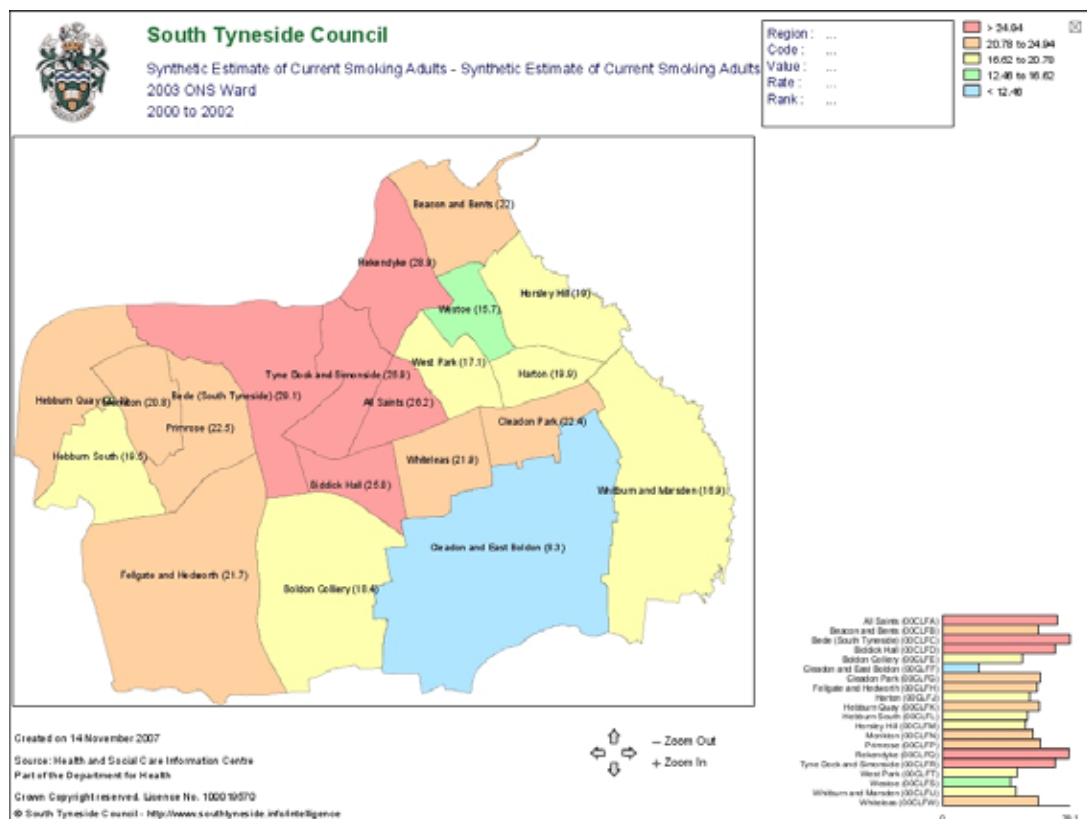
²⁵ Department of Health (2007) NHS Stop Smoking Service: Service and Monitoring Guidance 2007/08

²⁶ Department of Health (2004) *Choosing Health Making Healthy Choices Easier*

²⁷ Department of Health (2007) Commissioning framework for health and well-being

²⁸ Department of Health, 2003, "Tackling Health Inequalities: A Programme for Action", p56, Department of Health, London

At a local level smoking prevalence among adults is estimated at 32.9% in South Tyneside which is significantly higher than the England average of 26%²⁹. Applying this figure to the resident population estimates (ONS, mid 2006) suggests there are 40,632 people aged over 16 years who smoke in South Tyneside. Synthetic estimates of smoking prevalence by ward in South Tyneside (2000 – 2002) have been provided by the Health and Social Care Information Centre which is part of the Department of Health. This data highlights significant variation in prevalence between wards ranging from less than 15% in Cleadon and East Boldon to approximately 43% in Rekendyke and Bede. This is shown in the map below;



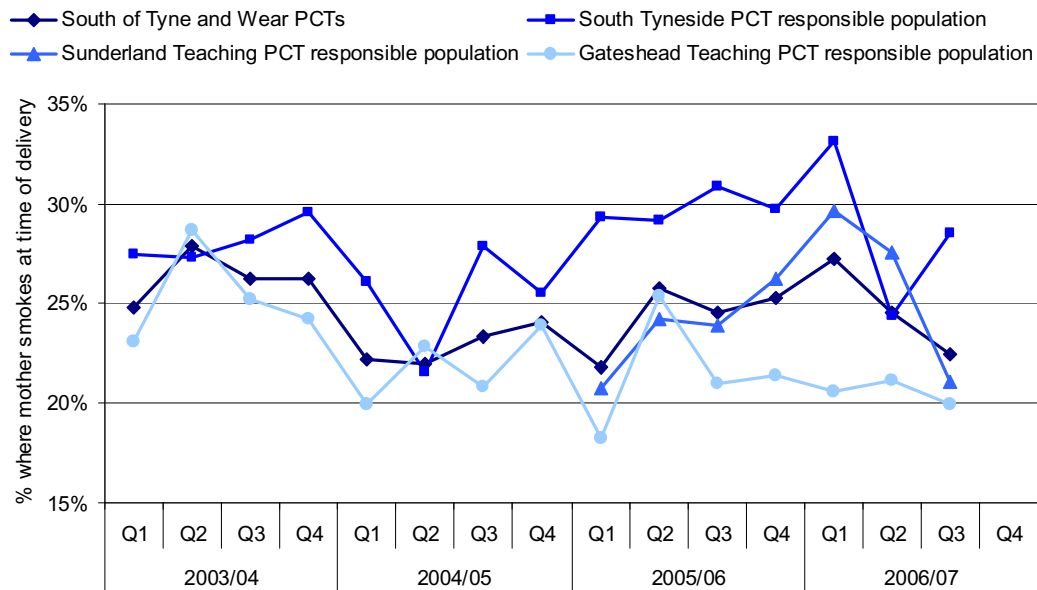
Smoking in Pregnancy

Smoking in pregnancy is a major issue for South Tyneside with evidence highlighting the prevalence as 67% higher than the national average. The latest figures for smoking in pregnancy shows a prevalence of 28.44% in South Tyneside compared to a national average of 17%³⁰. This figure is also considerably higher than our neighbouring areas in South of Tyne and Wear with a prevalence of 19.96% in Gateshead and 21.92% in Sunderland.

Percentage of maternities where mother smokes at time of delivery: South of Tyne and Wear PCTs

²⁹ Department of Health (2007) Community Health Profiles (North East Public Health Observatory)

³⁰ Bolling K (2007) Infant Feeding Survey :Early Results, p2 Information Centre, Leeds



Evidence based interventions / Local Action

Tobacco Control

South Tyneside has a local smoke-free alliance with comprehensive smoke free strategies and action plans in place. These plans are based on both the regional smoke free strategy, and national policy drivers, including Choosing Health. Local plans detail recommendations from the Overview and Scrutiny Review and Health Care Commission Reviews. These focus on an overarching vision of reducing smoking prevalence and associated disease, disability and death by;

- Stopping young people starting
- De-normalising smoking
- Providing a smoke free environment for people who want to quit smoking
- Reducing passive smoking
- Fiscal controls
- Media

The Health Act Smoke Free legislation was introduced on July 1st 2007 presenting a major step forward in health improvement.

Stop Smoking Services (SSS)

Specialist Advice

South Tyneside PCT provides a Stop Smoking Service (SSS) based within the Provider Services Directorate NHS South of Tyne and Wear. This service provides;

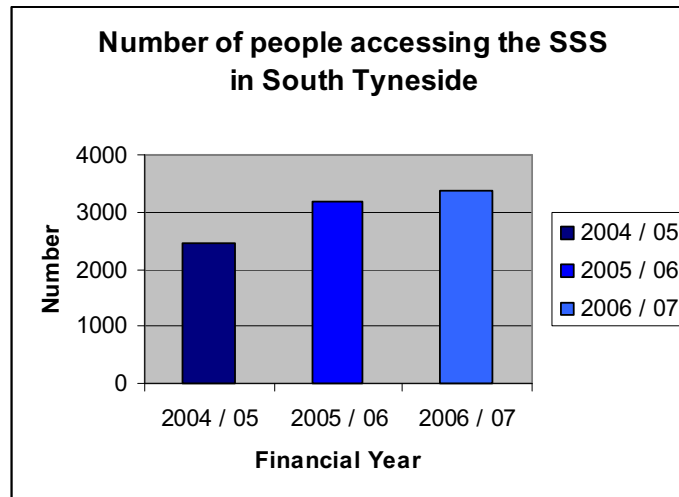
- Evidence based clinical treatment
- One to one services (e.g. for pregnant smokers)
- Community provision of one to one and group services for quitters in a variety of settings (e.g. general practice, prisons, pharmacies, dental practices, workplaces and schools/colleges)
- Provision of on-going training in smoking cessation methodology for a wide range of health and social care personnel
- Provision of policy support, consultation, and clinical services to employers,
- Ongoing contribution to tobacco control networks and initiatives

Intermediate Advice for Stop Smoking

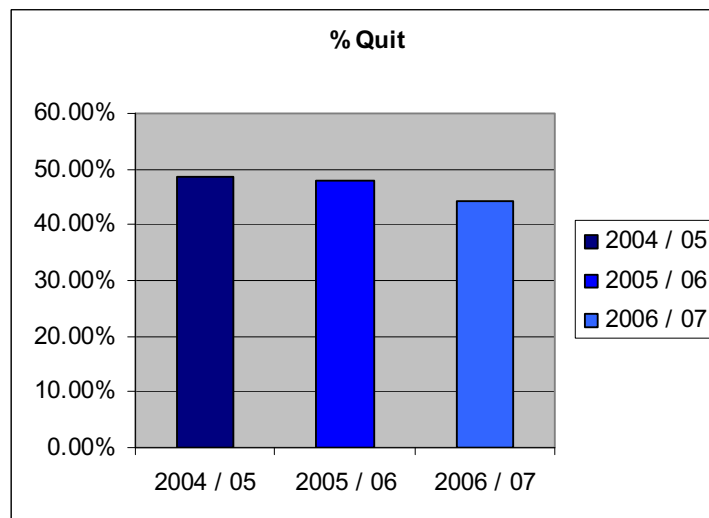
In addition to the specialist SSS there are also a wide range of intermediate stop smoking advisers, including independent contractors, and other PCT providers, including school nurses, health visitors.

Service Uptake

The number of people accessing the service has steadily increased over the past three years from 2448 people in 2004 / 05 to 3358 during 2006 / 07.

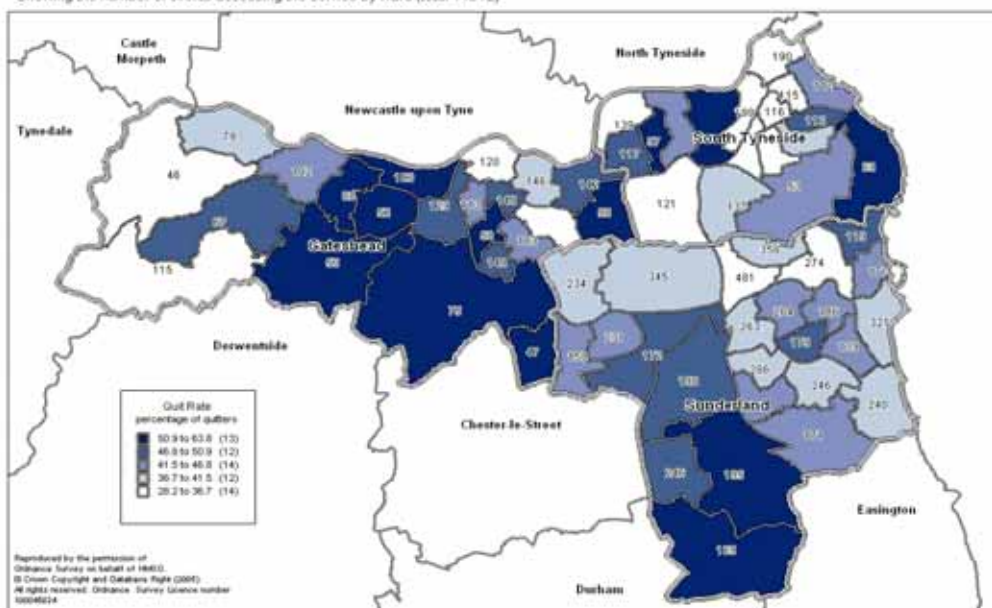


The percentage of people who have accessed the service and successfully quit at four weeks has remained relatively steady over the same years with a small reduction in performance during 2006 / 07.



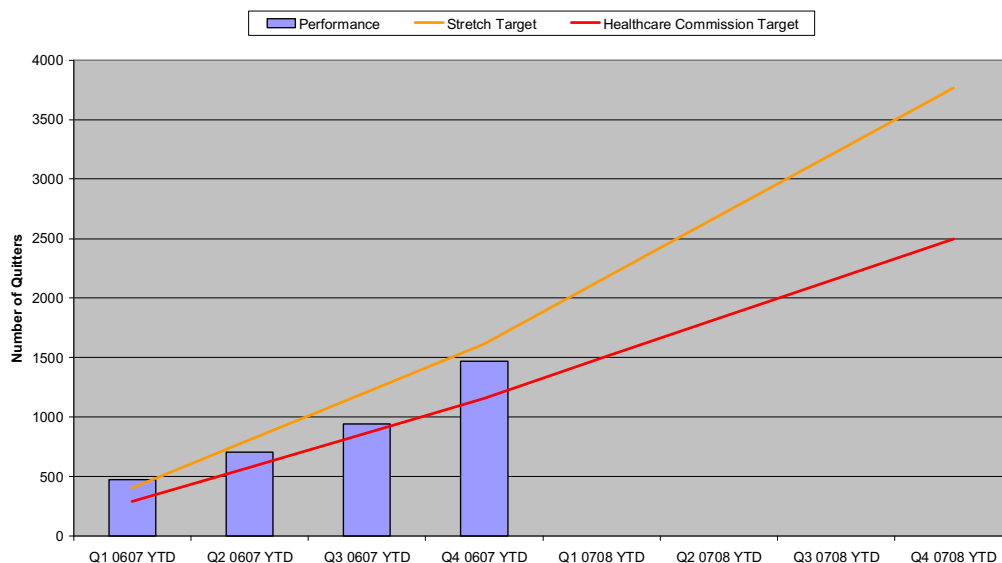
Analysis of numbers both accessing the service and successfully quitting at four weeks by electoral ward illustrates that services are appropriately targeting resources at more deprived communities, in accordance with good practice. However these areas generally have a lower quit rate, as would be expected, and so efforts should be made to increase the number of people accessing services from these areas to increase the number of 4 week quitters.

Smoking Cessation: Quit rate per as a percentage clients accessing the service (April 2006 - March 2007)
Showing the number of clients accessing the service by ward (total 11312)



Performance against targets outline that the stop smoking service in South Tyneside has exceeded the Healthcare Commission Target for 2006/07 but will need to increase performance to achieve the ambitious stretched target.

South Tyneside PCT 4 week Smoking Quitters against trajectories (cumulative)



Unmet need

Local surveys have shown that around 80% of smokers are interested in giving up, 40% are currently considering giving up and 20% are actively trying to give up (South Tyneside 2003).

Based on the data for the previous three years the local SSS has worked with an average of 2996 people annually with an average of 1396 (47%) successfully quit at four weeks. This highlights that the South Tyneside SSS service has reached between 6% and 8.3% of the total smoking population (40,632) within the borough each year. If we accept the local survey data

which shows the percentage of smokers and their current status in relation to quitting there is considerable unmet need.

| Percentages in quit position | Number in category | Unmet need in relation to numbers engaged with SSS | Unmet need in relation to numbers quit |
|------------------------------|--------------------|--|--|
| 80% Interested | 32506 | 29510 | 31110 |
| 40% Considering | 16253 | 13257 | 14857 |
| 20% Actively trying | 8126 | 5130 | 6730 |

Priority Action / Evidence Base

The Commissioning framework for health and well-being identifies some high impact changes which will result in a reduction in the inequalities in the life-expectancy gap between the Spearhead PCTs and the national average. These changes include:

- Reducing smoking prevalence with a particular focus on targeting deprived communities and reducing maternal smoking
- Implementing smoke-free legislation
- Tobacco control policies and partnerships

Linked Performance Indicators

NI 119 Self reported measure of people's overall health and well-being DH DSO

NI 120 all-age all cause mortality rate PSA 18

NI 121 Mortality from all circulatory diseases at ages under 75 DH DSO

NI 122 Mortality from all cancers at ages under 75 DH DSO

NI 123 16+ current smoking rate prevalence PSA 18

NI 126 Early access for women to maternity services PSA 19

NI 137 Healthy Life Expectancy at age 65

Recommendations

- Increase the number of intermediate SSS providers
- Increase the number of people accessing SSS
- Increase smoking cessation with pregnant women

High Impact Changes

Based on the evidence from the Health Inequalities Tool²⁴ to reduce the life expectancy gap by 10% it would be necessary during the next year to:

- Double the number of smoking quitters to 3,060

Obesity

Background

Nearly two thirds of men and over half of women in England are overweight or obese. The problem in England is increasing faster than in most other European countries. If prevalence continues to rise at the current rate, more than one in four adults will be obese by 2010³¹.

The prevalence of obesity has trebled since 1980³². In 2005, 22.1% of men and 24.3% of women were obese based on national estimates. Evidence also suggests that as many as two thirds of the adult population fitted into either the overweight or obese category. The report goes further to outline sociocultural patterns of prevalence with an increase in prevalence within lower socioeconomic and socially disadvantaged groups as well as a higher rate within particular ethnic groups (Black Caribbean's and Black Africans). Obesity is also rising among children; in the five years between 1996 and 2001, the proportion of obese children aged 6-15 years rose by 3.5%. Cases of maturity-onset diabetes are starting to emerge in childhood.

A recent report published by the National Heart Foundation (2007)³² highlighted both the cost and associated risks of obesity to England as a whole. Cost is documented as impacting on both the NHS, in relation to the treatment of obesity related conditions, and the Economy, in relation to sickness from work and associated benefits. In addition to this the cost to the individual is considered high both in terms of quality of life measures and life lost. Psychological consequences of overweight and obesity are a significant health burden³².

The House of Commons Health Select Committee (2004) estimated that the economic cost of obesity was between £3.3 and £3.7 billion per year. The direct costs of treating obesity (and its consequences) ranging from £990 million to £1, 135 million equating to between 2 and 2.3% of the total NHS expenditure. In addition the report outlined indirect costs defined as '*lost output in the economy due to sickness absence or death of workers*'. This cost in relation to this aspect was estimated as between £2.3 and £2.6 billion. The House of Commons Select Committee (2004) suggested that there were between 15.5 and 16 million days of certified incapacity which was directly related to obesity.

Health Benefits of weight loss

The health benefits of weight loss include an improvement in physical, psychological and social health³². The health benefits of losing 10Kg have been outlined to include³²:

| Condition | Benefit |
|---|---|
| Mortality | <ul style="list-style-type: none">• More than 20% fall in total mortality• More than 30% fall in diabetes-related deaths• More than 40% fall in obesity-related cancer deaths |
| Blood pressure (in hypertensive people) | <ul style="list-style-type: none">• Fall of 10mmHg systolic blood pressure• Fall of 20mmHg diastolic blood pressure |
| Diabetes (in newly diagnosed people) | <ul style="list-style-type: none">• Fall of 50% in fasting glucose |
| Lipids | <ul style="list-style-type: none">• Fall of 10% of total cholesterol• Fall of 15% of low density lipoprotein (LDL cholesterol)• Fall of 30% of triglycerides |

³¹ South Tyneside Obesity Strategy (2004)

³² National Heart Foundation (2007) Lightening the load: tackling overweight and obesity. A toolkit for developing local strategies to tackle overweight and obesity in children and adults. DH. London

| | |
|----------------|---|
| | <ul style="list-style-type: none"> • Increase of 8% of high density lipoprotein (HDL) cholesterol |
| Other benefits | <ul style="list-style-type: none"> • Improved lung function, and reduced back and joint pain, breathlessness, and frequency of sleep apnoea • Improved insulin sensitivity and ovarian function |

Prevalence

In order to determine the estimated prevalence of obesity in South Tyneside, the NICE Cost Impact Assessment Tool (2006) has been used.

|

Total Adult Population

Male = 57,456 (47.7%)
 Female = 62,951 (52.3%)
Total = 120,407 (100%)

Level 4

Hospital Based Obesity Service
 Specialist Weight Management Team /Bariatric Surgery

BMI > 40

Male 523 (0.5%)
 Female 1537 (1.2%)
Total 2060 (1.7%)

Level 3

Community-based services
 Cluster based specialist lifestyle clinics/ Exercise & Weight Management referral programmes and/or anti-obesity medication.

BMI 30-39

Male 12694 (10.5%)
 Female 13002 (10.8%)
Total 25696 (21.3%)

Level 2

Basic Lifestyle advice in Primary Care
 Weight Management Interventions

BMI 25-29

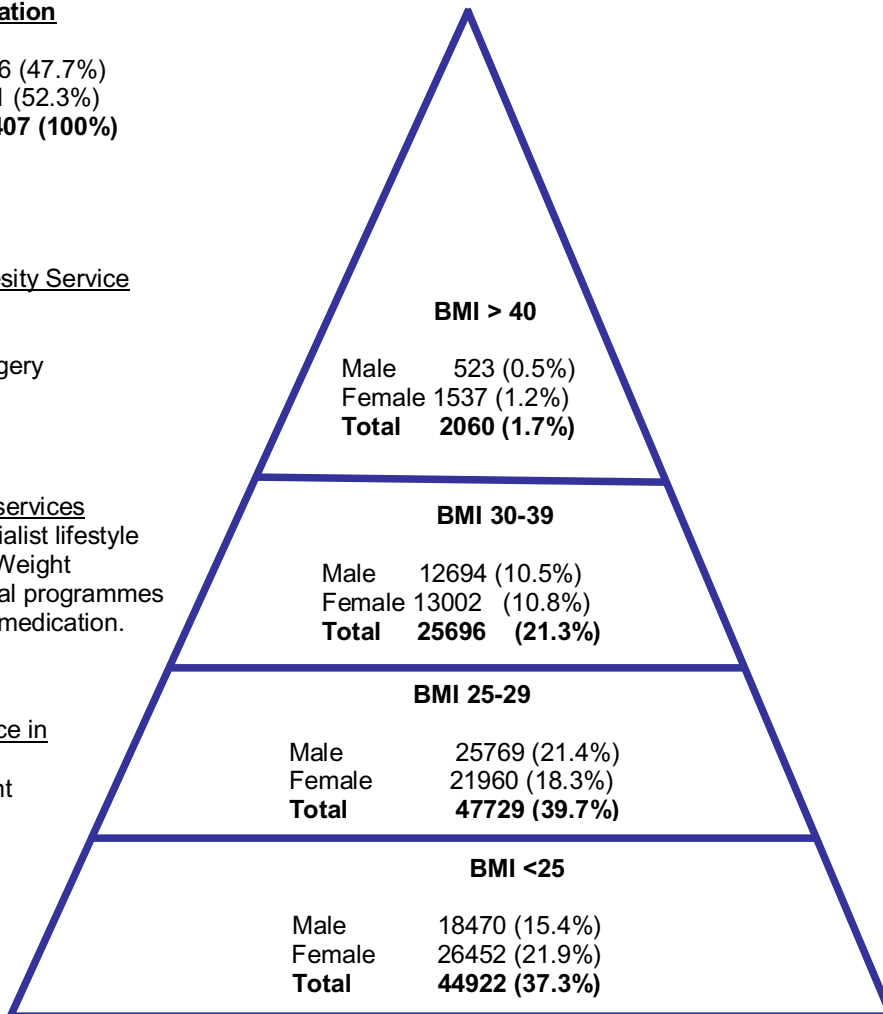
Male 25769 (21.4%)
 Female 21960 (18.3%)
Total 47729 (39.7%)

Level 1

General Population
 Early Intervention and Prevention

BMI <25

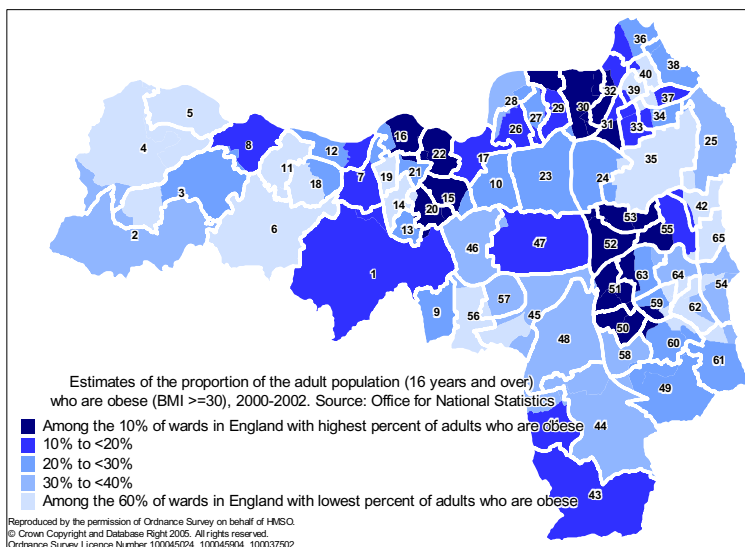
Male 18470 (15.4%)
 Female 26452 (21.9%)
Total 44922 (37.3%)



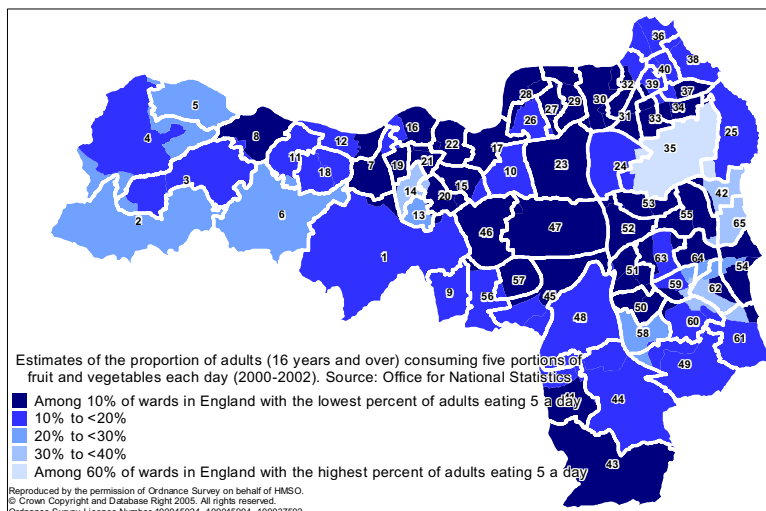
By using this tiered model, it should be expected that the greatest number of patients will be in Tier 1 (General Population). However it is evident that that this is now not the case with over half the adult population now at Tier 2 and above (overweight/obese) and requiring help with weight management.

It is important to note the rapid increase in obesity over the past two decades and the possibility that this trend might continue. Whilst these figures are an estimated prevalence of obesity, most obesity is undiagnosed and not all cases will be identified or treatment sought.

Estimates of the Proportion of Adult Population Who Are Obese By Electoral Ward



Estimates of the Proportion of Adult Population Who Eat Five Portions of Fruit and Vegetables Each Day by Electoral Ward



Maternal Obesity

There is concern with the increasing prevalence of obesity in recent years among adults, as observed in national surveys such as the Health Survey for England³³. A recent paper published by the North East Public Health Observatory³⁴ suggests that maternal obesity is associated with increased complications throughout pregnancy and increases the health risk to both mother and infant. The paper concluded that information relating to maternal obesity and the way in which this is collected, varies between maternity units in the North East region.

CEMACH (2007)³⁵ identified that over 50% of all maternal deaths where BMI was known were women in the overweight or obese category (BMI greater than 30). This reflects the 2004

³³ NHS Information Centre (2007) "Health Survey for England: updating of trend tables to include 2005 data", Information Centre, Leeds

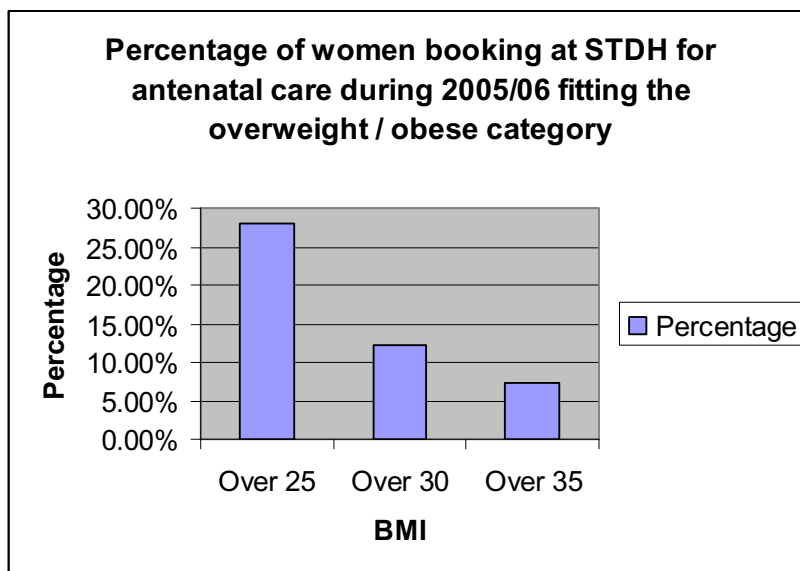
³⁴ Heslehurst N, Lang B et al (2006) "Maternal Obesity and Pregnancy Outcome: A Scoping Study", North East Public Health Observatory, Stockton

³⁵ CEMACH (2007) Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003 – 2005. Executive Summary and Key Recommendations. December 2007. CEMACH. London

report³⁶ where 35% of all maternal deaths were women in the obese category; 50% more than in the general population. Obese women of every age die from a variety of causes of maternal death because either their physical size precluded the availability of optimum care or their obesity had clinical implications for their health.

Antenatal obesity

Local data provided by the Foundation Trust for 2005 / 2006 identified that almost half of all women booking with South Tyneside had a BMI over 25 (overweight) with almost a fifth of women (19.5%) presenting with a BMI greater than 30 and 7.5% with a BMI over 35 both of which places them in the at risk category.



Children

The heights of children in reception year (ages 4 or 5 years) have been measured for many years to monitor child development. In 2005/06, for the first time, this monitoring was extended to measuring both height and weight, so that the prevalence of overweight and obese could be monitored at the population level. In 2006/07 this monitoring was extended to Year 6 pupils (ages 10 or 11 years). Figures are shown below, separately for Reception Year and Year 6, for the prevalence of overweight and obese within South Tyneside and neighboring PCT areas of Gateshead and Sunderland together with the number of measurements on which the prevalences are based. 95% confidence limits are shown, which indicate the level of uncertainty about each value. Because of variable data quality from area to area, the Department of Health did not publish the results from the 2005/06 exercise. There are plans to publish the results from the 2006/07 programme, at PCT level for all PCTs in England, in the spring of 2008.

³⁶ www.cemach.org.uk

Reception Year

| Proportion of children in Reception Year (4 or 5 years) who are overweight or obese | | | | | | | | |
|---|-----------------|------------|--------------|-------------|-------------|---------|-------------|-------------|
| Year and PCT | Pupils measured | % measured | % Overweight | Upper Limit | Lower Limit | % Obese | Upper Limit | Lower Limit |
| 05/06 Gateshead | 1497 | 75.5% | 19.0% | 21.0% | 17.1% | 11.3% | 12.9% | 9.7% |
| 06/07 Gateshead | 1852 | 99.6% | 14.4% | 16.0% | 12.8% | 10.3% | 11.7% | 8.9% |
| 05/06 S Tyneside | n/a | n/a | 12.2% | n/a | n/a | 9.7% | n/a | n/a |
| 06/07 S Tyneside | 1369 | 95.6% | 14.8% | 16.7% | 12.9% | 12.4% | 14.1% | 10.7% |
| 05/06 Sunderland | n/a | n/a | n/a | n/a | n/a | 13.1% | n/a | n/a |
| 05/06 Sunderland | 2511 | 91.7% | 15.6% | 17.0% | 14.2% | 12.6% | 13.9% | 11.3% |

Source: NHS South of Tyne and Wear

Year 6

| Proportion of children in Year 6 (10 or 11 years) who are overweight or obese | | | | | | | | |
|---|-----------------|--------------------------|--------------|-------------|-------------|---------|-------------|-------------|
| Year and PCT | Pupils measured | % of all pupils measured | % Overweight | Upper Limit | Lower Limit | % Obese | Upper Limit | Lower Limit |
| 05/06 Gateshead | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| 06/07 Gateshead | 2075 | 98.8% | 13.8% | 15.3% | 12.3% | 20.2% | 21.9% | 18.5% |
| 05/06 S Tyneside | n/a | n/a | 15.3% | n/a | n/a | 22.2% | n/a | n/a |
| 06/07 S Tyneside | 1607 | 91.2% | 15.7% | 17.5% | 13.9% | 20.2% | 22.2% | 18.2% |
| 05/06 Sunderland | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| 05/06 Sunderland | 2785 | 84.2% | 17.0% | 18.4% | 15.6% | 21.4% | 22.9% | 19.9% |

Source: NHS South of Tyne and Wear

Local Action

As part of the current obesity pathway a range of services, programmes and interventions are currently being delivered across South Tyneside.

Tier 1 (Prevention)

- Information is distributed to all GP practices, community groups and local authority provision by the Choosing Health Team.
- Currently GP practices collect Body Mass Index (BMI) information as part of the Quality and Outcomes Framework which provides incentives for assessing BMI and associated risk factors and for providing appropriate advice and treatment.

Tier 2 (Prevention)

- Community Nursing Teams offer brief lifestyle advice to patients as part of treatment plan.

Tier 2 (Management / treatment)

- Choosing Health Team provides support as part of a 12 week programme and includes healthy eating, behaviour change and the promotion of physical activity.

- Green Gym is run by the Ground Trust where people undertake gardening and other similar activities as part of a referral programme.
- Practice nurse led weight management clinics delivered in a small number of GP surgeries in South Tyneside.

Tier 3 (Prevention)

- The specialist diabetes Dietitian and Diabetes Specialist Nurses at South Tyneside District Hospital deliver 4 education programmes per year for patients with diabetes, which incorporates healthy eating advice. Each session lasts 1 day per week over a 4 week period.

Tier 3 (Management)

- Exercise referral programme for low – moderate risk clients for 12 weeks and provides exercise based rehabilitation programmes and exercise based treatment pathways for Primary Care teams. The service is utilised by the majority of GP's in South Tyneside.
- Pharmacological interventions prescribed by GP's in a range of practices across the area.
- A Pharmacy based weight management programme is being piloted in 5 outlets across the area, supported by Roche Pharmaceuticals.
- The specialist Diabetes Dietitian holds clinics at various GP practices within South Tyneside. Although some overweight/obese patients are seen, the majority of patients have co-morbidities e.g. Diabetes and hyperlipidaemia and also require weight management advice.
- The dietetic service at South Tyneside District Hospital provides a weight management clinic every week.

Tier 4 (Management / Treatment)

- The Dietetic Service at South Tyneside District General are in the process of setting up a weight management group aimed at patients with a BMI>30 or a BMI>28 with a co-morbidity. We are aiming to hold 1 hour programmes each week for a period of 8 weeks focusing on a different healthy eating topic each week.

Tier 5 (Management / Treatment)

- Bariatric surgery is carried out by CHS for patients meeting the NICE criteria. The Dietetic Service is involved in the bariatric surgery team at the assessment stage and post surgery. The agreed activity level for 2006/07 was 6 surgical procedures. However 74 assessments were undertaken with 20 procedures completed (27%)

Choosing Health Team

The Choosing Health Team was established in July 2005 to support individuals to modify individual lifestyle risk behaviours through either providing an individually tailored programme of structured care or signposting them into community services.

This primary prevention programme is focused on providing a range of intervention's for those at risk of developing Ischaemic Heart disease, (IHD) Obesity and related issues. The team has facilitated the creation of a pathway to enable health professionals across South Tyneside to refer those at risk in order to increase access to local opportunities for physical activity, improved diet, weight management, smoking cessation and address mental ill-health linked to those risk factors.

The team is made up of 6 PCT Health and Lifestyle Advisers and 6 Community Health Officers (employed by South Tyneside Council) aligned to the 6 Community Area Forums areas. The Choosing Health team undertake a range of community development activities including:

- Identify health issues within the smaller communities throughout South Tyneside

- Establish links with the Council's Area Partnership Coordinators to ensure strategic links with other local initiatives aimed at reducing wider determinants of health.
- Initiate the development of neighborhood health action and link the developing community health agenda into primary care through the development of local micro networks within communities

This joint South Tyneside Council/South Tyneside PCT Community based initiative, has been recognised as an innovative and effective joined up mode of delivering lifestyle improvements to those demonstrating risk factors for a number of conditions.

Service Costs - The following table shows the service costs of the Choosing Health Programme broken down between Staff and Non-Staff Costs.

- Between 2005/06 and 2006/07, staffing costs for implementation of the Choosing Health Programme have increased 6.4%. This rise will be mainly due to salary increases following the implementation of Agenda for Change
- Non-staff costs for the period 2005/06 and 2006/07 have shown a decrease of 14.1%. This may be attributed to the staff training and project outlay in the first year which was not required in Year 2 of the programme.
- Total Service Cost has increased by 3.6% since 2005/06, mainly as a result of the additional staff costs incurred.

| | 2005/06 | 2006/07 |
|-----------------|----------------|----------------|
| Staff | 427,772 | 455,008 |
| Non staff costs | 67,358 | 57,887 |
| Total | 495,130 | 512,895 |

Activity

Between 2005/06 the number of new clients joining the programme increased significantly to more than double the joining rate of 2005/06 (216% increase on the 2005/06 baseline)

| | 2005/06 | 2006/07 |
|---|----------------|----------------|
| Number of clients in programme | 425 | 918 |
| Number of clients joining programme (Target) | 792 | 792 |
| Number of clients joining programme (Actual) | 425 | 918 |
| Eligible Population aged 16 and over | 122,052 | 123,140 |
| Ratio of clients joining per 100,000 population | 348 | 745 |

In the first year of the programme the target number of new clients to join the programme was not achieved. This was due to initial set up, piloting, staff training and recruitment which caused a decrease in service throughput.

Due to the small increase of total service costs being off-set against the significant increase in number of clients joining the programme, this has had the positive effect in reducing the cost per contact hour by 52% in 2006/07 in comparison with the 2005/06 rate (i.e. £18.62 in 2006/07 in contrast to £38.83 in 2005/06)

| Unit costs | 2005/06 | 2006/07 |
|------------------------------------|-----------------|-----------------|
| Costs of Choosing Health Programme | £495,130 | £512,895 |
| Number of Clients seen per year | 425 | 918 |
| Cost per client | £1165 | £558 |

| | | |
|-----------------------|---------|--------|
| Cost per contact hour | £ 38.83 | £18.62 |
| Cost per working hour | £16.20 | £17.24 |

It is evident from the table below, that if the current cost of contact per hour was compared to delivery of the programme by other staff groups the current staff group represents excellent value for money. The current cost per contact hour of £18.62 is £2.38 per hour cheaper than the closest comparison of delivery by a Health Care Assistant at a rate of £21.00 p/hr.

| Job Type | Contact per hour cost |
|------------------------|-----------------------|
| Health trainer | 27 |
| *Health Care assistant | 21 |
| *Family Support Worker | 34 |
| *Health Visitor | 77 |
| *Social Work Assistant | 57 |

Cost effective intervention

The Choosing Health Team was created to provide an intervention programme for those at risk of developing obesity related issues. Evidence shows that people who have engaged in the programme have achieved significant improvements including weight reduction, regular physical activity uptake and healthy eating. Further evidence suggests that improvements have also been made in relation to mental health and well-being.

Data from the first evaluation demonstrates that 75% of participants who completed the 3 month programme (578) achieved a reduction in BMI. This provides an early indication of a cost effective intervention, preventing 0.5% of the adult population either becoming obese or reducing obesity in the high risk group.

If weight loss relative to trend remains constant for five years post-intervention before returning to baseline, the cost per QALY (quality adjusted life year) in the best performing non-pharmaceutical studies ranges from £174 to £9,971 (National Heart Foundation, 2007).

Sustaining BMI reduction is an important factor in determining the cost effectiveness of the Choosing Health Intervention longer term, which will be assessed on an annual basis. However, this analysis shows that the Service is already demonstrating clear cost (health and financial) benefits.

Unmet Need

It is estimated that the annual costs of treating obesity per 500,000 of the population is £21,500,000 per annum. National estimates suggest that 23% of the total population is obese. 23% of 500,000 people equates to 115,000 people which translates into a cost of £187 per annum for each obese person. This cost estimate takes into account hospital appointments and procedures, GP visits and prescription charges. This estimate takes account of the cost to the NHS in relation to the treatment of associated health conditions taking no account of the cost to the local economy in relation to sickness from work and related benefits.

South Tyneside has a population of 151,316 (ONS, 2005). By applying the above estimate this would equate to a local cost of £6,506, 588 per annum in obesity related diseases. However, as South Tyneside has a higher proportion of people fitting into the obesity category (circa 30%), the expected cost would be greater (£8,573,715.8). Using the crude estimates provided above for every 1% reduction in obesity (based on the local estimate of people in the obese category) would equate to a potential saving of £281, 105.43 locally.

Activity data provided by the various levels of service detailed above suggests a high level of unmet need in relation to obesity.

Priority Action / Evidence Base

NICE guidance (2006)³⁷ reviewed evidence from several cohort studies which indicated that pregnancy, menopause and smoking cessation are key stages in the life-course and are all associated with weight gain. They also identified from cohort studies that adults are more likely to maintain a healthy weight if they maintain an active lifestyle and reduce sedentary behaviour.

Further evidence indicates that adults are more likely to maintain a healthy weight if they consume a low fat diet containing less 'takeaway' foods, more fruit and vegetables, salad and fibre and little alcohol and reducing the consumption of confectionary and drinks high in sugar.

Physical activity

A review of evidence³⁸ regarding the impact of exercise on weight loss concluded a positive effect on body weight and cardiovascular disease in overweight or obese people, particularly when combined with diet. No adverse effects (quality of life, morbidity, costs or mortality) were identified. .

Postnatal exercise

Cochrane also evaluated the effect of diet and exercise for weight reduction in women after childbirth and to assess the impact of these interventions on maternal body composition. Evidence from this review suggests that a combination of dieting and exercise appear to be more effective than diet alone at helping women to lose weight after childbirth.

Surgery

Cochrane Systematic Reviews (2005)³⁹ assessed the effects of surgery for morbid obesity and concluded that surgery should only be considered when all other treatment has failed. The review found that surgery resulted in greater weight loss than conventional treatment, and led to improvement in quality of life and obesity related disease such as hypertension and diabetes although the comparative safety and effectiveness of different surgical procedures is unclear.

Psychological Interventions

Cochrane Systematic Review (2005)⁴⁰ assessed the effect of psychological interventions for overweight or obesity as a means of sustaining weight loss. The study concluded that people who are overweight or obese greatly benefit from psychological interventions, particularly behavioural and cognitive behavioural strategies, to enhance their weight reduction. They are predominantly useful when combined with dietary and exercise strategies.

Obesity management

Cochrane Systematic Reviews (2001)⁴¹ examined whether health professionals could effectively provide adequate care for overweight and obesity. It concluded that at present there is not enough evidence about the effectiveness of brief interventions for obesity management, shared

³⁷ Available online at www.nice.org.uk

³⁸ Shaw, K., Gennat, H., O'Rourke, P., and Del Mar, C., (2006) Exercise for overweight and obesity. Available online at www.cochrane.org/reviews/en/aboo3817.html

³⁹ Colquitt J, Clegg A, Loveman E, Royle P, Sidhu MK (2005) Surgery for morbid obesity available online at <http://www.cochrane.org/reviews/en/ab003641.html>

⁴⁰ Shaw K, O'Rourke P, Del Mar C, Kenardy J (2005) Psychological interventions for overweight and obesity available online at <http://www.cochrane.org/reviews/en/ab003818.html>

⁴¹ Harvey EL, Glenny A-M, Kirk SFL, Summerbell CD (2001) Improving Health Professionals' management and the organisation of care for overweight and obese people

care and in-patient care and that they warranted further investigation. In addition, the decision on the commissioning or planning of services must be based on the existing evidence on interventions with patients and good clinical judgement. The authors concluded that further research is needed to identify cost effective strategies for improving the management of obesity.

Healthcare settings and the role of health professionals

The HDA (2003) highlighted the following evidence to support improving the role of health care professionals in the management of obesity and overweight clients:

- Reminders to GPs to prescribe 'diets';
- A brief educational training intervention on obesity management delivered by behavioural psychologists to GPs;
- Encouraging shared care between GPs and hospital services;
- Use of inpatient obesity treatment services;
- Training for both health professionals and leaders of self-help weight loss clinics.

Pharmacological interventions

Cochrane Database of Systematic Reviews 2003 carried out an assessment of the effect and safety of approved anti-obesity medications in clinical trials of at least one year duration. The authors' concluded that studies evaluating the long-term efficacy of anti-obesity agents are limited to orlistat and sibutramine. Both drugs appear modestly effective in promoting weight loss; however, interpretation is limited by high attrition rates. More methodological rigorous studies to examine mortality and cardiovascular morbidity are required to fully evaluate any benefit from such agents.

Pharmacist led interventions

Choosing Health through Pharmacies (2005) suggests a strong evidence base for the delivery of a structured weight reduction and healthy eating programme in pharmacies although only as part as part of a multi-component delivery strategy with a programme of regular one to one support for the patient.

Effectiveness of Slimming on Referral service in Primary Care

NICE guidance (2006) reported that there is good evidence that a multi-component commercial group programme may be more effective than a standard self-help programme. Heshka et al, 2003 reported that Weight Watchers participants lost a mean of 4.6% (4.3 kg) of their initial weight after one year with a mean loss of 3.1% (2.9 kg) of initial weight at 2 years. The mean weight loss in the self help comparison group was 0% at 2 years.

Another study carried out in the former Derbyshire Health Authority area indicated that the slimming on referral programme had also been successful. The mean weight change at 12 weeks (62 participants) was 5.4 kg (s.d. 3.19) with a range +1.4 to -17.1 kg. Of the 62 people completing at 12 weeks, 31 achieved between 5% and 10% weight loss and four achieved greater than 10% weight loss. 56.5% of the 12 week completers achieved at least 5% weight loss (Slimming World, 2004).

Slimming World (2004) reported that the approach provides a highly cost effective alternative to pharmacological intervention. Attendance at a Slimming World group for 24 weeks would cost £84 compared with £225 for 24 treatments of sibutramine and £247 for 24 weeks treatment of orlistat.

