Gateshead Joint Strategic Needs Assessment 2009

CONTENTS

Executive Summary and Next Steps ... 1
1 Introduction ... 4
2 What is Joint Strategic Needs Assessment? ... 4
3 Progress to date ... 5
3.1 Circulatory disease pathway/service changes already happening or planned ... 6
3.2 Mental health pathway/service changes already happening or planned ... 6
4 Assessing the needs ... 7
4.1 Children and young persons needs assessment ... 7
4.2 Gateshead older people's strategy health impact assessment ... 7
4.3 Voluntary and community consultation ... 8
4.4 Mental health needs of children and young people ... 9
4.5 Needs assessment around drugs and alcohol ... 9
4.6 User Experience Survey of younger adults with physical and/or sensory impairment ... 10
4.7 User Experience Survey of people using community equipment and minor adaptations funded by Social Services ... 10
4.8 Gateshead Crossroads Survey of the health of young carers in Gateshead ... 11
4.9 JSNA consultation responses ... 11
4.10 Community safety strategic assessment ... 12
4.11 Housing needs & care assessment; appraisal of older people's aspirations ... 12
4.12 People with learning disabilities ... 13
4.13 Excess winter deaths ... 13
4.14 Indicative weighted place survey ... 14
4.15 Reducing health inequalities by ensuring fair access to services ... 14
4.16 Vulnerable groups; further assessment ... 15
4.17 Priorities from providers ... 16
5 Key aspects of the profile for Gateshead ... 16
5.1 Demography ... 16
5.2 Vulnerable groups ... 17
5.3 Social, cultural and economic issues ... 18
5.4 Current known health status ... 19
5.5 Neighbourhoods ... 19
5.6 Lifestyle ... 19
5.7 Education ... 20
6 Current met needs of the population ... 20
6.1 People with mental health needs supported to live at home ... 20
6.2 Number of carers receiving services ... 20
6.3 Uptake of cervical screening, particularly among learning disabled women ... 21
6.4 Immunisation ... 21

7 Related strategies and agreements 22
7.1 Spatial Planning 22
7.2 Vision for Adult Social Care 22
7.3 Local Area Agreement. 23
7.4 PSA targets and national indicators 23
7.5 Gateshead Homelessness Strategy 23
7.6 Gateshead Housing Strategy 23
7.7 "Being Healthy in Gateshead" 24
8 Community engagement in health 25
9 Process for prioritising commissioning priorities: defensible decision-making 27
10 Key issues and priorities for Gateshead in 2009 28
Part 1: Driving up life expectancy 30
Part 2: Choosing health 34
Part 3: Investing in health 40
References 46

Executive Summary and Next Steps

The Gateshead Joint Strategic Needs Assessment (JSNA) is being developed as a tool to inform effective commissioning, through an iterative process to ensure that all stakeholders are able to view the data, and contribute to our understanding of local priorities and issues. The JSNA must be considered alongside the Directors of Public Health Annual Report, the Overview and Scrutiny Committee Review of Inequalities and the Children and Young People's Plan 2007 The recommendations from all of these are critical to our work to tackle the determinants of ill health and to reduce inequalities, throughout the life course, and are inextricably linked with this JSNA. The work needs to be undertaken at all stages of life: children, adults and older people.

The process has involved scrutiny of the primary data set and secondary analysis to look for issues important to Gateshead. In addition the JSNA links with the *Community Safety Strategic Assessment*, *Housing* and *Spatial Strategies* and the *Vision for Adult Social Care*.

User, carer, resident and provider views have been sought through a range of consultative exercises and have greatly influenced the setting of priorities.

Emerging issues have then been assessed in terms of impact (death, years of life lost, hospital admissions and socio-economic implications), prevalence, trends, inequalities and effective, evidence-based interventions. Headline issues include: screening and early years; illness and chronic conditions; mental health and emotional well-being; drugs, alcohol and tobacco; sexual health; childhood obesity; poverty and exclusion; violence; and services for specific groups. These priorities can be split into three groups, as follows:

Major priorities for commissioning differently to effect change

- Mental health services, with particular attention to promoting health and wellbeing, and a range of service improvements. Specific areas emerging are: child and young person mental and emotional well-being; preventing isolation and loneliness in old age; and dementia. Clear links with housing developments to support independent living are required.
- Circulatory disease, healthy lifestyles (including children and young people), working with those at high risk, early identification and treatment working closely with the PCT-led initiatives in risk reduction, and obesity.
- Alcohol and drugs, working to address the cultural and social aspects alongside community safety, regulatory services, children's services and the PCT-led development of treatment services.
- Tobacco, working to address the cultural and social aspects alongside regulatory services, children's services, ante-natal services and the PCT-led development of treatment services.

- The ageing population of family carers of people with learning disabilities. In particular, working to provide supported accommodation options.
- Teenage pregnancy, working with

Major priorities to address the needs of disadvantaged groups

- Health inequality impact assessment applied systematically as indicated in the *OSC Review Service Improvement Plan*.
- Health equity audit developed as a tool, to address service reach to groups demonstrated to have low service take up, including screening uptake for people with learning disabilities.
- Narrowing the gap between the most disadvantaged and the average, focusing on children (including a focus on educational aspiration and attainment, violence, early years and developmental screening)
- Community-led lifestyle work (including young people) in the 5 wards with lowest life expectancy.
- Financial inclusion strategy.
- Work to ensure continuity of care in relation to health, housing and employment for people coming out of prison.
- Work to apply current understanding of vulnerability and protect groups and individuals.
- Eradicate homelessness through innovative methods to enable households to remain at home or avoid the need to apply as homeless. (Gateshead Homelessness Strategy – currently in draft)

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Priorities addressed through ongoing service improvement planning and development processes

- Sexual health service development and modernisation, including reducing the rate of chlamydia. A GUM clinic in Gateshead opened in 2008, filling a gap in local provision.
- Musculoskeletal conditions pathway work.
- Respiratory conditions pathway work.
- Modernised services for podiatry, continence and dentistry.
- PCT Commissioners have undertaken a tendering exercise to procure a GP-led Health Centre from April 2009. The centre will be based in Blaydon and will offer health services seven days per week, increasing accessibility for the local population, particularly hard-to-reach groups. This is consistent with key deliverables identified within the JSNA.
- Two GP practices are combining to form a new practice in Wrekenton, offering a wider range of facilities.

The strategic commissioning intention expressed by the JSNA is to work towards reallocation of resources along the care pathway of 5% from acute care to prevention or community based care (treatment/rehabilitation/support at

home/palliative care of the pathway), as indicated in 'Our Health, Our Care, Our Say'. It is proposed to aim for at least 1% transfer in 08-09, leading up to at least 3% by 10-11. Progress will be reviewed in terms of best outcomes for the health of the population, as well as monitoring our direction of travel in terms of resource allocation. Work is taking place with finance and commissioners to begin to assemble global expenditure profiles in relation to health and social care pathways for mental health and circulatory disease. The purpose is to develop a working model to demonstrate the strategic shift of resources we are aiming to create: mental health and circulatory disease have been selected as two important but discrete areas with contrasting delivery mechanisms, to help develop our methodology for pathway reform. This will then be applied to other priorities identified in the JSNA.

Next steps

1 Assessment of moving resources upstream. Finance and commissioning services to
   - 1.1 Analyse financial and service information in relation to mental health and circulatory disease in order to assess the viability of the Moving Resources Upstream analytical framework and to assess whether a 1% transfer from acute to prevention/community based interventions has occurred (after financial year end).
   - 1.2 Continue to develop an analytical framework to measure expenditures on acute versus preventive/community based interventions with relation to mental health and circulatory disease.
   - 1.3 Broaden the coverage of the Moving Resources Upstream analytical framework to include other high expenditure priority areas

2 Lead commissioners to develop from the assessment commissioning intentions to re-shape service delivery, with a coordinated approach to child and family services, housing, planning, adult social care and health issues.