Linked Performance Indicators

NI 8 Adult Participation in Sport DCMS DSO

NI 53 Prevalence of Breastfeeding at 6 – 8 weeks from birth PSA 12

NI 55 Obesity among primary school age children in Reception Year DCSF DSO

NI 56 Obesity among primary school age children in year 6 DCSF DSO

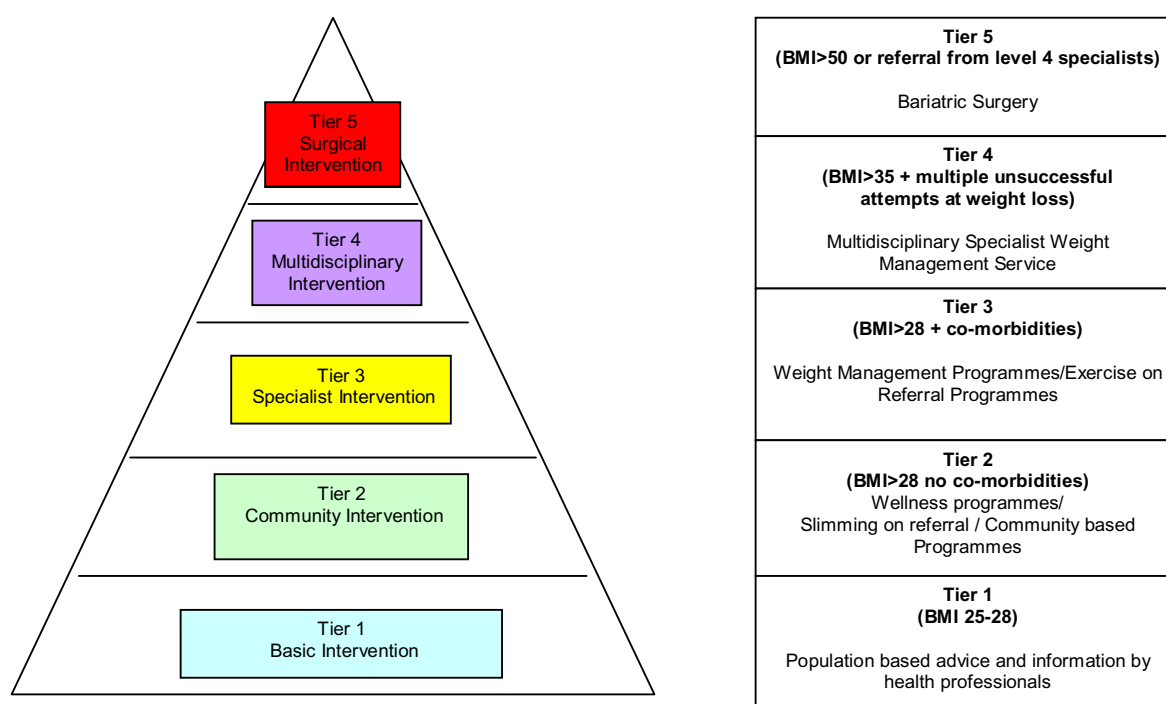
Ni 57 Children and young people's participation in high-quality PE and sport DCSF DSO

- NI 119 Self reported measure of people's overall health and well-being DH DSO
- NI 120 all-age all cause mortality rate PSA 18
- NI 121 Mortality from all circulatory diseases at ages under 75 DH DSO
- NI 122 Mortality from all cancers at ages under 75 DH DSO
- NI 123 16+ current smoking rate prevalence PSA 18
- NI 126 Early access for women to maternity services PSA 19
- NI 137 Healthy Life Expectancy at age 65

Recommendations / High Impact Changes

Further develop and increase the capacity of preventative and treatment services across South Tyneside.

A strategic and integrated approach must then be taken by all NHS providers, Local Authorities and partners in the community across South Tyneside to deliver a coordinated pathway of care, with services established which are capable of dealing with high numbers of patients.



In order to effectively support the needs of the South Tyneside population and based upon evidence, there is a need to:

1. Undertake a range of promotional campaigns including media interventions to increase awareness of what constitutes a healthy diet in order to improve dietary intakes, purchase behaviour and consumption delivered in the community setting;
2. Develop preventative activities in primary, secondary and tertiary care;
3. Implement a commercial weight management 'Slimming on Referral' programme in conjunction with GP practices;
4. Establish a Maternity Lifestyle Post to facilitate signposting, referral and support for services in accessing maternity and early years health services;
5. Develop a community based wellness service to improve access for vulnerable/hard to reach groups;

6. Ensure the Choosing Health Lifestyle team focus on supporting only low-medium risk patients (minor, stable physical activity limitations or two or less CHD risk factors). A specific criterion for accepting clients onto the programme should also be developed in order that particular groups are targeted effectively.
7. Ensure equitable access for targeted groups such as BME, where necessary delivering services in local communities;
8. Establish an integrated community based weight management programme for patients with a BMI >28 focusing on diet and physical activity as well as on general health counselling to support the achievement and maintenance of a healthy weight. This programme must be capable of dealing with high numbers of patients;
9. Increase the capacity of the Exercise on Referral programme (including mainstreaming the Exercise on Referral practitioner post currently funded through the LAA programme in order to maintain current programme capacity) to effectively deal with the increased number of patients accessing the programme. This programme should also focus only on supporting medium-high risk patients (adapted physical activity for people with severe or significant physical limitations related to chronic disease or disability);
10. Decommission the current pharmacy led intervention because of the lack of active support and advice for diet and physical activity provided as part of the scheme, the high costs associated with rolling out the programme, the unethical support currently being given by the pharmacological manufacturer, the inadequate results currently being achieved in the pilot sites along with the lack of conclusive evidence of pharmacy based interventions;
11. Establish a 'Specialist Weight Management Team' to provide a combination of regular one to one support which includes dietary, physical activity and behaviour therapy (stimulus control, dealing with problem situations, assertion and behaviour analysis) interventions;
12. Increase the annual activity levels agreed through the Northern Specialised Commissioning Group on behalf of South Tyneside PCT with City Hospitals Sunderland for surgical Interventions.

Alcohol

Background

Deaths caused by alcohol consumption have doubled in the past two decades, with more people becoming ill and dying younger. Approximately 70 per cent more men than women die from directly alcohol-related causes⁴². 27% of men and 14% of women drink over the recommended levels dangerous to health⁴³. Alcohol misuse has been linked to a variety of health complaints including coronary heart disease, stroke, cancer and liver disease. Growing evidence suggests that binge drinkers have a higher all-cause mortality rate than those who have the same average alcohol consumption but drink more frequently.

Inequality levels are stark with Department of Health analysis of ONS data highlighting that alcohol-related death rates are approximately 45% higher in areas of high deprivation. A growing body of research suggests that binge drinkers also have a higher all-cause mortality rate than those who have the same average alcohol consumption but drink more frequently. Furthermore Binge drinking is specifically related to accidents and violence, both of which impact on the health service. Overall probably around 1 in 16 of all hospital admissions are for alcohol-related causes⁴⁴. It is estimated that alcohol related diseases account for 1 in 8 NHS bed days and 1 in 80 day cases⁴².

Further evidence suggests that, at peak times, up to 70 per cent of all admissions to accident and emergency units are related to alcohol consumption. Patients who receive a brief intervention following visits to A&E make on average 0.5 fewer repeat visits in the following 12 months compared to those in a control group⁴⁴.

It is estimated that 3.5 per cent of all deaths from cancer are attributable to alcohol. Alcohol consumption is associated with raised blood pressure. Incidence of the condition approximately doubles in those who drink over six units per day⁴². Alcohol accounts for a dose-related increase in risk of cancers of the oral cavity, pharynx, larynx and oesophagus, and the highest risk is in conjunction with smoking⁴². Cancers at other sites, such as the liver, stomach, pancreas, colon, and rectum also have a dose-dependent association with alcohol consumption⁴².

Heavy drinking can contribute to anxiety and depression and can accelerate, or uncover a predisposition to, development of psychiatric disorder (including psychosis). Alcohol can have an effect on the action of psychotropic medication, and/or lead to non-compliance with medication. Between 16 and 41 per cent of suicides are thought to be attributable to be alcohol⁴².

Many activities are associated with the risk of accidents and alcohol can increase this risk⁴². Alcohol has also been described as a major factor in 20 – 30% of accidents with 65% of suicide attempts linked to excessive drinking⁴³. Alcohol has also been linked to: 38-45 per cent of deaths in fires; 7-25 per cent of deaths at work; and 23-38 per cent of drownings. 10% of admissions to hospital's general medical wards are related to alcohol. Around 5% are directly caused by alcohol, and include problems like cirrhosis and alcohol related falls, and a further 5% are indirectly linked to excess alcohol consumption and the increased risk of stroke and heart disease.

The amount of alcohol consumed by younger adolescents has steadily increased with young people who drink consuming twice the amount they were in 1990. Those in the 18-24 year age range who binge drink accounted for a third (30%) of all offences and a quarter (24%) of all violent offences reported in 2006.

⁴² Cabinet Office. The Prime Minister's Strategy Unit (2003). *Interim Analytical Report*

⁴³ Alcohol Concern Fact sheet 15: Brief Interventions. Alcohol Concern. London

⁴⁴ Alcohol Misuse Interventions DH 2005

National Strategy

In 2004, the Government published the Alcohol Harm Reduction Strategy for England. This strategy was the first cross-government statement on the harm caused by alcohol, which included an analysis of the problem and the programme of action to respond. In 2007 the government published a new strategy, Safe. Sensible. Social. The next steps in the National Alcohol Strategy, which has three key aims;

1. To ensure that the laws and licensing powers to tackle alcohol-related crime and disorder, to protect young people and deal with irresponsibly managed premises are being used widely and effectively.
2. To focus on three specific target groups in the population in relation to tackling alcohol related problems; young people under 18 who drink alcohol, 18–24-year-old binge drinkers and harmful drinkers
3. To work together to create an environment that actively promotes sensible drinking, through better information and communication and to promote a partnership approach to reducing the harm alcohol can cause.

The government's 2007 strategy focuses on action in relation to reducing the types of harm that are of most concern to the public, including: a reduction in the levels of alcohol-related violent crime, disorder and antisocial behaviour and a reduction in chronic and acute ill health caused by alcohol. Crime & Disorder Reduction Partnership strategies are required to address alcohol-related issues from April 2008. There are no currently national targets in relation to alcohol.

Prevalence

The North East of England has the second highest level of hazardous and harmful drinking and the equal highest level of dependency of the nine English regions⁴⁵. South Tyneside conforms to the North East pattern of heavy alcohol use. Data from the North West Public Health Observatory suggests that of the 354 Local Authorities in England South Tyneside is:

- The 7th worst in relation to hospital admissions for female alcohol use
- The 8th worst using an estimate for binge drinking
- The 11th worst in relation to hospital admissions for male alcohol use

National estimates suggest a breakdown for alcohol use within the total population. By applying these rates to the South Tyneside over 18 (circa 118,976) a crude estimate is produced. However it is important to note that South Tyneside has a greater problem than the national average and thus estimates are acknowledged to be below the expected level.

| National estimates for alcohol use in the total population | Approximate number of people in South Tyneside |
|--|--|
| <0.1% are severely dependent drinkers | 119 people in South Tyneside |
| <0.4% are moderately dependent drinkers | 476 people in South Tyneside |
| 4.1% are harmful drinkers | 4878 people in South Tyneside |
| 16.3% are hazardous drinkers | 19, 393 people in South Tyneside |
| 67.1% are low-risk drinkers | 79, 833 people in South Tyneside |
| 12% are non-drinkers | 14, 277 people in South Tyneside |

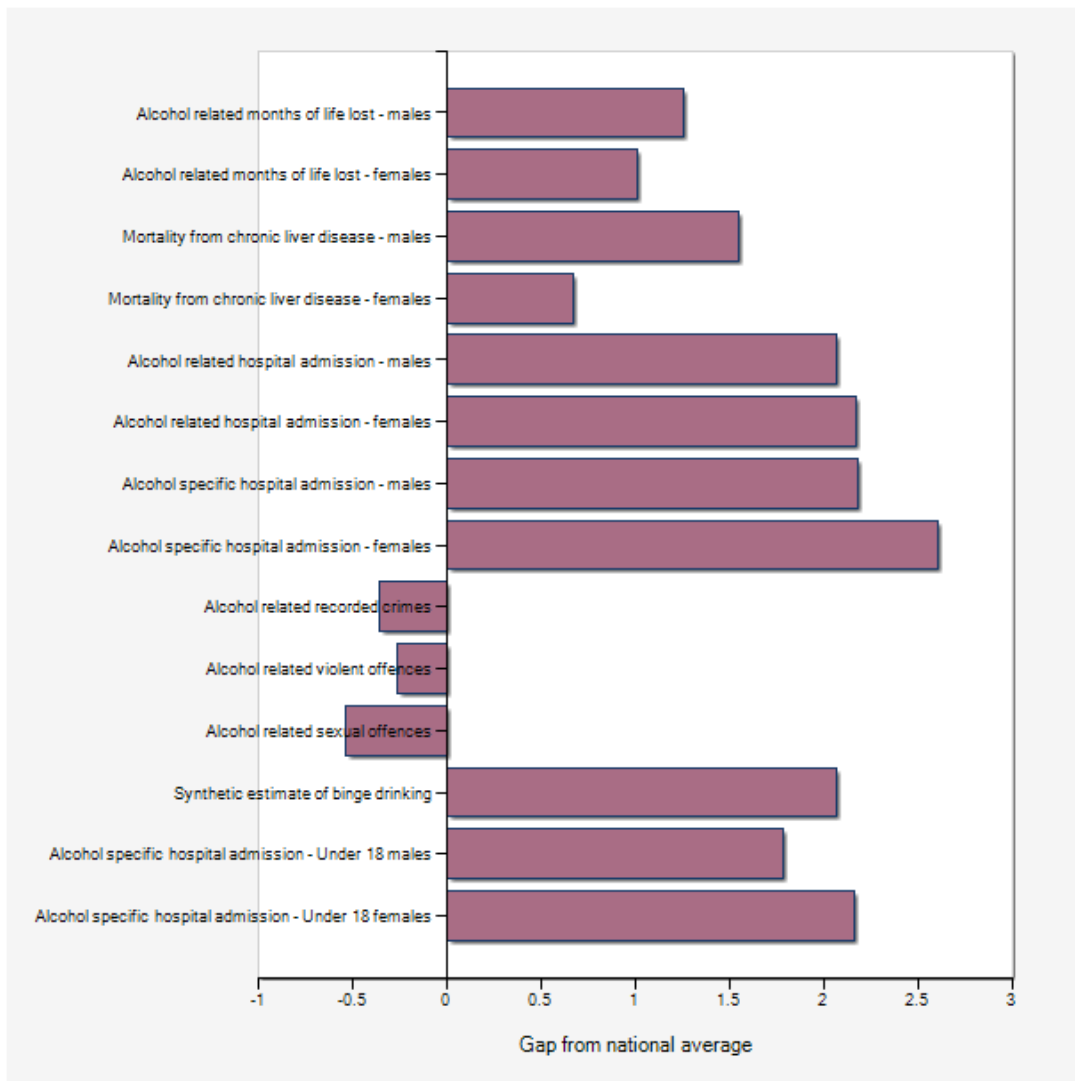
Estimates within the local strategy suggest:

⁴⁵ South Tyneside Alcohol Strategy Group (2006) Alcohol Strategy

- There are 6,000 harmful or dependent drinkers in South Tyneside
- 22,000 hazardous drinkers
- 12,000 people would benefit from alcohol treatment services
- Between 1,200 and 2,400 could seek help annually
- Of the estimated 12,000 problem drinkers in South Tyneside it would be expected that 4,400 would be women
- Young people's alcohol misuse is a problem. Local data shows 192 referrals to the MATRIX service during 2004/05.
- The School Health Profile (2005) outlined 68% of 13 – 14 year olds drink alcohol with 11% drinking so much they felt out of control
- In South Tyneside's Fear of Crime Survey, 65.4% of respondents stated that alcohol caused a problem in their area
- Alcohol misuse was stated as one of the three main contributors to anti-social behaviour

The best indicator for serious alcohol related harm is chronic liver disease. South Tyneside is 50% above the national average. Hospital episodes related to liver disease close to twice the national average. Admission for alcohol related mental and behavioural disorders are almost twice the national average.

South Tyneside: Gap from national average



Mortality from conditions directly related to alcohol consumption are 16.3 per 100,000 (2001-03) which is 50% above the national average (10.9 per 100,000).

Binge drinking and anti-social behaviour remains a major problem resulting in a significant impact on both crime and disorder including domestic violence, anti social behaviour and subsequent attendances at A&E. Alcohol related crime and disorder remains high with alcohol intoxication being a major factor in people being arrested particularly at weekends and anti-social behaviour in young people. Criminal damage, which correlates significantly with alcohol use, is above both the regional and national average. National evidence suggests domestic violence is also significantly correlated with alcohol use. In South Tyneside Domestic Violence is above the national average with one in seven women experiencing violence in contrast to one in eight.

There are two key indicators which can be used to measure ill-health in relation to alcohol; the proportion of adults binge drinking and hospital stays due to alcohol. In relation to binge drinking the data is defined as a synthetic estimate of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more units for women). The table below shows estimates for Gateshead, South Tyneside and Sunderland;

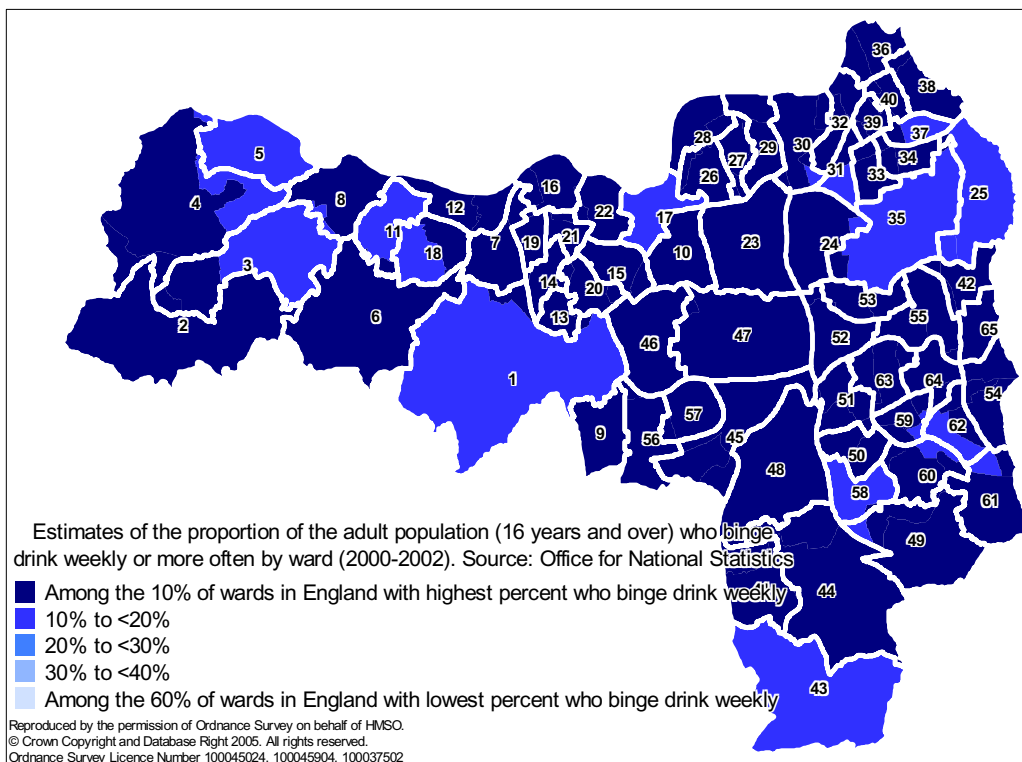
Binge drinking in adults 2005⁴⁶

| Gateshead % | Sunderland % | South Tyneside % | England average % | England worst % | England best % |
|-------------|--------------|------------------|-------------------|-----------------|----------------|
| 25.0 | 26.7 | 26.0 | 18.2 | 29.2 | 8.8 |

It can be seen from the table that levels of binge drinking are very similar across South of Tyne and high compared with the average for England. All the localities have been rated as three of the worst Local Authorities for binge drinking in England with Gateshead being placed 9th, South Tyneside 6th and Sunderland 4th respectively.

Estimates of the Proportion of Adult Population Who Binge Drink Weekly or More Often By Electoral Ward

⁴⁶ Source APHO and Department of Health 2007



| LA | Key | Ward | LA | Key | Ward | LA | Key | Ward |
|----|-----|-----------------------------------|----|-----|------------------------------|----|-----|-------------------------|
| GH | 1 | Lamesley Ward | ST | 23 | Fellgate and Hedworth Ward | SU | 45 | Washington East Ward |
| GH | 2 | Chopwell and Rowlands Gill Ward | ST | 24 | Boldon Colliery Ward | SU | 46 | Washington West Ward |
| GH | 3 | Winlaton and High Spen Ward | ST | 25 | Whitburn and Marsden Ward | SU | 47 | Washington North Ward |
| GH | 4 | Crawcrook and Greenside Ward | ST | 26 | Hebburn South Ward | SU | 48 | Shiney Row Ward |
| GH | 5 | Ryton, Crookhill and Stella Ward | ST | 27 | Monkton Ward | SU | 49 | Doxford Ward |
| GH | 6 | Whickham South & Sunnyside Ward | ST | 28 | Hebburn North Ward | SU | 50 | Sandhill Ward |
| GH | 7 | Lobley Hill and Bensham Ward | ST | 29 | Primrose Ward | SU | 51 | St. Anne's Ward |
| GH | 8 | Blaydon Ward | ST | 30 | Bede Ward | SU | 52 | Castle Ward |
| GH | 9 | Birtley Ward | ST | 31 | Biddick and All Saints Ward | SU | 53 | Redhill Ward |
| GH | 10 | Wardley and Leam Lane Ward | ST | 32 | Simonside and Rekendyke Ward | SU | 54 | Hendon Ward |
| GH | 11 | Whickham North Ward | ST | 33 | Whiteleas Ward | SU | 55 | Southwick Ward |
| GH | 12 | Dunston and Teams Ward | ST | 34 | Cleadon Park Ward | SU | 56 | Washington South Ward |
| GH | 13 | Chowdene Ward | ST | 35 | Cleadon and East Boldon Ward | SU | 57 | Washington Central Ward |
| GH | 14 | Low Fell Ward | ST | 36 | Beacon and Bents Ward | SU | 58 | St. Chad's Ward |
| GH | 15 | Windy Nook and Whitehills Ward | ST | 37 | Harton Ward | SU | 59 | Barnes Ward |
| GH | 16 | Bridges Ward | ST | 38 | Horsley Hill Ward | SU | 60 | Silksworth Ward |
| GH | 17 | Pelaw and Heworth Ward | ST | 39 | West Park Ward | SU | 61 | Ryhope Ward |
| GH | 18 | Dunston Hill & Whickham East Ward | ST | 40 | Westoe Ward | SU | 62 | St. Michael's Ward |
| GH | 19 | Saltwell Ward | SU | 41 | Houghton Ward | SU | 63 | Pallion Ward |
| GH | 20 | High Fell Ward | SU | 42 | Fulwell Ward | SU | 64 | Millfield Ward |
| GH | 21 | Deckham Ward | SU | 43 | Hetton Ward | SU | 65 | St. Peter's Ward |
| GH | 22 | Felling Ward | SU | 44 | Copt Hill Ward | | | |

Source: Office for National Statistics

A further measure of binge drinking or drinking to excess is the number of people receiving ambulance or paramedic treatment for alcohol overdose. North East Ambulance Service data for South of Tyne is shown in the table below.

Ambulance service treatment for alcohol overdose 2005-6

| | Number of people treated for alcohol overdose 2006-7 | Rate per 100,000 |
|-----------------------|--|------------------|
| Gateshead | 895 | 416.18 |
| South Tyneside | 797 | 592.71 |
| Sunderland | 1720 | 595.15 |

Source NEAS

Number of emergency admissions via A&E for alcoholic liver disease 2006-7

| | Number of admissions |
|---------------------------|----------------------|
| Gateshead PCT | 29 |
| South Tyneside PCT | 16 |
| Sunderland PCT | 34 |

Source Infonet

With regard to the number of hospital admissions these are categorised in relation to alcohol specific conditions and those which are alcohol attributable. The tables below shows admission rates for alcohol specific and alcohol attributable conditions for South Tyneside and the neighboring PCTs of Sunderland and Gateshead by gender (2005-6).

Alcohol specific hospital admissions males - standardised rate per 100,000 compared with England average 2005-6⁴⁷

| Gateshead rate per 100,000 | South Tyneside rate per 100,000 | Sunderland rate per 100,000 | England rate per 100,000 |
|----------------------------|---------------------------------|-----------------------------|--------------------------|
| 734.69 | 648.62 | 542.74 | 305.81 |

Alcohol specific hospital admissions females - standardised rate per 100,000 compared with England average 2005-6⁴⁸

| Gateshead rate per 100,000 | South Tyneside rate per 100,000 | Sunderland rate per 100,000 | England rate per 100,000 |
|----------------------------|---------------------------------|-----------------------------|--------------------------|
| 258.11 | 306.54 | 268.64 | 144.62 |

There are quite significant differences in relation to hospital stays due to alcohol amongst the three localities with Gateshead significantly higher in terms of male admissions. All the localities have a rate per 100,000 up to twice the national rate.

Admissions attributable to alcohol males - standardised rate per 100,000 compared with England average 2005-6⁴⁹ (not including A&E)

| Gateshead rate per 100,000 | South Tyneside rate per 100,000 | Sunderland rate per 100,000 | England rate per 100,000 |
|----------------------------|---------------------------------|-----------------------------|--------------------------|
| 1253.88 | 1263.26 | 1285.51 | 826.07 |

Admissions attributable to alcohol females - standardised rate per 100,000 compared with England average 2005-6⁵⁰ (not including A&E)

| Gateshead rate per 100,000 | South Tyneside rate per 100,000 | Sunderland rate per 100,000 | England rate per 100,000 |
|----------------------------|---------------------------------|-----------------------------|--------------------------|
| | | 656.74 | 461.51 |

⁴⁷ Source APHO and Department of Health 2007

⁴⁸ Source APHO and Department of Health 2007

⁴⁹ Source APHO and Department of Health 2007

⁵⁰ Source APHO and Department of Health 2007

| | | | |
|--------|--------|--|--|
| 671.93 | 692.66 | | |
|--------|--------|--|--|

The data for admissions for alcohol attributable conditions demonstrate that the rates overall are similar in the three localities with admissions for males around twice that of females. Admissions overall are significantly higher than rates for England. This data does not include A&E admissions.

Local Action

Alcohol Education is addressed through the Healthy School Programme. South Tyneside delivers tailor-made Alcohol Education Programs targeting schools and "at risk" groups of young people and promote annual campaigns in relation to sensible drinking. South Tyneside are also undertaking proactive work with young people in relation to the links with under age drinking, anti social behaviour and offending.

With regard to brief interventions and treatment research is being carried out in relation to The Screening and Brief Intervention (SBI) Programme for Sensible Drinking (SIPS) by the University of Newcastle in conjunction with the Institute of Health & Society. Pilots are due to take place during 2007/08 in Primary Care and A&E.

Assessment and treatment for hazardous, harmful and dependent drinkers is under review in South Tyneside. The comprehensive review is exploring the range of provision across the four tiers. Training in screening and brief intervention is being commissioned for a range of front line services including Primary Care, Police, Housing, Social Services and Youth Offending teams amongst others.

In South Tyneside a programme of innovative activity to tackle underage sales has been implemented by Trading Standards. The approach has been highlighted as a model of national good practice.

Service Use

Four tiers of alcohol treatment haven been suggested by the National Treatment Agency⁵¹

- Tier one** Includes provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions.
- Tier two** Includes provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.
- Tier three** Includes provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.
- Tier four** Includes provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

Unmet need

The numbers of adults in treatment or engaged with substance misuse services for support with alcohol problems is currently low across the three PCT areas.

⁵¹ Models of Care for Alcohol 2006

The Alcohol Needs Assessment Research Project⁵² provides a benchmark for numbers accessing treatment per annum and on this basis a recommendation that **capacity should be sufficient to enable 15-20% of the ‘in need’ population to be treated.**

Based on **20%** of harmful, hazardous and dependent drinkers in South Tyneside this equates to an estimated requirement for a capacity to ‘treat’;

| | Hazardous Tier 1 & 2 receiving screening & brief intervention | Harmful – Tier 3 | Moderate and severe dependent – Tier 3 & 4 |
|-----------------------|--|-------------------------|---|
| South Tyneside | 4,930 | 1,242 | 151 |

Current expenditure in relation to hospital admissions for alcohol specific and alcohol related disorders is high and is unlikely to decrease and may well increase unless there is significant investment in alcohol treatment and rehabilitation services.

Evidence shows that Screening and Brief Intervention (Tier 1 & 2 activity) is effective and can reduce weekly drinking by between 13% and 34%. In relation to the tiers of service provision there is little investment in South Tyneside. It is recommended that Screening and Brief Intervention is extended to increase current capacity to provide interventions for 20% of the population in need annually i.e.; 4,930 hazardous drinkers in South Tyneside

This will be achieved using a combination of the following approaches;

- Training a range of front line workers across partner agencies, in screening and brief intervention
- Providing incentive for GPs, pharmacists and other independent contractors to carry out opportunistic screening and brief intervention of clients

To significantly increase capacity and investment for providing treatment at tier 3. This would mean an increase of approximately five times the current investment in tier 3 treatment options to provide treatment for 20% of the population in need annually i.e.;

- 1,363 harmful and moderately dependent drinkers in South Tyneside

(Cost of tier 3 treatment per client is estimated as £600 - £800 per treatment cycle)

In relation to tier 4 detox and rehabilitation there quite large numbers of people going through inpatient detox, however this option is expensive (working out at approximately £1,094 per client and many of these clients could be supported with detox in the community (tier 3) at a significantly lower cost. For residential rehab the numbers are much smaller but this option is again very expensive working out at approximately £2,590 per person. Investment in tier 3 community detox is therefore recommended while retaining provision at tier 4 for severely dependent clients i.e. based on 20% of those in need annually; i.e. 30 severely dependent drinkers in South Tyneside

The approximate investment required to screen and treat 20% of hazardous, harmful and dependent drinkers is shown in the table below (with a detailed breakdown in appendix 1).

| | Current cost of hospital admissions for chronic liver disease per annum | Estimate of recommended investment per annum | Estimated potential savings per annum |
|--|--|---|--|
| | | | |

⁵² Alcohol Needs Assessment Research Project DH 2004

| | | | |
|-----------------------|--------|--------|--------|
| South Tyneside | £3,12m | £1,03m | £2,09m |
|-----------------------|--------|--------|--------|

Please Note: Costs calculated are a guide and do not, at this stage include costs such as A&E alcohol related attendances, all ambulance alcohol related call outs i.e. for assault or drink driving incidents and do not include police or other agency costs incurred in relation to dealing with binge drinking related incidents, alcohol related antisocial behaviour, violent incidents etc.

The following issues have been identified as a result of local alcohol needs assessment.

- There are major capacity gaps across all tiers but particularly tier 1 and 2 services in South Tyneside
- Difficulties accessing services due to capacity issues are resulting in waiting lists
- Lack of access points also present major concerns
- Slow progress through tiers of existing treatment services and barriers between services
- Barriers in accessing mental health services and inappropriate service provided when accessed for those who drink
- Identification and management of alcohol misuse during pregnancy and in early years
- Treatment for older people who drink
- Culturally sensitive treatment for minority groups
- Alcohol treatment for children and young people
- Treatment of alcohol induced dementias (working age and old age)
- Poor access and referral to treatment services at key 'capture points' such as A+E and in Primary care in South Tyneside in particular
- Poor clinical treatment in acute settings in the management of alcohol dependence and through care and after care
- Poor access to services for vulnerable groups and treatment for vulnerable populations such as prisoners.

In addition national research suggests that there is a large gap between the need for alcohol treatment and actual access to treatment with only approximately 1 in 18 (5.6%) alcohol dependent individuals accessing specialist alcohol treatment nationally per annum. Approximately one third of alcohol dependent individuals referred to treatment actually access treatment and approximately 36% of referrals to alcohol specialist services are self referrals⁵³.

| National estimates for alcohol use in the total population | Approximate number of people in South Tyneside | Approximate number of clients seen 2006-7 | Unmet need |
|--|--|---|------------|
| <0.1% are severely dependent drinkers | 119 people in South Tyneside | Actual number unknown (644 bed days) | Unknown |
| <0.4% are moderately dependent drinkers | 476 people in South Tyneside | 301 | 5053 |
| 4.1% are harmful drinkers | 4878 people in South Tyneside | | |
| 16.3% are hazardous drinkers | 19,393 people in South Tyneside | 188 | 19,205 |
| 67.1% are low-risk drinkers | 79,833 people in South Tyneside | 14 | 79,819 |
| 12% are non-drinkers | 14,277 people in South Tyneside | 0 | 0 |

⁵³ Alcohol Needs Assessment Research Project DH 2004

Priority Action / Evidence Base

A recent trial found that brief intervention trials can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 7.8 fewer mean drinks per week, with a significant effect on recommended or safe alcohol use⁵⁴.

Evidence suggests that hazardous and harmful drinkers receiving brief interventions are twice as likely to moderate their drinking 6 to 12 months after an intervention, when compared to drinkers receiving no intervention⁵⁵.

If consistently implemented, GP based interventions will reduce levels of drinking from hazardous or harmful to low risk levels for 250,000 men and 67,500 women each year⁵⁶.

The UKATT study (UK Alcohol Treatment Trial) also showed substantial reductions in alcohol consumption, dependence and problems. The study also showed better mental health related quality of life. The UKATT trial took place over 12 months. One example of the results achieved showed that the number of days on which clients reported that they had abstained from alcohol improved from 29% to 43% after three months and 46% after 12 months⁵⁷.

About one in six A&E patients was estimated by the staff to have an alcohol-related attendance in a national survey of perceptions of alcohol related attendance in A&E departments in England⁵⁸.

Cost effectiveness evidence

Recent studies suggest that alcohol treatment has both short and long term savings and analysis from the UKATT Study suggests that for every £1 spent on treatment, the public sector saves £5⁵⁹.

In relation to Screening and Brief Intervention the costs of administering FAST and other screening tests have been calculated. These were collected in one A&E department and are based on a grade E nurse administering the test. FAST had the lowest cost (£1,669 for an annual population of 50,000 patients in 2003). This was not significantly less than the other quick assessment methods but was significantly less than AUDIT (£10,400)⁶⁰.

WHO have estimated that costs of brief interventions for hazardous and harmful drinkers is approximately £1,300 per year of ill health or premature death averted⁶¹.

It costs on average between £400 and £600 to provide treatment for a dependent drinker, depending on the severity of his or her problem with alcohol (2006 prices)⁶². In a Scottish study alcohol treatment reduced long-term health care costs by between £820 and £1,600 per patient (2002/3 prices)⁶³.

⁵⁴ Alcohol Misuse Interventions – Guidance on developing a local programme of improvement. NHS National Treatment Agency for Substance Misuse. Department of Health 2005

⁵⁵ Alcohol Misuse Interventions – Guidance on developing a local programme of improvement. NHS National Treatment Agency for Substance Misuse. Department of Health 2005

⁵⁶ Alcohol Misuse Interventions – Guidance on developing a local programme of improvement. NHS National Treatment Agency for Substance Misuse. Department of Health 2005

⁵⁷ Alcohol Concern 2006

⁵⁸ Waller S, Thorn B, Harris S, Kelly M. Perceptions of alcohol-related attendance's in accident and emergency departments in England: a national survey. 1998

⁵⁹ UKATT Research Team (2005). *United Kingdom Alcohol Treatment Trial (UKATT): hypotheses, design and methods*, UKATT

⁶⁰ Hodgson, R.J., John, B., Abbasi, T., Hodgson, R.C., Waller, S., Thom, B., and Newcombe, R.G. Fast screening for alcohol misuse. *Addictive Behaviors*, (2003): 28(8):1453-1463.

⁶¹ Hutubessy, R., Chisholm, D., Tan-Torres Edejer, T. WHO-CHOICE (2003). *Generalized cost effectiveness analysis for national-level priority-setting in the health sector*

⁶² Alcohol Concern 2006

⁶³ Alcohol Misuse Interventions DH 2005

In relation to detoxification, one study compared costs in 4 centres. With an average stay of 19.25 days, the inpatient mean cost was £1072.75, and a mean time without relapse of 4.58 months⁶⁴.

Linked Performance Indicators

NI15 Serious violent crime rate
NI20 Assault with injury crime rate
NI21 Dealing with local concerns about anti-social behaviour and crime by the local council and police
NI39 Alcohol-harm related hospital admission rates
NI 119 Self reported measure of people's overall health and well-being DH DSO
NI 120 All-age all cause mortality rate PSA 18
NI 121 Mortality from all circulatory diseases at ages under 75 DH DSO
NI 122 Mortality from all cancers at ages under 75 DH DSO
NI 134 The number of emergency bed days per head of weighted population DH DSO
NI 137 Healthy Life Expectancy at age 65
NI 141 Number of vulnerable people achieving independent living CLG DSO
NI 143 Adults in contact with secondary mental health services settled accommodation
NI 150 Adults in contact with secondary mental health services in employment PSA 16
NI 151 Overall employment rate PSA 8
NI 152 Working age people out of work on benefits PSA 8
NI 173 People falling out of work and on to incapacity benefits DWP DSO

High Impact Changes

There is a large evidence base to support prevention treatment and control interventions for alcohol⁶⁵. High impact changes have been identified as follows;

- Screening & Brief Interventions (SBI) ; To implement SBI in A&E, Primary Care & Criminal Justice System to provide training in SBI
- Access to effective alcohol services – to establish equity of current service provision, investment identified for alcohol treatment, commissioning in line with Models of Care for Alcohol

Recommendations

Sustain the provision of targeted evidence based preventative interventions with young people to encourage responsible drinking and reduce antisocial behaviour.

Deliver effective public campaigns in relation to sensible drinking in conjunction with the Regional Alcohol Office

Enforce the Licensing Act 2003 including action in relation to selling alcohol to under 18s and action where premises are selling alcohol to customers who are already intoxicated.

Substantial investment is required in screening and brief intervention, assessment and treatment services across tiers 1, 2 and 3 including alcohol assessment and referral in police custody suites and in Accident & Emergency. Effective, accessible treatment services will have an impact on crime and disorder, antisocial behaviour and will ultimately lead to saving in relation to hospital admissions for alcohol specific and related disorders.

⁶⁴ Nalpas,B., Combescure,C., Pierre,B., Ledent,T., Gillet,C., Playoust,D., Danel,T., Bozonnat,M.C., Martin,S., Balmes,J.L., and Daures,J.P. Financial costs of alcoholism treatment programs: a longitudinal and comparative evaluation among four specialized centers. *Alcoholism: Clinical & Experimental Research*, (2003): 27(1):51-56.

⁶⁵ NTA Review of the Effectiveness of Treatment for Alcohol Problems 2006

Substance Misuse

Background

Reducing illicit drug use is a key element in improving health, social care and wellbeing of communities.

Reducing the harm caused by illegal drugs is one of the Governments top priorities. In 1998 the Government introduced the first cross-cutting strategy aimed at tackling drugs through an integrated approach. In 2002 this strategy was updated⁶⁶ to take account of emerging issues, sharpen its focus and improve effectiveness.

The four strands of the Government's Drug Strategy⁶⁷ are to:

- Reduce the supply of illegal drugs
- Prevent young people from becoming drug misusers
- Reduce drug related crime
- Reduce the use of drugs through increased participation in drug treatment programmes

Specifically the strategy aspires to:

- Reduce the harm that drugs cause to society, communities, individuals and their families
- Prevent today's young people becoming tomorrows problematic drug users
- Reduce the supply of illegal drugs
- Reduce drug related crime and its impact on communities
- Reduce drug use and drug-related offending through treatment and support
- Reduce drug related death through harm minimization

Drug misuse, however, does not occur in isolation. It is associated with other problems such as the misuse of other substances (for example, alcohol and tobacco), crime, youth offending, truancy and school exclusion, family problems and living in crime-ridden, deprived communities.

Harm Reduction

Harm reduction includes policies, programmes, services and actions that work to reduce the health, social and economic harms to individuals, communities and society. Harm reduction also provides an alternative to the prohibition of certain potentially dangerous [lifestyle](#) choices. The central idea of harm reduction is the recognition that some people always have and always will engage in behaviours which carry risks, such as drug use. The main objective of harm reduction is to mitigate the potential dangers and health risks associated with the risky behaviours themselves.

The National Treatment Agency has been driving forward the harm reduction agenda in relation to drugs, and Local Authorities have been tasked to improve local harm reduction interventions and reduce drug related deaths.

There are many definitions of drug related harm however they can be broadly broken down into, harm experienced by individual drug users themselves, and harm felt by third parties, the wider community and society in general. The South Tyneside Drug Action Team: Harm Minimisation Strategy outlines examples of harm including:

Health related harms such as:

- Risk of death
- Serious injury and physical sickness
- Psychological/emotional problems

⁶⁶ <http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/updated-drug-strategy-2002.pdf>
accessed 14th December 2007

⁶⁷ <http://drugs.homeoffice.gov.uk/drug-strategy/overview/?version=1> accessed 14th December 2007

Economic harms

- Foregone personal employment opportunities
- Heavy financial expenditure to support personal use

Personal/social harms

- Risk of drug related violence
- Family breakdown
- Breakdown of friendship and peer relationships and networks
- Stigma attached to criminal conviction
- Risk of incarceration
- Social isolation, stigmatisation and loss of personal dignity

The **third party** harms and costs to society cover similar dimensions.

- Public nuisance
- The social and economic costs of healthcare provision
- The costs of drug related property crime
- The costs of incarceration of serious offenders
- Other broader financial 'opportunity costs' associated with money being spent on problematic drug use which could have been spent in other more socially productive ways (Collins & Lapsley, 1992)

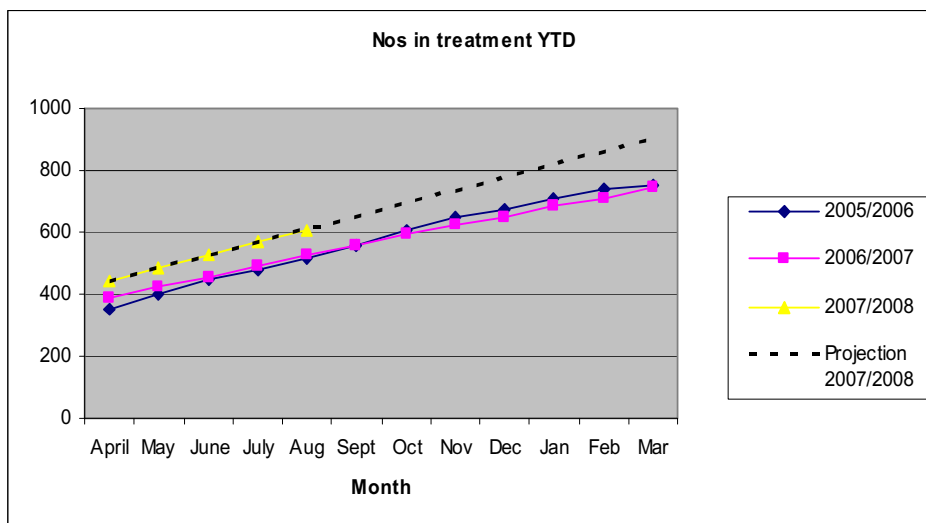
It is acknowledged that these examples although not exhaustive are often cross cutting in nature and mutually exacerbate overall levels of harm

Prevalence

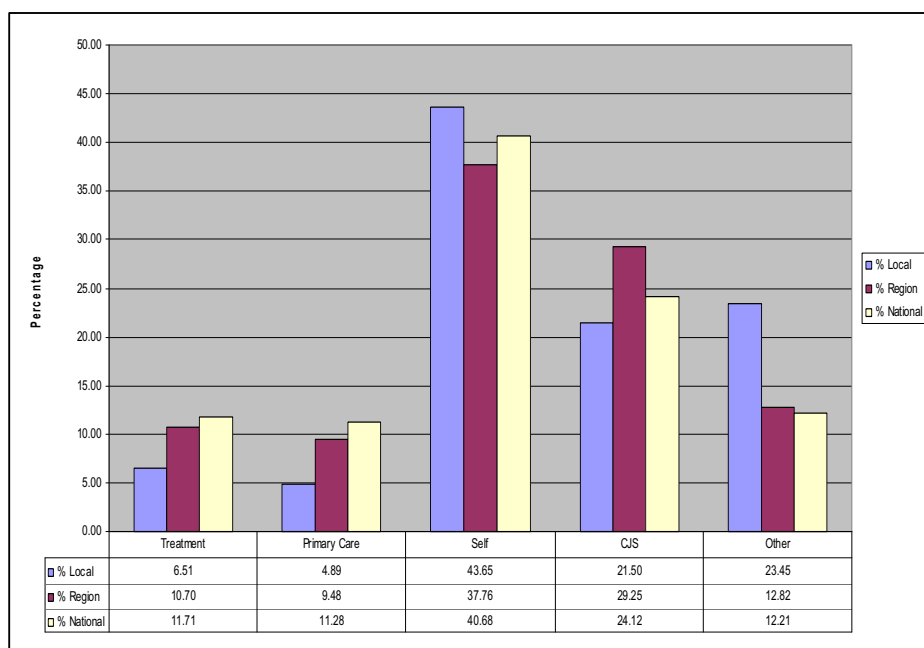
South Tyneside Drugs Action Team has produced a detailed Needs Assessment Report in October 2007. Information from this report has been provided within this section.

This data suggests that the numbers in treatment continue to rise in South Tyneside. At the end of 06/07 there were 784 clients in treatment. A projection based on current performance for numbers in treatment for 07/08 suggests that there will be in the region of 903 people in treatment.

Current year estimates for the problematic drug users (PDUs) are not yet available. However, if the estimates for 06/07 of 947 PDUs are used South Tyneside will have 95% of this population in treatment by the end of 2008.



Numbers in treatment



| GP | | Self | | Criminal Justice | | Other | | Total | |
|-------|-------|-------|-------|------------------|-------|-------|-------|-------|-------|
| 05/06 | 06/07 | 05/06 | 06/07 | 05/06 | 06/07 | 05/06 | 06/07 | 05/06 | 06/07 |
| 10 | 15 | 131 | 137 | 61 | 54 | 68 | 112 | 270 | 318 |

Referrals

There has been a rise of 18% in the number of referrals made to services in South Tyneside from 270 in 05/06 to 318 in 06/07. Data from 05/06 (Graph 1) comparing self referrals in South Tyneside to the local and national picture showed that South Tyneside had a higher percentage of self referrals than the region or national outlook, 43.65% as opposed to 37.76% regionally and 40.68% nationally. In 06/07 self-referrals have remained high and have shown an increase (5%) but not such a significant increase as the 'other' referral category.

Referrals into treatment from Criminal Justice sources, DIP, Prison and Probation for the area have shown a slight downturn from 05/06 of 12%. This is concerning as 05/06 data illustrated that referrals from the criminal justice sector were lower locally (21.5%) than the regional (29.25%) and national (24.12%) picture.

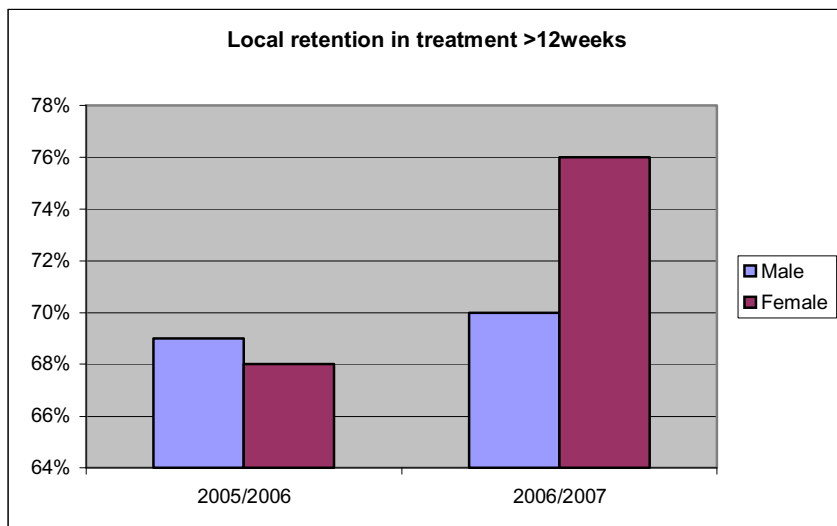
In South Tyneside criminal justice referrals are the second lowest referral category next to GP referrals although GP referrals have seen an increase in 05/06 due to the development of a new service. Therefore criminal justice referrals warrant some investigation due to the complexity of need of the client group. South Tyneside DIP Service was put out to tender in 06/07 and the drop in referrals may be as result of this and as the new service matures an increase in referrals is expected.