3 Children and Young People's Plan refresh to use the JSNA and address key issues, including reducing chlamydia and smoking in pregnancy.

4 Service improvement plans to address needs identified in relation to inequalities and service modernisation.

5 Continue to establish clear links across Health and Social Care Partnership, Children and Young People Partnership, Community Safety Housing, Culture and Economy, Development and Enterprise, including the Spatial Strategy.

6 To carry out a full health impact assessment to consider the effects of the recession, which will inevitably have a significant impact on the economy and health of Gateshead's population. (Early work on this is to be carried out through the Public Health Partnership.)

7 Local Authority and PCT to give high profile support to community engagement, particularly in the five identified neighbourhoods, as outlined in this JSNA.

1 Introduction

The Joint Strategic Needs Assessment (JSNA) for Gateshead has been conducted through an iterative process involving key stakeholder groups throughout its development. While the JSNA was intended to be completed every 3 years, this current version is a further development of the initial 2008 version and there is to be a full review in 2010 in tandem with the Local Area Agreement/Operational Planning Cycles.

The data gathering and analysis work reflected in the 2008 paper was carried out by a technical sub group led by the Director of Adult Social Care and the Director of Public Health (for membership see Technical Group Membership, discussed by the Health and Social Care Development Group in November 2007, and subsequently with other stakeholders including Children and Young People, Housing, Planning, Health and Social Care Partnership and Health and Social Care Development Group (2008 JSNA Consultation and Development Process). This 2009 version has been expanded to include a wider range of information and also presents an update of some of the activities that have taken place since the first document was produced, and the group broadened (see JSNA Steering Group Terms of Reference).

The JSNA proposes some next steps to ensure it fulfils its purpose of informing effective Commissioning.

The JSNA must be read alongside the Directors of Public Health Annual Report, the Children and Young People's Plan 2007 and the Overview and Scrutiny Committee Review of Inequalities

2 What is Joint Strategic Needs Assessment?

Commissioning Health and Wellbeing (Department of Health March 2007, final guidance 13 December 2007) set out a requirement for Joint Strategic Needs Assessment as a means for PCTs and local authorities to describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs. JSNAs are to look ahead 3-5 years and provide an opportunity to look ahead and support and direct the change required in local systems in order to:

- Re-shape services with local communities
- Reduce inequalities
- Increase social inclusion
- Maximise outcomes per pound spent

A good JSNA will:

- Define achievable improvements in health and wellbeing outcomes for the local community
- Send signals to existing and potential providers of services about potential service change
- Support the delivery of better health and well-being outcomes for the local community
- Inform the next stages of the commissioning cycle
- Aid better decision making
- Underpin the Local Area Agreement (LAA) and the choice of local outcomes and targets as well as the PCTs prospectus.

Commissioning Health and Wellbeing identifies a minimum data set in relation to a range of inputs: demography, social and environmental context, current known health status of populations, current met needs of the population, patient voice, public demands, analysis of inequalities in terms of outcomes and service access, programme budgets and outcomes.

Secondary analysis is expected to include: current inequalities by outcome and service access (geographical, ethnicity, gender, geography); projection of service use in 3-5 years time based on historical trends and current activity; projection of outcomes in 3-5 years time based on historical trends and current activity; value for money and return on investment. A number of tools have been developed nationally to assist with the predictive and analytical aspects of the assessment, and some are detailed in Tools for Predicting Need and Developing Services

3 Progress to date

Progress has been made already on aims and actions given in the 2008 JSNA.