Graph 2 Referral sources 2005/2006

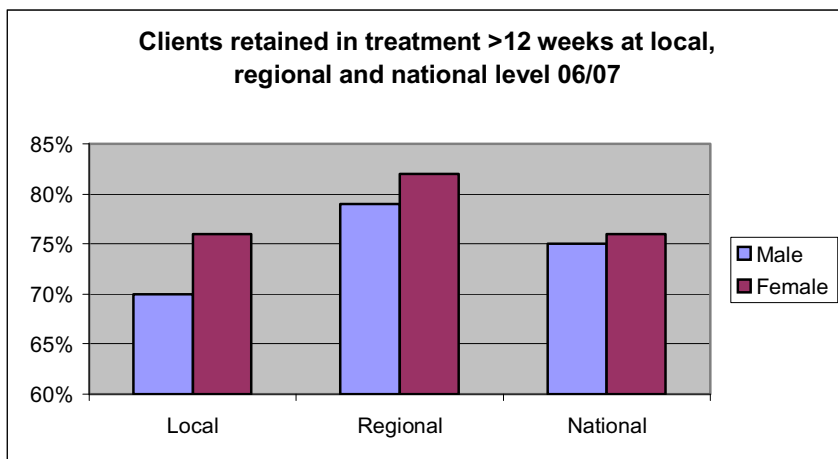
Table 1: Overall number of referrals into treatment agencies (tier 3 and 4) by Source 05/06 and 06/07

Retention

Retention was the main focus of the 06/07 needs assessment. In 05/06 the retention of male and female clients locally were almost on a par with 69% of men being retained in treatment > 12 weeks and 68% of women retained. This retention rate shifted noticeably in 06/07 with an increase to 76% of women retained whilst the retention of male clients has shown a slight increase to 70%. Despite the significant increase in the retention of female clients during 06/07 the partnership is still very much behind the regions retention rate for women at 82%.

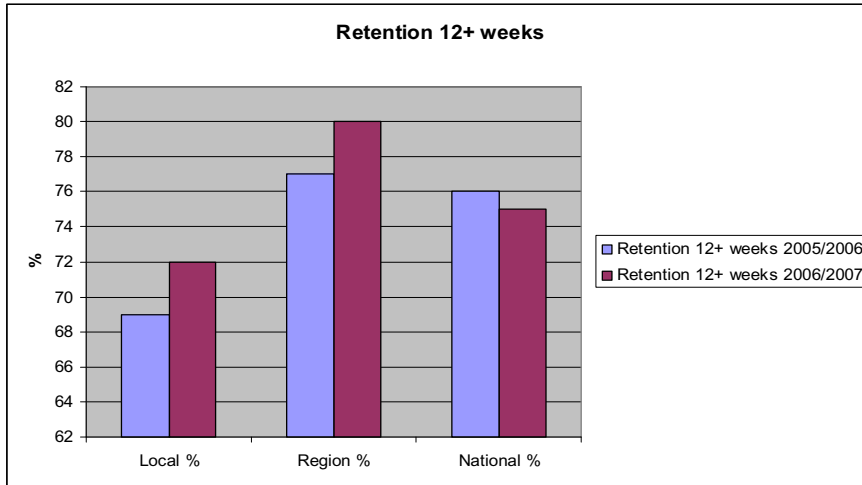


A comparison of retention by gender locally, regionally and nationally (Graph below) shows that the Regional retention at 79% is slightly ahead of the national retention rate of 75% for men in 06/07 whilst locally retention for men is lagging behind the regional rate.



There has been no change between 05/06 and 06/07 in the numbers of males retained >12 weeks. However females retained >12 weeks have increased from 43 to 73 an increase of 70%.

The graph below highlights that since 05/06 retention has increased locally from 69% to 72% in 06/07 whilst this is positive it has been acknowledged that further work is required if the 07/08 retention of 82% is to be met.

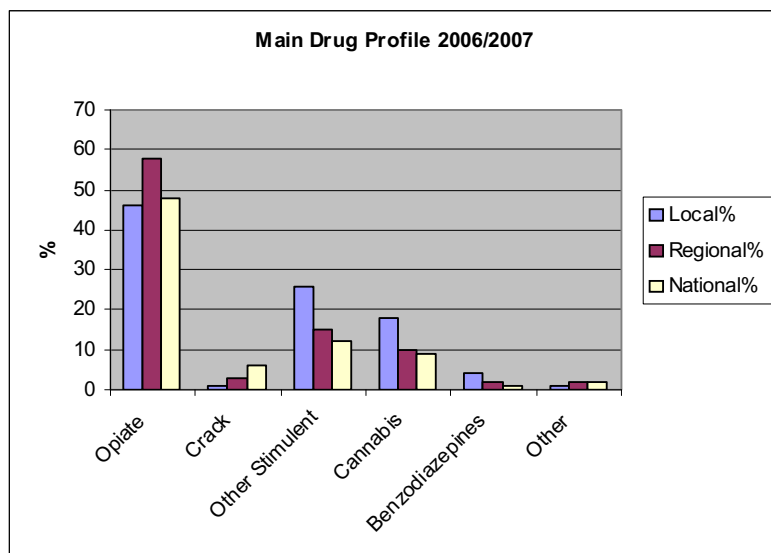


Drug Profile

The graph below outlines the main drug profile for South Tyneside in comparison to the regional and national picture for 2006/2007. South Tyneside has a lower proportion of Opiate Users in treatment in 06/07 than regionally and nationally. This picture is reflected with crack use with only 1% of clients using the drug as a main substance. Both stimulants and cannabis show higher proportions of use locally than the regional and national. Whilst there has been an increase in Stimulant users in treatment, numbers of Cannabis users as main drug have remained high but shown no increase or decrease on 05/06.

Another drug group that has shown an increase locally from 05/06 to 06/07 are Benzodiazepine user with an increase from 1% to 4%. In 06/07 there was a marginally higher percentage of Benzodiazepine users than the regional or national picture.

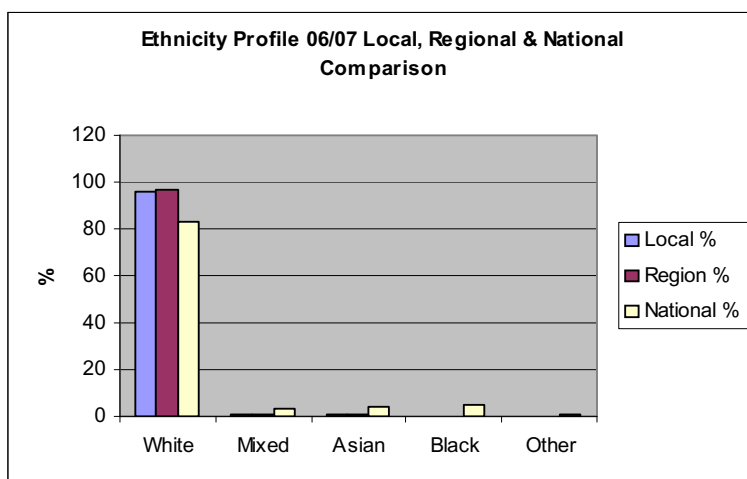
The 'Other' category of main drug has shown a fall of 2% from 05/06-06/07 locally and nationally whilst the regional outlook has shown no change.



Ethnicity

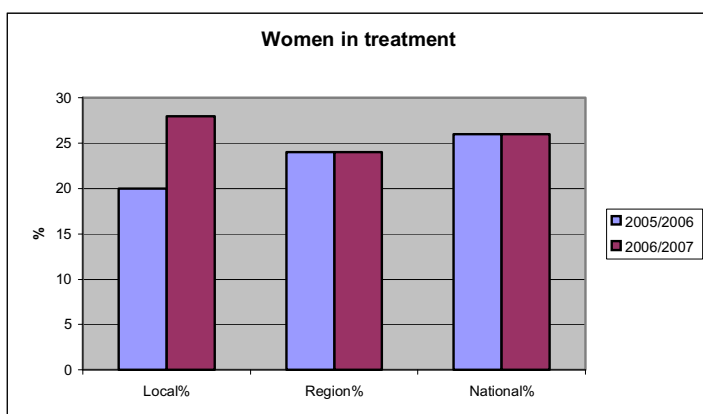
The highest proportion of clients in treatment both locally, regionally, and nationally belong to the White category. Locally there is a slightly lower percentage (2%) of those in the 'white' bracket. However, the local and regional 'white' in treatment population is higher than the national picture suggesting that more work may be required to engage with the ethnic population to encourage treatment use. This is further substantiated as locally there has been no change in the numbers of clients from ethnic backgrounds in treatment.

The retention project undertaken recently emphasised that within the partnership treatment agencies, *'there was limited knowledge among providers of the requirements of the BME community, though services could arrange access to interpreters there did not appear to be any other facilities.'* Dunn and Lidell, (2007)



Female Drug Use

In 06/07 the South Tyneside DAT Partnership had a higher proportion of women in treatment (28% n= 96) than the local and national outlook. This figure includes an increase of 8% in the numbers of women in treatment. This is a positive development as in 2005/2006 South Tyneside demonstrated a performance for women in treatment (n=63) that was lower than both the regional and national proportions.



Pregnancy and Substance Misuse

The outcomes for children of drug misusing women are diverse and complex dependant on both the type of drug and the individual user⁶⁸. Most drugs are accepted as teratogenic but the severity of the impact on the fetus is largely dependent on the type of drug and the level of use (Lester 2004). Outcomes can be characterised into immediate (neonatal / perinatal) outcomes and long-term neurodevelopment or behavioural outcomes. Further complications associated with both '*physiological and psychological functioning*' as well as impeding family stability and employment status are outlined⁶⁹.

Negative consequences highlighted include medical, developmental, emotional and behavioural problems. It is acknowledged that damage is confounded further by continuing drug use in the postnatal period⁶⁹. The debate around outcomes is often confounded further by factors impacting on outcomes related to socio-economic circumstances and it is often acknowledged that it's difficult to extrapolate the impact of the drugs alone⁶⁸.

Data from South Tyneside Foundation Trust Maternity department for the years 2004 – 2006 outlines approximately 2% of all women accessing maternity services disclosed a substance misuse problem. However in a recent local report only just over half of the women who felt they had a drug problem at the time of pregnancy disclosed this to midwifery services (53.8%)⁷⁰. If we apply this figure to the data provided from the hospital IT system we can approximately double the number of substance using women requiring antenatal care in each of the years.

| Year | Number | Estimated number |
|-------------|--------|------------------|
| 2004 / 2005 | 29 | 54 |
| 2005 / 2006 | 27 | 50 |

Using this crude estimate is possible to suggest that approximately 4% of women accessing maternity care will have a significant substance misuse problem and the associated social problems.

Local Action

A Harm Reduction Strategy is in place and covers a range of issues including; prevention of blood borne viruses, reducing supply of drugs, increasing the number of people in appropriate treatment, supporting service users and carers, managing risk to prison leavers and reducing drug related litter. A Harm Reduction Nurse has been in post since 2005 and has been very successful increasing the numbers of drug users immunised for hepatitis B and supporting them into treatment for hepatitis C. A number of needle exchanges are available across the borough accessed by over 60 people a week

Unmet need

Unmet need has been identified as follows;

- Estimates suggest that there were 947 problematic drug users in South Tyneside during 2006 / 07. Of these it is suggested that around 83% (784) were registered in treatment. This outlines a possible unmet need of 17% (163).
- Fewer women access services than men.
- Less than half of women disclose a substance misuse problem during pregnancy.

⁶⁸ Advisory Council on the Misuse of drugs (2003) 'Hidden Harm – responding to the needs of children of problem drug users'. The Home Office.

⁶⁹ Jansson, L.M., Svikis, D.S., Breon, D., and Cieslak, R. (2005) 'Intensity of Case Management Services: Does More Equal Better for Drug-Dependent Women and their Children?' *Social Work in Mental Health*. Vol. 3(4)

⁷⁰ Charlton, S. (2005) Barriers Facing Women Accessing Drug Service Provision within South Tyneside. South Tyneside Drugs Action Team (Unpublished)

- Identified barriers to treatment from service user survey – lack of childcare facilities, flexibility of services and restrictive opening times. Users perceptions – those who have been in treatment and, those who have not been in treatment but have heard of experiences from others
- Ethnicity profile indicated that those in treatment are predominantly of White British Ethnicity, 97.73%. On a par with the regional in treatment figures but 10% higher than the national picture. It is considered that more work needs to be undertaken to engage this underserved group in Drug Treatment.

Priority Action / Evidence Base

Linked Performance Indicators

NI 38 Drug-Related (Class A) offending rates PSA 25

NI 40 Drug Users in effective treatment PSA 25

NI 42 Perceptions of drug use or drug dealing as a problem

PSA 23 Make Safer Communities

PSA 25 Reduce the harm caused by alcohol and drugs

HO DSO Cut crime, especially violent, drug and alcohol related crime

Recommendations

- Further develop the Harm Reduction Strategy for drugs with a specific focus on preventing Drug Related Deaths
- Develop drugs Harm Reduction Service with a range of provision including alcohol SBI and sexual health services
- Develop integrate and promote specialist substance misuse midwives within existing and projected drug treatment systems
- Integrate harm reduction principles into the work currently being implemented in schools with an additional focus on targeted work with looked after young people, young people who are excluded and young people who regularly truant, young offenders and young people who are homeless.
- Reduce the risk of hidden harm to children and young people within the families of drug users, or with drug using parents
- Encourage, promote and integrate Blood Bourne Virus (BBV) vaccination testing and treatment programmes into existing and projected treatment systems
- Minimise risks to Prison leavers by improving the treatment interface between prisons and the community
- Develop and commission treatment services that have a common philosophy and culture based on harm minimization
- Ensure active involvement of service users and carers in the development and delivery of services
- Provide the widest range of referral opportunities and minimise the time between referral and treatment
- Increase the range of services available, particularly those for stimulant users
- Improve supported community integration for substance misusers
- Increase the Knowledge of the workforce, service users, carers and communities regarding the risks of drug related harm
- Engage in ongoing research, development and evaluation of need
- Ensure that the Ambulance Service, Paramedics, Police and Accident and Emergency departments are fully engaged in harm reduction protocols
- Learn from drug related deaths by carrying out confidential enquiries where appropriate and where possible adapt services and responses accordingly
- Increase public awareness through the effective use of public relations
- Develop systems that are responsive to the needs of BME communities

Sexual Health

Background

Sexual ill health costs the NHS more than £700 million per year in addition to the individual cost in terms of quality of life⁷¹. Attendances at GUM services rose steadily from the 1960s with a sharp rise during the 1990s. This increase in service demand was reflected with a significant increase in the incidence of STIs, unintended pregnancy and increasing prevalence of HIV. This trend has continued with a year on year increase in STI diagnosis during the previous 5 years⁷². Data from the HPA shows the number of new diagnoses of sexually transmitted infections (STIs) in GUM clinics in the UK rose by 2% between 2005 and 2006⁷³. Furthermore Britain has the worst record for teenage conceptions in Europe⁷⁴.

Controlling STI's requires effective primary prevention, timely access to effective services and appropriate treatment in order to prevent further onward transmission. Unsatisfactory treatment generates a 'vicious circle' where unmet need and demand for treatment leads to preventable onwards transmission thus maintaining a high demand for treatment and a high unmet need⁷⁵.

Within the overall increase in sexual ill-health there is recognition of further inequality relating both to geographical locations, poverty, social exclusion and within particular population groups. The Sexual Health Strategy acknowledges '*a clear relationship between sexual ill health, poverty and social exclusion*' (DH, 2001, Pg 3).

Sexual ill-health is clearly linked to poverty and social exclusion and disproportionately affects particular groups including:

- Men who have sex with men
- Certain ethnic groups (in particular asylum seekers and refugees)
- People from or who have visited areas of high HIV prevalence
- Sex workers (and their clients)
- The homeless
- Young people and particularly those in or leaving care
- People with a mental health problem, a conduct disorder and / or involvement in crime
- Teenage parents (or those who have already had an abortion)
- People with low educational attainment or no qualifications
- Disengagement from school
- Children of teenage parents
- Injecting drug users

There is also an acknowledgement that specific work with pregnant women is required to both improve outcomes and reduce risk for mother and baby.

(HPA, 2006, NICE, 2007 and DfES, 2006))

The NICE guidance (2007) identifies a number of behavioural factors that affect the probability of STIs. These behavioural factors include:

- Misuse of alcohol and/or substances
- Early onset of sexual activity

⁷¹ Health Protection Agency (2004) HIV and other Sexually transmitted Infections in the UK in 2003. Annual Report

⁷² Accessed online www.hpa.org.uk 26th October 2007

⁷³ Health Protection Agency (2007) Health Protection Report: Vol 1. Number 29 Published 20th July 2007. <http://www.hpa.org.uk/hpr/archives/2007/hpr2907.pdf> Accessed 25th July 2007.

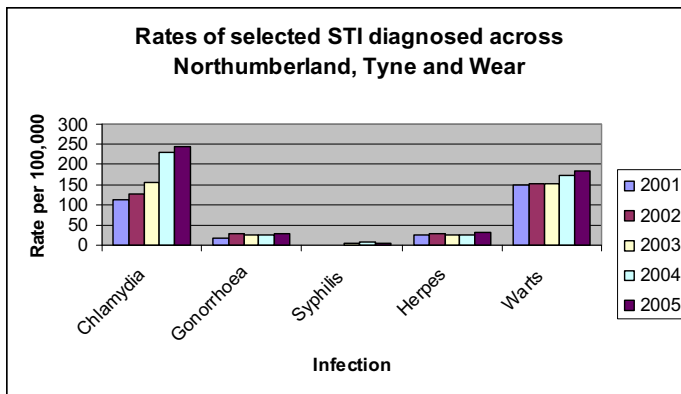
⁷⁴ Social Exclusion Unit, SEU (1999) 'Teenage Pregnancy'. London. The Stationary Office

⁷⁵ White PJ, Ward H, Cassell JA, Mercer CH, Garnet GP. Vicious and Virtuos Circles in the Dynamics of Infectious Disease and the Provision of Health Care: Gonorrhoea in Britain as an example. The Journal of Infectious Diseases 2005; 192: 824 - 836

- 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

Prevalence

Sexually Transmitted Infections - Reflecting the National trend the North East (2007⁷⁶) demonstrates an overall increase in selected STIs between 2002 and 2006. Chlamydia was the most commonly diagnosed STI showing a year on year increase for the previous five years with an overall increase of around 133%. The most recent data for Northumberland, Tyne and Wear (2006⁷⁷) reflects this with an increase in each of the key STI's further highlighting a greater problem than the rest of the North East across all documented STIs.



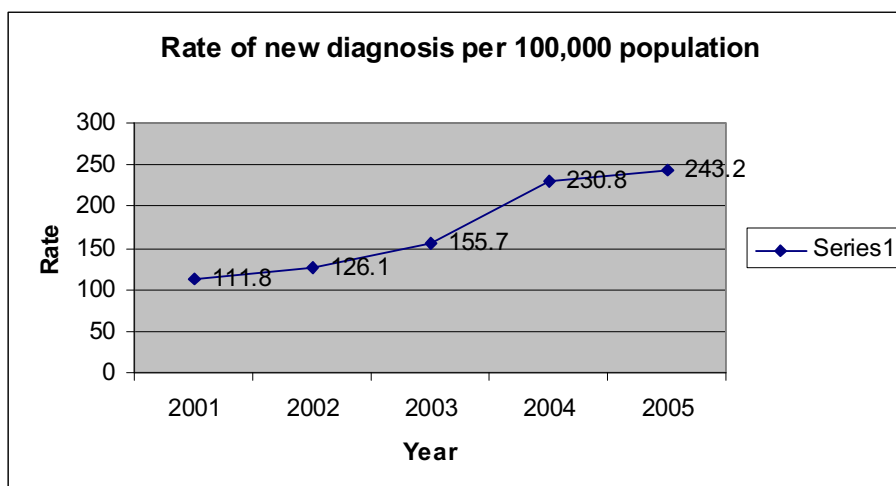
Reflecting the regional picture South Tyneside GUM service has seen a year on year increase in the number of STIs diagnosed.

Chlamydia

Northumberland, Tyne and Wear Strategic Health Authority area have an average rate of 243.2 per 100, 000 in 2005 (HPA, 2006). This figure varies dependent on the age of the population with a significantly higher rate of 1889.8 (per 100, 000) for young women aged 16 – 19 and 1412.3 (per 1000) young men aged 20 - 24. For young people under 25 including under 16s the rate is 947.3 per 100, 000. Excluding the under 16 rate as this distorts the prevalence this figure rises to 1380 per 100, 000 young people aged 16 to 24. This rate of Chlamydia diagnosis has increased dramatically over the past 5 years from an overall rate of 111.8 in 2001.

⁷⁶ HPA (2007) Diagnosis and rates of selected STIs seen at GUM clinics: 2002 – 2006. SHA level summary tables. www.hpa.org.uk Accessed 7th September 2007.

⁷⁷ HPA (2006) Diagnosis and rates of selected STIs seen at GUM clinics: 2001 – 2005. SHA level summary tables. www.hpa.org.uk Accessed 7th September 2007



The figures are met with some caution as they represent diagnosis in GUM and thus exclude diagnosis in GP's, family planning, young people's clinics etc. The data also clearly excludes undiagnosed infection in those not tested and therefore indicates levels of incidence not prevalence.

Estimated incidence (South Tyneside 2005)

By applying the Northumberland, Tyne and Wear SHA rates (HPA, 2006) to the population estimates for South Tyneside (ONS) it is possible to estimate the expected incidence.

| Age | Male | Female | Total | Population Estimates ONS 2005 | Estimated incidence - South Tyneside (number) |
|---------|--------|--------|--------|-------------------------------|---|
| <16 | 10.9 | 157.6 | 82.0 | 6181 (13 – 15 years) | 5 |
| 16 – 19 | 767.4 | 1889.8 | 1316.4 | 8, 697 (15 – 19 years) | 114.5 |
| 20 – 24 | 1412.3 | 1475.3 | 1443.6 | 9, 289 | 134.9 |

Data from the National Chlamydia Screening Programme (1st April 2003 – 31st March 2006) found that the prevalence of the infection was 10.4 % for women and 10.7 % for men. It has been outlined that there are varying diagnosis levels based on both age (as above) and the screening venue ranging from 17.3% in GUM clinics to 8.1% in general practice (Adams et al 2004). As with other STI's patterns of prevalence are acknowledged to differ based on both levels of sexual activity and risk taking. It follows therefore unsurprisingly that people accessing GUM will fit the criteria for 'risk' than a more general audience in General Practice.

Accepting the NCSP findings from the second year of the programme suggests that 10.4% young women and 10.7% of young men have Chlamydia. This figure is taken from the screening group aged 15 – 24. In order to apply this figure to the under 16 population consideration is required as to the proportion of young people sexually active. As Adams (2004) suggests sexual behaviour is a crucial determinant of prevalence and young people accepting the screen are likely to be sexually active and thus a distortion of the figures is possible. In order to facilitate this estimate data has been taken from the NATSAL survey (2001) in relation to the proportion of young people sexually active by aged 16.

Estimated prevalence of Chlamydia infection in young people under 16 in South Tyneside

| Total aged 13 - 15 | Estimated number by gender | NATSAL estimates for sexual activity | South Tyneside Estimate number sexually active | Estimated incidence under 16 with Chlamydia |
|--------------------|----------------------------|---|--|---|
| 6181 (approximate) | 3090 | 38% of young women sexually active (North East average) | 1174.2 | 122.11 |
| | 3090 | 25% of young men sexually active (North East average) | 772.5 | 82.65 |

This estimate suggests that there is a significant proportion of unmet need in relation to under 16 Chlamydia diagnoses with the HPA data showing diagnosis of approximately 3.2 compared to the estimate based on the NCSP findings showing a prevalence of approximately 122 young women and 83 young men under 16.

Estimated prevalence of Chlamydia infection with young people over 15 by age (South Tyneside)

The prevalence calculations for this table have been based on estimated levels of sexual activity ranging from a median age of 16 for first sexual intercourse to Brook's (2000) estimate of 90% sexually active by age 20. For this purpose two figures have been provided for the 15 – 19 age group to show the scope of the possible prevalence based on 50% (NATSAL, 2001) or 90% (Brook, 2000) of the population being sexually active.

| Age group | Total population (10.55%) | | Male (10.7%) | | Female (10.4%) | |
|--|---------------------------|--------|--------------|--------|----------------|--------|
| 16 – 19 | 8,697 | | 4348.5 | | 4348.5 | |
| Proportion sexually active (estimated) | 50% | 90% | 50% | 90% | 50% | 90% |
| | 4348.5 | 7827.3 | 2174.25 | 3913.6 | 2174.25 | 3913.6 |
| Estimated prevalence | 458.8 | 825.8 | 232.6 | 418.8 | 226.1 | 407 |
| 20 - 24 | 9,289 | | 4,674 | | 4,615 | |
| Proportion sexually active (estimated) | 90% | | 90% | | 90% | |
| | 8360.1 | | 4206.6 | | 4153.5 | |
| Estimated prevalence | 881.99 | | 450.11 | | 431.96 | |

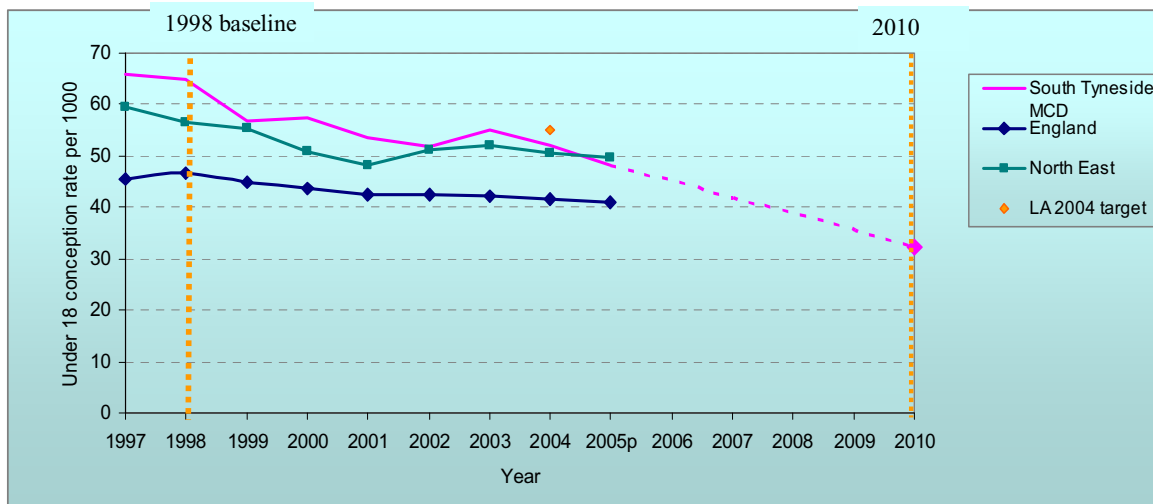
Using these calculations it could be estimated that the total prevalence of Chlamydia in South Tyneside within the 13 – 24 age group ranges from 1546 to 1913 (dependent on levels of sexual activity). This 'expected' number is much higher than the number outlined by applying the SHA rate to the population estimates (ONS) suggesting a significant proportion of unmet need.

Teenage Pregnancy

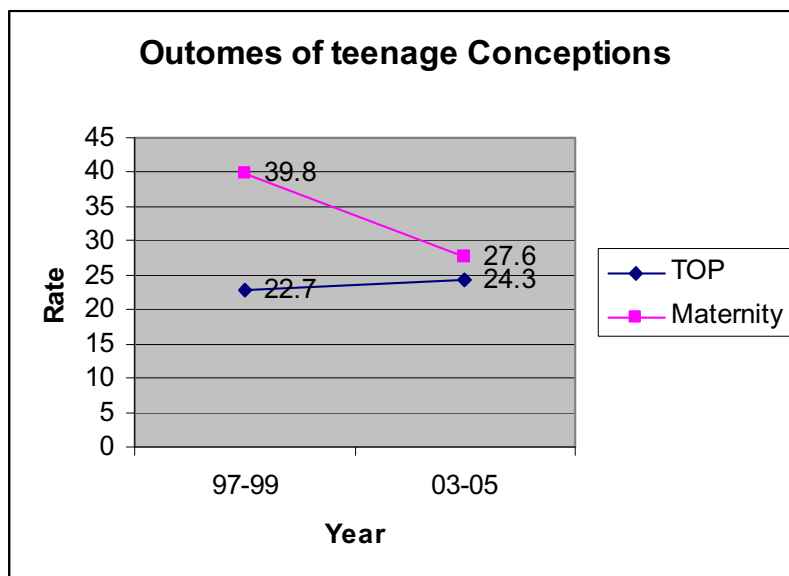
The latest conception data (2005) for South Tyneside shows an overall reduction of 25.8% since the 1998 baseline. The interim target of a 15% reduction by 2004 was exceeded in South

Tyneside. The trajectory set to ensure the target is met has been exceeded for 2005. The National Teenage Pregnancy Unit highlighted the Local Strategy during 2006 as one of the top performing areas in the country with both a significant reduction and excellent services. Despite a significant reduction the teenage conception rate in South Tyneside remains considerably higher than the national average.

Under 18 Conception Rate and trajectory required to meet the target

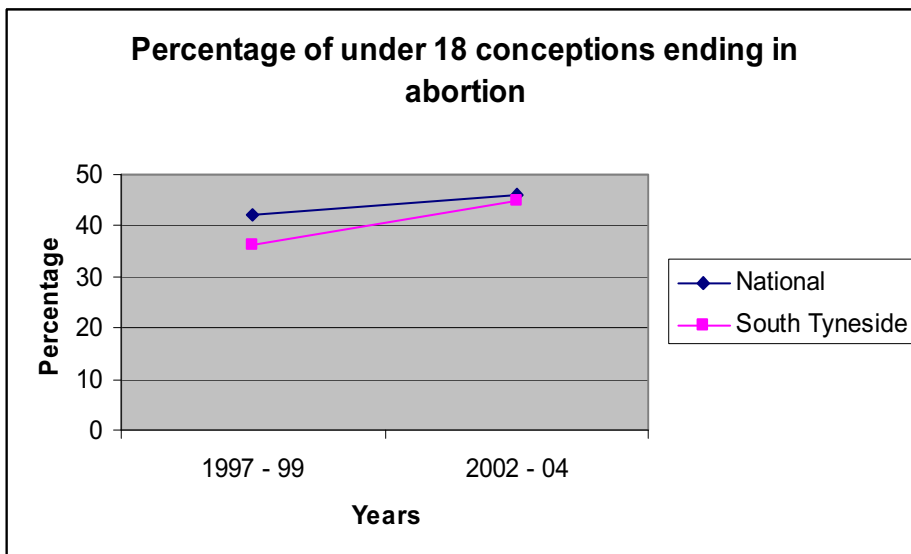


Outcomes - Comparison of outcome data for under 18 conceptions during the aggregated years 1997 – 99 and 2002 – 04 shows that there has been a 27% reduction in the rate of young people continuing with pregnancy alongside a small increase of 5.9% in the rate of young people opting for termination. The table below outlines the rate change by outcome with the pink line reflecting the rate of young people continuing with pregnancy and the blue line reflecting termination of pregnancy (TOP).



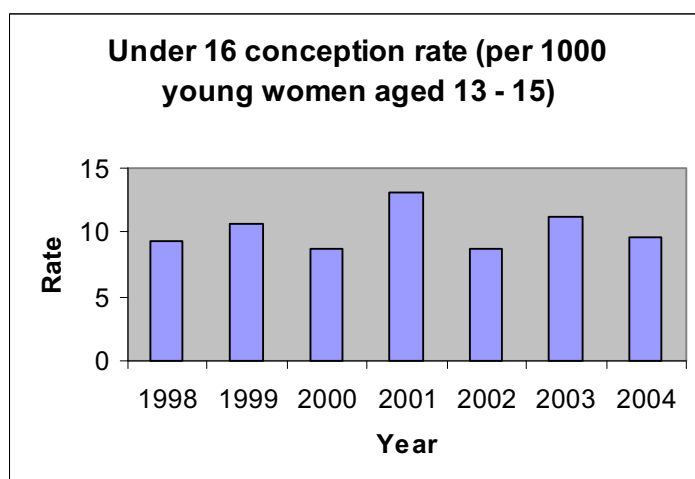
South Tyneside has historically encompassed a smaller proportion of young people opting for termination when compared to the national average. This change in outcome data appears to provide evidence of a more rapid reduction in the number of young people who would have continued with their pregnancy compared to the number opting for termination. This outcome may reflect an increase in the availability and access to services resulting in earlier identification of pregnancy and therefore providing a broader range of options alongside better support to

enact a particular outcome. This apparent shift in conception outcome is contributing to reducing the outcome gap with the national average.

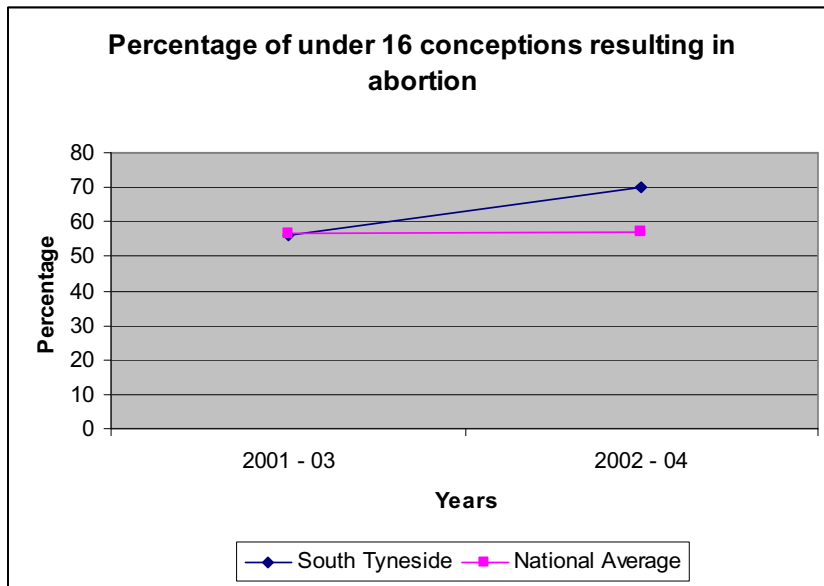


Conceptions under 16 - The under 16 rate of teenage conceptions (per 1000 young women aged 13 – 15) represents very small numbers and thus at a National level was considered to be undulating to such an extent that a specific target for this age group was deemed unrealistic. With recognition of the specific limitations regarding monitoring this age group there remains an acknowledgement locally of the crucial role in reducing this rate.

The actual number of under 16 conceptions in South Tyneside has ranged from 28 to 43 with an average of 32 per year. The under 16 rate is currently showing a 4.2% increase from 1998 to 2004 however the actual number is one. Using aggregated data for 2002 – 04 the South Tyneside rate is above the average for England at 9.9 per 1000 compared to 7.8 per 1000 at a National level. The table below presents the under 16 conception rate in South Tyneside from 1998 to 2004.



Young people under 16 are known to be more likely to opt for termination than their older counterparts. Interestingly data shows that young women conceiving under 16 in South Tyneside are more likely to opt for termination than the national average with a substantial increase in this proportion in recent years. Again a level of caution is required based on the small numbers involved.

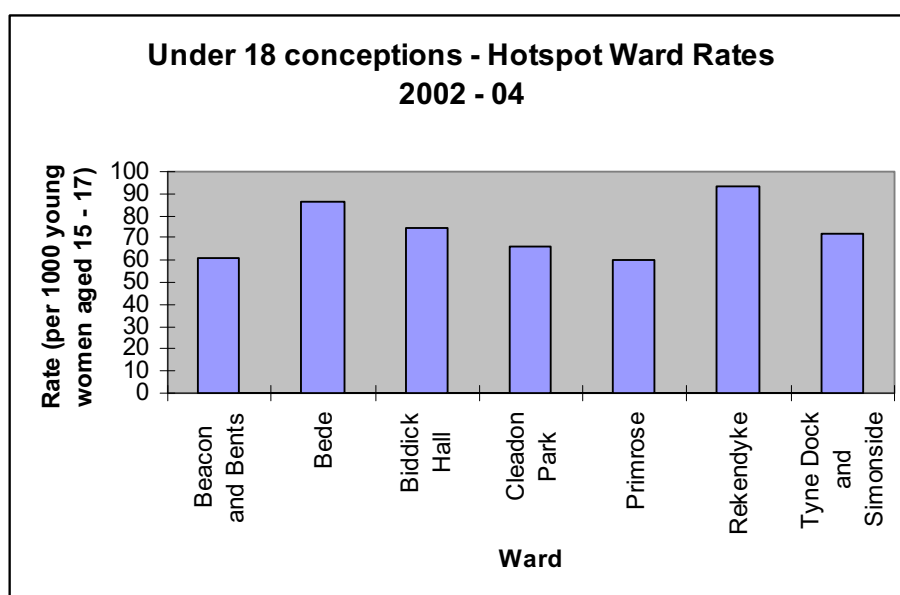


Hotspot data - Hotspot areas are wards with an under18 conception rate among the highest 20% in England. Out of the 20 wards in South Tyneside, nine were identified as 'hotspot' areas based on the 2000 – 02 data.

| | | |
|-----------|--------------|-----------------|
| Primrose | Biddick Hall | Boldon Colliery |
| Bede | Hebburn Quay | Cleadon Park |
| Rekennyke | Whiteleas | Horsley Hill |

Teenage conception data for the aggregated years 2002 – 2004 was received in January 2007. This data highlights only seven wards remaining to fit the criteria for a 'hotspot' ward (Rate above 54.3 per 1000). The data also demonstrates that there has been a change in 'hotspot' wards as the latest data contains five of the original nine with two further additions. Four of the original nine ward level conception rates have moved below the level to fit the criteria as a 'hotspot ward'. However it is important to note that ward conception numbers are relatively small (even when aggregated over three years) and thus rates should be interpreted with some caution as they can vary markedly from year to year. Despite this level of caution this apparent reduction in 'hotspot' wards signals a shift in South Tyneside and provides an indication for the third indicator highlighting a move towards a reduction in inequality between wards in South Tyneside and the National average.

Hotspot wards 2002 – 04 (Rate over 54.3 per 1000 young women aged 15 – 17)



Ethnicity

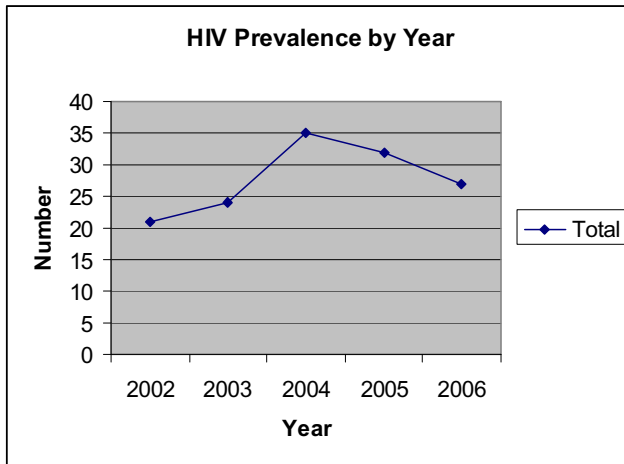
Young women from certain ethnic groups have been outlined nationally at an increased risk of teenage conception. This finding is not reflected locally with young women from a 'white' ethnic background featuring disproportionately in the teenage conception rate when compared to the national average (98.6% versus 89.3%). The only other small ethnic population group featuring within this rate in South Tyneside is the Bangladeshi population who comprise 1.4% of the teenage conception rate in South Tyneside compared to 0.7% nationally (ONS, 2001).

| Population | South Tyneside | England |
|-------------|----------------|---------|
| White | 98.6% | 89.3% |
| Bangladeshi | 1.4% | 0.7% |

Whilst in South Tyneside the Bangladeshi proportion of the total teenage conceptions is low compared to the white population it is important to note that BME groups only make up 2.7% of the total population in South Tyneside.

HIV - SOPHID data (based on patients last seen for treatment in 2006)

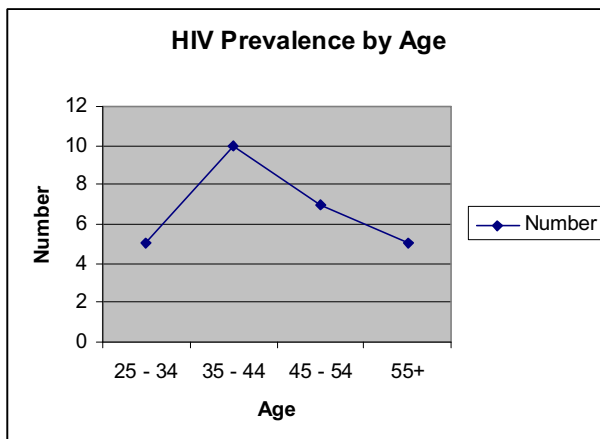
In 2006 there were 27 people living with HIV in South Tyneside. This forms part of an undulating trend across the previous five years and is the only area South of Tyne and Wear to see a reduction from the previous year.



Age

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



Transmission route

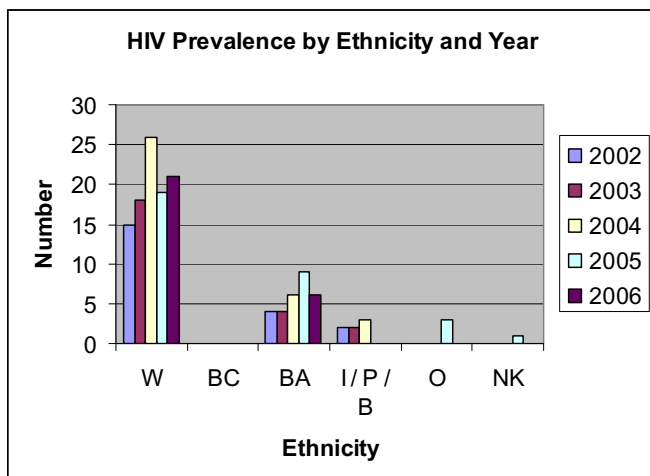
The data depicts further variation in the route of transmission with sex between men and sex between men and women being the most frequent route. In 2006 92.6% of people living with HIV acquired the infection through sexual contact.

Ethnicity

Ethnic variation is also a significant indicator with an increase risk amongst people from White and Black – African communities. With a recognition of the relatively small numbers involved the total HIV prevalence in South Tyneside 77.8% are white and 22.2% are from the Black African Community.

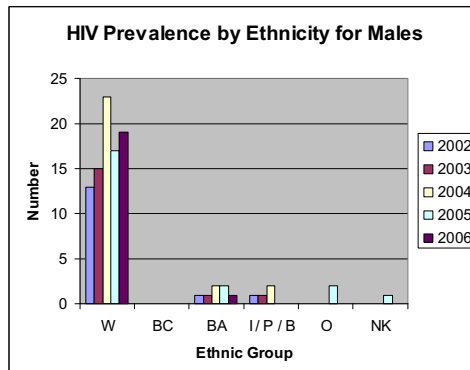
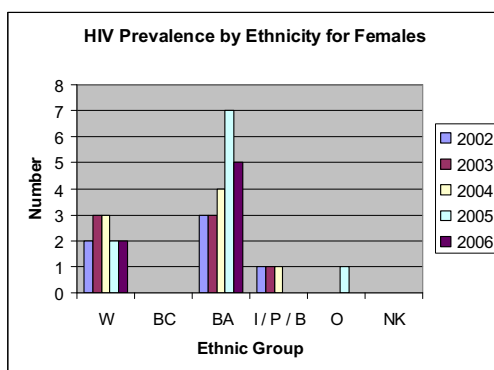
Key

| | |
|-----------|----------------------------------|
| W | White |
| BC | Black – Caribbean |
| BA | Black – African |
| I / P / B | Indian / Pakistani / Bangladeshi |
| O | Other |
| NK | Not known |



Ethnic Variation by Gender

Data shows that for women the Black-African community has the highest prevalence and for men the white community illustrates the highest prevalence.



Evidence Based Interventions / Local Action

South Tyneside is part of the South of Tyne and Wear Sexual Health Strategy group with a local implementation group. A local comprehensive Health Needs Assessment was undertaken (2007) and focused work has been identified and implemented based on the needs identified.

Better Prevention

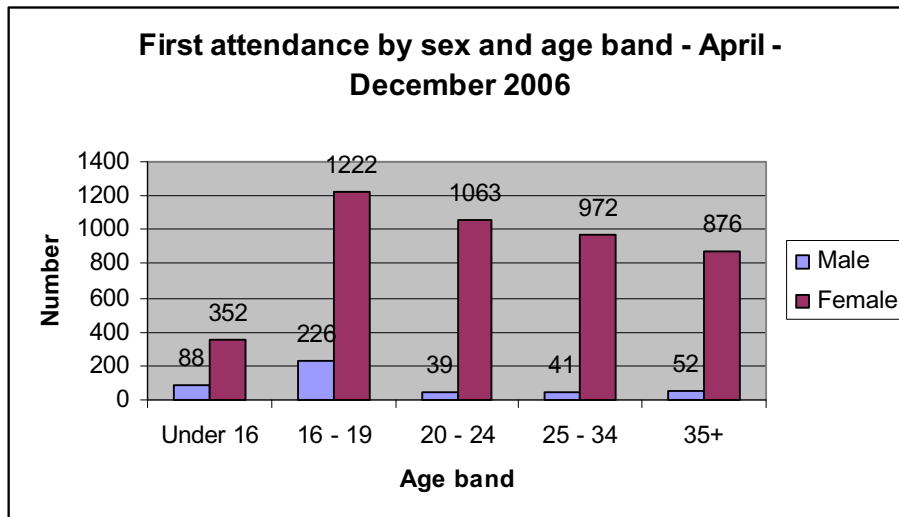
Population wide prevention campaigns and targeted work with groups and individuals with an increased risk, in particular young people and men who have sex with men have been undertaken. However the central feature of delivery has focused on the development of universal sexual health promotion through schools and youth settings. Some work has been undertaken to address the needs of vulnerable young people including those not in education, employment or training (NEET) and children looked after (LAC).

Better Services

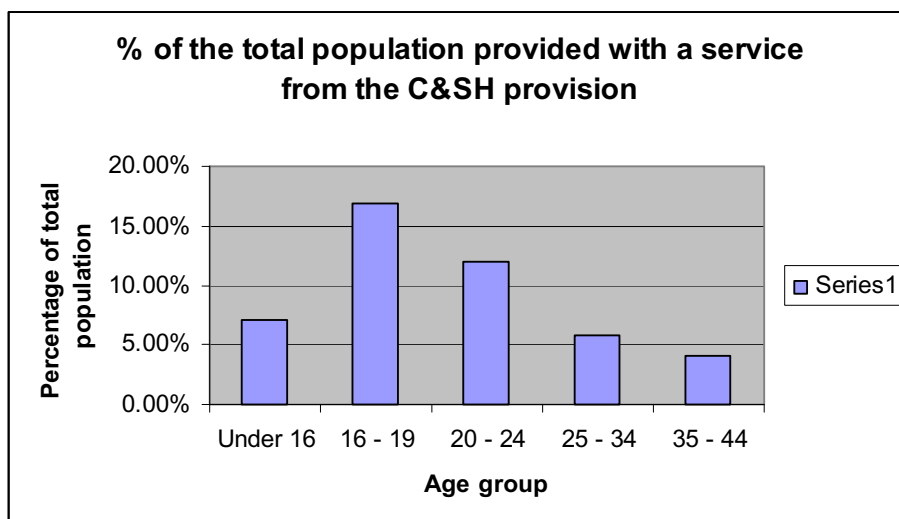
GUM Services – GUM provision is available within the national required timescale of 48 hours. Development in South Tyneside has focused on service modernisation and improvement with particular attention to the development of nurse led clinics alongside medical support.

Contraceptive services - Contraception services are available 7 days per week with emergency contraception available on a Sunday from the Foundation Trust. Excluding the emergency contraception provision on a Sunday there are a further 11 clinics running at seven venues across the borough six day per week. Within these 11 clinics there are three dedicated sessions for young people under 25 (Grapevine). Between April and December 2006 there were a total of 4931 first attendances at these clinics. The age group 16 – 19 accounted for the largest proportion of these attendances with 29%.

Females accounted for 91% of all attendances. The highest attendance overall was with females aged 16 – 19 (1222 attendances).



This data highlights based on the previously documented population estimates (ONS) that the C&SH provision have supplied a service for 7.7% of the total South Tyneside population (men and women) between April and December 2006 (based on activity data detailing first attendance). As this data includes only 9 of a twelve month period there is an expectation for contact with a further 2.5% of the total population by the end of the financial year (March 2007).