To assess progress towards the movement of expenditure to preventive rather than acute care, two specific areas were considered: heart disease/stroke and mental health. An interim report, Moving Resources Upstream: Baseline for Mental Health and Cardiovascular Pathways in Gateshead, has been produced on the issues arising and the findings to date. Only after the year end will the picture be clear and we will have a chance to ensure we have identified all the contributions to the shift towards preventive or community care. The main activities already identified that are contributing to this ‘upstream’ movement are:

3.1 Circulatory disease pathway/service changes already happening or planned

- The secondary care-based team going out into the community has already been mentioned. Further discussions are to be held to try to estimate costs around this.
- Blaydon has now a primary care centre where monitoring of rehabilitation can take place.
- Increasingly risk assessment is expanding in primary care. There is likely to be increased investment in primary care on, for example, atrial fibrillation as a risk factor for stroke. It is worth noting that this will not be a direct transfer from secondary care spend.

3.2 Mental health pathway/service changes already happening or planned

- One of the Tranwell unit's three wards is to be closed this financial year in favour of intensive day service. This will lead to a need for more crisis teams in the short term because the infrastructure is not there to cope. However, it will result in a considerable saving in secondary care. Debates are around where the money saved will go.
- A dementia specialist team is being piloted in the (local authority) domiciliary care service. This is a definite move towards the early preventive end of the spectrum, although it is not a transfer from secondary care.
- Last year there was a move towards more LA community care with an increase in support time recovery workers, funded by a special grant.
- Promoting independence centres have been established this year for people discharged from hospital, for the assessment and improvement of independence skills, mainly targeting older people.
- The emphasis of home help has changed: previously it was on shopping/cleaning etc, now it is aimed at promoting independence. The workforce has been reformed and retrained to NVQ level 2, leading to a reduction in the number of people returning to hospital.
- Currently there is work on the reprovision of some NTW services based in Trust-owned residential villas. Residents will be moving into supported accommodation or supported environment with care packages this financial year.
- A social work team has been located in QE hospital, carrying out assessment.
- South of Tyne and Wear now has a full time senior public health staff member leading on the public mental health promotion agenda. It is not unrealistic to assume that about one third of the cost of this can be attributed to Gateshead. Initiatives under this remit include the development of a public mental health promotion strategy and a suicide prevention plan.

4 Assessing the needs

A wide range of sources was used to assess the needs of population. The indicators and data (as given in the data annex) were studied to identify areas where Gateshead's performance or status is poorer than average (see also section 5, discussing key aspects of Gateshead's profile). Many national targets, to which the Primary Care trust and the local authorities have to agree, are also informed by evidence and do influence the priorities chosen.

Public engagement is clearly key to the process. Early discussion with the Community Care Forum and Community Network took place through the Health and Social Care Development Group. Some material already exists, for example through the consultation on the *Vision for Adult Social Care* and see section 7.2), and the desk research conducted for the Overview and Scrutiny Committee into health implications of consultations carried out by the Council in the last 4 years.

Additionally, many surveys and consultations were carried out to assess the views of stakeholders and individuals on priorities and issues, so that these could be incorporated. The main consultations and needs assessments are outlined below. All informed the production of this Joint Strategic Needs Assessment.

4.1 Children and young persons needs assessment

This was carried out to inform the Gateshead's Children and Young People's Plan 2006-09 (reviewed *2007/08*) Lists of the organisations involved in the original plan and in review appear Children and Young People's Plan 2006-09 and Consultation on review of Children and Young People's Plan respectively. The Plan was based very much on the outcomes of '*Every Child Matters*' namely:

- Be healthy;
- Stay safe;
- Enjoy and achieve;
- Make a positive contribution;
- Achieve economic well-being.

Findings from the assessment formed an essential part of the basis for the Children and Young People's Plan 2006-09 and the actions identified are provided in the issues and priorities table in the final section of this document.

4.2 Gateshead older people's strategy health impact assessment

The Gateshead older people's strategy underwent a health impact assessment, Health Impact Assessment of Gateshead's Older People's Strategy which resulted in a range of information and views being collected. It included both an appraisal workshop with key stakeholders (identified by an Older People's Health Impact Steering Group) and discussion groups with:

- members of the Older People's Assembly (OPA);
- BME representatives from Gateshead Muslim Society and Naqshbandia Aslamia Trust;
- BME representatives from Gateshead Visible Ethnic Minority Support Group and SEWA.