When this figure is broken down further the service has supplied between 7.4% and 28.4% of the female population with access to contraception and sexual health depending on age.

Specific work regarding pregnancy options counselling and postnatal and post termination of pregnancy (TOP) contraception planning have been highlighted nationally as innovative practice. A comprehensive review of the postnatal contraception plan for 2005 – 2006 took place in February 2007. This review highlighted that 85% of all young women under 20 choose to receive their care from the Young Women's Pregnancy Service. In 2005, 153 young women accessed postnatal contraception planning and, of these 121 gave birth during the year. In 2006, 165 young women accessed postnatal contraception planning and, of these 135 gave birth during the year.

Unmet need

There is unmet need in relation to primary prevention particularly focussing on vulnerable groups. Sexual health promotion capacity building is required within professionals working with identified at risk groups.

Whilst services have recently achieved 48 hour access (GUM) thus improving access work with vulnerable groups is required to increase access to STI screening for men who have sex with men, Injecting Drug Users, Sex workers and Young People. Early indications from the roll out of the national Chlamydia Screening programme suggest considerable unmet need with an incidence over 50% higher than the national average. Alongside this focus on vulnerable groups the condom card scheme requires attention to ensure the systems are robust and access to condoms are increased with a particular focus on vulnerable groups

Local need has depicted a priority to build on the postnatal and post termination contraception plan through broadening the provision to all women regardless of age and thus requires additional resources.

Priority Action / Evidence Base

Reflecting the National Strategy the proposed vision is based on the needs identified for the three levels of sexual health service⁷⁸ alongside a requirement for primary prevention. The vision supports the delivery of the key sexual health targets. The vision considers a requirement for the development of a network across South of Tyne and Wear in order to provide the full range of effective and accessible clinical services at all levels that both complements and support local primary care provision.

⁷⁸ 'Effective Commissioning of Sexual Health and HIV services' (2003).DH

Better Services: A community model of integrated C&SH and GUM adopting a hub and spoke approach is proposed. Services in South Tyneside are multi-disciplinary providing clinical effectiveness, value for money and development for all staff groups.

Level three services are provided in each locality with provision for the treatment of HIV through regional pathways. Additional Level 2 spokes will be developed both to meet the needs of geographical access and to support the development of Local Enhanced Services within General Practice.

Better Prevention: Prevention is required through a whole systems approach across the sexual health continuum. Primary Prevention is required both in terms of universal messages, focussed work with targeted high risk groups (e.g. young people and MSM) including theoretical models of behaviour change. Secondary prevention is required within services in relation to both screening asymptomatic clients and partner notification. Tertiary prevention includes the treatment of STIs in a timely and effective manner to improve the individual outcome alongside reducing onward transmission.

Linked Performance Indicators

NI 112 Under 18 conception rate PSA 14

Teenage conception rate linked to:

NI 84 Achievement of 2 or more A* - C grades in Science GCSEs or equivalent DCSF DSO

NI 87 Secondary school persistent absence rate DCSF DSO

NI Participation of 17 year olds in education or training DCSF DSO

NI 116 proportion of children in Poverty PSA 9

NI 117 16 to 18 year olds who are not in education, training or employment (NEET) PSA 14

NI 113 Prevalence of Chlamydia in under 20 year olds DCSF DSO

NI 119 Self-reported measure of people's overall health and well-being

PSA 10 Raise the educational achievement of children and young people

PSA 11 Narrow the gap in educational achievement between children from low income and disadvantaged backgrounds and their peers

Recommendations / High Impact Changes

- Increase access to sexual health screening (with a particular focus on vulnerable groups)
- Integrate the delivery of contraception and sexual health services and GUM.
- Implement a network model for sexual health across the NHS South of Tyne and Wear
- Implement the Chlamydia Screening Programme throughout PCTs and Local Authority Provider Services
- Increase access to postnatal and post TOP contraception
- Develop Local Enhanced Services within General Practice

Mental Health

Background

Mental health problems are among the most common forms of ill-health and they can place a heavy burden on individuals, their families and friends and the community at large. The prevalence of both mental health problems in general and specific illnesses varies with a variety of demographic characteristics including age, gender, ethnicity and socio-economic status. Nationally it is estimated that:

- One in four people in Britain will experience a mental health problem at any one time
- Half of all women and a quarter of all men will be affected by depression at some point in their lives
- Around one in ten children between the ages of 5 and 15 in the UK are experiencing mental health problems requiring professional help.

Increasing recognition of mental illnesses, notably depression, as a major public issue has led national and international public policies to place a greater emphasis on improving the population's mental and emotional wellbeing. These policies acknowledge that mental distress is shaped by life experiences such as poverty, unemployment, poor educational attainment, bad housing, trauma, racism and abuse. They aim to tackle inequalities and ensure that the needs of individuals are addressed with respect and an understanding of diversity. Addressing the stigma and social exclusion associated with mental illness are important elements of this work.

This policy agenda shaped the development of the National Service Framework for Mental Health, which set the standards for improving preventative and treatment services. The Social Exclusion Unit's report on Mental Health and Social Exclusion sets out the key actions to address the social exclusion experienced by people with mental health problems, including better access to preventative programmes and physical healthcare, and supporting those with mental health conditions back into work.

In relation to suicide, around 5000 people take their own lives in England every year. In the last 20 years, suicide rates have fallen in older men and women, but risen in young men. In men under 35, suicide is the most common cause of death. Around three quarters of people who commit suicide are not in contact with mental health services.

Specific risk factors for suicide are:

- Being male
- Living alone
- Unemployment
- Alcohol or drug misuse
- Mental illness

The National Suicide Prevention Strategy for England is helping to guide local action to reduce suicide rates. A national target has been set to reduce death rates from suicide and undetermined injury by at least a fifth by the year 2010

Mental health problems cost over £77 billion a year through care costs, economic losses and premature death (SCMH, 2003). 900,000 people are claiming incapacity benefit for a mental health problem. Wanless (2002; 2004) calculated that the cost benefit of better mental health care would be a net saving of £3.1 billion a year. This does not take into account the savings from promoting mental health and preventing problems in the first place. On the basis of the evidence base referred to above, there is a strong economic case to be made for mental health promotion.

Prevalence

There is little reliable and readily available information on the number of people with mental illness. Many common mental health problems such as depression and anxiety are managed

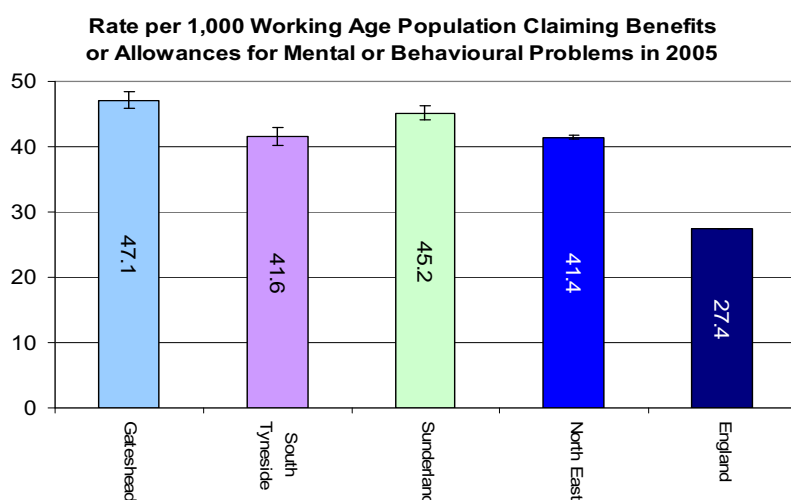
entirely within primary care, and many people with these conditions may not even present to a health professional. Hospital admissions due to mental health problems are, thus, not a good indicator of the prevalence of mental illness. The prevalence of certain long-term conditions within primary care is now measured by the NHS Information Centre as part of the Quality Outcomes Framework, but the mental health indicator only measures the prevalence of severe and enduring mental health conditions such as psychosis. Below are two proxy indicators of the prevalence of mental illness.

Rate of claiming benefits or allowances due to mental or behavioural problems

The 2007 Community Health Profiles⁷⁹ gathered together figures for Local Authority areas showing the rate of claiming benefits or allowances due to mental or behavioural problems among people of working age.

| | Number claiming benefits or allowances | Crude rate claimants per 1,000 population of working age | Lower 95% Confidence Limit | Upper 95% Confidence Limit | Significantly higher (H) or lower (L) than England |
|----------------|--|--|----------------------------|----------------------------|--|
| Gateshead | 5540 | 47.1 | 45.8 | 48.4 | H |
| South Tyneside | 3820 | 41.6 | 40.2 | 42.9 | H |
| Sunderland | 8050 | 45.2 | 44.2 | 46.2 | H |
| North East | 65630 | 41.4 | 41.1 | 41.7 | H |
| England | 859050 | 27.4 | 27.4 | 27.5 | |

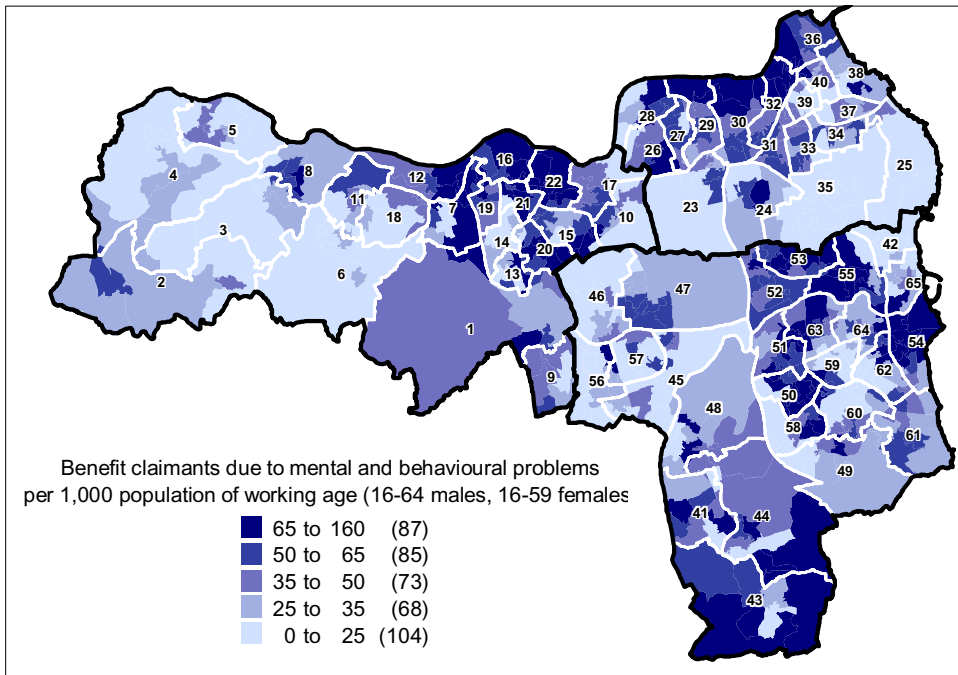
Source: 2007 Community Health Profiles, Association of Public Health Observatories



This data highlights that the rate of benefit claimed in South Tyneside as a result of mental or behavioural issues is significantly higher than the national and North East average it is slightly lower than neighbouring areas in Sunderland and Gateshead. Rate of claiming benefits or allowances due to mental or behavioural problems by small geographical area

The Office for National Statistics process returns from the Department of Work and Pensions to determine the number of benefit claimants by Lower Tier Super Output Area (LSOA). This is a geography used in the 2001 Census and each LSOA has about 1500 residents. The map below shows the rate of claiming benefits due to mental or behavioural problems per 1,000 people of working age.

⁷⁹ Association of Public Health Observatories, 2007, "Community Health Profiles", available at www.communityhealthprofiles.info (last accessed 14 November 2007)



The data shown in this map highlights a number of the Lower Tier Super Output Areas in the worst category for benefit claimants due to mental and behavioural problems with a concentration along the riverside wards.

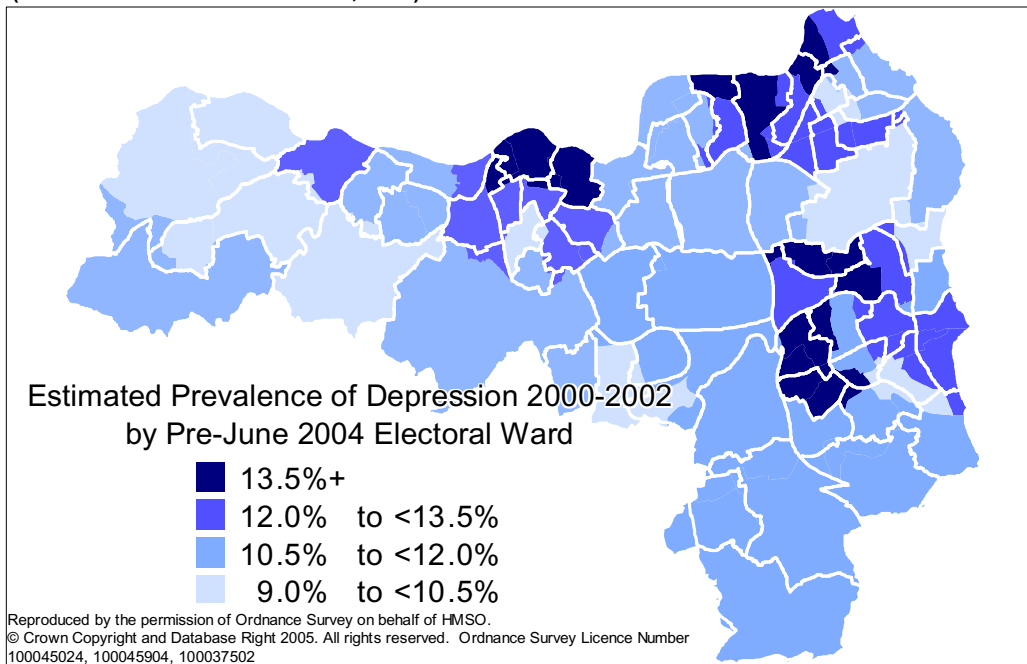
Estimated proportion of the population who have suffered depression

Further evidence based on the results of a survey of psychiatric morbidity in 2000⁸⁰ across England has generated estimates of depression prevalence by electoral ward. The map below shows figures for wards in Gateshead, South Tyneside and Sunderland prior to June 2004, with the new ward boundaries laid on top. These estimates were summarised in a series of reports by the Centre for Public Mental Health outlining mental health need for PCT populations⁸¹.

⁸⁰ Singleton N et al (2000) Psychiatric morbidity among people living in private households: Summary report. ONS. London

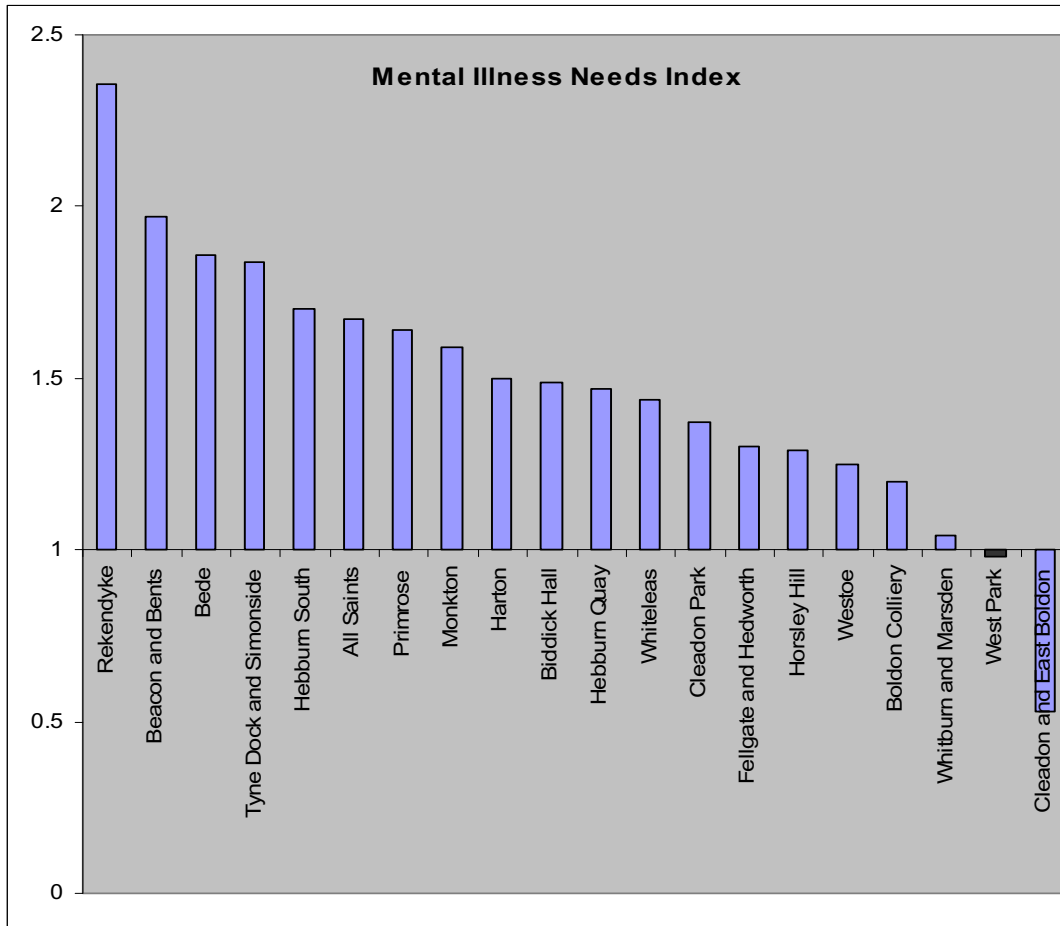
⁸¹ Centre for Public Mental Health. (2002) Profile of Mental Health Need, Service Provision and Activity in South Tyneside PCT. Available online at <http://www.dur.ac.uk/mental.health/serviceMapping/South%20Tyneside.doc>

Map showing estimated prevalence of depression by electoral ward in 2001
(Centre for Public Mental Health, 2002)



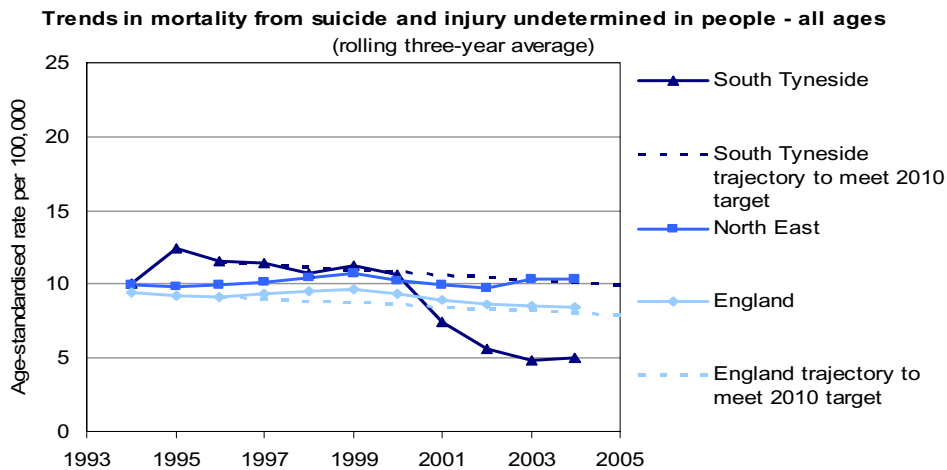
By applying data illustrated within the MINI 2000 survey⁸² detailing illness severe enough to require hospital treatment it is possible to compare the local prevalence to the England average. This data suggests that there are higher rates of severe mental illness in all but two wards across South Tyneside.

⁸²<http://www.dur.ac.uk/mental.health/serviceMapping/South%20Tyneside.doc>



Suicide

Mortality due to suicide and undetermined injury is the headline indicator which is more commonly used to indicate the mental health status of a population. The tables below outlines the trends over time in the directly age-standardised mortality rate due to suicide and undetermined injury among people of all ages in South Tyneside.

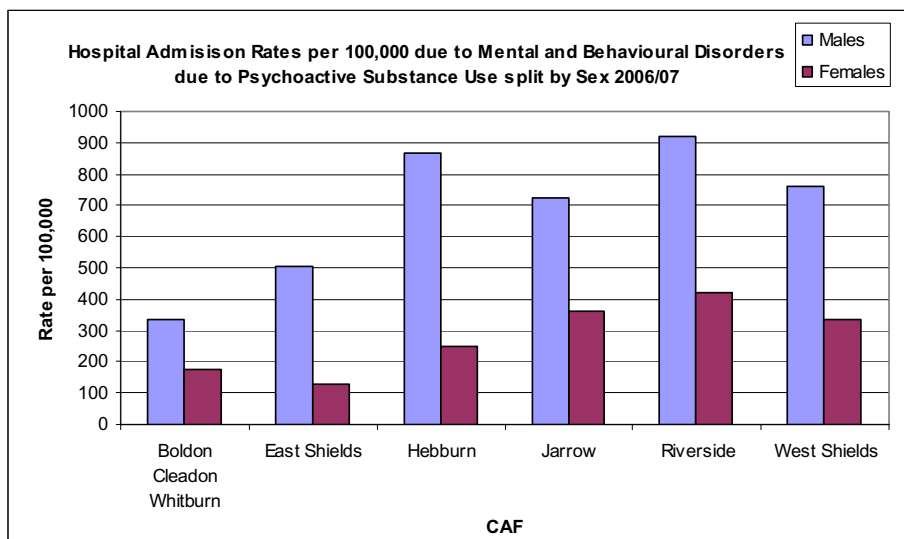


A national target has been set to reduce death rates from suicide and undetermined injury by at least a fifth by the year 2010. South Tyneside is ahead of the schedule required to achieve a 20% reduction in the overall suicide rate.

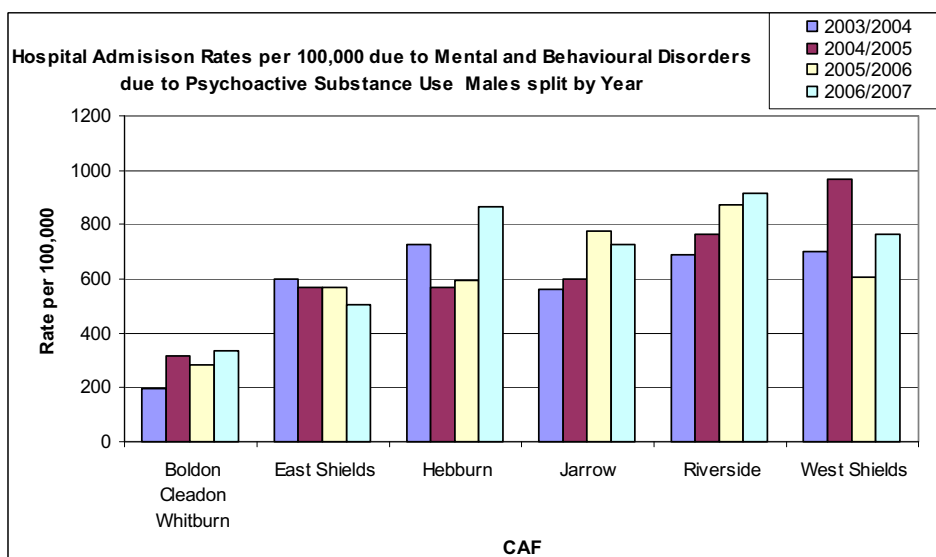
Drug and alcohol use

Mental health is further linked to drug and alcohol use with psychiatric co-morbidity among people with chronic substance misuse problems accepted as widespread with reported rates of depression ranging from 70 – 90% (Burns, 1985; Regan, 1985).

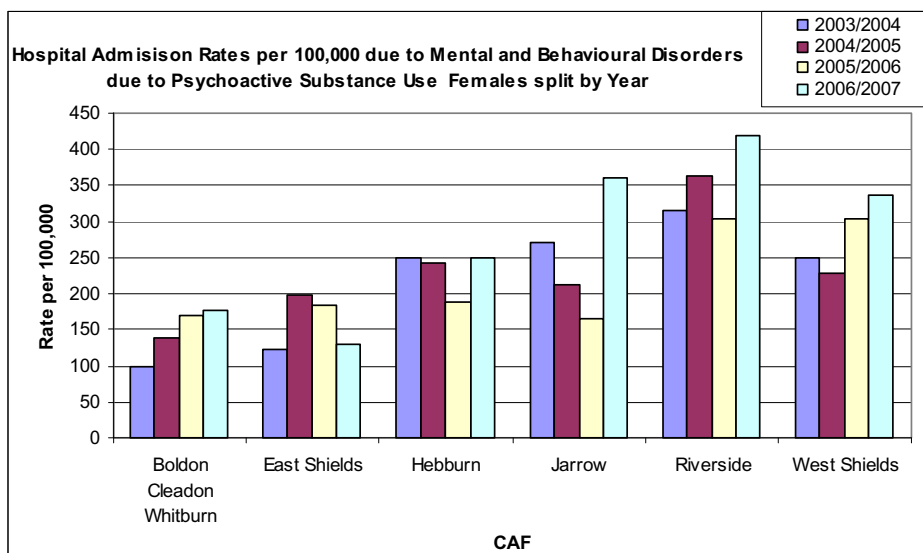
The rate of admissions from mental and behavioural disorders due to psychoactive substances vary between the CAF areas in South Tyneside and are consistently higher for men than women.



Data also suggests whilst the rate of admission varies by year there are some CAF areas which have consistently increased over the past four financial years with only one area showing a similar decrease.



The same data for women shows a less consistent picture with variations across all areas. However in all but one CAF area the rate of admission has increased in the most recent financial year (2006/07).



Evidence Based Interventions / Local Action

South Tyneside PCT is implementing a health impact approach to promoting mental health and preventing mental illness. This involves looking beyond prevention to the relationship between mental well-being and physical health; behavioural problems; domestic violence; child abuse; living and working conditions such as homelessness, poverty and unemployment and risk-taking behaviour such as drug and alcohol misuse and unsafe sex. It involves addressing the mental health impact of public policies, programmes and plans. It also involves the implementation of a needs-led approach to the development of strategies and plans to tackle mental health issues, with effective targeting of evidence based prevention programmes.

Action locally is being implemented at three levels:

- Strengthening individuals – or increasing emotional resilience through interventions to promote self-esteem, life coping skills, and relationship and parenting skills
- Strengthening communities to increase social inclusion and participation, develop health and social care services which support mental health, anti-bullying strategies at school and workplace and promotion of self-care networks
- Reducing structural barriers to mental health through initiatives to reduce discrimination and inequalities and promote access to services, with specific support for the most vulnerable

Unmet need

Evidence suggests whilst there is significant unmet need in relation to all levels of mental ill-health quantifying this remains difficult. By applying the evidence presented at the start it is possible to estimate levels of mental ill-health within South Tyneside.

| Category | Total population | Estimate of population affected |
|---|--|---------------------------------|
| Half of all women will be affected by depression at some point in their lives | 65, 282 women aged 15 and over | 32, 641 affected |
| A quarter of all men will be affected by depression at some point in their lives | 59, 894 men aged 15 and over | 14, 974 affected |
| Around one in ten children between the ages of 5 and 15 in the UK are experiencing mental health problems requiring professional help | 18, 625 children aged between 5 and 15 | 1863 affected |

Employment

The European Agency for Safety and Health at Work identified Stress as one of the top emerging risks for workers and employers⁸³. They particularly linked this to:

- Job insecurity
- High or low job demand
- Complex tasks leading to mental exhaustion
- Low job control or low decision level poor support amongst others

Priority Action / evidence Base

Mental health promotion involves any action to promote the mental wellbeing of individuals, families, organisations and communities. It works at three interconnected and interdependent levels:

- Strengthening individuals - Through increasing emotional resilience through activities to promote self-esteem and develop life skills such as communicating, negotiating, relationships and parenting skills.
- Strengthening communities – Through increasing social support, social inclusion and participation, improving community safety and neighbourhood environments, promoting childcare and self-help networks, promoting mental health in schools and workplaces.
- Reducing structural barriers to mental health – Reducing discrimination and inequality in society and promoting access to education, employment, housing and support for people who are vulnerable.

Evidence provided suggests action is required across a range of levels⁸⁴.

Marketing Mental Health Promotion

Strengthening peoples' knowledge, skills and capacity to achieve positive mental health is required through work with the media, families, schools, further education, employers, community, voluntary and public sectors. Social marketing & new technology should spearhead this work.

Raised awareness of protective factors should include the following "Positive Steps":

- Keeping physically active
- Eating well
- Drinking in moderation
- Valuing yourself & others
- Talking about your feelings
- Keeping in touch with friends and loved ones
- Caring for others
- Getting involved & making a contribution
- Learning new skills
- Doing something creative
- Taking a break
- Asking for help

⁸³ European Agency for Safety and Health at Work (2005) 'Expert forecast on emergency physical risks related to occupational safety and health. Belgium Accessed online at www.hse.gov.uk

⁸⁴ **CSIP (2007) Mental Health Promotion: A Toolkit for Commissioners and Local Strategic Partnerships**

Creating an environment in which individuals & communities (focusing on the isolated, deprived & vulnerable) are more able to take action to look after their mental health.

Co-ordinated activity to challenge the stigma & discrimination associated with mental health problems.

Equality and Inclusion

Programmes to narrow inequalities in health, education, regeneration, sustainable development and employment will contribute significantly to improved public mental health. A key priority will be to improve access to a wider range of sources of support for emotional and psychological difficulties, notably for black and minority ethnic groups, older people and those who are vulnerable or at risk e.g. people with a learning disability, homeless people, prisoners, carers and looked after children.

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

Work with young people to:

- Address bullying in schools and other settings
- Reduce the number of young people who believe that violence is acceptable

Early Years: Children and Families

Strengthening support & training for those who deliver services for very young children.

Develop local interventions for parents, carers and children e.g. Through Children's Centres that:

- Improve parenting skills
- Strengthen child / carer / parent relationship
- The promotion of maternal mental health, in particular women at increased risk of, or experiencing post-natal depression
- Address factors associated with family conflict, maltreatment and poor attachment
- Address behavioural problems in children
- Improving language skills and impulse control in toddlers
- Promote family mental health
- Promotes child-centred, active learning
- Develop community interventions to reduce the stigma associated with seeking help for parenting difficulties.
- Target parenting skills initiatives for those with particular needs e.g. Families of offenders and prisoners
- Provide good quality, affordable childcare.
- Home visits and social support for new parents.

Young People: Schools

The promotion of emotional health and well-being is an essential criterion for National Healthy School Status. Schools need support to:

- Promote and support use of The Primary National Strategy curriculum resource on Social and Emotional Aspects of Learning (SEAL).

- Develop & implement anti-bullying strategies based on effective approaches i.e. involving the whole school, parents & the community.
- Identify and address emotional problems and challenging behaviour early.
- Develop opportunities for young people to develop appropriate levels of independence and opportunities to succeed e.g. through creative play and access to the natural world.
- Utilise a Social competence approach that develops generic skills which increase mental and social well-being.
- Promote positive mental health (rather than preventing mental illness through brief, class-based intervention programmes).

Securing the availability of all the above “best practice” for the most vulnerable young people who may not be in school, or not on a regular basis e.g. looked after children and young offenders. .

Young People: Outside School

Develop community interventions to:

- Promote self-esteem and enable young people to make a positive contribution e.g. through making volunteering the norm for young people and increasing the number and diversity of volunteers
- Foster greater public awareness of, and sensitivity to the emotional needs of children and young people
- Promote access to a positive relationship with at least one warm, caring adult
- Consult young people, draw on their expertise and involve them in all aspects of developing interventions
- Focus on strengthening life skills and building social support.

Primary Care

Interventions to promote mental health should focus on:

- Linking primary care practitioners with community based organizations able to influence the determinants of health and promote social inclusion e.g. benefits advice, adult education, housing
- Enable access to primary care by vulnerable groups,
- Encourage vulnerable groups to access community support e.g. Gay, lesbian and bisexual people, people with a learning disability, men, black and minority ethnic communities
- Address the physical health of people with long-term mental health problems
- Provide brief interventions to reduce alcohol intake
- Provide opportunities for social prescribing e.g. exercise, arts, learning, bibliotherapy
- Signpost into education and life-skills training

Older People

Tackle age-discrimination – including low expectations for the mental health of older people among service providers and older people themselves.

- Improve detection and diagnosis of depression
- Strengthen personal support networks
- Provide opportunities for social, educational, leisure and physical activity
- Develop programmes to alleviate the fear of crime
- Enable access to transport
- Provide access to information and practical help, in order to reduce feelings of exclusion and isolation

A key role for public mental health is to develop joined up action across LSP partners to support opportunities for social involvement and to tackle social, economic and physical barriers to social activity. These include befriending, intergenerational projects, approved trader schemes and targeted outreach to the most isolated and vulnerable.

Black and Minority Ethnic Groups

There is a lack of evidence with specific relevance to these communities. However, on the basis of the evidence available, the following approaches which are broadly effective across the population are worth consideration as potentially effective means of promoting the mental health of BME groups.

- Tackling racism is likely to be the most effective means of promoting the mental health of Black and Minority Ethnic Communities.
- Black & minority ethnic communities (particularly refugee, asylum seeker & newly arrived communities) attach higher levels of stigma to mental health problems. Culturally appropriate action is required to:
 - Raise awareness and understanding about mental health problems & treatment options
 - Increase availability of resources in community languages
 - Develop mental health advocacy

Employment

Tackle unemployment and worklessness as a major public mental health issue. Priorities for local activity should include:

- Support to address the emotional and psychological impact of unemployment
- Support to ensure that people with mental health problems are able to gain salaried employment or meaningful activity
- Support is available for people following absence from work due to mental health problems
- Workplaces do not discriminate against employees or customers with mental health problems

These priorities can be secured through The Mindful Employer initiative (<http://www.mindfulemployer.net/index.html>) and Action on Stigma (<http://www.shift.org.uk/employment.html>)

Workplace

The promotion of mental health in the workplace requires a “whole organization” approaches that includes:

- Redressing the effort/reward imbalance
- Improving two-way communication and staff involvement
- Enhancing social support especially from managers to those they manage
- Increasing job control and the scope for decision making
- Workload assessment
- Developing an organisational culture which values staff
- Enhancing team working
- Role clarity
- Policies to tackle bullying and harassment
- Adoption of Health & Safety Executive Stress Management Standards

Workplace mental health policies should include:

Promoting the mental health of all staff, e.g. mental health risk assessment and training in how to protect personal mental health

Support for people with mental health problems in work, and returning to work

Taking a positive approach to employing people with existing, or a history of, mental health problems

Communities and Neighbourhoods

High levels of social capital (e.g. trust, reciprocity, participation & cohesion) are protective for mental health. Strong social networks, social support and social inclusion play a significant role in preventing mental health problems and promoting mental health.

Building community mental health should focus on:

- Addressing the fear of crime
- Investing in opportunities for arts, creativity and exercise
- Provision of open access stress management workshops
- Improved access to green open spaces in urban environments
- Equitable access to resources and services
- Support for parents and carers
- Activities that bring the community together
- Sharing of local information
- Initiatives to promote tolerance and trust
- Friendly physical environment
- Dealing with crime and anti-social behaviour
- Robust local democracy and opportunities to participate

Linked Performance Indicators

- NI 50 Emotional health of children PSA 12
- NI 51 Effectiveness of child and adolescent health (CAMHs) services DCSF DSO
- NI 58 Emotional and behavioural health of children in care DCSF DSO
- NI 69 Children who have experienced bullying
- NI Children who have run away from home/care overnight DCSF DSO
- NI 119 Self-reported measure of people's overall health and well-being DH DSO
- NI 151 Overall employment rate PSA 8
- NI 152 Working age people on out of work benefits PSA 8
- NI 153 Working age people claiming out of work benefits in the worst performing neighbourhoods DWP DSO
- NI 173 People falling out of work and on to incapacity benefits DWP DSO
- PSA 8 Maximise employment opportunity for all
- PSA 16 Increase the proportion of socially excluded adults in settled accommodation and employment, education or training.

Recommendations / High Impact Changes

- 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 (DOH)

Long term Conditions

Background

Chronic diseases (long term conditions – LTC) such as coronary heart disease, diabetes, and chronic obstructive pulmonary disorder, although largely preventable, are a major cause of premature mortality and contribute to the overall burden of disease. Over 15 million people in England have a long term condition⁸⁵. National data suggests⁸⁶:

Prevalence

- By age 60 over half of people have at least one LTC
- The prevalence of LTC will increase by 25% over the next 20 years due to an aging population

Health service use

- Estimates suggest that 69% of Primary and acute sector spending is on those with LTC
- People with LTC account for 55% of GP appointments, 68% of outpatient and A&E appointments and 77% on inpatient bed days

Risk factors

- People with LTC have higher health risk factors and take more risky life-style choices

Social Care implications

- As the number of LTC a person has increases so does lack of independence

Wider determinants

- People with LTC are less likely to work
- Houses with weekly incomes up to £300 are twice as likely to have a resident with LTC than those living in a house with a weekly income of over £1000

Risk factors which contribute to developing chronic disease are well documented with links to obesity, nutrition, physical activity, psychosocial stress and smoking. Chronic diseases and their risk factors are increasingly related to lower socio-economic status and to poverty. The increase in chronic diseases is seen disproportionately in poor and marginalized populations and is contributing to the increasing health gap between communities.

Effective prevention activity as outlined in the health inequality section and providing effective treatment and care for those with long term conditions are equally important in tackling these diseases.

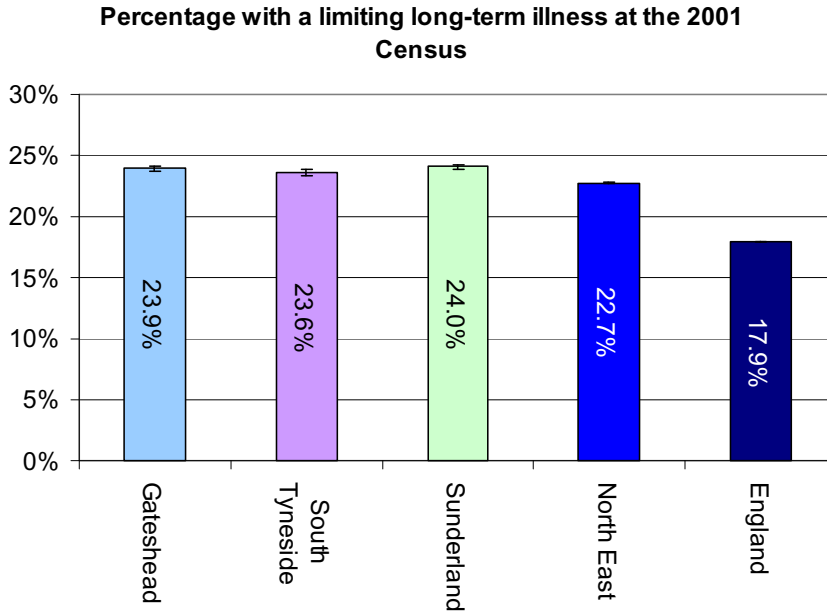
Prevalence

The epidemiological evidence provided in the health inequalities section of this report outlines persistent “disease specific” health inequalities in South Tyneside. South Tyneside has prevalence across all long term conditions which is higher than the national average. Almost a quarter of South Tyneside residents have a long term condition⁸⁷.

⁸⁵ ONS (2005) General Household Survey available online at www.statistics.gov.uk

⁸⁶ Darzi Discussion Documents (2007) Long term conditions: Supporting Information, Data and Evidence

⁸⁷ Office of National Statistics, based on the 2001 Census



In relation to specific conditions South Tyneside shows a higher prevalence across all conditions detailed with the exception of asthma which presents a marginally lower than the national average.

| Condition | South Tyneside Average % | National Average % |
|-----------------------------|--------------------------|--------------------|
| Diabetes | 4.2% | 3.59% |
| Asthma | 5.6% | 5.79% |
| COPD | 3.0% | 1.42% |
| CHD | 5% | 3.55% |
| STROKE/TIA | 2.2% | 1.61% |
| Peripheral vascular disease | 1.1% | NA |
| Heart failure | 1.2% | 0.78% |
| Atrial fibrillation | 1.5% | 1.29% |
| Hypertension | 14.6% | 12.4% |

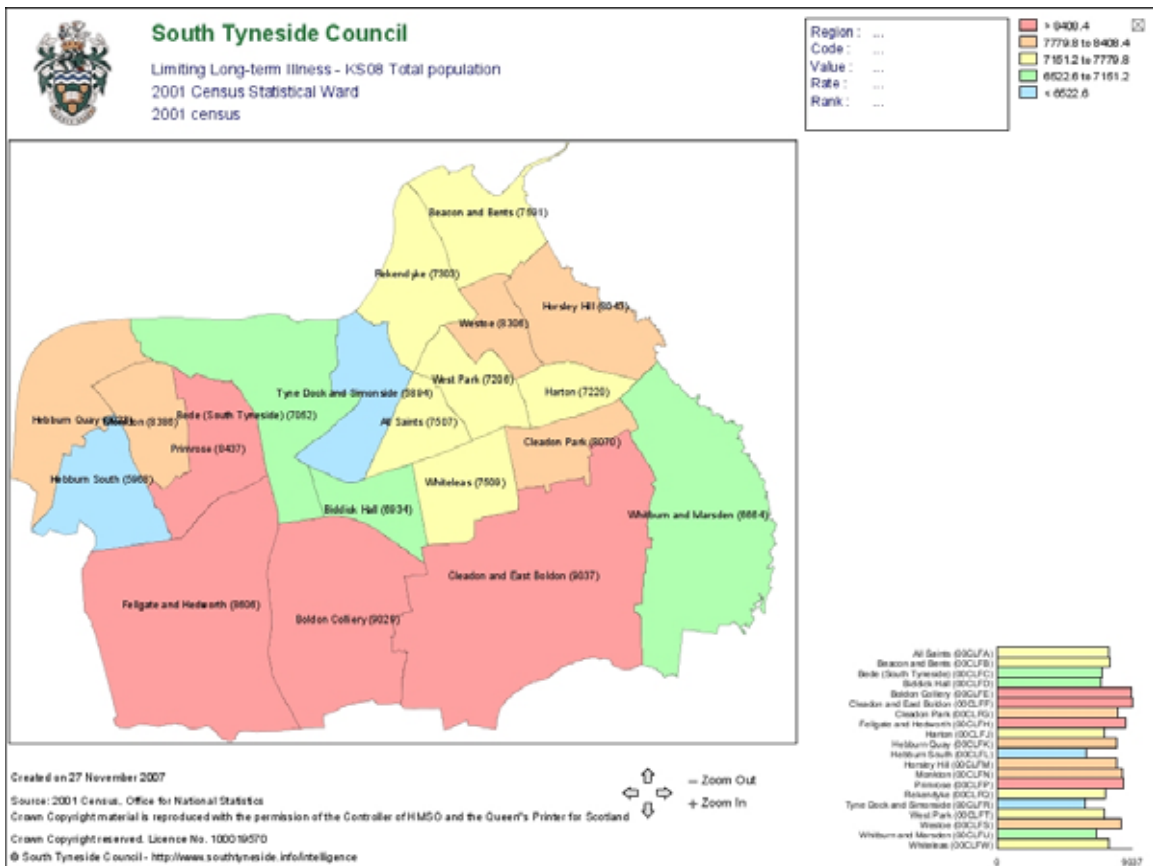
Source: QMAS⁸⁸ Data Jan 2007⁸⁹

There are large inequalities across South Tyneside in the experience of chronic diseases⁹⁰. Ward level data outlines variation in prevalence across South Tyneside. This data needs to be viewed alongside data presenting age variation across the Borough as it is expected that wards with a higher older population will also present a higher number of people with LTC.

⁸⁸ Quality Outcomes Framework is the system used to assess the quality of treatment delivered by GPs. Payment is made to GP practices for their performance against a range of quality indicators.

⁸⁹ South Tyneside PCT (2007) Chronic Disease Management Strategy

⁹⁰ STPCT. Health equity Audit in Primary Care. Public Health Department, STPCT 2006 (unpublished report).



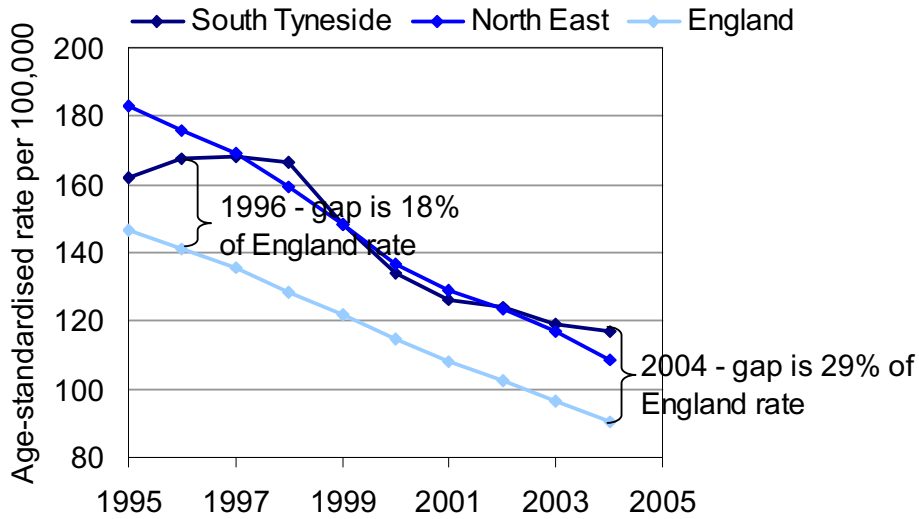
Circulatory Disease

Circulatory disease presents a major contribution to the life expectancy gap in South Tyneside accounting for 28% of the gap for women (58% of which is CHD) and 27% for men (69% of which is CHD). Coronary Heart Disease is a major cause of premature death in South Tyneside, in both men and women, and the Standardised Mortality Ratios for this disease is higher than the national average at 126.

South Tyneside is scheduled to meet “Our Healthier Nation” target of a 40% reduction in the premature mortality rate due to all circulatory disease between 1996 and 2010. However similar progress has been made across England, resulting in a widening gap between South Tyneside and the England average in 2004 contributing further to striking inequalities. It is crucial to note that whilst concern for the apparent widening gap is important the increase presents one year data and requires some caution with the overall trend reducing.

The gap between South Tyneside and the England rate is expressed as a percentage of the England rate.

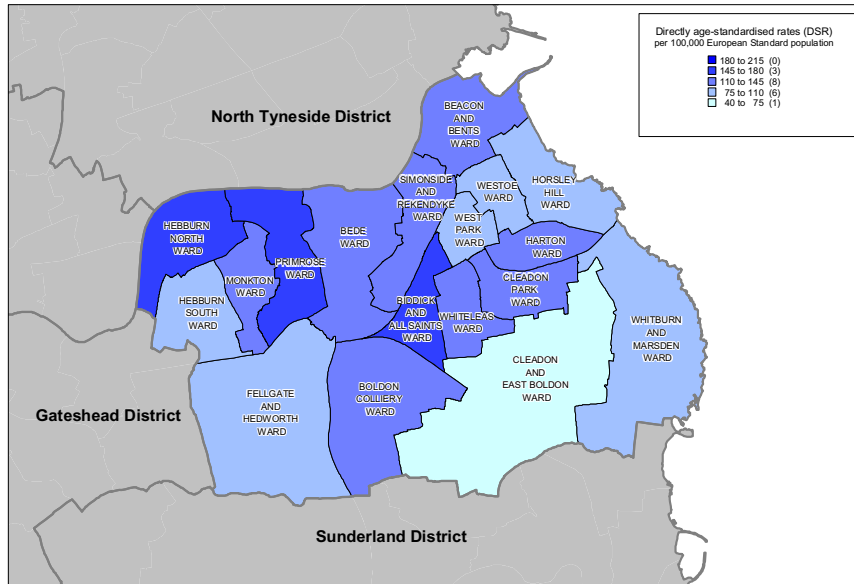
Mortality rates due to all circulatory disease in South Tyneside and England among people under 75 years



Source: Clinical and Health Outcomes Knowledge Base

The baseline mortality rate (1995-97) was 167.3 which is equivalent to 956 deaths. The rate during 2003-05 had fallen by 30.3% to 116.7 which is equivalent to 625 deaths. The implications are different for men and women with a significantly higher rate and a slightly smaller reduction for men across all years. The rate in South Tyneside is higher than both the North East average and the average seen in neighboring areas of Gateshead and Sunderland.