The assessment is based upon:

- evidence from the literature review concerning determinants of older people's health;
- research, surveys and consultations with older people which have identified their views and experiences;
- evidence from the appraisal workshop involving representatives from health services, local government and the voluntary sector;
- evidence from discussion groups with BME representatives and members of the OPA.

4.3 Voluntary and community consultation

Comments from Voluntary Sector Providers formed a vital part of the consultation process that led to the production of the 2008 JSNA. Further consultation with community and voluntary sector is discussed in section 4.9.

Some of the key points arising from the first consultation were as follows:

- Emotional wellbeing is inextricably linked to obesity, smoking and alcohol, housing and the ability to use transport.
- Service users are involved, not only in planning, but also the running and evaluation of services.
- There is a need to ensure that there is appropriate accommodation with support for people with mental health problems in our communities. Many service users experience poor quality accommodation and are isolated in the community.
- Older people are not a homogenous group. There are different age groups within the category' older people' which need different responses. The age band 65-105 contains two generations.
- Isolation is a key issue for physical and mental health.
- Young people should be a greater priority. There is a growing problem of homeless young people who have mental health or mental health related problems with alcohol.
- Transport is another key issue. The hills in Gateshead pose a particular challenge. The possibility of de-centralising activities and services needs to be considered.

- Drug and alcohol services are, mostly, not accessible or geared up towards older people yet people aged 55 to 74 have the highest rates of alcohol related deaths in the UK.

4.4 Mental health needs of children and young people

The mental health needs of children and young people in Gateshead Children's Trust was based on the ChiMAT tool and involved consideration of local epidemiological information (incidence and prevalence of certain diseases or conditions), an audit of existing services and analysis of service usage and the views of all stakeholders, including children, young people and their families. The district has regularly carried out research into the needs of children and young people, using a health related behaviour questionnaire.

Some of the key findings of the assessment, in addition to prevalence figures given in section 5.2 (vulnerable groups) are as follows:

- Individual risk factors for mental health problems include: low IQ and learning disability; sensory impairment; physical illness
- Prevalence of mental disorders is greater among children where certain factors exist in their homes. These include lone parent families, families with low gross weekly household incomes and households where the interviewed parent has no educational qualification.
- Risk factors in the community include socio-economic disadvantage and homelessness.
- Self-esteem increases with age and there are higher scores in Gateshead than in the reference sample.
- There has been a positive increase in physical activity levels and a reduction in smoking levels.

4.5 Needs assessment around drugs and alcohol

As part of the Needs Assessment process, and in accordance with National Treatment Agency guidance, an expert group of key stakeholders was established, the membership of which including representatives from the NTA, PCT, DAT, SMART, CAMHS, Change for Children team, Police, ASB and YCL. Secondary data, obtained from a variety of sources including the National Drug Treatment Monitoring Service (NDTMS), TellUs3, Youth Justice Board data, and LAC data were analysed and presented to this group for discussion and interpretation.

Further, qualitative, information was gathered via consultation with a number of groups of young people. These groups consisted of young people already engaged with our service, young people from the Youth offending service, young people in the looked after system as well as a 'control' group of young people

accessed through Gateshead Youth Assembly which also included representatives/young people from BME communities in Gateshead.
Some of the key findings of the Young People's Substance Misuse Treatment System 2009/10 Needs Assessment are as follows:

282 clients accessed the service in 2007/08.
In comparison to the numbers accessing treatment, there has been a steady increase of new presentations to the treatment system.

- Future demand is likely to increase with the ongoing marketing and promotion of the service and the official launch of treatment services for young people planned for early in 2009
- Discharge levels are slightly lower than new presentations, accounting for a steady swelling of numbers in treatment.
- Of all offences committed under the influence of alcohol (2334) in 2007/08, 29% (669) were committed by young people. Of these offences, 82% (549) were anti-social behaviour related, while 16% (108) were due to street drinking. Additionally, those areas known to be areas of deprivation and transient housing, as well as problematic hotspots for adult alcohol-related offences, mirror those involving young people. 57% of all offences committed under the influence of alcohol, by young people, occurred in Gateshead town centre and/or the Bensham area.
- The success of treatment delivered by SMART appears to be highly effective, with 80% of clients leaving in a planned manner with a further 9% leaving treatment via referral. 5% (14) of clients did not receive a care plan – of these 71% (10) were discharged in an unplanned way.

4.6 User Experience Survey of younger adults with physical and/or sensory impairment

During February 2007, 522 questionnaires were sent to randomly selected clients within the sample frame population and an overall response rate of 44% was achieved. Key points of the PSSRU User Experience Survey of younger adults with physical and sensory impairment include:

- 68% of respondents stated that they were receiving help with personal care.
- 40% of respondents reported feelings of loneliness or social isolation.
- 51% of respondents had used or heard of Direct Payments, whereas 25% were unaware of them.

4.7 User Experience Survey of people using community equipment and minor adaptations funded by Social Services

During February 2008, 545 questionnaires were sent to randomly selected clients within the sample frame population and an overall response rate of 69% was achieved. Key points of the PSSRU User Experience Survey of people using

community equipment and minor adaptations funded by Social Services 2007/08 include:

- 90% of respondents were happy with the help that they had received.
- 81% were satisfied with their assessment process.
- 68% did not find the waiting time a problem; 27% did, to some extent.

4.8 Gateshead Crossroads Survey of the health of young carers in Gateshead

For the Gateshead Crossroads Survey of the health of young carers include: living in Gateshead 2007, questionnaires were distributed to young carers (aged 8 to 16 years), known to Gateshead Crossroads, at events in 2007. 56 questionnaires were returned, representing 20% of the Crossroads young carers caseload. In addition, focus groups were held for young carers during summer activities organised for them. The purpose was primarily to identify the tasks carried out by young carers and highlight the health and support issues of concern to them. Key findings from the Survey of Young Carers include:

- A high proportion had been caring for 5-10 years, mostly for a parent.
- Most reported that tiredness was affecting their school or college performance.
- Those providing physical care reported having back problems.
- Those caring for someone with mental health problems reported anxiety and lack of sleep.

4.9 JSNA consultation responses

A consultation in 2009 elicited responses (Responses from JSNA Discussions) from the following groups: council tenants forum; BME/diversity forum; mental health service user group; LGBT forum; Age Concern; Mental Health Concern; Parkinson's Disease Society. Topics included mental health, older people, well-being, young people, lifestyle, employment and benefits. Key findings include problems experienced by certain groups, e.g.:

- Black and minority ethnic groups, being both socially excluded (and sometimes harassed) and also excluded from mental health services because of their communities attaching high levels of stigma to mental health problems. Signposting to appropriate services is important where there are language difficulties.
- Older people being just under the threshold for means tested benefits and therefore not putting heating on because of high costs.
- Young people often require specifically designed services.
- Older people suffer mental health problems other than dementia – depression and anxiety need to be properly addressed.

- The large scale movement of people off Incapacity Benefit needs to be treated sensitively, particularly during a recession.
- There is a need for more affordable housing to rent, particularly for mental health service users.
- There can still be stigma attached to claiming benefits among people with long-term conditions. Benefits take-up should be maximised.

4.10 Community safety strategic assessment

This exercise, conducted in early 2008, also identifies alcohol as a priority, as well as tackling hate crime which has a clear line to mental health/emotional wellbeing.

4.11 Housing needs & care assessment; appraisal of older people's aspirations

For assessment of the local situation, Gateshead Housing Needs and Support Survey and the Appraisal of Older People's Aspirations were carried out in 2006. Findings were discussed with team managers in social services as well as the Older Persons' Assembly and Disability Forum. Supporting People were heavily involved in the research and some of their inclusive forums and user groups participated.

Both studies used secondary data, questionnaires and interviews (including staff in social services).