Mortality from all circulatory (ICD10 I00-I99) in persons aged under 75 years 2003 to 2005 (Pooled)

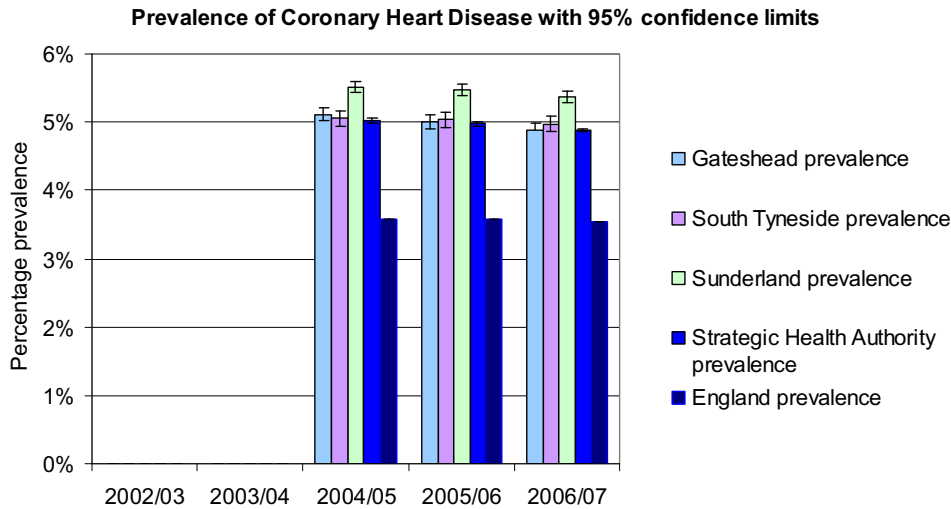


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Source: Z:\Groups\MapInfo\Floor Targets 2006 Mortality from all Circulatory (ICD10 I00-I99) in persons aged under 75 years

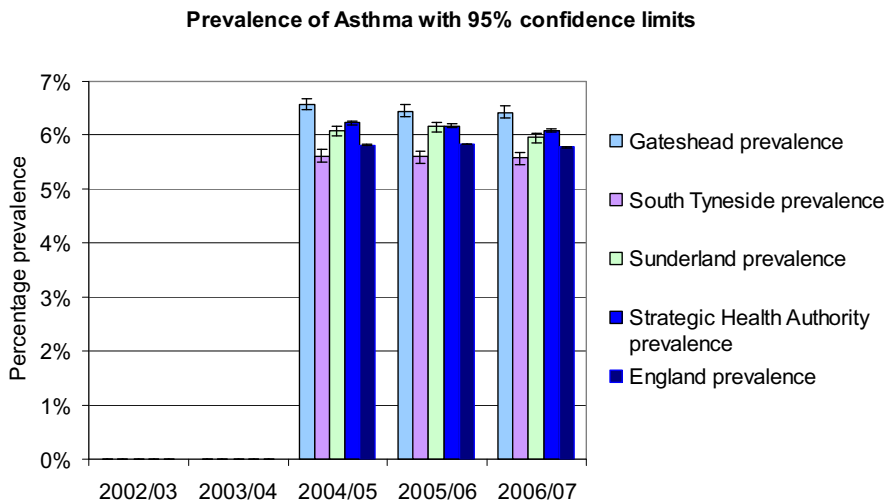
In relation to Coronary Heart Disease South Tyneside has a prevalence of around 5%⁹¹. This rate is again higher than the England average, in line with the SHA and Gateshead average and lower than Sunderland's prevalence. However in relation to the life expectancy gap linked to circulatory disease CHD contributes 58% of the gap for women and 69% of the gap for men.

⁹¹ Source: NHS Information Centre www.ic.nhs.uk



Asthma

As detailed above South Tyneside has a lower prevalence of asthma than the England prevalence. This is unexpected due to the prevalence of risk factors such as smoking and potentially suggests under diagnosis. Local information suggests that there is difficulty with the way the condition is coded and the subjective nature of diagnosis leading to this apparent disparity.



Chronic Obstructive Pulmonary Disease (COPD)

COPD (also known as Chronic Obstructive Airways Disease) is a group of diseases characterised by an irreversible restriction of airflow in the airway. COPD is the overarching term for chronic bronchitis, emphysema and a range of other lung disorders. COPD is the UK's fifth biggest killer disease claiming more lives than breast, bowel or prostate cancer. It is the second most common cause of emergency admission to hospital and one of the most costly inpatient conditions treated by the NHS⁹².

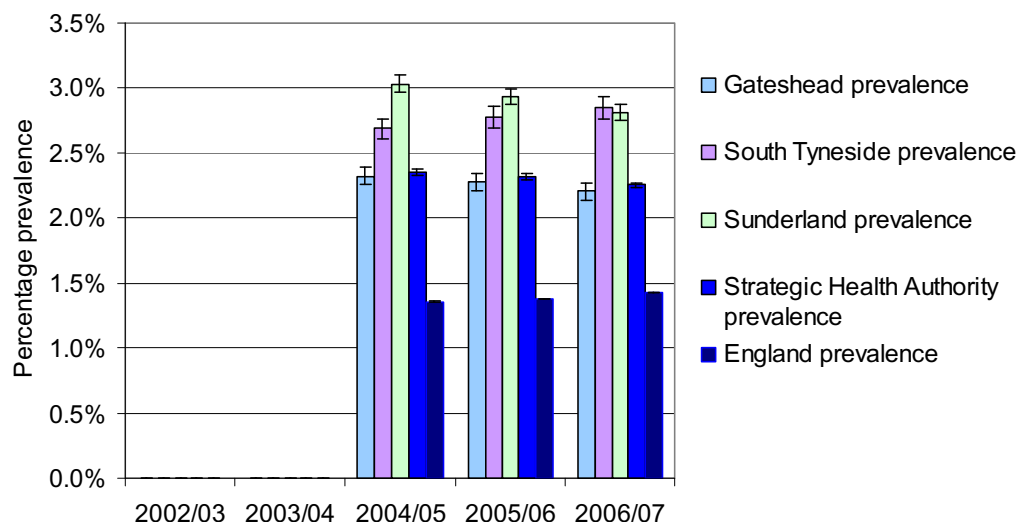
Smoking is a major risk factor for COPD and is responsible for 80 per cent of cases. COPD may also be due to other airborne irritants such as coal dust or solvents, as well as congenital

⁹² Invisible Lives British Lung Foundation 2007

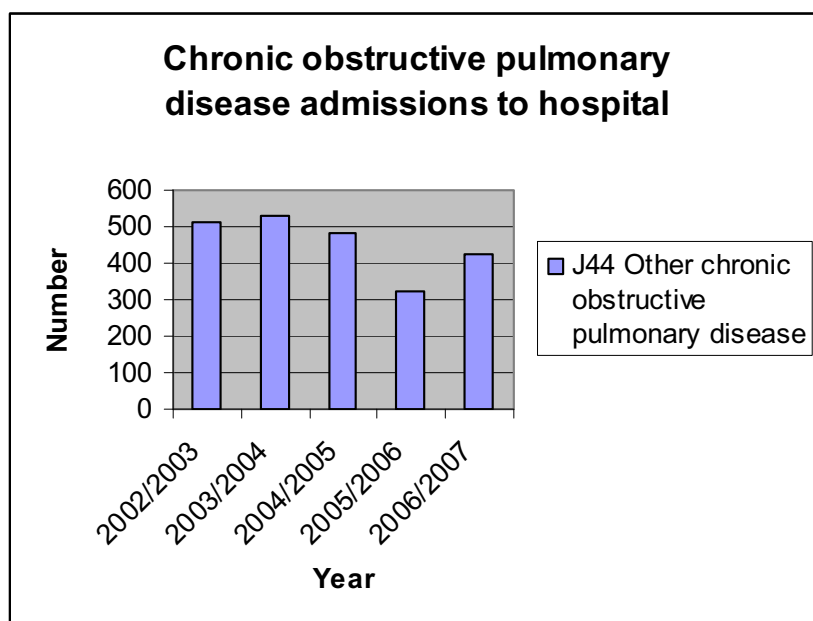
conditions and allergy. COPD prevalence is high and rising in South Tyneside. This is unsurprising when considering the issue of smoking prevalence across the borough.

South Tyneside has been identified as a 'hot spot' for COPD⁹³. This relates to people living in postcode areas at high risk of future hospital admission with COPD.

Prevalence of COPD with 95% confidence limits



Admissions to hospital where COPD is the primary diagnosis



Diabetes

The rapidly increasing number of people developing diabetes around the world is creating a major public health concern. Concern is growing about the steadily increasing prevalence of diabetes in Western countries, primarily due to changes in lifestyles with a heavy burden of the

⁹³ British Lung Foundation 2007

disease falling on people from some ethnic minority groups and those from socially excluded groups^{94, 95}.

The associated complications of diabetes such as blindness, renal failure and lower limb amputations and the immense material, social and psychological implications of living with diabetes, place huge pressures on the individuals themselves, their families, their support networks and the healthcare system⁹⁶.

Diabetes mellitus is a medical condition in which levels of sugar (glucose) in the blood become too high. Insulin, a hormone produced by the pancreas, helps to control the amount of glucose in the blood. If either the pancreas fails to produce enough insulin, or the body cannot make use of the insulin available, diabetes can result. Long term high blood glucose levels (hyperglycaemia) are associated with damage, poor function and failure of various organs of the body, the eyes, kidneys, nerves, heart and blood vessels are particularly at risk.

There are four subcategories of diabetes:

- **Type 1 Diabetes**

Type 1 diabetes (also known as insulin dependent diabetes) occurs if the body is unable to produce any insulin. This type of diabetes usually occurs before the age of 40. It is treated by regular insulin injections and by diet.

- **Type 2 Diabetes**

Type 2 diabetes (also known as non-insulin dependent diabetes) is much more common. This occurs when the body can still produce some insulin, but not enough, or when the insulin that is produced is not used properly by the body (insulin resistance). Type 2 diabetes usually occurs in people over the age of 40, although it can occur in younger people, especially in some ethnic groups. It is usually treated by diet alone or by diet and tablets. Occasionally it is treated with insulin injections.

- **Gestational Diabetes**

Gestational diabetes is defined as any degree of impaired glucose regulation, resulting in raised blood glucose levels of variable severity, which is first recognized during pregnancy. This includes Type 1 diabetes presenting for the first time during pregnancy; Type 2 diabetes identified during pregnancy, which in many cases was probably present but undiagnosed before the pregnancy; and lesser degrees of impaired glucose regulation, which in most cases reverts to normal after the pregnancy. A disproportionately high number of women who develop gestational diabetes are from minority ethnic groups.

- **Other specific types, e.g. Drug Induced Diabetes**

Diabetes can be diagnosed by finding very high glucose levels in the blood or the urine. If blood glucose levels are only mildly raised, a glucose tolerance test (in which a high sugar drink is taken followed by a series of blood tests) can be used to make the diagnosis.

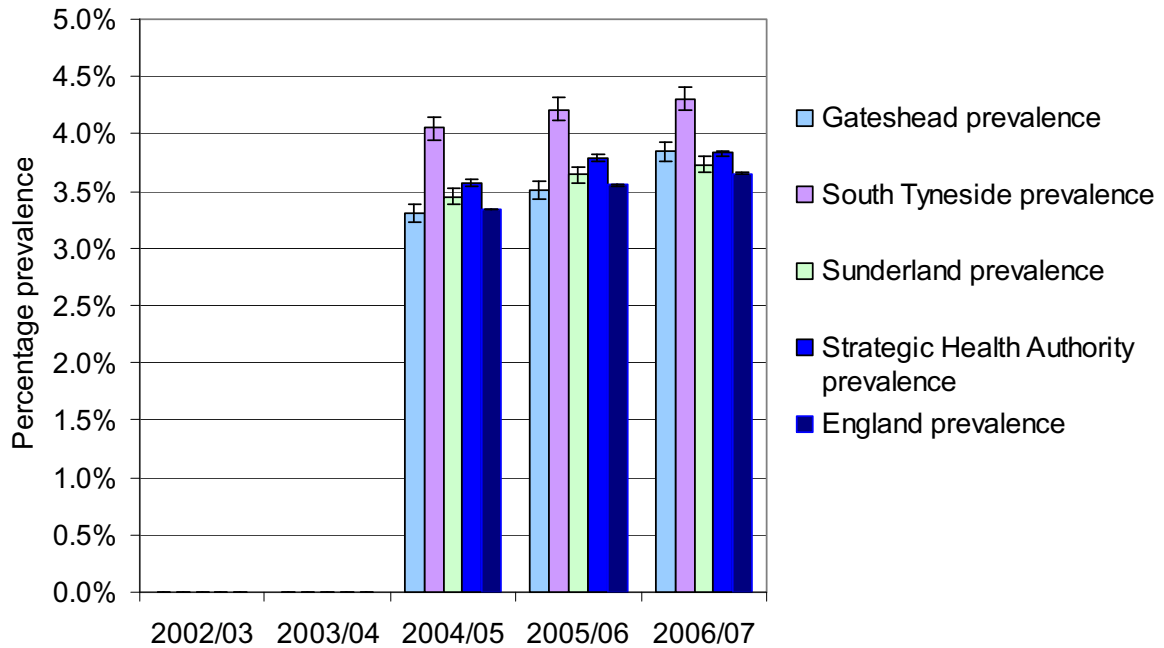
Data shows that diabetes prevalence is significantly higher for South Tyneside than the national, regional and local PCT neighbours prevalence.

⁹⁴ Tang, M., Chen Y., and Krewski D., (2003). Gender-related differences in the association between socio-economic status and self-reported diabetes. *International Journal of Epidemiology*, 32, 381-385.

⁹⁵ Department of Health (2001). *National Service Framework for Diabetes*. London: The Stationary Office.

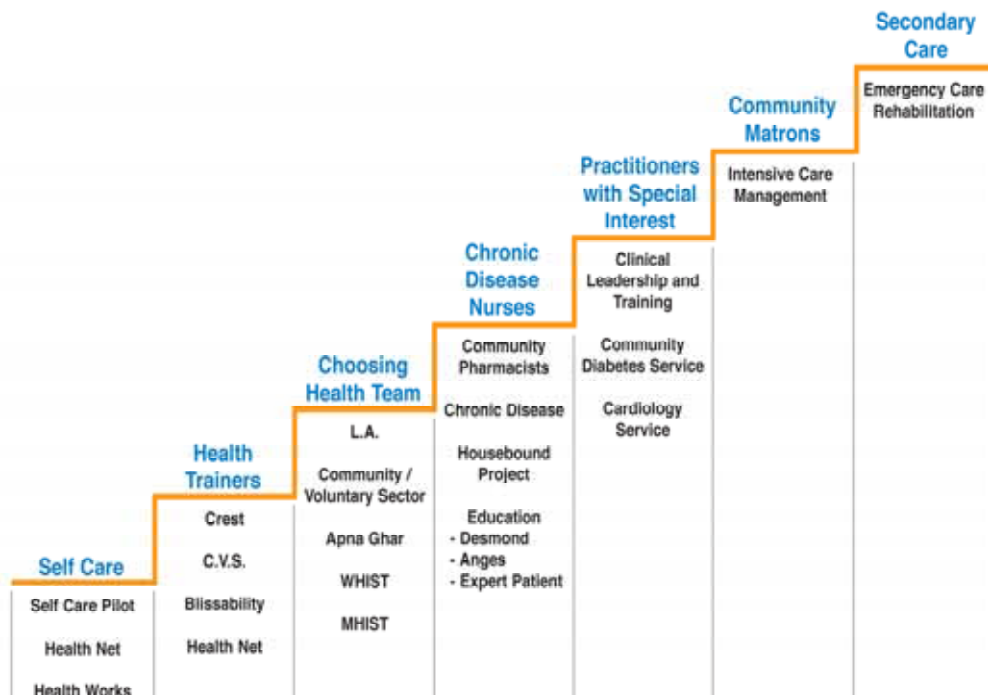
⁹⁶ Cravey, A., et al., (2001). Developing socio-spatial knowledge networks: a qualitative methodology for chronic disease prevention. *Social Science and Medicine*, 52, 1763-1775.

Prevalence of Diabetes (type I and type II) with 95% confidence limits



Local Action

Local action has been developed through a whole systems approach addressing an evidence based approach to primary, secondary and tertiary prevention. The diagram below provides specific detail in relation to each aspect.



Level 0: Public health and health promotion (primary prevention)

- Worked with the Northern Network of Cardiac Care to develop a primary prevention toolkit to facilitate the identification and management of people at high risk of cardiovascular disease

- Developed evidence based health promotion programmes including: smoking cessation, active living, healthy eating and weight management
- Employed health trainers to work with local people providing advice and signposting to appropriate health services. Health Trainers are employed from the local community providing employment opportunities for local people. This helps people access advice to tackle various lifestyle issues and thereby prevent, delay or improve their chronic disease management
- Developed a Self Care Pilot

Level 1: Supported self management

- Implemented disease specific patient education and training, e.g. the DESMOND programme for those with newly diagnosed diabetes (T2); developed the AngES programme for those with newly diagnosed angina
- Facilitated structured care within GP practices through supporting development of disease registers and structured secondary prevention. This includes development of a chronic disease management nursing team and completion of a chronic disease housebound project.
- Implemented a self care pilot to help improve quality of life, patient satisfaction and better use of resources for example primary care consultations.
- Delivered Expert Patients Programme courses across the borough and trained people with long term conditions to become Expert Patient Programme Lay Tutors.

Level 2: Disease management for higher risk patients

- Developed and implemented disease specific managed care through the implementation of some Integrated Care Pathways (ICPs) E.g. Heart Failure, Stroke etc
- Developed and implemented care management
- Appointed Practitioners with Special Interests and community based specialist nurses to provide more specialised primary care-based clinical services, to contribute to service development and to support the training and development of primary care/community staff, e.g. in diabetes and cardiology.

Level 3: Case management for very high intensity users

- Identified our Very High Intensity Users (VHIUs) or frequent users
- Begun to implement case management and appoint a team of community matrons
- Worked with locality Based Older Peoples Teams

Unmet need

There is considerable unmet need in relation to Long Term Conditions at the various levels of prevention. In relation to prevention the chapters on obesity, smoking and alcohol all identify gaps which affect LTCs. The Life Expectancy chapter also identifies issues in relation to screening and diagnosis of LTCs. Finally in order to manage LTCs additional attention is required within both self and community care in order to affect the numbers of people presenting to hospital with acute circumstances affected by their LTC.

Priority Action / Evidence Base

There is an increasing body of evidence to support the clinical and cost-effectiveness of public health interventions to tackle the risk factors associated with these diseases. The Health Development Agency⁹⁷ outlined evidence based public health interventions including approaches focusing on tackling alcohol abuse, tobacco control, encouraging physical activity and promoting better nutrition.

⁹⁷ Health Development Agency (2004) *The evidence of effectiveness of public health interventions –and the implications*, June 2004

Self Care - Self care was highlighted in the NHS Plan⁹⁸ as one of the key building blocks for a patient centred health service. Research highlights that supporting self care leads to improved health outcomes and a rise in patient satisfaction. Evidence indicates that effective self-care symptom management improves outcomes e.g. reduction in pain, anxiety / depression and quality of life, with increased independence. These positive effects are matched by a significant impact on the use of services, with fewer primary care consultations (a 40% reduction) and a decrease in the use of hospital resources⁹⁹.

For patients presenting with severe, unstable or deteriorating chronic disease, there is good evidence that a care management approach can improve health outcomes for patients. Good care management involves appropriate and early identification of need and responding promptly with individual systematic support from multi disciplinary teams. Access to specialist and structured primary and community based care, linked to self care and education has demonstrated significant improvements in mortality, morbidity, resource use and a reduction in emergency or unplanned admissions to hospital e.g. patients with heart failure, chronic obstructive pulmonary disorder, asthma, depression and diabetes¹⁰⁰.

As patients develop multiple chronic diseases, their care becomes complex. These patients are often very highly intensive users of the health and social care service and due to their vulnerability; simple problems can lead to rapid deterioration and a 'crisis. Evidence has shown that intensive, ongoing and personalised case management can improve both quality of life and health outcomes for these patients, reducing emergency admissions and enabling those who are admitted to hospital, to return home more quickly¹⁰¹. Evidence further denotes the importance of a single point of contact for high intensity patients with a named case manager (Community Matron). The case manager both co-ordinates patient care and assists the patient in navigating the range of health and social care professionals as appropriate.

Linked Performance Indicators

NI 119 Self reported measure of people's overall health and well-being DH DSO

NI 120 all-age all cause mortality rate PSA 18

NI 121 Mortality from all circulatory diseases at ages under 75 DH DSO

NI 123 16+ current smoking rate prevalence PSA 18

NI 124 People with a long-term condition supported to be independent and in control of their condition DH DSO

NI 125 Achieving independence for older people through rehabilitation / intermediate care PSA 18

NI 126 Early access for women to maternity services PSA 19

NI 129 End of life palliative care enabling people to choose to dies at home DH DSO

NI 134 The number of emergency bed days per head of weighted population DH DSO

NI 136 People supported to live independently through social services (all ages) PSA 18

NI 137 Healthy Life Expectancy at age 65

NI 139 People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently PSA 17

Recommendations

Evidence suggests we adopt the following high impact changes:

- Identify and manage uncontrolled / unidentified hypertension with an identified high impact intervention, i.e. implementation of the NICE guidelines.
- Increase Statin prescribing to patients without CVD

⁹⁸ Department of Health, (2000) *NHS PLAN* UK

⁹⁹ World Health Organization (2002) *National cancer control programmes: policies and managerial guidelines*, 2nd ed. Geneva,

¹⁰⁰ Department of Health (May 2004) *Data from Chronic Disease Management: A compendium of information*

¹⁰¹ Department of Health (2005) *Supporting people with long term conditions*. January 2005

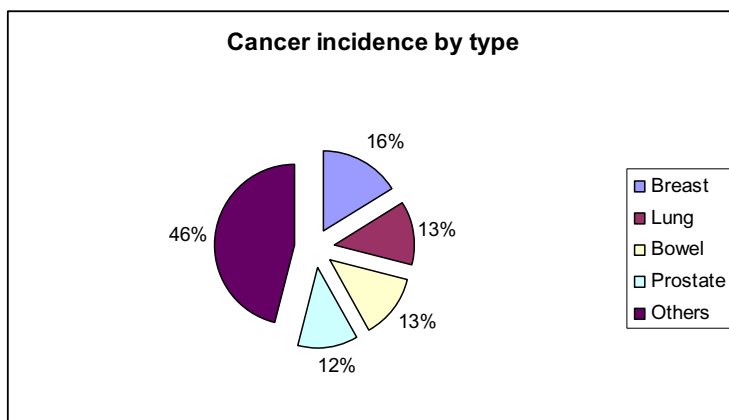
- Increase access to smoking cessation
- Increase access to the Choosing Health targeted comprehensive programme of prevention / risk factor management and reduction on those >50.
- Management of obesity through the use of a formal supported pathway of care adopting NICE guidelines.
- Develop preventative programmes related to alcohol use

Cancer

Background

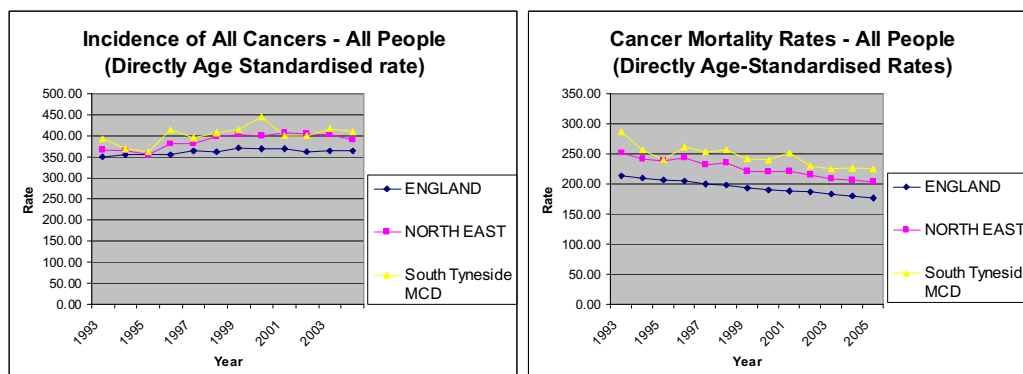
Cancer incidence, mortality and survival rates vary between gender and across socio-economic groups¹⁰³. Men have a significantly higher age standardised incidence of cancer than women or though more women have cancer overall¹⁰². Historically cancer incidence has been linked to areas of deprivation; however the trend in cancer incidence has reversed for women showing higher rates in more affluent areas with the same trend for men across socio-economic group¹⁰². Breast cancer reflects this picture with a higher incidence within more affluent groups whereas lung cancer incidence remains linked to deprivation. However mortality presents a strong and consistent picture with clear gradients across socio-economic groups. Mortality is highest in the most deprived groups with lower mortality in the most affluent areas. This picture points towards the issues associated with inverse care where more affluent families are able to identify early concerns and negotiate better diagnosis and treatment.

UK cancer incidence statistics¹⁰³ highlight four main cancers accounting for over half of all cancers diagnosed during 2004.



Prevalence

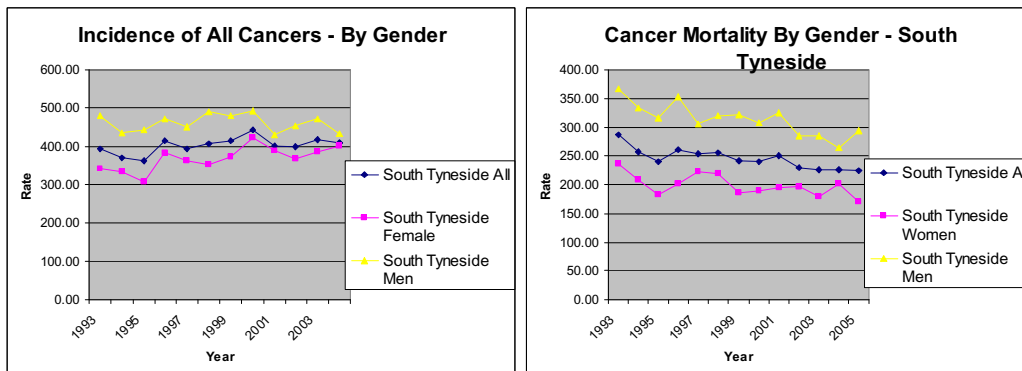
Data highlights that cancer incidence across all cancers are consistently higher in South Tyneside than the national rate for England with a smaller difference between the local and the regional figures. The standardised mortality ratio for all cancers under 75 years is significantly higher than the national average at 126. The rate in South Tyneside has undulated over the past ten years but has largely seen a small increase in incidence.



¹⁰² NYCRIS (2004) Socio-economic factors and cancer: Incidence, mortality, and survival (1991 – 2000) available online at www.nycris.gov.uk

¹⁰³ <http://info.cancerresearchuk.org/cancerstats/incidence>

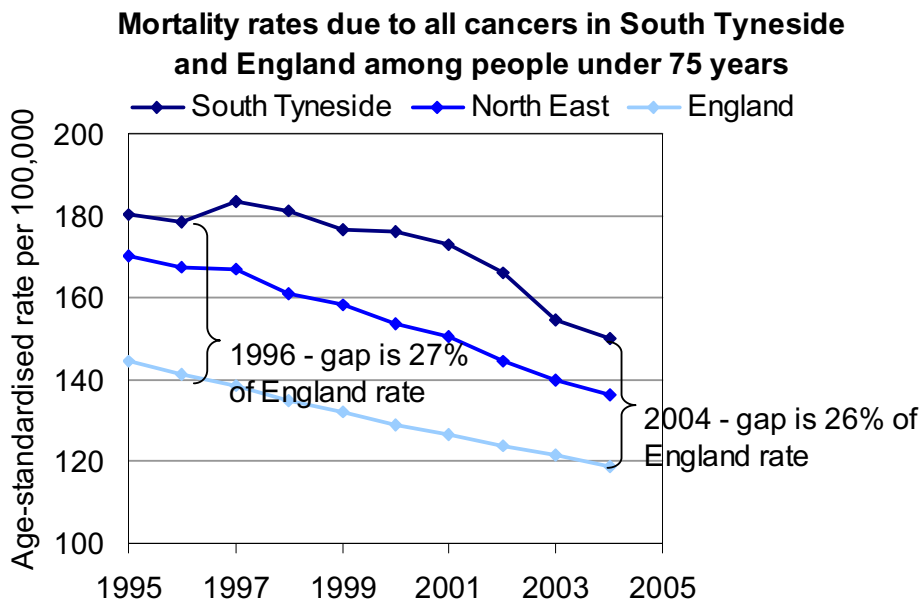
Cancer incidence by gender has seen an undulating rate for men with a more obvious increase for women. This is largely attributable to improved pathways and diagnosis in Primary Care resulting in a higher incidence but lower mortality. There is a less apparent increase in incidence for men. Cancer mortality has been shown to fall which is further evidence of improved diagnosis and treatment. However gender difference in incidence and mortality are important when considering with men showing a slower increase in cancer incidence alongside a considerably higher rate of mortality from cancer than women.



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

The following graph identifies the gap in premature mortality rate for all cancers between South Tyneside PCT and England as a whole. This shows that the premature mortality gap for South Tyneside is significantly higher than the rate for the North East region and the national average.

Table 7 The gap between the South Tyneside and England rate in both 1996 and 2004 is expressed as a percentage of the England rate.

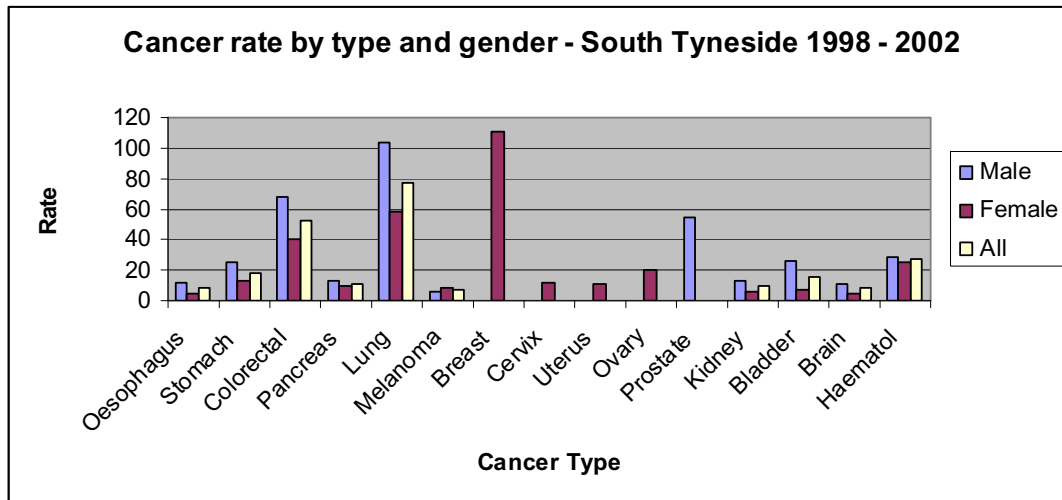


Source: Clinical and Health Outcomes Knowledge Base

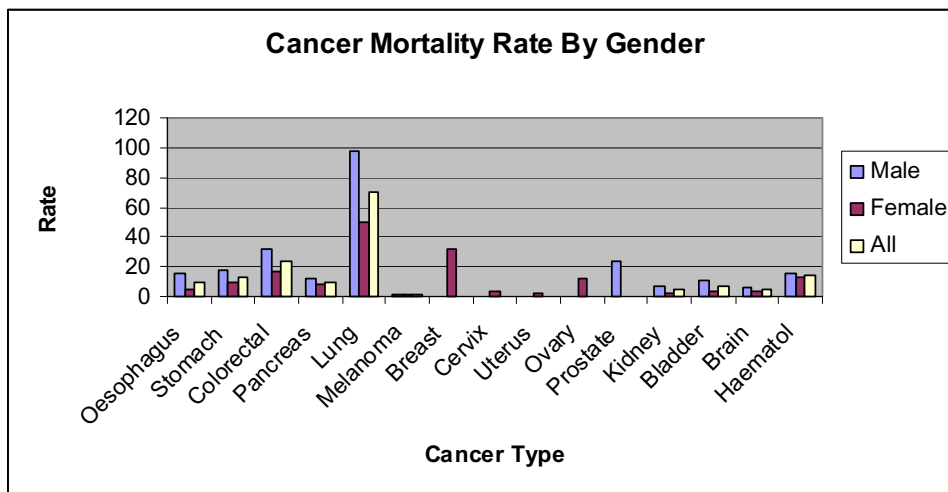
Between 2003 and 2005 there were 5,900 deaths in South of Tyne and Wear, and 380,000 in England due to cancer. This represented 28% and 26% of all deaths respectively. The proportion of all cancer deaths due to lung cancer is uniformly higher across South of Tyne and Wear than for England as a whole. In South Tyneside 28% of all cancer deaths is caused by lung cancer.

Cancer rates (1998 – 2002)

For women the highest rate of cancer (per 100,000) is within breast cancer with lung cancer showing the greatest prevalence for men and all genders combined.



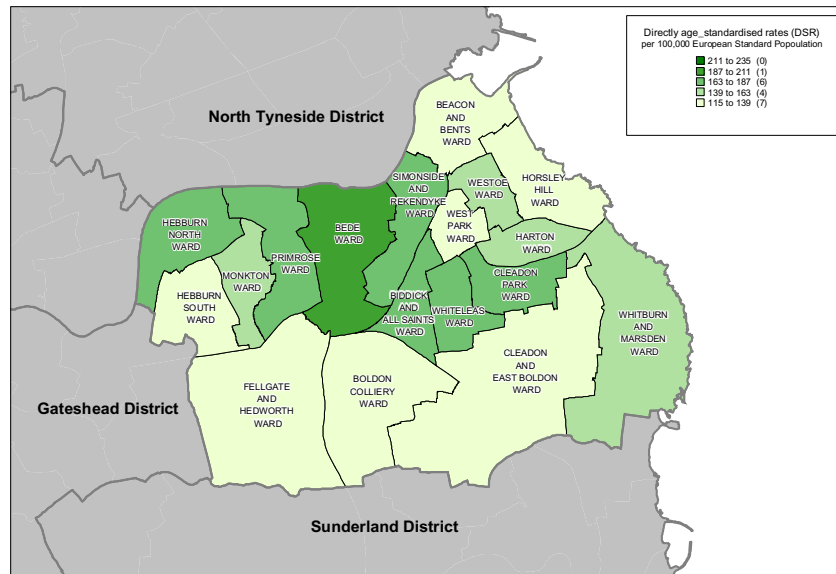
The mortality rate presents a dissimilar picture than cancer incidence with the highest rate for cancer death related to lung cancer across both gender groups. Whilst breast cancer shows the highest incidence rate the corresponding mortality rate is lower. This data suggests that lung cancer presents a major issue for South Tyneside reinforcing the evidence presented within the section exploring the issues for the life expectancy gap in South Tyneside.



Cancer mortality by Ward

Ward level data shows variation between wards in relation to cancer mortality with a concentration of higher rate wards along the riverside.

Mortality from all cancers (ICD10 C00-C97) in persons aged under 75 years 2003 to 2005 (Pooled)

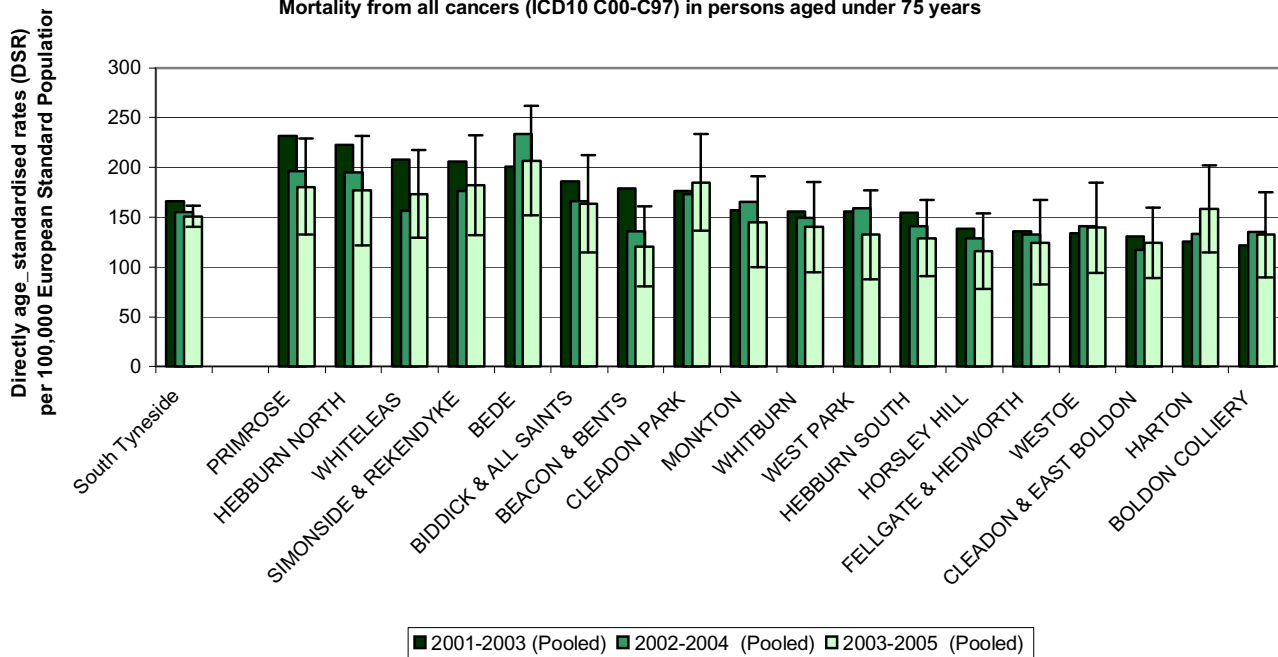


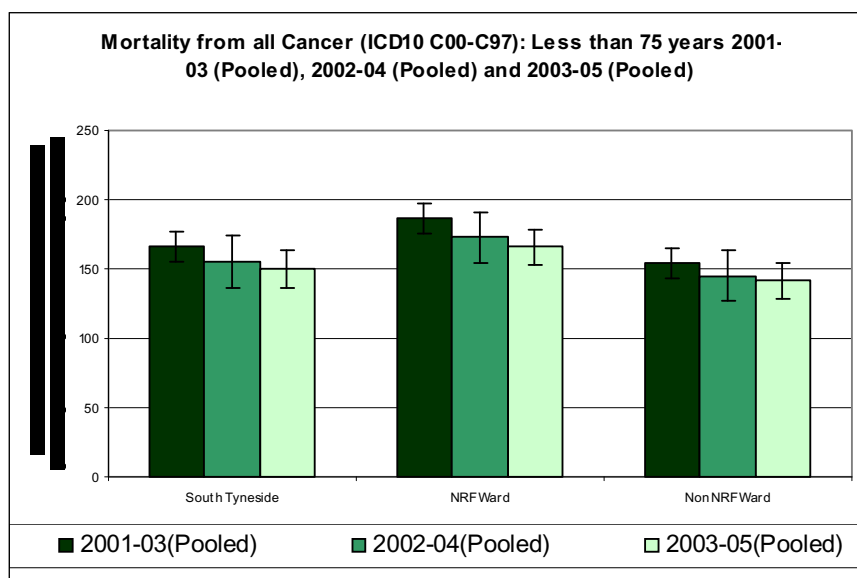
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Source: Z-Groups/MapInfo/Floor Targets 2006. Mortality from all cancers (ICD10 C00-C97) in persons aged under 75 years

Across South Tyneside as a whole, the rate for Cancer is ahead of the projected rate for narrowing the inequalities gap. (150 against trajectory target of 163 for 2003-05)

Mortality from all cancers (ICD10 C00-C97) in persons aged under 75 years





Lung Cancer

Lung cancer is the second most common cancer in the UK (excluding non-melanoma skin cancer)¹⁰⁴. Lung cancer has always been more common in men, particularly those aged over 40 years¹⁰⁵. Smoking is known to be the cause of most lung cancers (nine out of ten cases¹⁰⁴) with the risk increasing with the number of cigarettes smoked and also the earlier they began smoking. People who have prolonged or close contact with asbestos also have a higher risk of lung cancer (particularly if they smoke) the HSE¹⁰⁶ outlined evidence suggesting that around 8% of cancer in men and 1.5% of cancers in women were linked to occupation. Other risk factors for lung cancer include:

- Exposure to radon gas or other chemicals
- Air pollution
- Scarring from previous lung disease
- A family history,
- Past cancer treatment
- Diet

Breast Cancer

Breast cancer is the most commonly diagnosed cancer in women with nearly a third of all cancers (30%) diagnosed in women occurring in the breast. The lifetime risk is 1 in 9 for women. 1% of all breast cancer cases diagnosed are men with 290 men diagnosed nationally during 2001. The majority of men who get breast cancer are aged over 60.

For most women, increasing age is the single biggest risk factor with over 80% of cases occurring in women aged over 50. The estimated risk of developing breast cancer according to age is:

- Up to age 25 1 in 15,000
- Up to age 30 1 in 1,900
- Up to age 40 1 in 200
- Up to age 50 1 in 50
- Up to age 60 1 in 23

¹⁰⁴ <http://www.cancerhelp.org.uk/help/default.asp?page=2962>

¹⁰⁵ <http://www.cancerbackup.org.uk/Cancertype/Lung/Causesdiagnosis/Causes>

¹⁰⁶ European Agency for Safety and Health at Work (2005) 'Expert forecast on emergency physical risks related to occupational safety and health. Belgium Accessed online at www.hse.gov.uk

- Up to age 70 1 in 15
- Up to age 80 1 in 11
- Up to age 85 1 in 10

Local Action

There is a clear link between the risk factors like obesity, smoking, alcohol and sexual health and cancer incidence. Local actions in relation to these risk areas have been outlined within the specific sections. However in addition to primary prevention measures several screening programmes have been implemented in order to facilitate early screening and diagnosis with the intention of improving treatment.

Breast Screening

The National Breast Screening Programme was set up by the Department of Health in 1988 to invite a defined population of eligible women (aged 50 to 70) for screening every three years. Because the programme is a rolling one which invites women from GP practices in turn, not every woman will receive an invitation as soon as she is 50 years old. Mortality rates have decreased nationally since the introduction of the breast screening programme and it is estimated that the reduction in mortality from breast cancer amongst women aged 53-64 choosing to participate in the screening programme is approximately 35% [CHI, 2003]. Earlier detection of cancer has resulted in increased survival rates.

In South of Tyne the local programme is co-ordinated and provided by the Breast Screening Unit based at the Queen Elizabeth Hospital Gateshead. Data for coverage of breast screening for women aged 53-64 is available by Primary Care Organisation for 2003 to 2006.

The table below shows screening coverage as a percentage of the eligible population in South Tyneside and compared with England

| | 2003 | 2004 | 2005 | 2006 |
|----------------|-------|-------|-------|-------|
| South Tyneside | 76.2% | 80.5% | 80.9% | 80.1% |
| England | 75.3% | 74.9% | 75.5% | 75.9% |

Source: NHS Information Centre

The data shows that the coverage in South Tyneside is higher than that for England as a whole. The data also shows that coverage increased in South Tyneside between 2003 and 2006.

Cervical Screening

The NHS Cervical Screening Programme was set up in 1988 by the Department of Health. Cervical Screening is offered to all women between 25 and 64 every three to five years. Whilst cervical screening cannot be 100 per cent effective, cervical screening programmes have been shown to reduce the incidence of cancer in a population of women, for example;

| | 20-39 years | 40-54 years | 55-69 years |
|--------------------|-------------|-------------|-------------|
| 3 yearly screening | 41% | 69% | 73% |
| 5 yearly screening | 30% | 63% | 73% |

The effectiveness of a programme can be judged by coverage. This is the percentage of women in the target age group (25 to 64) who have been screened in the last five years. If overall coverage of 80 per cent; can be achieved, the evidence suggests that a reduction in death rates of around 95 per cent; is possible in the long term.

Risk factors for cervical cancer include:

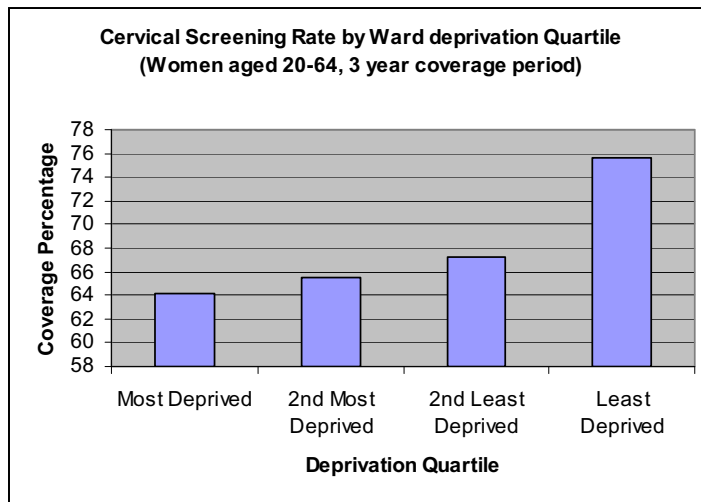
- First had sex at an early age
- Smoke
- Not using condoms
- Having several sexual partners or have had a sexual partner who has had several other partners
- Taking immunosuppressant drugs [DoH, 2003].

In relation to South Tyneside data is available in relation to the coverage of the programme for 2005-6 and 2006-7, and is shown in the table below compared with England.

| | 2005-6 | 2006-7 |
|-----------------------|---------------|---------------|
| South Tyneside | 79.3% | 78.3% |
| England | 79.5% | 79.2% |

Data shows that coverage in South Tyneside falls slightly short of 80% and that there has been a slight decrease in coverage from 2005-6 to 2006-7.

There is a clear link between cervical screening take-up and ward deprivation status. Evidence from the Health Equity Audit (2004)¹⁰⁷ shows the coverage rate for all women aged 20-64 within South Tyneside wards, categorised into deprivation quartiles. This suggests that screening needs to be targeted at those wards with higher deprivation status, as coverage is significantly lower in these wards.



Source: South Tyneside PCT

Bowel screening

The NHS Bowel Cancer Screening Programme is now being rolled out across the country and will achieve nation wide coverage by 2009. The Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 69. People over 70 can also request a screening kit. About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year. Around 98 in 100 people will receive a normal result and will be returned to routine screening. They will be invited for bowel cancer screening every two years if still within the eligible age range. Around 2 in 100 people will

¹⁰⁷ Northumbria University (2004) Health Equity Profile: South Tyneside PCT

receive an abnormal result. They will be referred for further investigation and usually offered a colonoscopy.

Priority Action / Evidence Base

Primary Prevention

The risk factor sections for alcohol, obesity and smoking addresses priority action, evidence base and unmet need which would impact on cancer rates

Secondary Prevention

Whilst the screening rates appear favorable overall further targeted communication and education work is required in order to increase screening uptake with a particular focus on deprived communities across all screening programmes and the younger age groups specifically for cervical screening.