For the *Housing Needs and Support Survey*, Gateshead Council commissioned a company to analyse future housing needs in Gateshead, including additional support needs. 32,198 residents were contacted by post or in person and a 17% response rate was achieved.

The Appraisal of Older People's Aspirations consisted of 1,000 face to face interviews and 3,000 postal questionnaires of people over 55. The aims included providing an analysis of demand, turnover and supply for Council accommodation, and identifying where supply and demand are unevenly matched. Much of the data was gathered through examining existing analyses.

Both reports and summaries are available on the Strategy Team web page on the Council web site Some of the main points emerging were:

- Three quarters of respondents to the housing study were in receipt of some form of financial support.
- 37% of respondents had an income of less than £500 per month and 70% had an income of less than £700.
- Nearly 75% of over 75s live on their own.

- Additional support is necessary for the 23.4% of the population with a limiting long-term illness (which is 35% higher than the national figure).
- 23.7% of all households need cavity wall insulation and 14.4% need loft insulation.
- 15% need help with general repairs, 13.8% with home improvements and 12.9% with improving safety and security.
- Homelessness is an issue. 4,500 individuals stayed temporarily with a friend/family in the preceding year as they did not have a home.
- There is a need for transient sites for Gypsies and Travellers, as unauthorized sites have become an increasing problem.

4.12 People with learning disabilities

Two discussions were held with people with learning disabilities, specifically on the topic of primary care. Some of the key points around Learning Disabilities and Primary Care are as follows:

- Dentists, opticians and general practitioners often talk to the accompanying carer rather than to the patient.
- Access to facilities is sometimes difficult, either up stairs or without automatic doors.
- Dental charges, prescription costs and costs of spectacle frames can be high.
- Some patients are told when the doctor is ready by their name on a screen and a beep. There could be problems if they can't read or are hard of hearing.

Headline findings from a recent tri-partite visit involving the Mental health Act Commission, CSCI and the Healthcare Commission are available *The Joint Review of Commissioning of Services for People with Learning Difficulties and Complex Needs.* file not yet sourced, key officer is Don Watson, Sarah please source and add to list of files for upload on Council website.

4.13 Excess winter deaths

An investigation of the issues around Excess Seasonal Deaths was carried out during 2008, looking at the figures, the needs and the actions already under way or needed. Some of the key points are as follows:

- The fuel poor tend to be:
    - Single pensioners;
    - Families on low incomes;
    - Disabled people.
- 49% of fuel poor households contain a person over 60.

- There is a 23% excess of deaths from heart attacks and strokes during the winter months and this is greater in poorly heated homes.
- Uptake of flu vaccine is an important part of a strategy to reduce excess winter deaths.
- Fuel poverty is linked with heart attacks, strokes, respiratory conditions, accidents and poor mental health.
- The problem is likely to increase because of rising fuel costs and a greater proportion of elderly in the population.
- The Decent Homes initiative, improved chronic disease management and improved self-care can help to offset the factors that exacerbate the problem.

4.14 Indicative weighted place survey

A postal 'Place Survey' took place in 2008, from which 2475 returns were returned (out of 6000 mailed out). This asked for people's assessments of a range of different issues, including crime and disorder, fair treatment by local services, social integration and anti-social behaviour (indicative weighted place survey results). Some of the key points arising were:

- 81.3% expressed overall/general satisfaction with the local area (a rise from previous surveys).
- 32.7% perceived drunk or rowdy behaviour as a problem.
- 32.0% perceived drug use or drug dealing as a problem.
- 39.8% felt that older people received the support they needed to live independently.

4.15 Reducing health inequalities by ensuring fair access to services

Ensuring 'fair' access to the service involves comparing a measure of health need with a measure of service uptake within different population groups. The measure of health need chosen for analysis (Reducing health inequalities by ensuring fair access to services*)* was the proportion of adults who smoke, based on results from the 2008 South of Tyne and Wear Lifestyle Survey. The assessment showed that various groups of smokers were accessing stop smoking services less than others. Targeting in disadvantaged areas appeared successful but certain groups within the more well-off sectors were not using the services. The following groups are under-represented among service users and, from lifestyle survey results, show above average smoking prevalence:

- Well educated singles and childless couples colonising inner areas of provincial cities.
- Older people living in small council and housing association flats.