Linked Performance Indicators

NI 119 Self reported measure of people's overall health and well-being DH DSO

NI 120 All-age all cause mortality rate PSA 18

NI 122 Mortality from all cancers at ages under 75 DH DSO

NI 123 16+ current smoking rate prevalence PSA 18

NI 129 End of life palliative care enabling people to choose to dies at home DH DSO

NI 134 The number of emergency bed days per head of weighted population DH DSO

NI 137 Healthy Life Expectancy at age 65

Recommendations / High Impact Changes

- Increase the uptake of screening with a particular focus on the vulnerable groups
- Increase the number of intermediate SSS providers
- Increase the number of people accessing SSS
- Increase smoking cessation with pregnant women

High Impact Changes

Based on the evidence from the Health Inequalities Tool¹⁰⁸ to reduce the life expectancy gap by 10% it would be necessary during the next year to:

- Double the number of smoking quitters to 3,060

¹⁰⁸ Association of Public Health Observatories – Health Inequalities Tool – Working in partnership with the Department of Health. Accessed online at www.lho.org.uk on 15th November 2007

Children

National Policy Drivers

A range of legislation and guidance including the National Service Framework for Children, Young People and Maternity Services, the 10 year strategy for Child Care and the 5 Year Strategy for Children and Learners has informed the Every Child Matters: Change for Children Programme. This legislation and guidance set out a range of standards, objectives and goals for the future of Children's Services.

The Children Act 2004 establishes the legislative framework, systems and processes that will achieve these standards and drive forward the necessary changes at a local level. Children's trust arrangements are the main mechanism for delivering this change programme. The success of these arrangements in each Children's Service Authority will primarily be measured by the extent to which they deliver improved outcomes for children and young people across the 5 themes; *Be Healthy; Staying Safe; Enjoy and Achieve, Making a Positive Contribution and Economic Well-Being*. The central tenet of Every Child Matters is that these outcomes can at best, and in some cases only, be delivered through effective collaborative working. The new Joint Area Review inspections will examine how well agencies have worked together to achieve the outcomes, which concern all children and the 'whole child'.

The Children Act 2004 requires all Children's Services Authorities to establish 'children's trust arrangements' by 2008 and there is an expectation that most will have done so by 2006. These arrangements must have 4 essential components:

- Professionals will be enabled and encouraged to work together in more integrated front-line services that are built around the needs of children and young people;

- A range of integrated systems and common processes must be developed to facilitate joint working;
- A joint planning and commissioning framework, that can include pooled budgets, must be established between agencies to ensure key priorities are identified and addressed;
- Strong inter-agency governance arrangements in which shared ownership is coupled with clear accountability.

Section 10(1) of the Children Act 2004 (The Act) places a statutory duty on each Local Authority (Children's Services Authority) to make arrangements to promote co-operation between themselves, their relevant partners and other persons or bodies the authority considers to be appropriate. The Act defines Children's Services Authorities as those councils that have responsibility for both Local Education Authority (LEA) and Social Services functions. Partner agencies are under a reciprocal duty to co-operate. The partner agencies listed in The Act are:

- The Police Authority
- The Local Probation Board
- The Youth Offending Service
- The Strategic Health Authority and Primary Care Trust
- The Connexions Partnership
- The Learning Skills Council for England

Other partners that need to be involved in the Change for Children agenda include:

- Children, young people and their families
- Schools, colleges and academies
- Primary care providers
- NHS Trusts and Foundation Trusts
- Voluntary and community sector
- Private for profit and not for profit sectors
- Immigration and National Asylum Support Service
- Jobcentre Plus
- Children and Families Family Court Advisory Service (CAFCASS)
- Regeneration and Enterprise Partnerships
- Community Safety and Crime Reduction Partnerships

The Children's National Service Framework for Children, Young People and Maternity Services

The Children's NSF 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 for children, young people and pregnant women, the NSF aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood.

The standards require services to:

- Give children, young people and their parents increased information, power and choice over the support and treatment they receive, and involve them in planning their care and services.
- Introduce a new Child Health Promotion Programme designed to promote the health and well being of children pre-birth to adulthood.
- Promote physical health, mental health and emotional well-being by encouraging children and their families to develop healthy lifestyles.
- Focus on early intervention, based on timely and comprehensive assessment of a child and their family's needs.

- Improve access to services for all children according to their needs, particularly by co-locating services and developing managed Local Children's Clinical Networks for children who are ill or injured.
- Tackle health inequalities, addressing the particular needs of communities, and children and their families who are likely to achieve poor outcomes.
- Promote and safeguard the welfare of children and ensure all staff are suitably trained and aware of action to take if they have concerns about a child's welfare.
- Ensure that pregnant women receive high quality care throughout their pregnancy, have a normal childbirth wherever possible, are involved in decisions about what is best for them and their babies, and have choices about how and where they give birth.

The Every Child Matter Framework has five outcomes:

- Be Healthy
- Stay Safe
- Enjoy and Achieve
- Make a Positive Contribution
- Achieve Economic Well-being

Be Healthy

The Every Child Matters Outcomes Framework has five aims for the Be Healthy outcome:

- Children and Young People are physically healthy (measured by infant mortality and obesity amongst <11s)
- Children and Young People are mentally and emotionally healthy
- Children and Young People are sexually healthy
- Children and Young People live healthy lifestyles
- Children and Young People choose not to take illegal drugs

Life style profile of children

A Young People's Health and Lifestyle profile involving the 843 males and 799 females within Year 9 of South Tyneside Comprehensive Schools was undertaken between May and June 2004. The aim of the survey was to find out more about health and health related behaviour of young people. Table One shows a summary of the key findings which revealed that there is a need for more investment and effort in promoting exercise and healthy eating, minimising substance misuse harm, tackling smoking, enhancing mental well being, better understanding sexual health issues and ensuring safe environment amongst young people.

Key Findings of Young People's Health & Lifestyle

| | |
|---|-------|
| Category | |
| Gender respondents | |
| Proportion Males / Females | 51:49 |
| BMI | |
| Proportion of overweight children | 13% |
| Proportion of obese children | 13% |
| Physical activity | |
| Proportion of children exercising less than twice a week | 13% |
| Diet | |
| Proportion of children eating less than one portion of fruit or vegetables each day of the week | 73% |

| | |
|--|-----|
| Substance abuse | |
| Proportion of children who are smoking | 33% |
| Proportion of children who drink alcohol | 68% |
| Proportion of children who tried (cannabis) drugs | 25% |
| Well being | |
| Proportion of children who often feel depressed | 15% |
| Proportion of children who often feel panicky | 10% |
| Proportion of children who often feel lonely | 11% |
| Proportion of children who often feel angry | 29% |
| Proportion of children who often experience sudden change of mood | 24% |
| Living conditions | |
| Proportion of children who have visited the dentist in the last 6 months | 86% |
| Proportion of children who are living with a smoker | 57% |
| Proportion of children who are caring for someone | 13% |
| Proportion of children who are feeling Unsafe when going out after dark | 46% |

Some universal services are preventative across all the five outcomes, an example being the **Healthy Schools Programme**.

The National Healthy Schools Status (NHSS) is available to all schools. South Tyneside's performance to date and targets are shown below. For details of the National Healthy Schools programme please see appendix 1.

| | 2007 | | | | 2008 | | | | 2009 | | | |
|----------------------|-------|------|-----|-----|-------|------|-----|-----|-------|------|-----|-----|
| | April | July | Oct | Dec | April | July | Oct | Dec | April | July | Oct | Dec |
| Achieved NHSS | 4 | 8 | 18 | 26 | 31 | 35 | 40 | 44 | 46 | 47 | 48 | 50 |
| % | 6 | 12 | 26 | 39 | 46 | 52 | 60 | 65 | 67 | 70 | 72 | 75 |

Childhood obesity

Data on childhood obesity is shown in the earlier obesity chapter. Other indications of childhood obesity linked behaviours include breastfeeding, school nutrition and levels of physical activity are outlined below. For details of prevention activity and treatment interventions please see appendix 4.

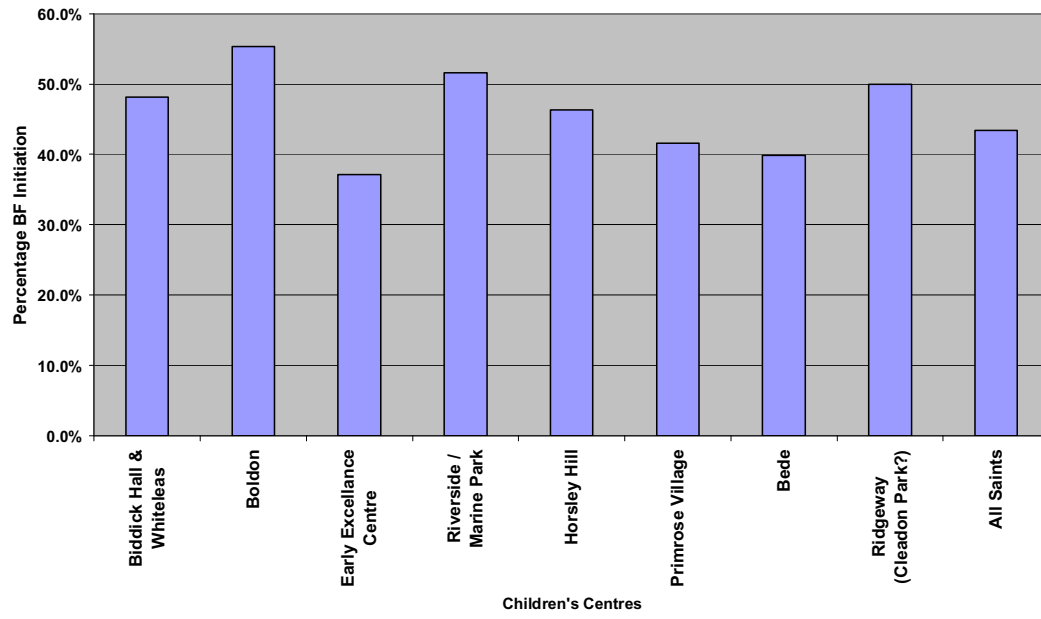
Breastfeeding Initiation rate

Table 1 : South Tyneside breast feeding initiation figures 06/07 until Q2 2007 *

| | 2006/2007 | | | | 2007/2008 | |
|--|-----------|-------|-------|-------|-----------|-------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| Percentage of mothers initiating breastfeeding | 45.0% | 47.3% | 45.3% | 47.6% | 54.7% | 53.4% |

Breast feeding initiation rates varies across children's centres

Breast feeding (BF) initiation rates by Children's Centres, South Tyneside
Mar 2006 - Mar 2007



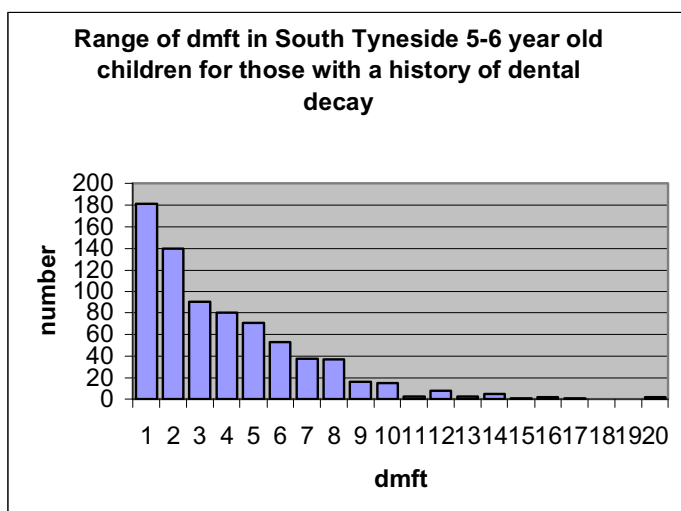
Dental Health

Information relating to the oral health, particularly the prevalence and severity of tooth decay, of children and young people is provided by a rolling programme of epidemiology programmes co-ordinated by the British Association for the Study of Community Dentistry (BASCD) and undertaken by the PCT Salaried Dental Services.

The most recent survey carried out in 2006 was a full population survey of children in year 1 (aged 5-6 yrs), and while not directly comparable with previous surveys which looked at 5-year-old children gives a good indication of current disease levels and inequalities.

Dental decay affects large numbers of 5-year-old children in South Tyneside. 55% of children in year 1 (aged 5-6 yrs), examined between March and May 2006, have active decay or have had fillings or extractions (%dmft>0), (BASCD Survey, 2006). The average number of decayed, missing and filled teeth (dmft) for all children is 2.15. However the average number of teeth affected for those children who have decay (mean dmft for dmft>0) is 3.92.

Decay experience is not evenly distributed. Approximately 30% of children examined share 80% of the decay experience.



The dental health of children in South Tyneside remains worse than regional and national averages. Please see Appendix 5 for further detail.

Mental and emotional health

South Tyneside has a significant level of demand for Child and Adolescent Mental Health Services (CAMHS).

Of the risk factors identified as having an impact on the mental well-being of children and young people, in South Tyneside there are approximately:

- 3,252 children in special school without statement of educational need and 754 with 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 are in families that are income deprived
- 166 children on the Child Protection register
- 268 looked after children

- 909 school exclusions
- 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
- 862 young people were active to the Youth Offending service during 2004.

A comprehensive Health Needs Assessment was carried out in 2006 and is available on request.

Sexual health

Sexual activity levels (an indicator of risk)

The NATSAL (Johnson et al, 2001) survey suggested a median age of between 16 and 17 for first sexual experience with 27% of young women and 28% of young men having sex under the age of 16. For the North East this figure is even higher with approximately 38% of young women estimated to be sexually active before 16. In contrast only 25% of young men in the North East were sexually active before aged 16 which is lower than the national average. This data also suggests that a significant proportion of young women sexually active in the North East would be with partners of an older age. Further analysis of sexual ill-health suggests that the burden of disease falls within distinct age groups with higher rates of chlamydia, warts and herpes within younger females than males also reflecting age related variation. Brook et al (2000) suggests that by aged 20 almost 90% of young people are sexually active. Data from the population estimates 2005 (ONS) suggests that there are approximately 6181 young people in the 13 – 15 age group. If there were approximately equal proportions of young women and men in this age bracket this suggests there are 3090 in each gender group. Whilst it is accepted that this proportion wouldn't be equally split in terms of gender for the purpose of estimations of prevalence this calculation will be applied.

| Age | Estimated number by gender | NATSAL estimates for sexual activity | South Tyneside Estimate |
|--|----------------------------|---|-------------------------|
| Total aged 13 - 15 6181 (approximate) | 3090 | 38% of young women sexually active (North East average) | 1174.2 |
| | 3090 | 25% of young men sexually active (North East average) | 772.5 |
| Total aged 16 - 19 | 8,697 | 50% estimated sexually active | 4348 |
| | | 90% estimated sexually active | 7827 |
| Total aged 20 - 24 | 9,289 | 90% estimated sexually active | 8360.1 |
| Total range expected | | | |

Young People (aged 16 – 24)

Young people make up approximately 11% of new HIV diagnosis each year alongside a disproportionate representation within the diagnosis rates for Chlamydia, gonorrhoea and genital warts (HPA, 2006).

Young people are acknowledged as a group affected by increased behavioral risk. The HPA (2006) outline a number of different behavioral factors when compared to their older counterparts contributing to this increased risk:

- Higher number of sexual partners
- Higher number of concurrent partners
- Higher frequency of partner change
- Reducing age of first sex (NATSAL, 2000)

Teenage pregnancies

South Tyneside has a range of services which support the Teenage Pregnancy strategy which aims to reduce the number of teenage pregnancies by 2010. Details of services are included in Appendix 6.

South Tyneside has developed a multi-agency Teenage Pregnancy Strategy and Implementation Plan which is available on request.

Concern has been expressed around the level of skill and confidence required to negotiate safer sex and the inadequate opportunities for this particular group to develop these skills. Early sexual activity has been linked to subsequent sexual health status (Wellings et al, 2001). Wellings et al (2001) outlined a number of factors associated with early sexual activity including;

- Early menarche
- Early school leaving age
- Family disruption and disadvantage
- Poor educational attainment

'Teenage Pregnancy Next Steps (2006) outlines further risk indicators linked to self esteem and educational attainment. Young people who display more than one risk factor will have an increased level of risk (Next Steps, 2006). In response to this South Tyneside has established a risk and resilience board to co-ordinate its approach to risk taking behaviour.

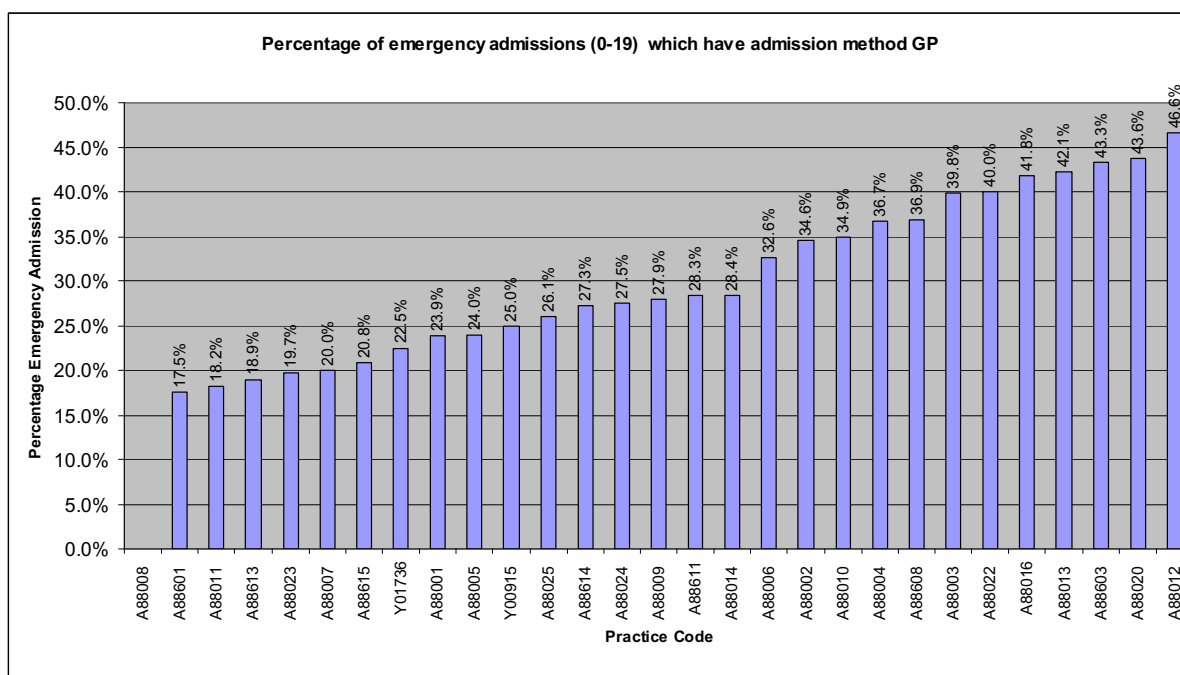
Staying Safe

The definition of 'staying safe' is:

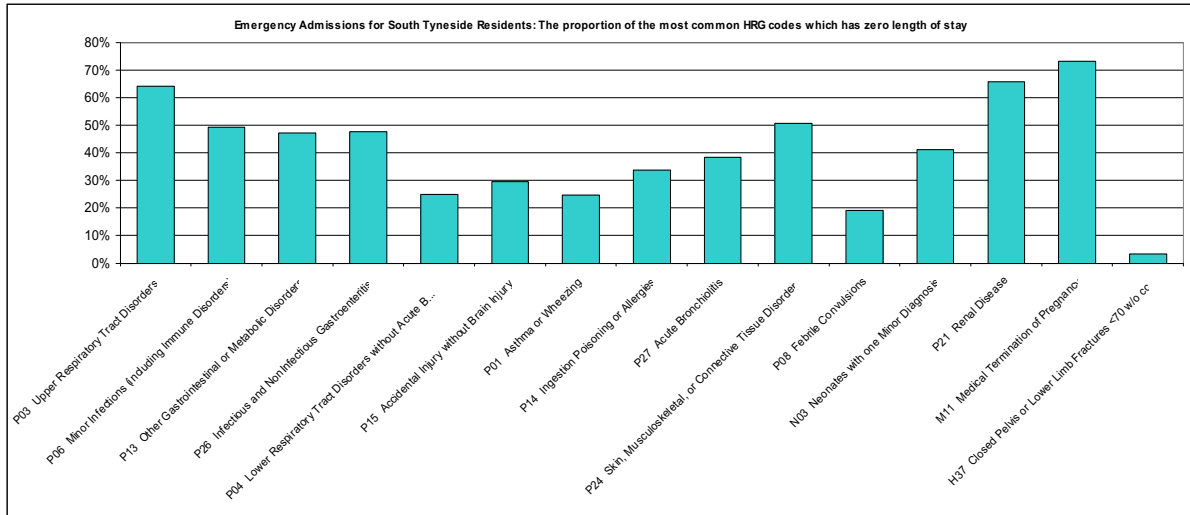
- Children and young people are safe from maltreatment, neglect, violence and sexual exploitation
- Children and young people have security, stability and be cared for

To help ensure children and young people are free from accidental injury and death, the newly reconfigured Local Safeguarding Children's Board (LSCB) has established a sub-group considering accident prevention, avoidable admissions and self-harm. The group is currently drafting a strategy for approval by the LSCB.

Emergency Admission 0-19 years

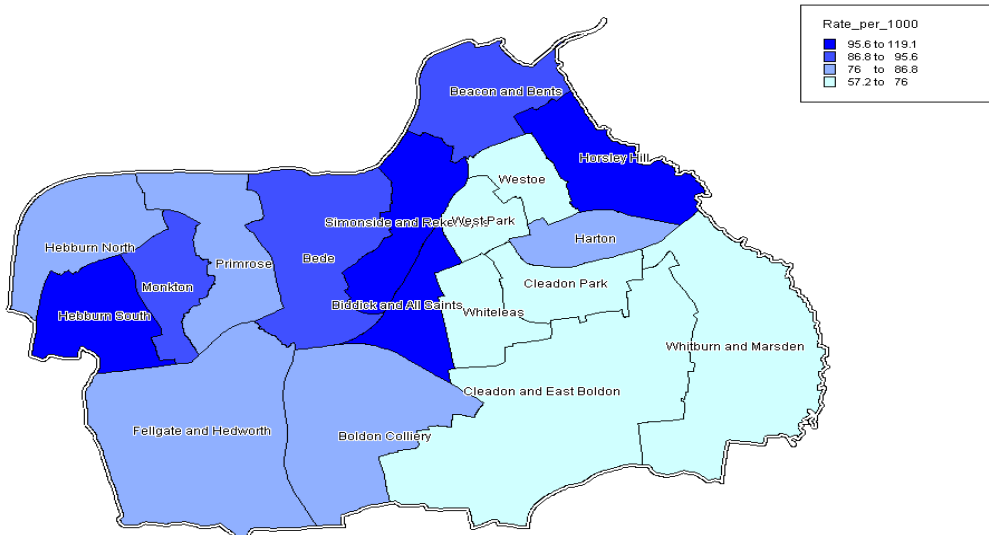


There is a wide variation in admission between Practices ranging from a percentage of 17.5 to 46.6. Further work is underway to look at why this difference exists and whether there is any best practice to be learnt from those practices with fewer admission rates. Of the causes, Respiratory Tract Infections are the highest.



Health Inequalities

South Tyneside PCT: Emergency Admissions aged 0-19

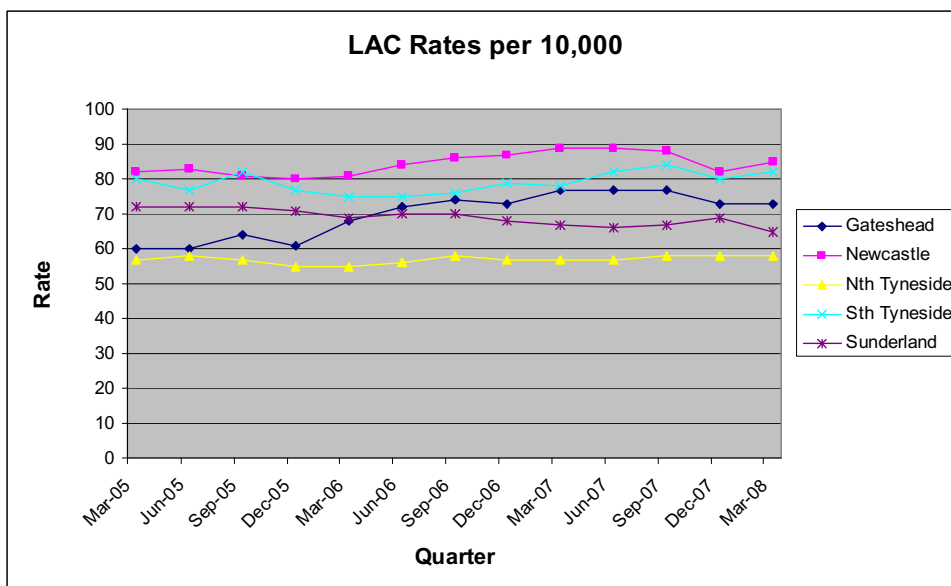


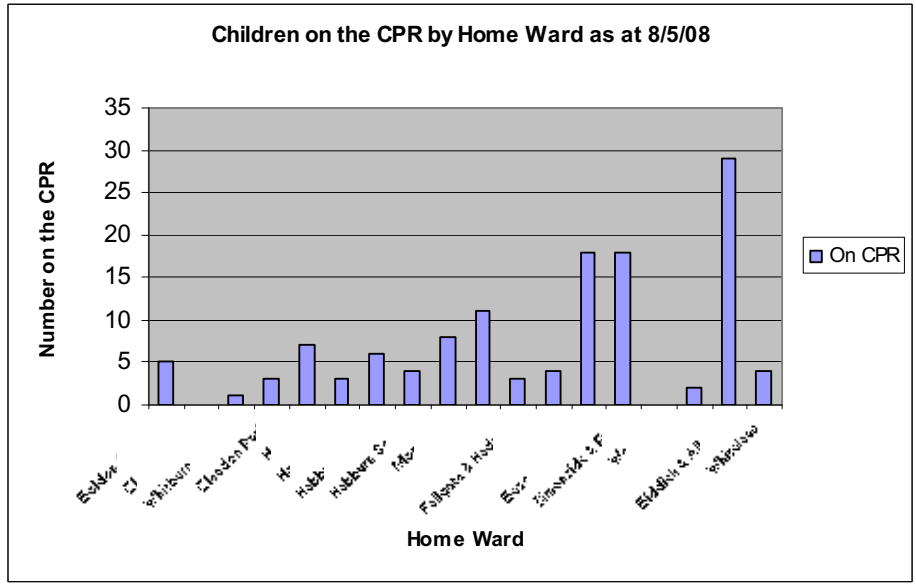
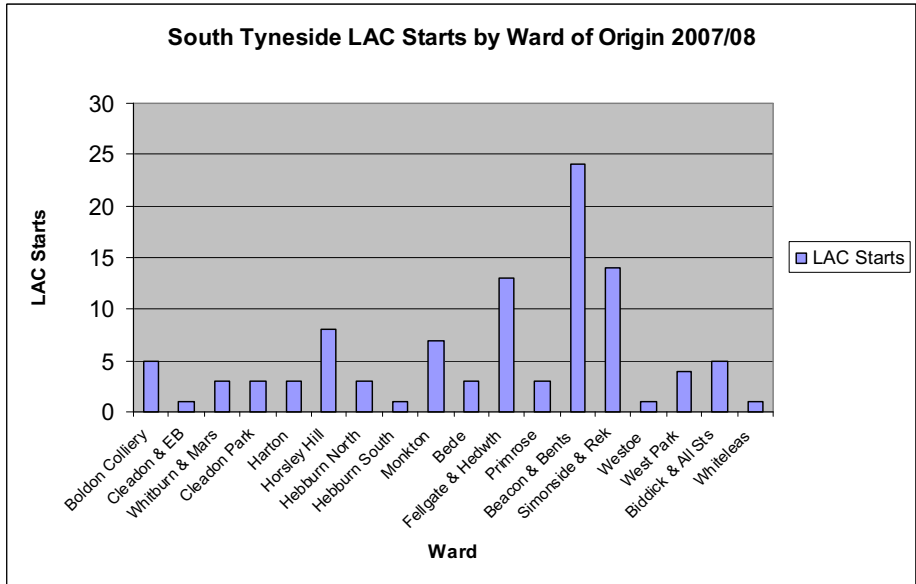
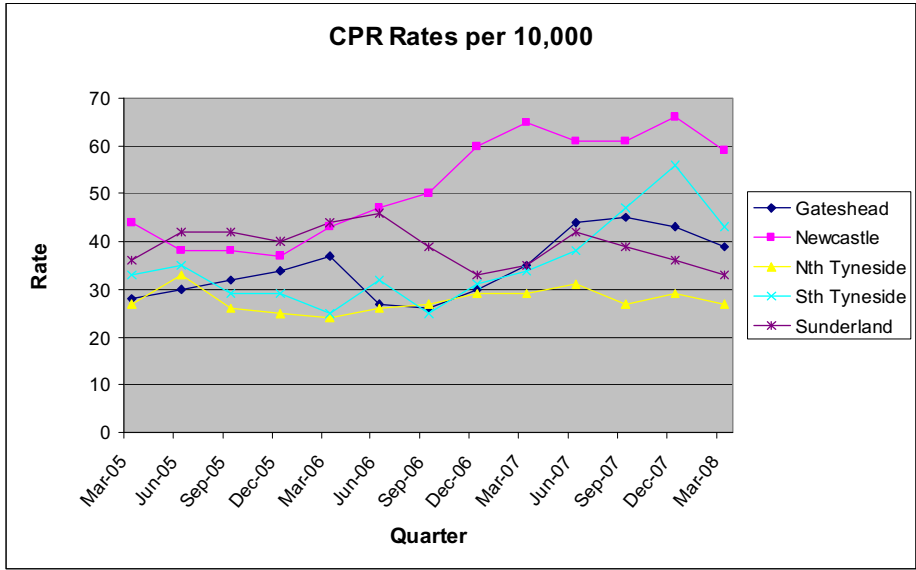
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As the above map highlights the emergency admission accident rate is directly proportional to the level of deprivation in the borough. A copy of the strategy will be available on request from September 2008.

Looked After Children

Certain groups of children are more vulnerable and therefore services are provided to help these groups stay safe. Vulnerable children include those 'looked after' by the statutory services and those subject to child protection plans. There is a looked after children's placement strategy being developed and will be available on request. The graphs below indicate the level of need for these services. Please see appendix 7 for further details.





The Assessment and Family Support Service is dealing with a steadily increasing number of contacts, mostly from the police. The increase in the number of contacts mainly affects the Duty Service and Out of Hours Duty Service. Although services are getting more contacts, fewer are progressing to referral so far in 2007/08. Most referrals (consistently over 80%) progress to initial assessment.

In 2006/07, up to 33% of initial assessments led to core assessments and around half resulted in no further action. However in the period from July to September 2007, 60% of initial assessments led to core assessments and only 5% had no further action. The increasing number of core assessments is reflected in an upward trend in the number of Child Protection registrations.

Children and young people choose not to choose illegal drugs

The Matrix service of the Drug and Alcohol service has conducted an extensive needs analysis which is available on request and will be incorporated into a future edition of the JSNA.

Older people

The information presented in this section includes data assembled by the Care Services Improvement Partnership and detailed within the Projecting Older People Population Information Systems (POPPI) section. POPPI data is derived by analysis of the data maintained within the Office of National Statistics information systems.

Older people could be broadly seen as three groups, as defined by NSF:

- a. Entering old age (65-74 yrs)
- b. Transitional phase (75-84 yrs)
- c. Frail older people (85+ yrs)

Key issues impacting of the health of older people

- Socio-economic status
- Housing
- Community safety (crime and a fear of crime)
- Geographical access to services
- Lifestyle
 - Smoking
 - Alcohol
 - Diet
 - Exercise

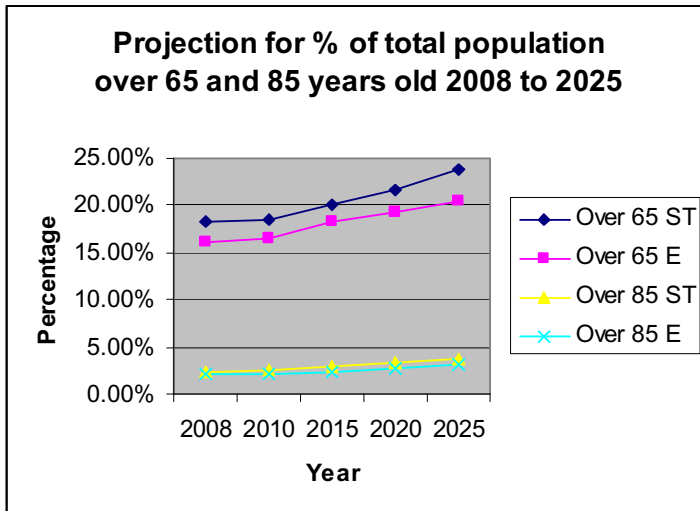
Key Issues

- An increase in the number of people within the population over 65 is expected.
- The prevalence of long term conditions are expected to increase by approximately 25% due to an aging population
- People with long term conditions are higher users of all health services accounting for an estimated 55% of GP appointments, 68% of outpatient and A&E appointments and 77% of in patient bed days¹⁰⁹
- The number of people requiring social care services is expected to increase over time
- The number of people living with dementia is expected to increase over time with the rate of dementia higher with women than men
- The number of people living with undiagnosed osteoarthritis is high (87.5% of the total prevalence)
- It is estimated that there are a significant number of women living with osteoporosis

Population over 65 years as a percentage of total population (South Tyneside and England)

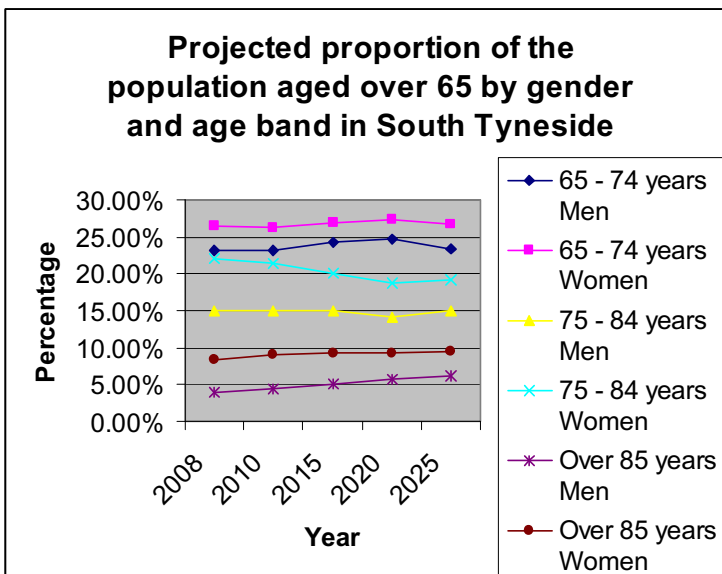
This data highlights for both South Tyneside and England there is an increasing trend in the percentage of the total population aged both over 65 and over 85 years. The local trend mirrors the national picture, however in South Tyneside people over 65 make up a greater proportion of the total population than the national average.

¹⁰⁹ General Household Survey 2005



Age prevalence by gender (South Tyneside)

Further analysis splitting age prevalence by gender groups shows that in South Tyneside there are a greater proportion of females living into old age. This picture again reflects the national trend for age prevalence by gender.

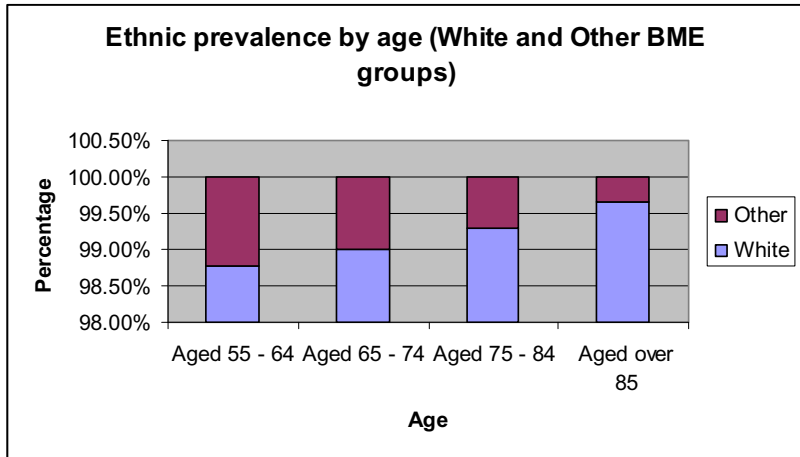


Age prevalence by ethnicity (South Tyneside)

The majority of South Tyneside residents are in the White ethnic group. This ranges from 98.78% in the 55 – 64 age groups to 99.65% of the 85+ age group.

This data highlights the proportion of the total community who fit the category 'White' increases with rising age. The Black or Black British ethnic groups also show an increase in prevalence albeit a less steep incline with all other ethnic groupings falling in prevalence across the age bands.

This data is based on a snapshot of current prevalence and it is expected that this reflects a growing proportion of the total population within ethnic groups other than White rather than an inequality, however this requires further analysis.

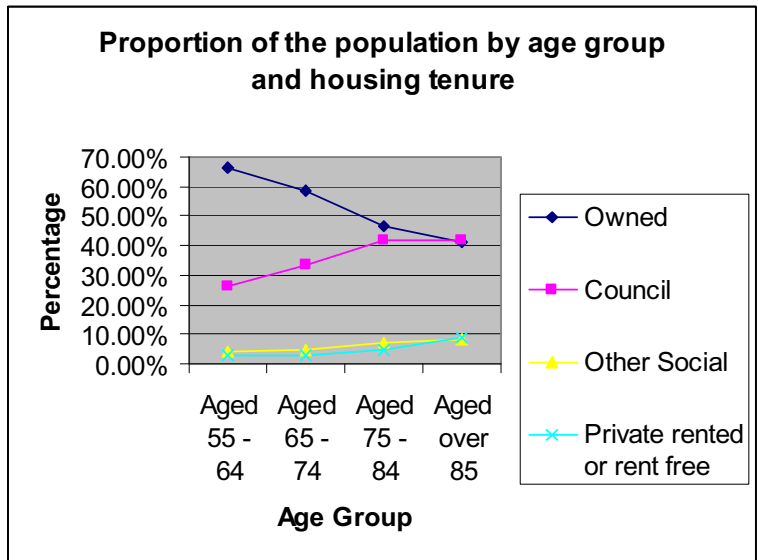


Social Care

This next section details information relating to the social care needs of this older population. This sections addresses housing and care issues.

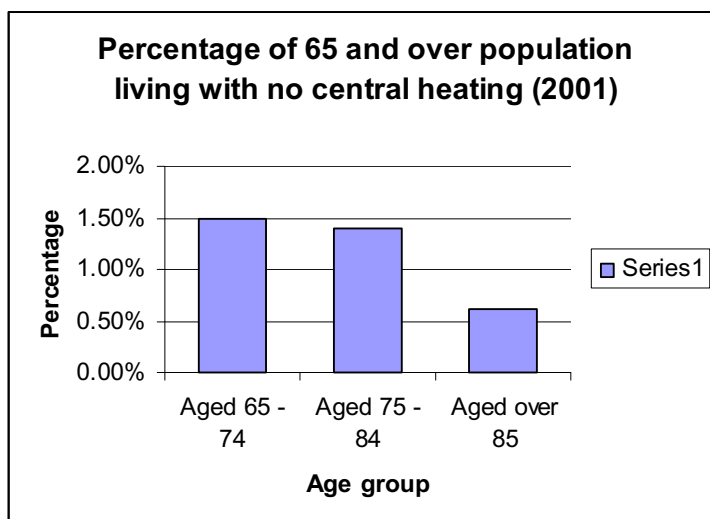
Housing

Data analysed for housing tenure suggests a decrease in people owning their home between the age of 55 and over 85 years with an opposite increase in renting across the same age groups. This picture could reflect a generational trend in house buying across the age groups or issues with poverty however further analysis is required before any commentary is presented.



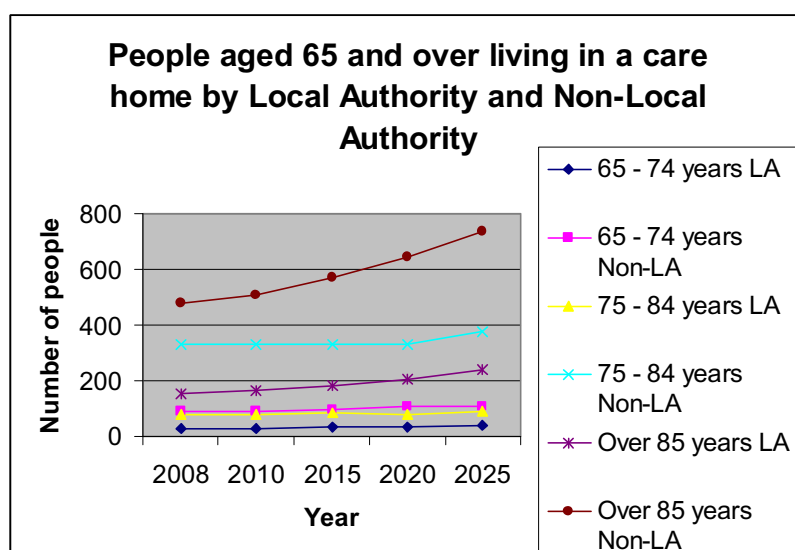
Central Heating

In 2001 there were a small percentage of older people living without central heating. This ranged from 1.49% in the 65 – 74 age groups to 0.61% in the over 85 age group. This issue requires consideration within the Affordable Warmth Strategy in the Local Authority to ensure these older people are not experiencing any difficulty in relation to this aspect.



Number of people living in Care homes

In relation to older people living within either a Local Authority or Non-Local Authority Nursing home there is a small increase projected over the next few years. The greatest increase is within the over 85 age group and in particular those who are living within non-Local Authority care homes.

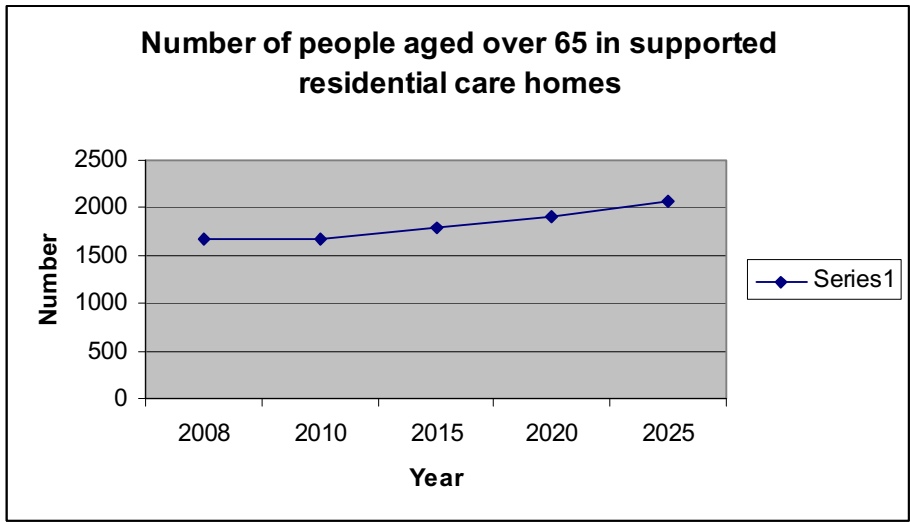


Supported residents in care homes

The information presented in this section is derived from Community Care Statistics 2005-06 (Referrals, Assessments and Packages of Care for Adults), National Statistics/Health and Social Care Information Centre. The Referrals, Assessments and Packages of Care Project (RAP) was developed to provide a consistent set of national statistics on adult community care, purchased or provided by Councils with Social Services Responsibilities (CSSRs).

The 2005-06 RAP figures have been applied to the ONS 2005 mid-year population estimates of the 65 and over population, to give estimated projections of the numbers predicted to be in supported residential and nursing care during the year, to 2025.

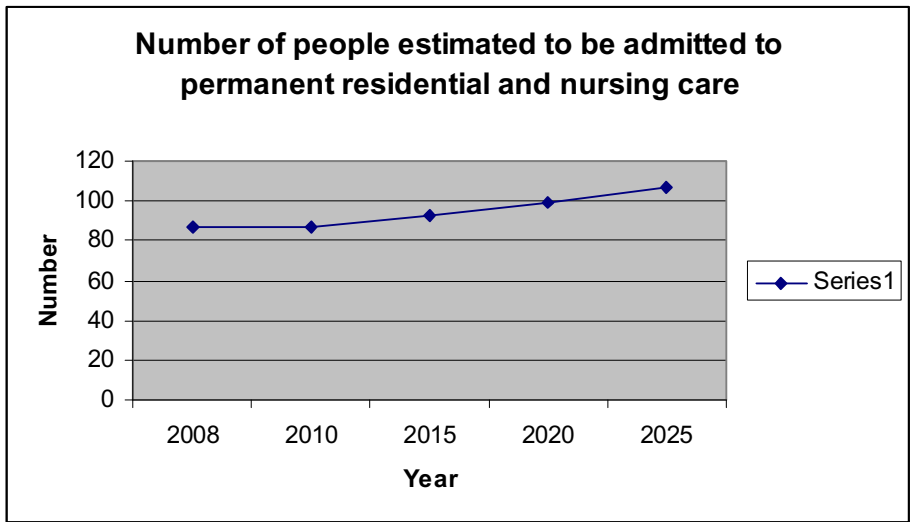
The number of people aged over 65 residential care either purchased or provided by the CSSR is expected to increase from 1,668 in 2008 to 2,065 in 2025.



Admissions to supported permanent residential and nursing care

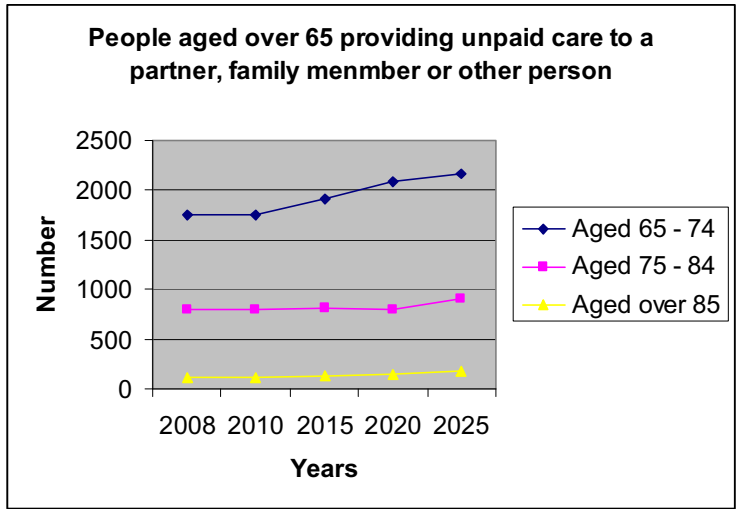
The information in this section is taken from Social Services Performance Assessment Framework Indicators 2005-2006, CSCI / National Statistics, reference A0/C72. The performance assessment framework indicators are a collection of performance indicators which combined reflect how local councils are providing for their residents.

The 2005-06 performance figures have been applied to the ONS 2006 mid-year population estimates of the 65 and over population, to give estimated projections of the rate per 10,000 people predicted to be admitted to supported permanent residential and nursing care during the year, to 2025.



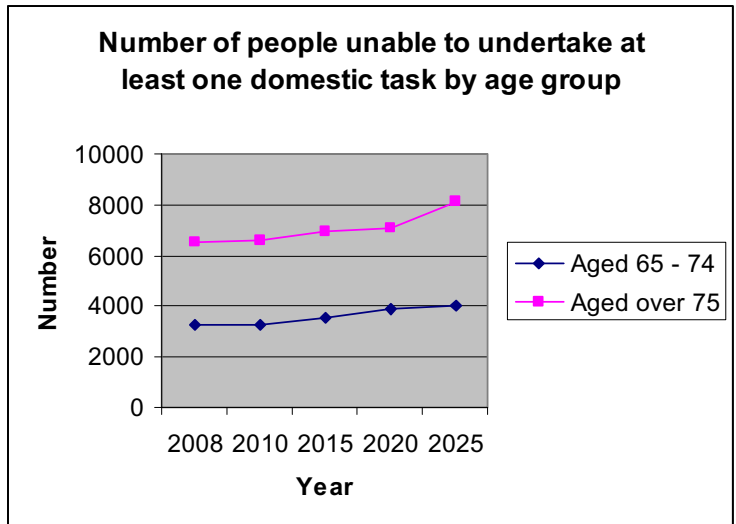
Provision of unpaid care

The number of people aged over 65 providing unpaid care is projected to increase by almost 22% from 2,663 in 2008 to 3,243 in 2025. This increase is reflected within each of the age groups detailed.



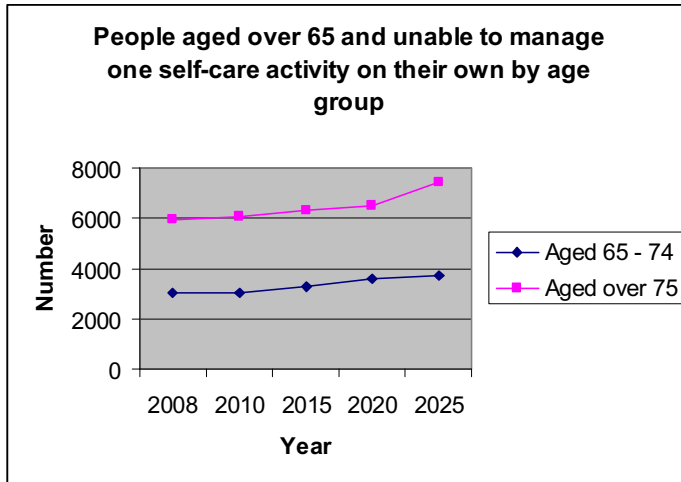
People aged over 65 and unable to manage at least one domestic task on their own

Tasks included in this category are household shopping, washing and drying dishes, cleaning windows inside, jobs involving climbing, hovering, hand washing clothes, opening screw tops and dealing with personal affairs. The number of people unable to manage at least one domestic task increases with age and is projected to increase over time.



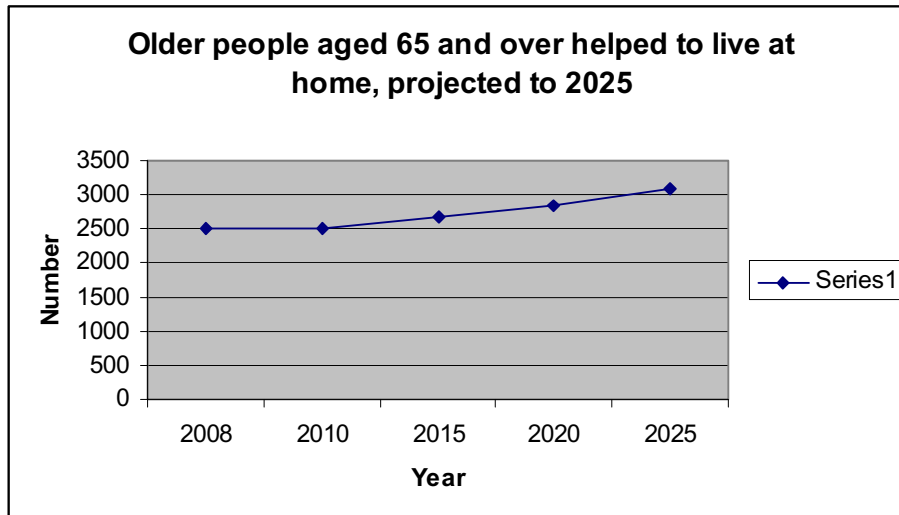
People aged over 65 and unable to manage at least one self-care activity on their own

Activities which are included under this heading include: bathing, showering or washing, dressing or undressing, washing their face and hands, feeding themselves or cutting their toe nails. It is projected that the number of people unable to manage at least one self-care task will increase over time and also by age.



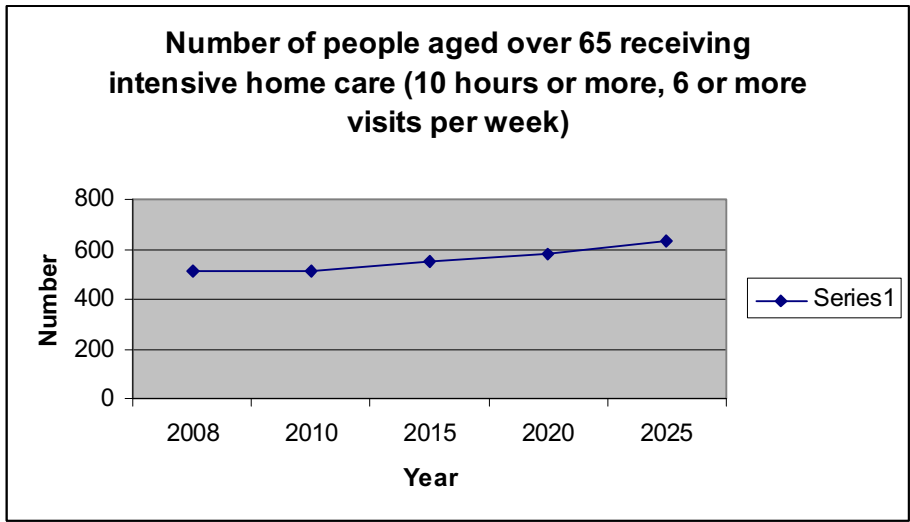
Homecare

The number of people who require help to live at home is expected to increase over time from 2,500 to 3,095.



Intensive home care

The number of people receiving intensive home care is expected to increase over time from 511 in 2008 to 633 in 2025.



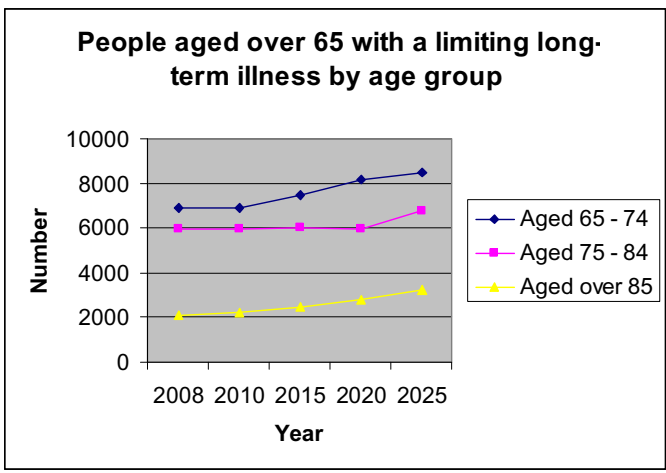
Health

This section provides detail regarding the number of older people living with specific health concerns. This section also projects the number of people within each illness group expected between now and 2025.

There are limitations for the data presented here which requires acknowledgement. The information is based on current trends and doesn't account for the impact of the increase in risk factors such as obesity and alcohol use or any of the evidence based interventions and high impact changes which are currently being proposed and implemented.

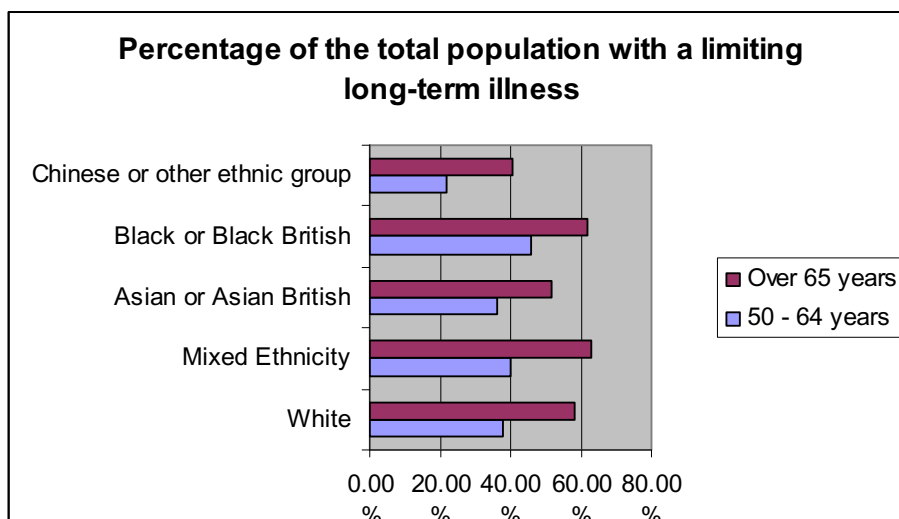
Limiting long term illness

Data presented in this section is based on figures taken from the 2001 census. Numbers have been calculated by applying percentages of people with a limiting long-term illness in 2001 to projected population figures. This information therefore doesn't account for new trends in risk factors relating to long term conditions or work which is being developed to tackle these issues. However this information suggests approximately a 24% increase in the number of people in this category between 2008 and 2025.



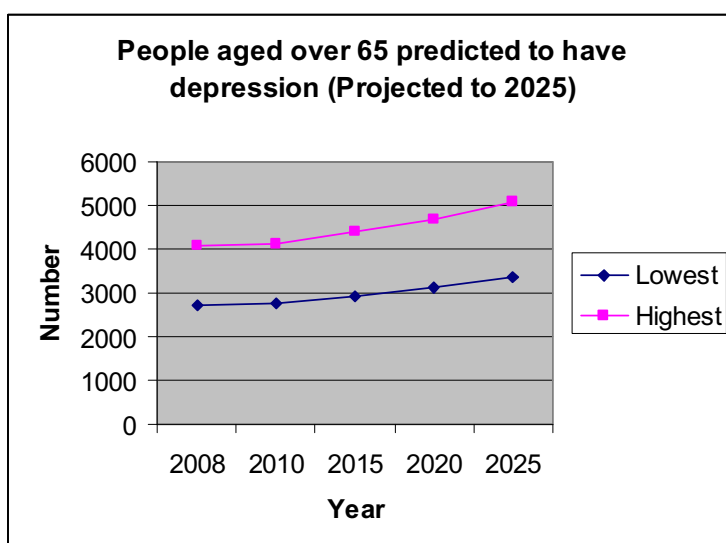
Ethnicity

The percentage of people with a limiting long-term illness varies within ethnic groups and between age groups.



Depression

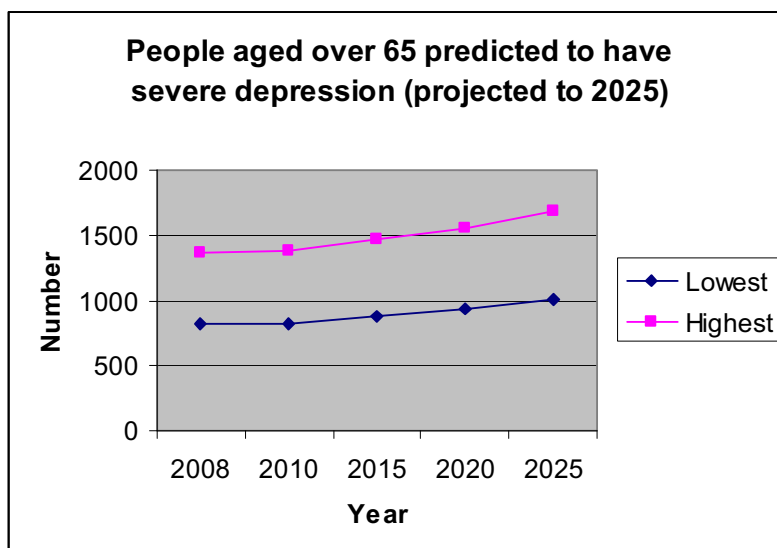
The data in this section has been derived by accepting evidence to suggest that 10 - 15% of the 65 and over population are estimated to have depression¹¹⁰. This clearly doesn't account for local variation. To accommodate for there are two estimates presented one being the lowest prediction and one being the highest. As South Tyneside suffers from significant deprivation across a range of indicators it is expected that there will be a greater number of people over 65 with depression than the national average. The prevalence rates have been applied to ONS population projections of the 65 and over population to give lowest and highest estimated numbers of people predicted to have depression to 2025.



Severe depression

In relation to severe depression, figures have been calculated by applying the estimate that 5% of people over 65 are suggested to have severe depression¹¹⁰ to the population projections. Again a figure has been presented for the lowest and the highest expected number.

¹¹⁰ Baldwin, R. (1996) Depressive Illness, in Jacoby, R. and Oppenheimer, C. (eds) Psychiatry in the Elderly, Oxford University Press



Dementia

Dementia is defined in the International Classification of Diseases (10th revision) as

“A syndrome due to disease of the brain, usually of a chronic and progressive nature, in which there is impairment of multiple higher cortical functions”¹¹¹

Dementia includes a number of conditions such as Alzheimer’s disease (60% of cases), vascular dementia (15% - 20%) and dementia with Lewy bodies (15% - 20%). The precise diagnosis is important for some clinical interventions and may have an impact on disease progression. In practice, however, mixed forms are frequent and much of the care needed depends more on severity and degree of dependence.

Dementia is characterised by a progressive decline in memory and other cognitive functions from mild disturbance of recent memory and abstract thinking to loss of personal identity, unintelligible speech, incontinence and gross impairment of mobility. Aggressive or challenging behaviour can also often be a feature.

The above description is based very much on a medical model of dementia. From a social perspective, dementia is regarded as a disability. There is a cognitive impairment but the way people with dementia are treated by, or excluded from society results in disability. It is, therefore, more than clinical damage to the brain.

Dementia is predominantly a disease of old age. There are, however, a number of cases of young onset.

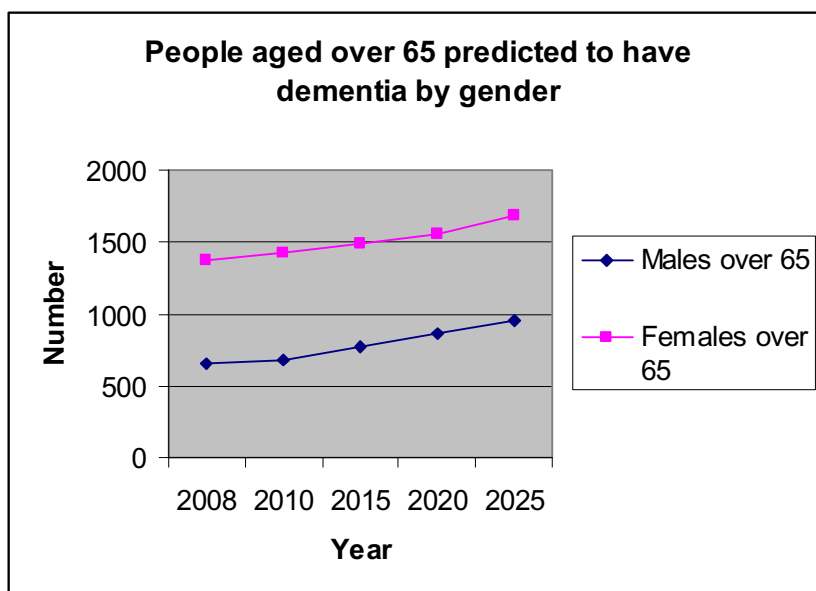
For the purpose of this section and to facilitate estimates of the number of people aged over 65 living with dementia the most recent relevant source of UK data from population samples has been used. The Medical Research Council’s Cognitive Function and Ageing Study (MRC CFAS), February 2002 involved a longitudinal examination of population samples of people aged 65 and over in six sites across England and Wales. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2025.

For men, 1.4% of 65-69 year olds; 3.1% of 70-74 year olds; 5.6% of 75-79 year olds; 10.2% of 80-84 year olds; and 19.6% of men aged 85 and over are predicted to have dementia. For

¹¹¹ World Health Organisation. *The ICD-10 Classification of Mental and Behavioural Disorders: clinical description and diagnostic guidelines*. Geneva: WHO, 1992

women, 1.5% of 65-69 year olds; 2.2% of 70-74 year olds; 7.1% of 75-79 year olds; 14.1% of 80-84 year olds; and 27.5% of women aged 85 and over are predicted to have dementia.

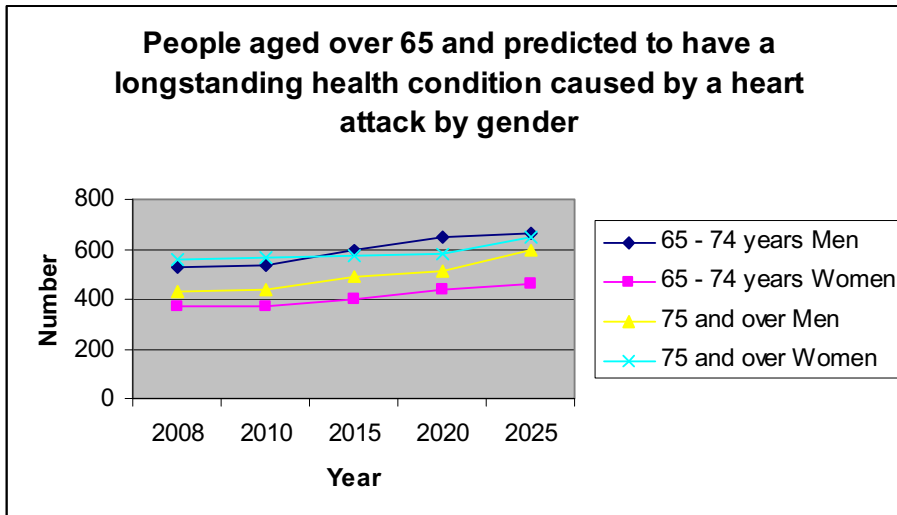
By accepting this data estimates suggests an increase in the number of people living with dementia over the the next seventeen years with a greater number of women living with dementia. This difference between genders may be partly attributed to the difference in life expectancy between men and women however it is important to note that there is a greater proportion of women expected with dementia with growing age.



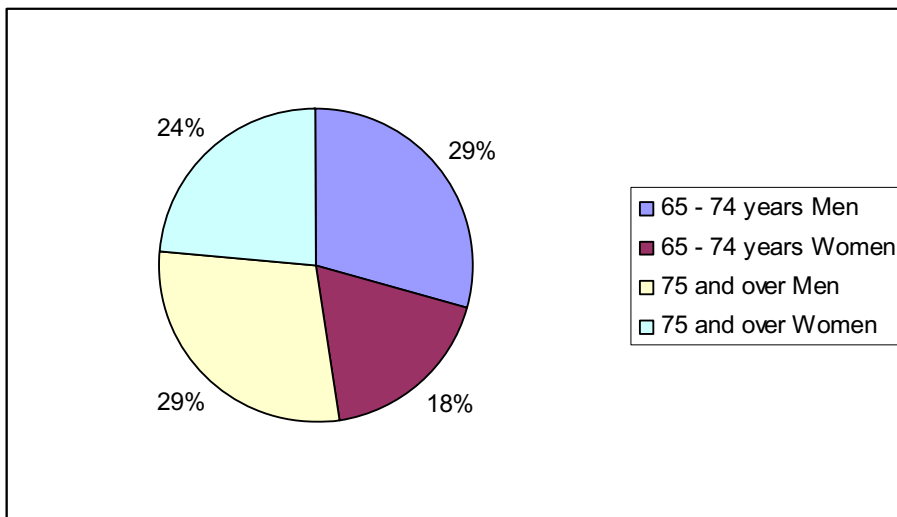
Heart Attack

Data presented in this section is based on the 2004/05 General Household Survey, National Statistics, General health and use of health services, Chronic sickness: rate per 1000 reporting selected longstanding conditions, by sex and age. Information on chronic sickness was obtained by asking about any longstanding illness that has had an effect or will have an effect over a period of time.

This data suggests that 8.4% of 65-74 year old males, 8.3% of males aged 75 and over, 5.1% of 65-74 year old females, and 6.7% of females aged 75 and over report heart attacks. Prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have a heart attack to 2025.



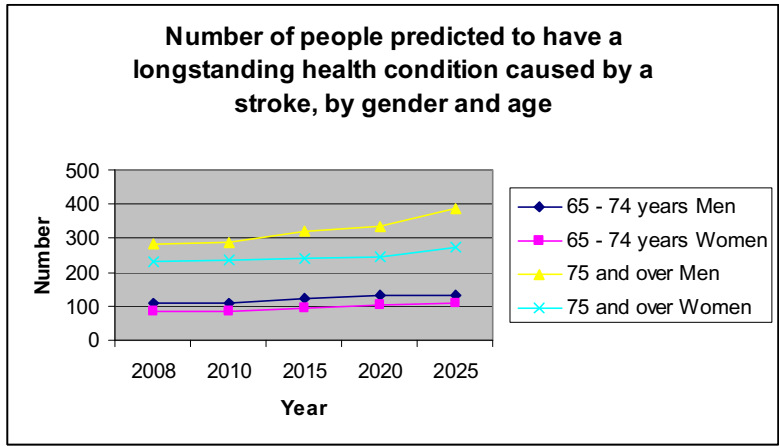
Of the total number of people over the age of 65 who are predicted to have a longstanding health condition caused by heart attack the prevalence is within the male population who account for 58% of the predicted population affected.



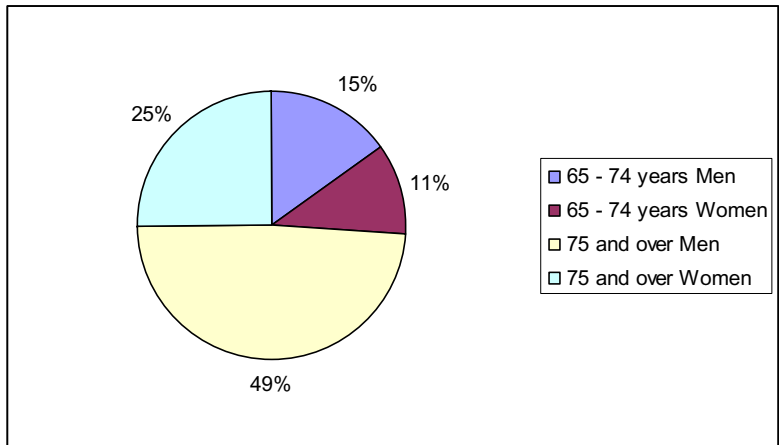
Stroke

Prevalence rates used in this section are based on the 2004/05 General Household Survey, National Statistics, General health and use of health services, chronic sickness: rate per 1000 reporting selected longstanding conditions, by sex and age. Information on chronic sickness was obtained by asking about any longstanding illness that has had an effect or will have an effect over a period of time.

Using this calculation it is expected that 1.7% of 65-74 year old males, 5.4% of males aged 75 and over, 1.2% of 65-74 year old females, and 2.8% of females aged 75 and over report strokes. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have a stroke to 2025.



Of the total number of people over the age of 65 who are predicted to have a longstanding health condition caused by stroke the greatest prevalence is within the male population who account for 64% of the predicted population affected.

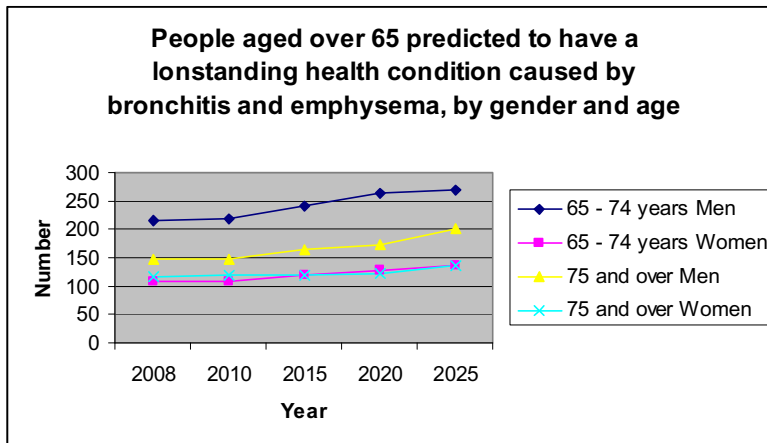


Bronchitis / emphysema

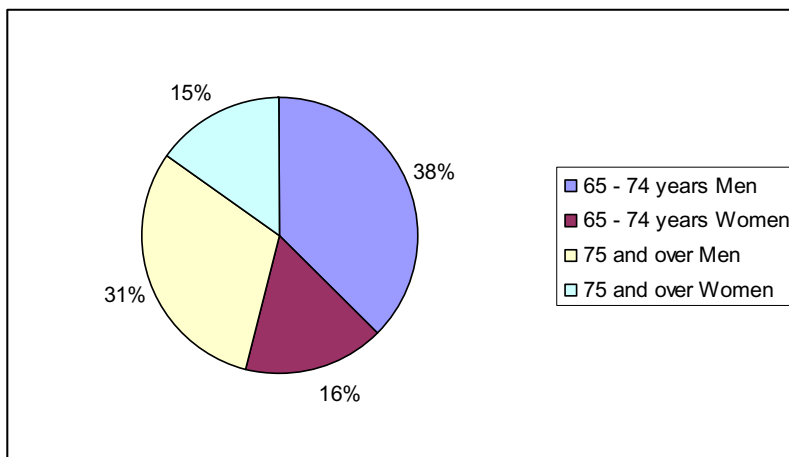
Prevalence rates are based on the 2004/05 General Household Survey, National Statistics, General health and use of health services, chronic sickness: rate per 1000 reporting selected longstanding conditions, by sex and age. Information on chronic sickness was obtained by asking about any longstanding illness that has had an effect or will have an effect over a period of time.

Using this calculation it is expected that 3.4% of 65-74 year old males, 2.8% of males aged 75 and over, 1.5% of 65-74 year old females and 1.4% of females aged 75 and over report bronchitis and emphysema. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have bronchitis and emphysema to 2025.

This data suggests an increase over the next 17 years in the number of people affected by these conditions.

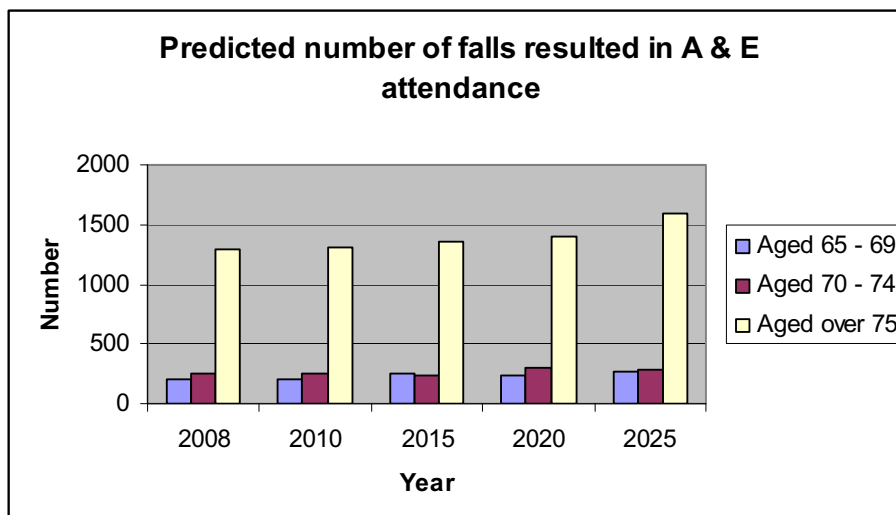


Of the total number of people predicted to have a longstanding health condition related to bronchitis and emphysema men are disproportionately affected accounting for 69% of the total number.

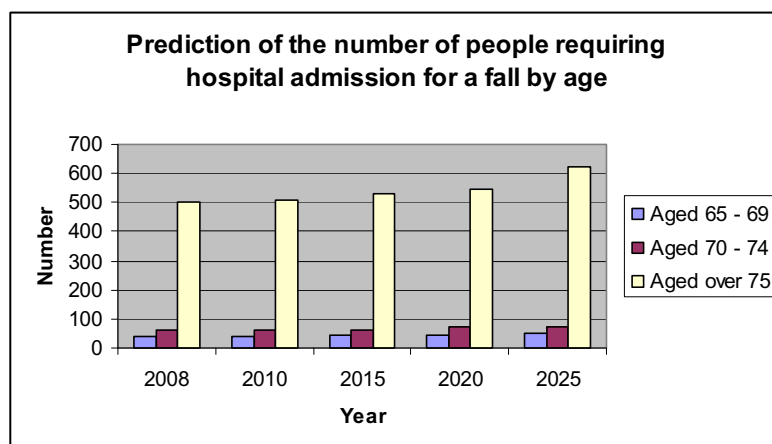


Falls

This section is split into two aspects; firstly a prediction on the number of older people attending A & E as a result of falls and secondly the number of hospital admissions predicted as a result of falls.



This data outlines the importance of this issue and in particular for the over 75 age group. Furthermore the data predicts a rise of around 24% in the number of people requiring treatment from 1,734 in 2008 to 2,145 in 2025.



As above hospital admissions related to falls are disproportionately represented within the over 75 population. The total number in this category is set to rise by approximately 24% from 599 admissions in 2008 to 741 in 2025.

Osteoarthritis

Osteoarthritis is by far the most common joint disease. Knee osteoarthritis is more common than hip osteoarthritis, but taken together they affect 10–20% of people aged over 65, becoming a major cause of pain and disability in the elderly¹¹². About 8 million people in this country are affected with only 12.5% requesting treatment. Unmet need is high (87.5%) which is largely due to under diagnosis as many people never realise they have osteoarthritis.

By applying this data to the South Tyneside population over 65 it is possible to estimate between 2739 and 5478 people with this condition in South Tyneside with approximately between 342 and 685 receiving treatment.

Osteoporosis

Osteoporosis means 'porous bones'. Bones comprise a thick outer shell and a strong inner honeycomb mesh of tiny struts of bone. Osteoporosis resulting in thinning or breaking of the struts. This makes the bone more fragile and prone to break. It often remains undetected until the time of this first broken bone. Broken wrists, hips and spinal bones are the most common fractures in people with osteoporosis.

It is estimated that around one in two women and one in five men over the age of 50 in the UK will break a bone, mainly because of osteoporosis¹¹³. By applying this figure to the South Tyneside population it is expected that around 14,678 women and 5002 men.

Risk of osteoporosis is largely genetic however other risk factors include

- Women who have early menopause or hysterectomy (before the age of 45)
- Men with low levels of testosterone (known as hypogonadism)
- People who have broken a bone after only a minor trauma (called a fragility fracture)
- People who take corticosteroid tablets (For conditions such as asthma or arthritis)
- People with a family history of osteoporosis, particularly if your mother has broken her hip

¹¹² <http://www.arc.org.uk/arthritis/patpubs/6025/6025.asp> accessed 14th December 2007

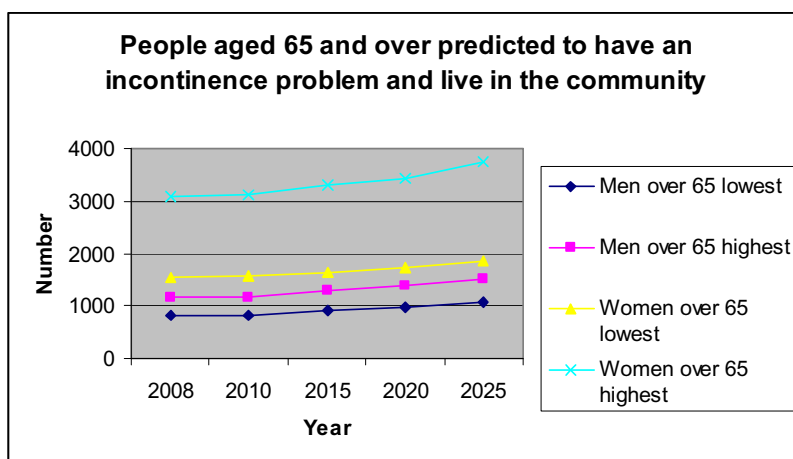
¹¹³ ¹¹³ <http://www.nos.org.uk/about.htm> accessed 14th December 2007

- People with medical conditions which affect the absorption of foods, such as Crohn's disease, coeliac disease or ulcerative colitis
- People with medical conditions which leave them immobile for a long time
- People who drink excessive amounts of alcohol
- People who smoke
- Women who are underweight or have developed an eating disorder

Continence

The POPPI information acknowledges the difficulty in accurately measuring the prevalence of incontinence due to the diversity of definitions linked to the subjective nature of defining the problem. In addition to this people under-report the problem because of embarrassment. In order to partly resolve this, incontinence has been defined as the involuntary/ inappropriate passing of urine/faeces that has an impact on social functioning or hygiene. It also includes nocturnal enuresis (bedwetting)¹¹⁴.

The prevalence of incontinence for people living at home is between 7-10% for men aged 65 and over and 10-20% for women aged 65 and over. The highest and lowest prevalence rates have been applied to ONS population projections of the 65 and over population to present the estimated range of numbers predicted to have incontinence problems to 2025.



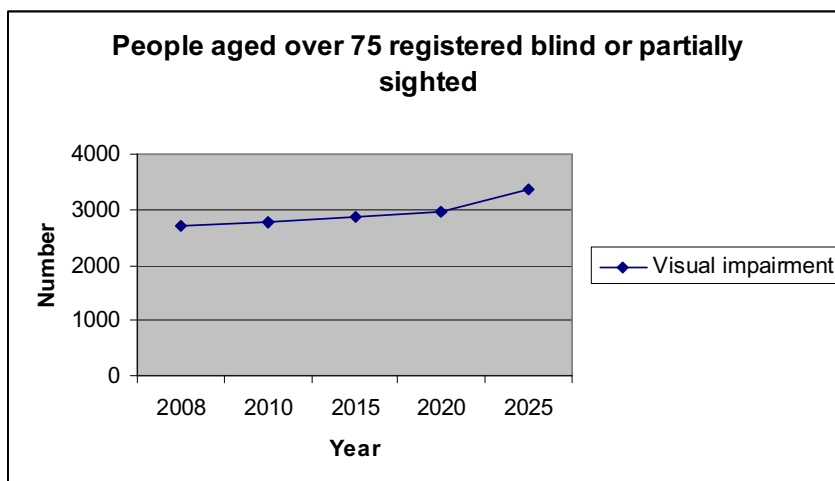
This data highlights, in line with a growing older population, a steady increase in the number of people expected to have incontinence problems over the next 17 years.

Visual impairment

20% of people aged over 75 are registered blind or partially sighted¹¹⁵. An estimate of prevalence is not available for the 65 - 74 age group. The prevalence rate has been applied to ONS population projections of the 75 and over population to provide estimated numbers predicted to be registered blind or partially sighted to 2025.

¹¹⁴ DH (2000) Good Practice Continence Services available online at www.doh.gov.uk/continenceservices.htm

¹¹⁵ RNIB (2002) Progress in Sight: National Standards of Social Care for Visually Impaired Adults

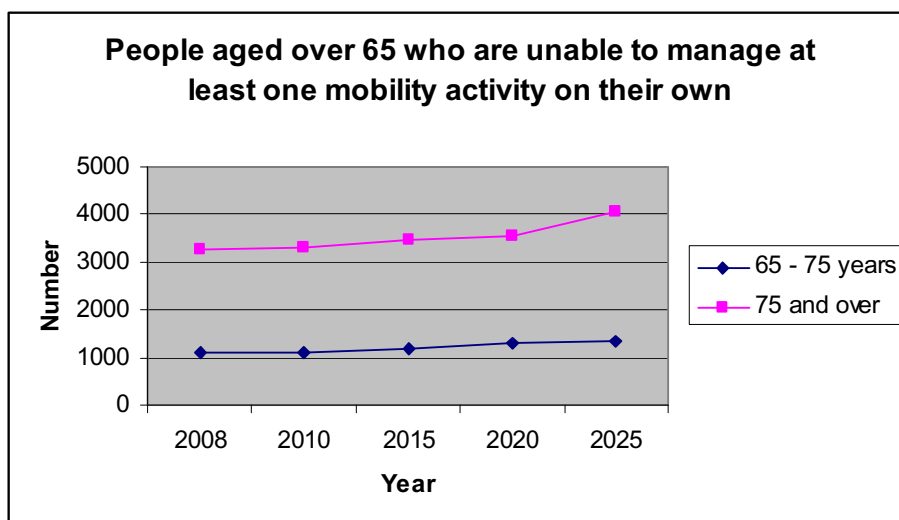


It is expected that in line with a growing elderly population that the number of people with visual impairment will increase by 24% over time.

Mobility

Mobility is defined as the inability to manage at least one mobility activity alone. Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed

Prevalence estimates are derived from an Independent Study Carried Out on Behalf of the Department of Health as Part of the 1998 General Household Survey¹¹⁶ and shows that 8% of 65-74 year olds, and 24% of people aged 75 and over are unable to manage on their own at least one of the mobility activities listed. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be unable to manage at least one of the mobility activities listed, to 2025.



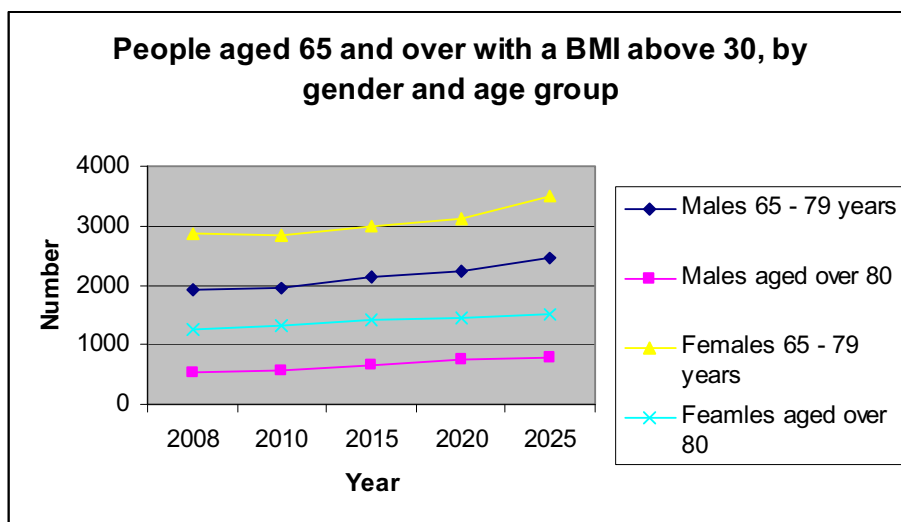
This data suggests there will be an increase of 24% in people living with mobility barriers ranging from 4,360 in 2008 to 5,408 in 2025.

¹¹⁶ Bridgwood, A. (1998) People Aged 65 and Over: Results of an Independent Study Carried Out on Behalf of the Department of Health as Part of the 1998 General Household Survey

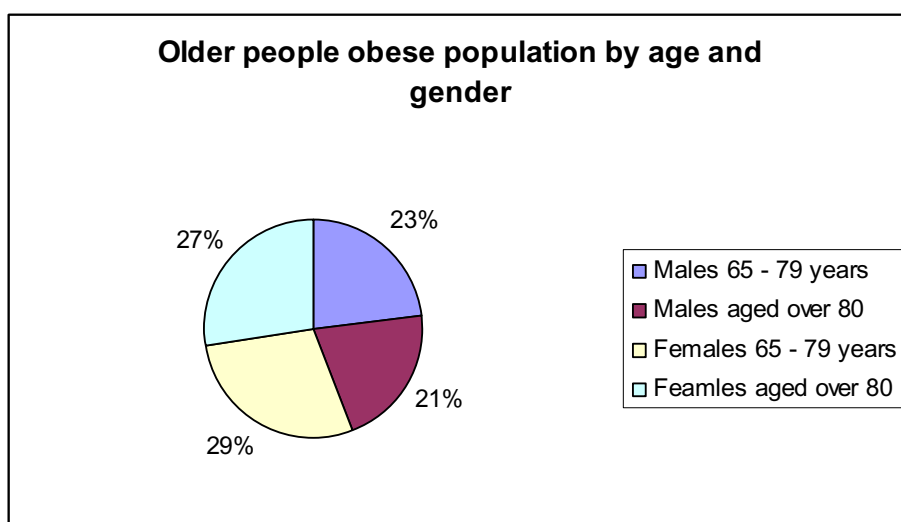
Obesity

The estimates presented in this section are taken from a national survey¹¹⁷ commissioned to provide better and more reliable information about various aspects of people's health, and to monitor selected health targets. Each year the survey focuses in on a specific disease, condition or population group. In 2000 the main focus of the Health Survey for England was on the health of older people.

The survey data outlined that 22% of men and 27% of women aged 65-79 have a BMI above 30; 20% of men, and 26% of women aged 80 and over have a BMI of over 30. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be defined as obese, to 2025.



Within the total population predicted to be obese females are marginally over represented accounting for 56% of the obese population over 65.



¹¹⁷ DH (2000) Health Survey for England 2000, The Health of Older People, DH

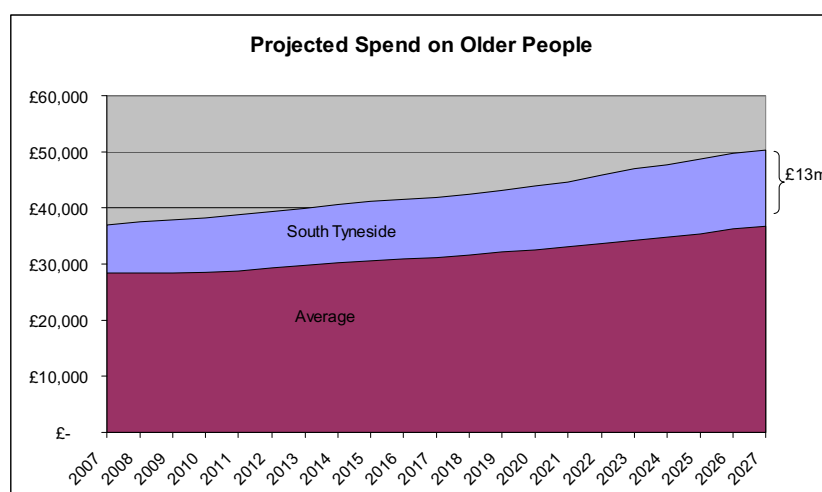
Potential Expenditure increases in relation to health and social care for older people in South Tyneside

Two factors are likely to lead to overall spending increases:

1. Demographics
2. Cost Inflation

Over 65s are projected to increase in the Borough, but significantly over 85s will increase more rapidly. This is important because there is effectively a watershed in demand for social care at age 85. This is due to both additional physical frailty and a marked increase in dementia.

At the last count (2002/3) 44% of all over 85s were clients of social services, as opposed to 7% of the 65-74 age group. In the next twenty years over 65s will increase by 30% but over 85s by 64%. This will have an impact on overall spending levels. If current spending per client continues as now (well above the national average) spending overall will increase by £13m per year. (A simple spend per capita calculation produces a figure of £10m. This is because a calculation based simply on all over 65s masks the rapid increase in the more dependent over 85s).



Cost Inflation

The Social Services Pay and Price Index has been running well ahead of inflation. The Wanless report into social care (Securing Good Care for Older People, Kings Fund, 2006) suggested that this is set to continue. The report estimates that prices may exceed inflation by 2% in order to stimulate sufficient supply to meet increasing demand.

Pay and Price increases at 1.5% above inflation would increase overall spending by £31m (including the effect of demographics) over the next 20 years and by £38m at 2%.

The table below shows the predicted spending increases;

Population Projections

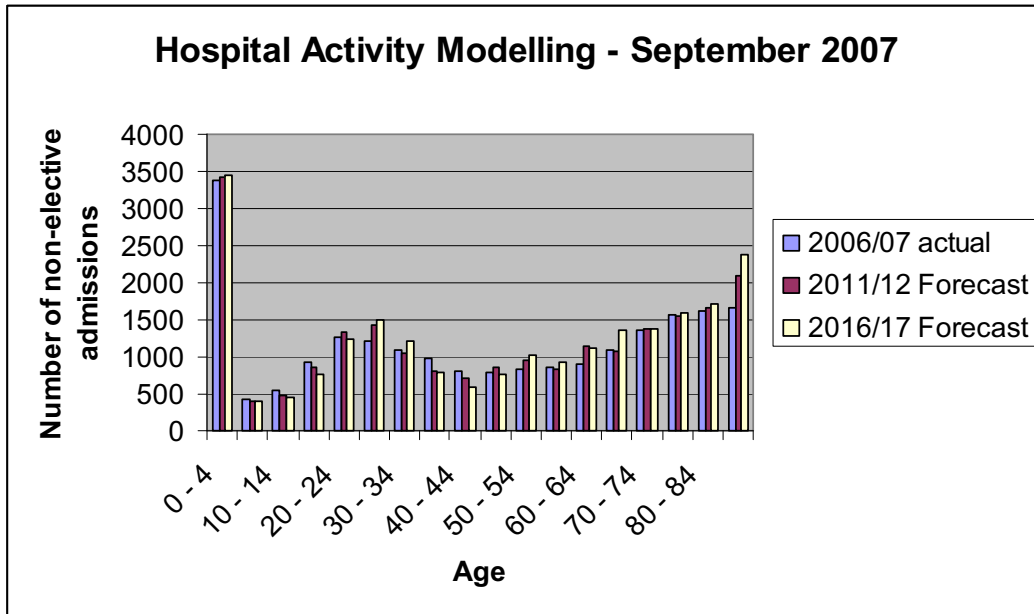
| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|--------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|--------------------|
| 65-74 | 13.8 | 13.7 | 13.7 | 13.7 | 13.9 | 14.2 | 14.6 | 14.8 | 15.1 | 15.5 | 15.7 |
| 75-84 | 10.2 | 10.1 | 10.1 | 10.1 | 10.1 | 10.1 | 10.1 | 10.2 | 10.2 | 10.1 | 10 |
| 85+ | 3.3 | 3.5 | 3.6 | 3.7 | 3.8 | 3.9 | 4 | 4.1 | 4.2 | 4.3 | 4.4 |
| Estimated Clients | 4668 | 4733 | 4780 | 4826 | 4888 | 4956 | 5032 | 5114 | 5183 | 5238 | 5278 |
| Projected Spend (£,000) | £ 37,040 | £ 37,558 | £ 37,929 | £ 38,299 | £ 38,785 | £ 39,329 | £ 39,931 | £ 40,582 | £ 41,126 | £ 41,562 | £ 41,883 |
| 65-74 | 16 | 16.3 | 16.6 | 16.7 | 16.7 | 16.8 | 17 | 17.2 | 17.6 | 18 | Change |
| 75-84 | 10 | 10.1 | 10.2 | 10.4 | 10.8 | 11.1 | 11.3 | 11.6 | 11.9 | 12.1 | |
| 85+ | 4.5 | 4.6 | 4.7 | 4.8 | 5 | 5.1 | 5.2 | 5.3 | 5.4 | 5.4 | 164% |
| Estimated Clients | 5347 | 5436 | 5525 | 5621 | 5797 | 5914 | 6017 | 6140 | 6279 | 6349 | 1682 |
| Projected Spend (£,000) | £ 42,427 | £ 43,136 | £ 43,845 | £ 44,604 | £ 46,005 | £ 46,929 | £ 47,745 | £ 48,727 | £ 49,824 | £ 50,385 | £ 13,345.33 |

Estimated spend per client older person (average from 2005/6) = £7,935

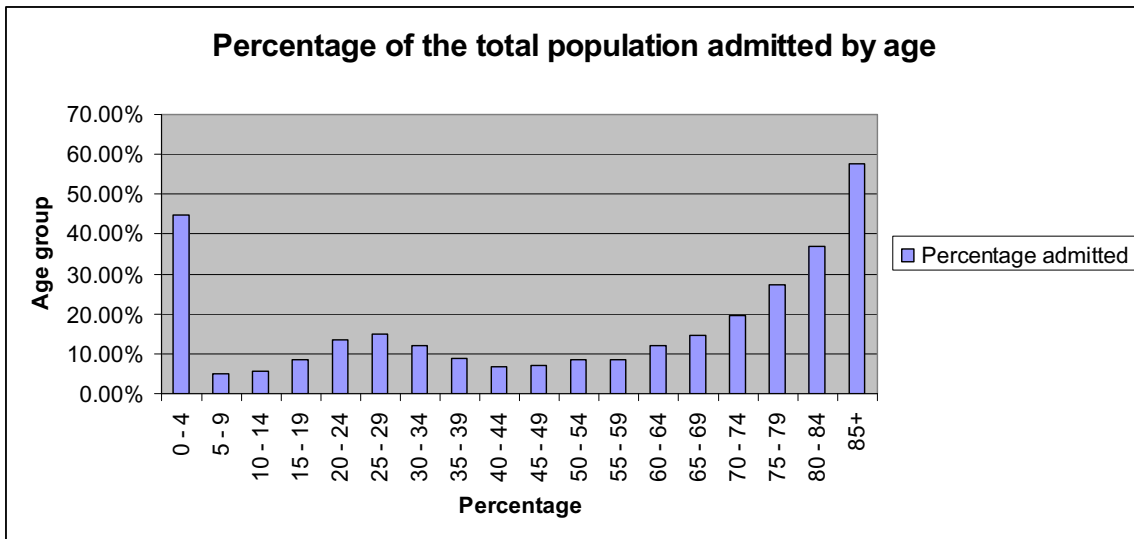
Hospital Episodes

Predictive Modelling for Hospital Admissions

The data outlined the predicted number of admissions based on age. These estimates outline specific age groups requiring further attention in relation to hospital admissions. There is significant activity in the 0 – 4 age group followed by a dip which steadily increases to the age of 34 and then further reduces to age 50 when it begins to rise steadily with age.



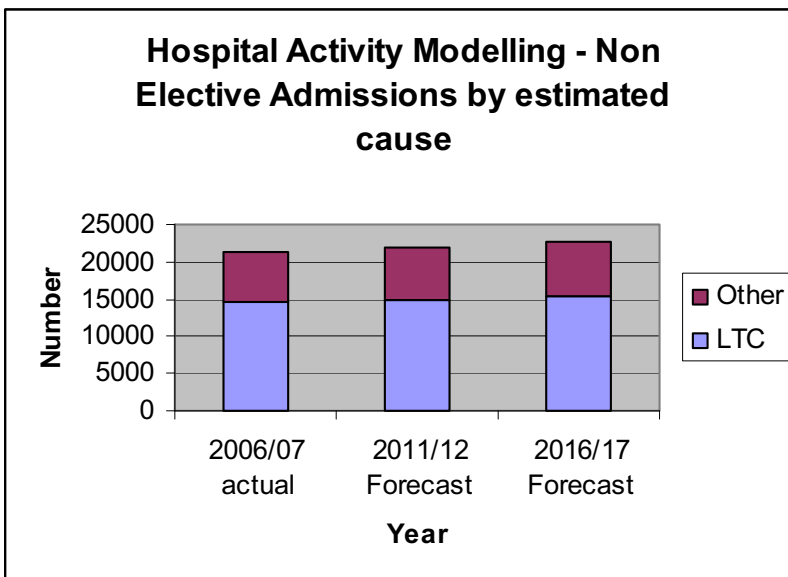
Whilst it is expected that there will be some patients who have accessed for appointments more than once and others who have accessed for none by applying the appointment numbers to the total population in each age group it is possible identify high user ages. This analysis is consistent with the above numbers outlining specific issues for the population under four and over 70.



Long Term Conditions

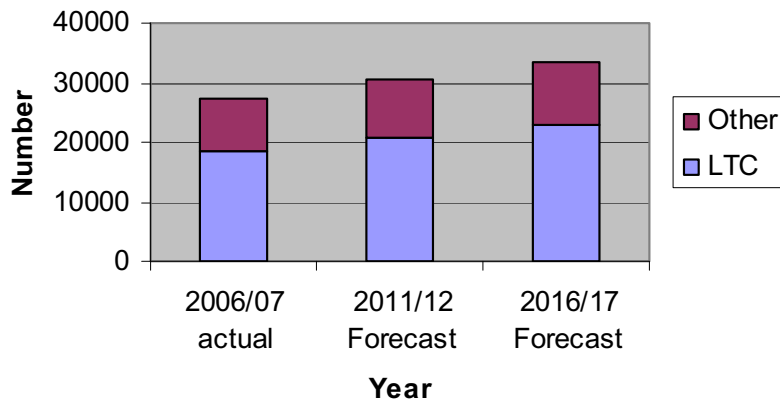
Estimates have suggested that 68% of all outpatient and A & E appointments are linked to Long Term Conditions. The graphs below outline the number of appointments due to LTC for both elective and non-elective admissions. Predictions suggest there will be an increase of around 22.5% for all admissions.

For non-elective admissions it is estimated that LTC accounted for around 14488 admissions in 2006 / 07 rising to 15440 admissions in 2016/17.



For elective admissions it is estimated that LTC accounted for around 18,578 admissions in 2006 / 07 rising to 22,753 admissions in 2016/17.

Hospital Activity Modelling - Elective Admissions by estimated cause



Appendix 1

National Healthy Schools Programme

The programme has four Core Themes

1. PSHE - Personal Social and Health Education including SRE and drug education (alcohol, tobacco and volatile substance abuse)

- SRE in primaries (Lucinda and Godfrey resource) – 32/57 schools involved at various stages
- SRE in secondaries – Is delivered at year 8 and 10 and all 9 schools are involved. Following restructuring, there is a gap in delivery of SRE and the team is looking at avenues to sustain the programme.
- DAT education – Is no longer delivered
- Eight teachers and two school nurses have been supported to complete the Accredited Personal, Social and Health Education module provided by DfES.

2. Healthy Eating

- Food in schools group oversees the activities of this strand
- School meal uptake for 06/07

| | South tyneside | National |
|-------------|----------------|----------|
| Primaries | 63% | 40% |
| Secondaries | 45% | 35% |

- All primary schools are trained and have a copy of the food in schools resource – ‘Food a fact of life’ (British Nutrition Foundation)
- Secondary schools to be trained on BNF resource Food Life Skills in November. 7/9 secondary schools ,4/6 special schools and Alternative education are signed up to the training event in November

3. Physical Activity

- Works closely with Sports Partnership, Childhood Obesity Group and Sports and Physical Activity Group.
- 2 hours of curriculum PE and 3 hours out of school hours physical activity is being delivered in schools
- In 06/07, 92% of pupils in each year group had participated in at least two hours of high quality PE and out of hours school sport in a typical week(National Average 86%) Source : Physical Education, School Sport, Club Links, survey results 2006 – 2007(PESSCL)
- To include more female Looked after Children to participate in sports/physical activities.

4. Emotional Health and Wellbeing

- Primary SEAL (Social and Emotional Aspects of Learning) is a whole school approach to create the environment to promote social and emotional skills at an early age using focussed learning opportunities.
- 92% (47/51) Primary schools are engaged in this programme.
- South Tyneside has already surpassed the Government target of 80% of Primary schools by March 2008.
- Secondary SEAL

Whole secondary school approach to continue and embed the principles of Primary SEAL. Two schools are rolling the programme out in 2007 (Mortimer Community College and Harton Technology College)

Target - To involve 75% of the schools by 2011.

- DEAL (Developing Emotional Aspects of Learning)
- Samaritans resource targeting 14 to 16 year olds
- Successfully piloted in 1 secondary school - Brink burn
- South Tyneside has 16 trainers trained to deliver the programme
- CPD Training session conducted and resources was handed over to 9 secondary schools

1 school has also planned a date for trainers going in to train their staff

- Emotional resilience programme
- This programme uses positive psychology to equip year 7 students with skills to cope more effectively with adversities throughout life. Delivered in year 7
- 7 of the 9 sec schools are engaged – Mainstream, LAC, Alt ed and special schools also have provision and are involved at various stages
- Anti bullying
- A policy for South Tyneside is being developed.

Key antibullying activities include:

- Preparation and initial training for pilot settings in Restorative Interventions/ Restorative Conversations.
- Establishing baseline data re the nature and prevalence of bullying in South Tyneside with termly anti-bullying logs and analysis of data from other sources eg information from mid term applications for school transfer.
- Individual casework.
- Articles within public and Council documents eg Gazette articles during Anti-bullying Week, Team Talk and On View articles in November, School Governor newsletter and MP newsletter.
- School Governor training.
- Anti-bullying Week 2007 – peer support resources and activity ideas, Kindathon activity, information afternoon. This is being evaluated.

Preventative services

The Healthy Schools Programme is a preventative programme. The programme supports and contributes to the Childhood Obesity strategy, Teenage Pregnancy and Sexual Health Strategy, No Smoking Strategy, Food in Schools programme, Drug and Alcohol Targets, Sports and Physical Activity Action Plan.

Health Inequalities

Implementation of the Healthy Schools Programme is affected by access to facilities like open play grounds and impacts on some schools, for example, in built up areas. The NCMP data will be added as an indicator across the school regarding uptake and obesity levels.

Arrangements for patient/public/user involvement in the service

Pupil evaluation
Staff evaluation
Parental involvement in Governor's meeting
Packed lunch initiative

Programme budget for 2007/08

Not confirmed. Requested is £ 60,000 from NRF

Please describe the number and skill mix of staff in the service

| Staff type | Whole time equivalent |
|-------------------------------------|-----------------------|
| Manager | 0.2 |
| Manager | 0.4 |
| Educational Psychologists (2) | 0.5 |
| Admin | 0.4 |
| Healthy School Support Officers (3) | 3 |

Outcomes

South Tyneside is undertaking an outcome exercise to link to the outcomes booklet already developed. At the moment the only outcome is surpassing the targets for

engaging and accreditation of schools as healthy schools and Smoke Free School Award and FIS uptake.

Appendix 2

Children with Disabilities

Preventative services are services provided to better support the family in looking after their child, and so may prevent family breakdown. A further impact of these services is to minimise the numbers of children looked after full time Services commissioned by South Tyneside Council include:

- After School Care (PHAB Club)
- Outreach support (allied health care, St Cuthbert's Care)
- Residential short breaks (St Cuthbert' s Care)

Preventative measures which could be taken or developed to reduce demands on the service and/or make more effective use of the service include more work with mainstream providers to improve access to social and leisure and childcare related services for children with complex needs

South Tyneside Active Network is a forum for parents of disabled children

Survey work with parents of severely disabled children indicate that they would like more services located closer to home and greater levels of integration of services

Programme budget for 2007/08

Social care budget £999, 824

Staff in the service

| Staff type | Whole time equivalent |
|--|--|
| Manager | 2 managers, |
| Practitioner (please specify type e.g. Health Visitor) | 1 senior Practitioner 4.5 Social workers 1 SWA 1 scale 7 nurse 1scale 6 nurse 1 scale 5 nurse 1 scale 4 nurse 1 scale 3 nurse |
| Admin | 2 |

Service outcomes

The Nursing element of the service is involved in the full range of preventative health priorities – teenage pregnancy, obesity, smoking cessation, but there are not particular recording arrangements around these initiatives in respect to this group of young people.

Appendix 3

Support for children experiencing domestic violence

There is a range of services in South Tyneside, provided by statutory and voluntary agencies, which can provide support for children and young people who are affected by domestic violence. However, many of these services are not specifically targeted at children and young people but, by the very nature of their provision, have a residual, positive impact on them.

Services specific to Children & Young People:

- CAMHS - Child and adolescent mental health services (CAMHS) promote the mental health and psychological wellbeing of children and young people, and provide high quality, multidisciplinary mental health services to all children and young people with mental health problems and disorders to ensure effective assessment, treatment and support, for them and their families. From January to June 2008, South Tyneside CAMHS received approximately 53 referrals of young people, with 19 of those still to be seen. Of those 53, approximately half of them have domestic violence identified as impacting on their current issues.
- NSPCC Brighton Grove, Newcastle - Offers a therapeutic (assessment & counselling) service for children and young people aged between 4-18 who have suffered harm and abuse. Services include family therapy, direct and indirect play therapy, developmental attachment and counselling. The team also provides work with carers. Referrals from carers and children/young people are accepted. Currently, there are approximately five children referred from South Tyneside that are still receiving a service.

Other services that provide residual benefits to Children & Young People experiencing domestic violence:

The following services are not specifically targeted at children and young people, or focussed on domestic violence issues. However, they can provide residual benefit to children and young people suffering domestic violence as a secondary issue, by providing wider support to parents and families, and in other ways.

- Places for People Women's Refuge - PfP provide refuge support, which is staffed 24 hours a day, 7 days a week. The service offers advice, support and safe and secure temporary accommodation for women with or without children, who are experiencing domestic abuse, from all Boroughs. Refuge facilities comprise eight houses (three which accommodate two women without children, with separate bedrooms and five 3-bedroom houses for women with children) and one self-contained 3-bedroom, purpose-built bungalow for women with or without children, with mobility issues and full wheelchair access. The refuge also offers a communal area, Women's Group and an OFSTED registered crèche. In addition, an outreach service can also support up to seventeen women at any one time. This service provides one-to-one appointments and the development

of support plans. Referrals to the refuge come from a number of agencies, including South Tyneside Homes, Social Services and the Police.

- Homelessness Team - The Council's Homelessness Prevention Team provides a central point for homelessness advice and assistance. If clients are homeless or threatened with homelessness the team can support them. The team also has a selection of Homeless Units across the Borough. The Team can: Refer a person to the Women's Refuge directly, contact Options, Contact Children's Services if there is a child involved and exercise nomination rights. The team can also provide assistance with housing applications, once emergency or temporary accommodation has been found.
- Multi-agency Risk Assessment Conference (MARAC) – The MARAC identifies victims of domestic abuse who are most at risk of experiencing violence. The key element of MARAC is the risk assessment, which will be carried out by agencies referring in to the process. Information shared through the MARAC will be used to promote the safety of women and their children suffering from domestic abuse.
- Options – A voluntary sector service that provides (i) confidential and non-judgmental advice to women over 18 on domestic violence issues, in a safe place, (ii) contact with and referral to other relevant organisations, (iii) weekly support groups giving opportunities to meet survivors of domestic violence and make new friends and (iv) bilingual staff and interpreters.
- Domestic Violence training – The Domestic Violence Forum, with support from Adult & Community Learning, has provided training for practitioners and volunteer workers to raise awareness of domestic abuse issues, including: understanding abuse, dispelling myths, impact issues on survivors, seeking help, gender issues and so on. The individuals trained are then able to use these skills and knowledge to support families and individuals, including children. The Children & Young Peoples Directorate provides domestic abuse training to staff on a regular basis and is supporting the Domestic Violence Forum to deliver an ongoing programme of domestic abuse awareness training for front line staff across the Borough.
- South Tyneside Domestic Abuse Perpetrator Programme (STDAPP) – The Programme is a multi-agency partnership between statutory and voluntary agencies in South Tyneside that aims to work with perpetrators of domestic abuse to increase the safety of women and children. It is a comprehensive tertiary prevention model, meeting Respect Minimum Standards and based around a motivational, experiential approach.
- Sanctuary Scheme - This scheme aims to support victims of domestic violence by making it possible for them to stay living safely in their own home. The scheme means that victims of domestic violence might not need to move house, transfer their children to another school, change address, change doctors or move away from surrounding family and friends.

- Supporting People - offers vulnerable people the opportunity to improve their lives through high quality supported housing services, which meet needs and encourage independent living within the community. One of the programme's priority client groups is "women fleeing domestic violence". SP currently funds services such as the Women's Refuge, Dock Street/Ingham Project/Sharp & Ingham Mone On (all for young people at risk) and Churches Key.
- TULIP Group - a support group for parents who are experiencing domestic abuse from their children and teenagers. The possibility of developing a young persons TULIP group is currently being investigated.
- South Tyneside Early Prevention Panels (STEPP) - STEPP is a boroughwide youth crime prevention initiative, which became operational in January 2004. It offers voluntary support to young people aged 8-16, who are behaving in ways that put them at risk of offending - be it truancy, school exclusion, friends or family members involved in offending or anti-social behaviour, problems within the family, mental health issues, drug misuse, anti-social behaviour and other risk *factors*. The programme works closely with its partner agencies - Social Services, Education Welfare, Connexions, Housing, Youth Offending Service (YOS), the Police - and others to identify young people at risk.
- Matrix – a team of workers employed by different agencies who are trained to deal with substance use issues affecting young people. The Matrix works with young people under 19, families and carers whose lives have been affected by substance misuse or those who are at risk of developing substance use issues.
- Connexions - Connexions is a confidential advice and support service for all 13-19 year olds (up to age 25 for young people with special needs). Connexions has been set up with the help of young people, for young people, who have a real say in how the service is run and how it develops in the future. The service helps young people prepare for adult life by offering advice and support on a wide range of lifestyle issues, including: education, training, careers, employment, health and personal development. Connexions can also help with other important issues such as bullying, domestic abuse, problems at home or at work, drugs, relationships or money.

Appendix 4

Childhood Obesity

Since obesity figures are showing an increasing trend, it is to be assumed that the activity needs to increase to meet the increasing demand and also focussed preventative action to reverse the trend. The main services/ initiatives trying to achieve a reduction in obesity are

- Mini Mend
- Early Years dietician
- MEND
- Breast Friends
- Food In Schools
- School sports partnership
- Increasing physical activity in looked after children
- National Child Measuring Programme

Met needs of the population

It is difficult to give exact figures but data available are shown below. The main services trying to achieve a reduction in obesity are

- MEND - Four programmes have been completed and 43 children graduated
- Early Years Dietician - Target to train 96 early years staff in early year's nutrition in 17 months. 18 childcare establishments' menus assessed individually
- Breast Friends – 150 - 200 women per quarter access their services including advice and support. However, given 1500 maternities per year only about 50% is covered.
- Food In Schools - School meal uptake for 06/07

| School Type | South Tyneside | National |
|-------------|----------------|----------|
| Primaries | 63% | 40% |
| Secondaries | 45% | 35% |

To achieve 100% coverage an increase in uptake of about 40 % in primary and 55% in secondary schools is needed

- School sports partnership - In 06/07, 92% of pupils in each year group had participated in at least two hours of high quality PE and out of hours school sport in a typical week(National Average 86%)
- Increasing physical activity in looked after children - In the very early stages
- School Travel plans have been developed by 76% of schools across the borough

| Service | Provider | Commissioned by | Impact |
|--------------------|--|-------------------|--|
| Mini MEND and MEND | Psychology Dept, dietician (Foundation trust), Sports partnership, | PCT (NRF funding) | Holistic approach which improves the lifestyle of not only the child but the family as a unit. |

| | | | |
|----------------------------|--|---------------------------------|---|
| | Health development (Council) | | |
| Food In Schools | Healthy Schools, Council Catering Dept and Health Development Dept | PCT (NRF partially) and Council | Improves healthy eating and helps change ethos in schools. |
| Breast Friends | Volunteer Mums | PCT (NRF) | Improves BF rates and thereby tackle obesity |
| Early Years Dietician | Dietician | PCT (NRF) | Capacity building in early years by increasing trained staff on giving nutrition advice thereby improving healthy eating. Reduce Obesity |
| Schools sports partnership | Schools sports partnership | Council | Improving physical activity and reducing obesity |

Preventative Measures

The following preventative measures could be developed to reduce demands on the service and/or make more effective use of the service:

- Breast Feeding Education in schools – to gradually help change the attitude of the next generation towards breast feeding and thereby reduce obesity, reduce admissions for infections, and reduce eczema and allergies.
- Strengthening Tier 2 of the obesity strategy based on increased activity of Health Visitors and School Nurses providing family interventions for children and young people who are overweight or obese or at risk of becoming overweight or obese

Health Inequalities

Childhood obesity is a health inequalities issue. Children from low socio-economic backgrounds are more likely to be overweight or obese; women from low socio-economic backgrounds and those with low educational attainment are less likely to breastfeed. This is reflected in geographic variations of obesity as shown in the earlier obesity chapter and the breastfeeding section detailed under 'Be Healthy'.

Patient/public/user involvement in the service

The Breastfeeding Peer Support Programme provides a comprehensive approach to public involvement through training and support for local women in the specific area of breastfeeding support. This method ensures the views of local women are included in the development of the breastfeeding strategy.

Evaluation reports for both MEND and Breast Friends are available.

Programme budget for 2007/08

Childhood obesity (including MEND, Breast friends and Early Dietician) was £70,000. At the time of writing future funding of the service is uncertain.

Staff in the service

| Staff type | Whole time equivalent |
|-----------------------------------|-----------------------|
| Manager | |
| Consultant Clinical Psychologists | |
| Assistant Psychologist | |
| Dietician | 0.2 |
| Sports Development Officer (3) | 0.5 |
| | 0.1 |
| Health Development Officer | 0.1×2 |
| | 0.2×1 |
| | 0.3 |

Outcomes

MEND

- 4 programmes were completed by July 2007, 85.4% retention rate and 43 children graduated
- Average waist circumference reduction of 3.93cm per child, over the 9 weeks
- Significant improvement in resting ($p=0.052$), after exercise ($p<0.001$) and recovery ($p=0.002$) heart rate
- Overall BMI had a mean reduction of 0.77 units per child (29.15 to 28.38)
- On average, parents/carers lost 4.5 pounds and had a BMI reduction of 0.79 units

Appendix 5

Dental Health

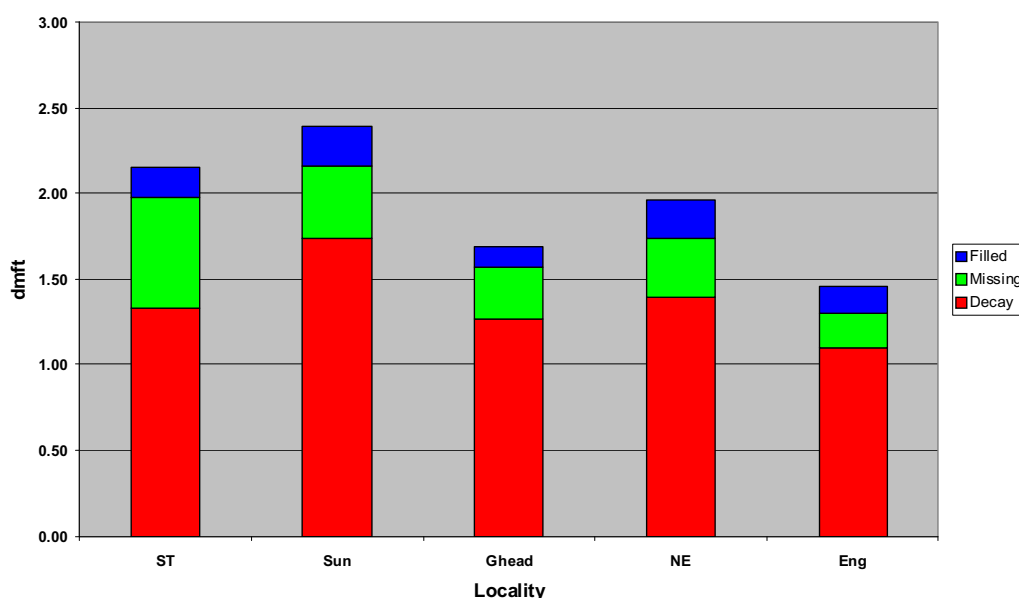
Year 1 BASCD Results, 2005/06

| | South Tyneside | Gateshead | Sunderland | North East | England |
|----------------------|----------------|-----------|------------|------------|---------|
| Dmft | 2.15 | 1.69 | 2.39 | 1.97 | 1.47 |
| %dmft > 0 | 54.9 | 52.7 | 56.2 | 50.3 | 38.0 |
| Mean dmft for dmft>0 | 3.92 | 3.2 | 4.26 | 3.93 | 3.86 |
| %Caries Free | 45.1 | 47.3 | 43.8 | 49.7 | 62.0 |
| Care Index | 8 | 7 | 10 | 11 | 11 |

Care Index = $\text{ft/dmft} \times 100\%$ (decayed, missing, or filled teeth)

The following chart shows a breakdown of dmft into separate components for South Tyneside, compared to Sunderland, Gateshead, the North East and England.

BASCD 2006 Comparison of dmft for Year 1 Children in South Tyneside, Sunderland, Gateshead, North East and England



Significant decay amongst children remains untreated and many children will present in pain from decayed teeth. 113 children under 6 years of age had teeth extracted under a general anaesthetic between April 2005 and March 2006. Standardised rates per 100,000 for children under 6 are shown by ward (appendix?)

Decay rates are high despite high reported attendance rates at an NHS dentist. Overall attendance rates are not an indicator of good oral health. However it may be proposed that many of the children with the highest decay rates are those who do not attend.

Registration with a GDP ceased with the introduction of the new dental contract in April 2006. The last available information re attendance is therefore registration rates as of end March 2006 at which time 69% of 0-9 year olds were registered with a dentist.

Registration Rates for 0 –18 years for South Tyneside PCT, March 2006

| Age | 0 -2 years | 3 -5 years | 6 -12 years | 13 –17 years | All under 18 |
|---------------|------------|------------|-------------|--------------|--------------|
| Number | 1,691 | 3,566 | 11,713 | 9,114 | 26,084 |
| Rate | | | | | |

| 0 – 9 | | 10 - 17 | | All under 18 | |
|--------|-------|---------|-------|--------------|-------|
| Number | Rate | Number | Rate | Number | Rate |
| 11,682 | 69.0% | 14,402 | 85.4% | 26,084 | 77.2% |

NHS dental care is currently accessible at 22 general dental practices throughout South Tyneside (appendix???) and from the PCT Salaried Dental Service for special care patients and on referral from health professionals.

Information is also available for older children. The following tables show the latest available information on oral health of children aged 11 and 14yrs.

BASCD Survey Report 2004/2005 – Children aged 11 years

| | South Tyneside | Gateshead | Sunderland | NT&W | England |
|----------------------|----------------|-----------|------------|------|---------|
| DMFT | 0.75 | 0.90 | 1.05 | 0.83 | 0.64 |
| % DMFT>1 | 36.9 | 42.5 | 41.1 | 38.5 | 30.4 |
| Mean DMFT for DMFT>1 | 2.04 | 2.12 | 2.55 | 2.15 | 2.09 |
| Care Index | 40 | 20 | 36 | 34 | 40 |

Care Index = FT/DMFT x 100%

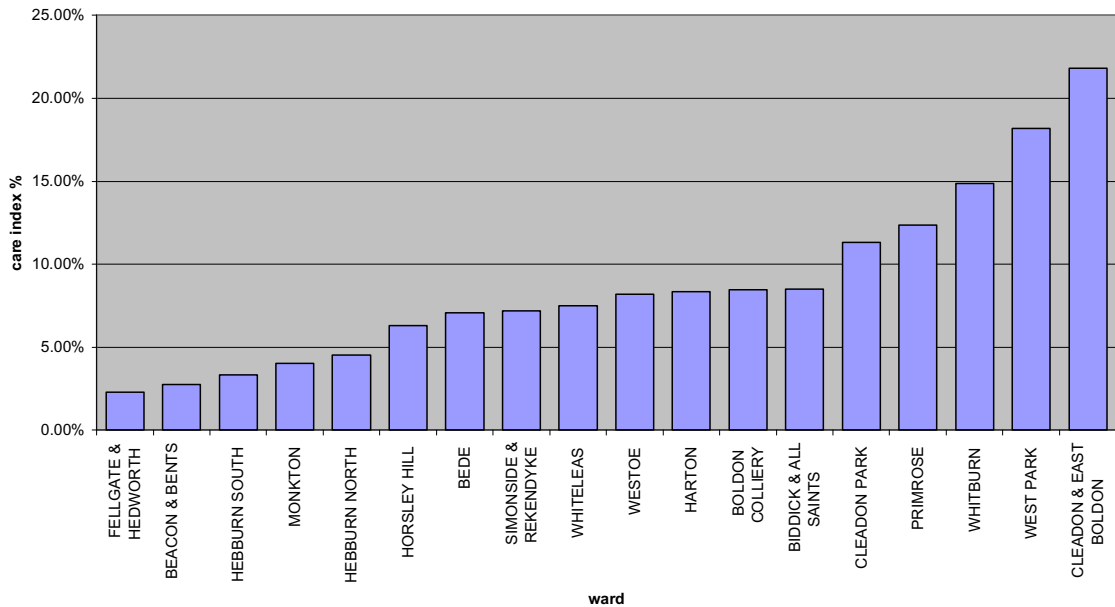
BASCD Survey Report 2002/2003 – Children aged 14 years

| | South Tyneside | Gateshead | Sunderland | NT&W | England |
|--|----------------|-----------|------------|------|---------|
| | | | | | |

| | | | | | |
|----------------------|------|------|------|------|------|
| DMFT | 1.65 | 1.24 | 2.15 | 1.70 | 1.43 |
| % DMFT>1 | 60.0 | 51.7 | 64.2 | 57.9 | 48.0 |
| Mean DMFT for DMFT>1 | 2.75 | 2.40 | 3.35 | 2.93 | 2.98 |
| Care Index | 58 | 52 | 52 | 48 | 55 |

National trends show that decay rates in older age groups have dropped dramatically over the last 30 years, mainly due to the introduction and now widespread use of fluoride toothpaste and the overall trend shows continued improvement. Oral health in England in this age group is the best in Europe. However inequalities do exist and the north of England, on average, is worse than the South. Decay is still linked to social position and deprivation although the difference is not as marked as in younger age groups. Oral health is generally worse in those with special needs and in looked after children.

South Tyneside BASCD 2006 Care Index by Ward



Appendix 6

Sexual Health

Preventative services

| Service | Commissioner | Provider | Impact |
|---------------------------------|---------------------------|--|---|
| Contraception and sexual health | PCT / Children's Alliance | Clinical service providing contraceptive and sexual health services to young people | Reduction in teenage conceptions Reduction in Maternities Reduction in TOP's Reduction of STI's Reduction of pelvic inflammatory disease. |
| Drop Ins in schools | PCT / Children's Alliance | Delivered by Sexual Health Team and school nurses. Provide SRE / health advise which includes sexual health and condom distribution. | Reduction in teenage conceptions Reduction in Maternities Reduction in TOPs Reduction of STIs Reduction of pelvic inflammatory disease. |
| Condom Card Scheme | PCT / Children's Alliance | School Nursing service Sexual Health Team | Reduction in teenage conceptions Reduction in Maternities Reduction in TOPs Reduction of STIs Reduction of pelvic inflammatory disease |
| Pregnancy Options | PCT | Provides advise and support for young women pregnancy and options | Reduction in teenage conceptions Reduction in Maternities Reduction in TOPs Reduction of STIs Reduction of pelvic inflammatory disease |
| Chlamydia screening programme | PCT | Provide opportunistic Chlamydia screening for young people aged 15 – 25 years | Reduction in teenage conceptions Reduction in Maternities Reduction in TOPs Reduction of STIs Reduction of pelvic inflammatory disease |

| | | | | |
|-----------------------------|-------------------------|---|---|--|
| SRE | PCT Children's Alliance | / | SRE delivered in multi agency settings which are both universal and targeted | Reduction in teenage conceptions Reduction in Maternities Reduction in TOPs Reduction of STIs Reduction of pelvic inflammatory disease |
| Media | PCT Children's Alliance | / | A range of mediums used to deliver safe sex messages to young people | Reduction in teenage conceptions Reduction in Maternities Reduction in TOPs Reduction of STIs Reduction of pelvic inflammatory disease |
| Support for teenage parents | PCT Children's Alliance | / | Holistic support provided for young parents from conception. Also works with young parents re prevention on unintended subsequent pregnancy | Reduction in teenage conceptions Reduction in Maternities Reduction in TOPs Reduction of STIs Reduction of pelvic inflammatory disease Increase in young mothers participating in EET Reduction in numbers of low birth weight babies Reduction in infant mortality Increase numbers breastfeeding |

Activity

| Service | 04/05 | 05/06 | 06/07 | 07/08 | 08/09 | 09/10 |
|--|----------|---------|---------|-------------|-------|-------|
| Grapevine | | | 3945 | Approx 5000 | | |
| Drop ins – Schools | | | | 47 | | |
| Condom Card | | 46 | 260 | 143 | | |
| Pregnancy Options / post natal contraception | 110/ 106 | 86 / 43 | 76 / 41 | 80 / 49 | | |
| Chlamydia Screening | | | | 678 | | |

| | | | | | | |
|---------------------------------|-----|-------------|---------|--------------|--|--|
| Programme | | | | | | |
| Universal | | 2669 | | | | |
| Targeted | | | | | | |
| Young Women's pregnancy service | 161 | 171 | 163 | 128 | | |
| SS+ Team | | 101 | 95 | 59 part year | | |
| Young Action Volunteers | | 25 | 30 | 26 part year | | |
| Housing | | 22 / 25 | 19 / 30 | 31 / 22 | | |
| Reintegration Officer | 8/3 | 10/10 | 11/5 | 6/2 | | |

Unmet needs of the population

| | |
|---------------------------|--------------------------|
| Young people aged 15 - 24 | Total population 19, 935 |
| | Female population 9, 839 |
| | Male population 10, 096 |

| Age | Total | Male | Female |
|---------|-------|------------------|--------|
| 13 - 15 | 6181 | 3090.5 (154 Gay) | 3090.5 |
| 16 – 19 | 8607 | 4303.5 (215 Gay) | 4303.5 |
| 20 – 24 | 9289 | 4674 (234 Gay) | 4615 |

Patient and Public Involvement

Patient and Public Involvement includes:

- TP Action Planning Annual Event
- Mystery Shopper Project
- SRE evaluation
- Grapevine Annual Survey

Programme budget for 2007/08

According to the Next Steps Guidance (2006) every £1 spent on teenage pregnancy prevention results in a £4 saving to the public purse.

| Service area | Cost | Saving |
|---|-----------|----------|
| Teenage Pregnancy Local Implementation Fund | £165, 000 | £660,000 |

The LIF currently funds a number of posts which are fundamental in delivering the local strategy. The budget in 2007 / 08 was £155, 000 LIF. An additional £39,321.65 has been allocated by Adult and Community Learning to support the educational provision for young parents over 16. (Funding allocation August '07 – July '08)

South Tyneside Youth Support Service provides 6 hours staffing to support the Young Mum's to Be course.

Number and skill mix of staff in the service

| Project and posts | WTE | Employing organisation |
|---------------------------------|----------|-------------------------------|
| Contraception and Sexual Health | | |
| Clinical lead | 0.1 | Primary Care Trust |
| HCA | 0.08 | Primary Care Trust |
| HCA | 0.08 | Primary Care Trust |
| Nurse | 0.08 | Primary Care Trust |
| Nurse | 0.08 | Primary Care Trust |
| Nurse | 0.11 | Primary Care Trust |
| Total | | Primary Care Trust |
| Options Adviser | 30 hours | Primary Care Trust |
| Young Parents Worker | FT | Primary Care Trust |
| Sex Education Team Youth Worker | FT | Local Authority Youth Service |
| P/T Midwife | 0.5 WTE | Foundation Trust |
| Admin support | 20 hours | Primary Care Trust |
| Sure Start Plus Strategic Lead | 30 hours | Primary Care Trust |
| ESF funded health visitor | FT | Primary Care Trust |
| TOTAL | | |

Appendix 7

Looked After Children

DETAILED LAC QUARTERLY DATA FOR SOUTH TYNESIDE FOR 2007/08

Compiled by Gary Fawcett, Inform House
Updated to 31/3/08 at

excluding respite care LAC

LAC Total By Age Group

| | 31/03/2007 | % | 30/06/2007 | % | 30/09/2007 | % | 31/12/2007 | % |
|-------------|------------|------|------------|------|------------|------|------------|------|
| LAC <1 | 29 | 12% | 28 | 11% | 24 | 9% | 19 | 8% |
| LAC 1 - 4 | 39 | 15% | 43 | 16% | 46 | 17% | 44 | 17% |
| LAC 5 - 9 | 44 | 17% | 46 | 17% | 51 | 19% | 47 | 18% |
| LAC 10-15 | 104 | 41% | 107 | 40% | 107 | 40% | 105 | 41% |
| LAC 16 - 17 | 36 | 14% | 41 | 15% | 37 | 14% | 39 | 15% |
| Total LAC | 252 | 100% | 265 | 100% | 265 | 100% | 254 | 100% |
| Rate/ 1,000 | 7.79 | | 8.36 | | 8.36 | | 8.01 | |

LAC Starts by Age Group

| | In Year To 31/03/2007 | % | In Quarter to 30/06/2007 | % | In Six Mths to 30/09/2007 | % | In Nine Mths to 31/12/2007 | % |
|--------------------|--------------------------|------|--------------------------------|------|---------------------------------|------|----------------------------------|------|
| including restarts | | | | | | | | |
| LAC <1 | 34 | 31% | 6 | 19% | 10 | 17% | 18 | 23% |
| LAC 1 - 4 | 26 | 24% | 3 | 9% | 8 | 13% | 13 | 16% |
| LAC 5 - 9 | 18 | 17% | 7 | 22% | 17 | 28% | 18 | 23% |
| LAC 10-15 | 26 | 24% | 15 | 47% | 23 | 38% | 28 | 35% |
| 16 - 17 | 4 | 4% | 1 | 3% | 2 | 3% | 3 | 4% |
| Total Starts | 108 | 100% | 32 | 100% | 60 | 100% | 80 | 100% |
| Rate/ 1,000 | 3.34 | | 4.04 | | 3.79 | | 3.36 | |

LAC Leavers by Age Group

| | In Year To 31/03/2007 | % | In Quarter to 30/06/2007 | % | In Six Mths to 30/09/2007 | % | In Nine Mths to 31/12/2007 | % |
|-------------------|--------------------------|-----|--------------------------------|-----|---------------------------------|-----|----------------------------------|-----|
| including reeased | | | | | | | | |
| LAC <1 | 6 | 6% | 1 | 5% | 2 | 4% | 3 | 4% |
| LAC 1 - 4 | 28 | 29% | 4 | 21% | 10 | 21% | 28 | 35% |
| LAC 5 - 9 | 22 | 22% | 4 | 21% | 9 | 19% | 13 | 17% |
| LAC 10-15 | 21 | 21% | 8 | 42% | 13 | 28% | 17 | 22% |

| | | | | | | | | |
|---------------|------|------|-----|------|------|------|------|------|
| 16 - 17 | 7 | 7% | 1 | 5% | 6 | 13% | 7 | 9% |
| Age 18 | 14 | 14% | 1 | 5% | 7 | 15% | 10 | 13% |
| Total Leavers | 98 | 100% | 19 | 100% | 47 | 100% | 78 | 100% |
| Rate/ 1,000 | 3.03 | | 2.4 | | 2.97 | | 3.27 | |

| LAC Starts by Main Need including restarts | In Year To 31/03/2007 | % | In Quarter to 30/06/2007 | % | In Six Mths to 30/09/2007 | % | In Nine Mths to 31/12/2007 | % |
|--|--------------------------|------|--------------------------------|------|---------------------------------|------|----------------------------------|------|
| N1 Abuse or Neglect | 88 | 81% | 28 | 88% | 49 | 82% | 65 | 81% |
| N2 Disabled | 0 | 0% | 1 | 3% | 1 | 2% | 2 | 3% |
| N3 Parental Illness | 7 | 6% | 0 | 0% | 4 | 7% | 5 | 6% |
| N4 Family in Acute Stress | 1 | 1% | 0 | 0% | 2 | 3% | 2 | 3% |
| N5 Family Dysfunction | 2 | 2% | 0 | 0% | 1 | 2% | 1 | 1% |
| N6 Socially Unacceptable Behaviour | 4 | 4% | 3 | 9% | 3 | 5% | 3 | 4% |
| N7 Low Income | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| N8 Absent Parenting | 6 | 6% | 0 | 0% | 0 | 0% | 2 | 3% |
| Total Starts | 108 | 100% | 32 | 100% | 60 | 100% | 80 | 100% |

| LAC Starts by Group Size including restarts | In Year To 31/03/2007 | % | In Quarter to 30/06/2007 | % | In Six Mths to 30/09/2007 | % | In Nine Mths to 31/12/2007 | % |
|---|--------------------------|------|--------------------------------|------|---------------------------------|------|----------------------------------|------|
| One child only | 57 | 53% | 22 | 69% | 37 | 62% | 51 | 64% |
| As part of two together | 34 | 31% | 4 | 13% | 6 | 10% | 12 | 15% |
| As part of three together | 9 | 8% | 6 | 19% | 12 | 20% | 12 | 15% |
| As part of four or more together | 8 | 7% | 0 | 0% | 5 | 8% | 5 | 6% |
| Total Starts | 108 | 100% | 32 | 100% | 60 | 100% | 80 | 100% |

| LAC Leavers by Reason including receased | In Year To 31/03/2007 | % | In Quarter to 30/06/2007 | % | In Six Mths to 30/09/2007 | % | In Nine Mths to 31/12/2007 | % |
|--|--------------------------|-----|--------------------------------|-----|---------------------------------|----|----------------------------------|-----|
| E11 Adopted Unopposed | 28 | 29% | 0 | 0% | 2 | 4% | 11 | 14% |
| E12 Adopted Consent Dispensed | 0 | 0% | 2 | 11% | 2 | 4% | 5 | 6% |
| E2 Died | 1 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |
| E3 Cared For by Other LA | 0 | 0% | 3 | 16% | 3 | 6% | 3 | 4% |

| | | | | | | | | |
|-------------------------------|----|------|----|------|----|------|----|------|
| E4 Returned to Parents | 31 | 32% | 8 | 42% | 24 | 51% | 36 | 46% |
| E41 Residence Order | 12 | 12% | 3 | 16% | 3 | 6% | 5 | 6% |
| E43 SGO to Foster Carers | 7 | 7% | 0 | 0% | 1 | 2% | 2 | 3% |
| E44 SGO to Other Carers | 0 | 0% | 1 | 5% | 1 | 2% | 1 | 1% |
| E5 Supported Ind Living | 5 | 5% | 1 | 5% | 5 | 11% | 5 | 6% |
| E6 Non-Supp Ind Living | 6 | 6% | 0 | 0% | 1 | 2% | 3 | 4% |
| E7 Transfer to Adult Services | 1 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |
| E8 Other | 7 | 7% | 1 | 5% | 4 | 9% | 5 | 6% |
| E9 Sent to Custody | 0 | 0% | 0 | 0% | 1 | 2% | 2 | 3% |
| Total Leavers | 98 | 100% | 19 | 100% | 47 | 100% | 78 | 100% |

Total LAC by Placement Type

| | 31/03/2007 | % | 30/06/2007 | % | 30/09/2007 | % | 31/12/2007 | % |
|-------------------------------------|------------|------|------------|------|------------|------|------------|------|
| Placed for Adoption | 18 | 7% | 24 | 9% | 29 | 11% | 23 | 9% |
| F1 Foster Rel/Friend In Bor | 23 | 9% | 25 | 9% | 24 | 9% | 20 | 8% |
| F2 Foster LA Own In Bor | 100 | 40% | 99 | 37% | 83 | 31% | 91 | 36% |
| F3 Foster Agency In Bor | 4 | 2% | 6 | 2% | 9 | 3% | 5 | 2% |
| F4 Foster Rel/Friend Out Bor | 7 | 3% | 3 | 1% | 2 | <1% | 3 | 1% |
| F5 Foster LA Own Out Bor | 17 | 7% | 13 | 5% | 12 | 5% | 13 | 5% |
| F6 Foster Agency Out Bor | 41 | 16% | 45 | 17% | 44 | 17% | 49 | 19% |
| H1-2 Secure Res Care (Out Bor) | 3 | 1% | 1 | <1% | 1 | <1% | 1 | <1% |
| H3 Res Home In Bor | 15 | 6% | 19 | 7% | 15 | 6% | 14 | 5% |
| H4 Res Home Out Bor | 7 | 3% | 8 | 3% | 10 | 4% | 12 | 5% |
| S1 Res School (Out Bor) | 3 | 1% | 3 | 1% | 3 | 1% | 2 | <1% |
| Other Res Care | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Placed with Parents | 11 | 4% | 15 | 6% | 28 | 11% | 18 | 7% |
| Independent Living | 3 | 1% | 4 | 2% | 5 | 2% | 3 | 1% |
| Total LAC | 252 | 100% | 265 | 100% | 265 | 100% | 254 | 100% |
| Total Foster (exc Placed for Adopt) | 192 | 76% | 191 | 72% | 174 | 66% | 181 | 71% |
| Total Res Care | 28 | 11% | 31 | 12% | 29 | 11% | 29 | 11% |

Total LAC by Legal Status

| | 31/03/2007 | % | 30/06/2007 | % | 30/09/2007 | % | 31/12/2007 | % |
|-----------------------|------------|------|------------|------|------------|------|------------|------|
| C1 Interim Care Order | 71 | 28% | 75 | 28% | 83 | 31% | 79 | 31% |
| C2 Full Care Order | 119 | 47% | 120 | 45% | 116 | 44% | 114 | 45% |
| D1 Freeing Order | 5 | 2% | 5 | 2% | 4 | 2% | 2 | <1% |
| E1 Placement Order | 20 | 8% | 21 | 8% | 26 | 10% | 22 | 9% |
| V2 Voluntary S20 | 37 | 15% | 42 | 16% | 34 | 13% | 37 | 15% |
| Other | 0 | 0% | 2 | <1% | 2 | <1% | 0 | 0% |
| Total LAC | 252 | 100% | 265 | 100% | 265 | 100% | 254 | 100% |

Total LAC by Gender & Ethnicity

| | 31/03/2007 | % | 30/06/2007 | % | 30/09/2007 | % | 31/12/2007 | % |
|-----------|------------|------|------------|------|------------|------|------------|------|
| Boys | 134 | 53% | 142 | 54% | 141 | 53% | 139 | 55% |
| Girls | 118 | 47% | 123 | 46% | 124 | 47% | 115 | 45% |
| Total LAC | 252 | 100% | 265 | 100% | 265 | 100% | 254 | 100% |
| A: White | 237 | 94% | 251 | 95% | 256 | 97% | 247 | 97% |
| B: Mixed | 10 | 4% | 10 | 4% | 8 | 3% | 6 | 2% |
| C: Asian | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| D: Black | 3 | 1% | 3 | 1% | 0 | 0% | 0 | 0% |
| E: Other | 2 | 1% | 1 | <1% | 1 | <1% | 1 | <1% |

Total LAC by Time in Care

| | 31/03/2007 | % | 30/06/2007 | % | 30/09/2007 | % | 31/12/2007 | % |
|-----------------|------------|------|------------|------|------------|------|------------|------|
| < 6 mths | 46 | 18% | 43 | 16% | 42 | 16% | 37 | 15% |
| 6 mths - <2 yrs | 76 | 30% | 91 | 34% | 82 | 31% | 82 | 32% |
| 2 - 4 yrs | 34 | 13% | 32 | 12% | 47 | 18% | 38 | 15% |
| 4+ yrs | 96 | 38% | 99 | 37% | 94 | 35% | 97 | 38% |
| Total LAC | 252 | 100% | 265 | 100% | 265 | 100% | 254 | 100% |

DETAILED LAC DATA for SOUTH TYNESIDE ANALYSIS as at 31/3/08

LAC Total, Starts and Leavers

- * Total LAC finished the year higher than at the end of the third quarter and than at the end of 2006/07
- * The rate of LAC starts was even higher than last years level and the rate of LAC leavers also increased
- * A higher % of starts are aged 5-9 and 10-15 and a lower % aged <5 this year than last year
- * Abuse or neglect continues to be the main need code for four out of five starts
- * There has been a slightly higher % of single child LAC starts this year and a lower % of two child starts
- * Adoptions increased in the third quarter but they, Residence Orders and SGOs as reasons for leaving care finished below last years level

LAC Placements, Legal Status, Gender, Ethnicity and Time in Care

- * After falling in the first two quarters the number and % of LAC in foster placements increased in the last two quarters
- * The number and % of LAC placed with parents increased in the second quarter but then fell back
- * The % of LAC placed in residential care has remained low and stable
- * There has been little change in the types of LAC legal status
- * Boys continue to outnumber girls
- * There was a slight decline in the small number and % of non-white LAC between the end of last year and the end of this year
- * There was a temporary increase in the number and % of LAC in care for between two and four years in the second quarter

Health care of looked-after children, twelve months to 30 September 2004

| Authority | No. LAC | Numbers | | | Percentages | | | PAF C19 |
|-------------------|----------------|------------------------|---------------------------------|------------------|------------------------|----------------------|------------------|----------------|
| | | Imms Up to Date | Teeth checked by Dentist | Annual HA | Imms Up to Date | Teeth checked | Annual HA | |
| Gateshead | | 170 | 140 | 150 | 91 | 76 | 80 | 77.9 |
| Newcastle | | 125 | 260 | 200 | 40 | 82 | 63 | 72.7 |
| N-Tyneside | | 135 | 100 | 155 | 84 | 63 | 97 | 80.1 |
| S-Tyneside | | 140 | 155 | 130 | 73 | 81 | 67 | 74.1 |
| Sunderland | | 280 | 310 | 285 | 88 | 97 | 88 | 92.4 |