- Older people preferring to live in familiar surroundings in small market towns.

For each of these groups, the PCT has a corresponding list of postcodes and these can be used to target marketing activity or to inform the location of new Stop Smoking clinics.

The method of assessment use can be used with a range of conditions, illnesses or social factors to highlight apparent anomalies in service uptake. See also section 8 (Community engagement in health).

4.16 Vulnerable groups; further assessment

There has been much consideration of the needs of vulnerable groups in general (Vulnerable Groups – Identification and Meeting the Needs). The approach to reducing vulnerability to poor health involves ensuring identification of vulnerable groups or individuals and aiming to reduce stigma, as well as providing services for them.

All children are vulnerable to a certain extent, as they are dependent on the adults who care for them as they undergo rapid physical, mental and social development. There are some circumstances that can make children more vulnerable and can affect their development and the chances they have for a happy, fulfilled life. We have identified a number of key areas where further work is required to gather intelligence and provide an evidence base. This work will be carried out through the integration of key 'risk factors' building resilience, the Think family pathfinder and the Family Nurse Partnership pathfinder.

Young offenders are recognised as a group where there are problems with health and education. Young offenders are at risk of becoming involved in crime and anti-social behaviour. Some useful information exists already on certain aspects, such as substance misuse. There is also CAMHs information that could prove helpful. As yet, there has not been sufficient analysis to determine broader health needs but we are in the process of accumulating evidence from a variety of sources, including research from Family Intervention Projects linking youth crime and ADHD. Reducing re-offending is a big LAA target, so work will be extended in this area.

Specific areas where we have not yet accumulated sufficient evidence or information include: runaways, children seeking asylum from families, sex exploitation and forced marriages. Work is continuing to build a picture of these important areas so that future plans can incorporate related actions.

4.17 *Priorities from providers*

A provider viewpoint was given (JSNA Priorities, provider comments), looking at service provision with particular relation to older people. Main elements of services are described, giving a useful reference point when considering alternative approaches. The importance of NICE guidance is stressed when choosing which services or treatments to adopt.

The development of GP-led practices provides a new mechanism for the development of 'gold standard' primary care in relation to preventive services and management of chronic disease. Agreement on where these are has been reached and services will come on stream in 2009.

5 Key aspects of the profile for Gateshead

The **Data Annex** accompanying this report is based on the minimum data set identified in A Commissioning Framework for Health and Wellbeing. It has also been augmented to include relevant information from a range of sources, including surveys (as described in section 4). The annex is divided into sections:

- Demography, which includes population breakdowns (by age and certain characteristics such as ethnicity, disability and vulnerable groups) and forecasts for the same groups.
- Social and environmental context, which includes certain economic data and educational attainment data.
- Current known health status of the population, which includes data around chronic disease, obesity, mortality from different causes, teenage conceptions, various lifestyle information and uptake of screening and immunisation;
- Current met needs of the population, discussed in section 6;
- Public voice, discussed in section 8 (and, to a certain extent, in section 4).

Where information forms part of a National Indicator the number is referred to in the title.

The following paragraphs briefly outline key points identified from the data. Reference is made to the relevant paragraph number of the *Data Annex*.

5.1 *Demography*

Key points:

- Ratio of older people to people of working age set to rise from 17.8% in 2008 to 22.2% in 2025, initially higher but then lower than for the NE as a whole, but higher than for England at all times see 1.2
- Projected changes show a dramatically increasing picture for over 65s projected to increase 1.3% 2006-2008 (436,400 people) but 15.7% 2006-2015 (498,700 people) and over 85s projected to increase 2.7% 2006-2008 (3,800 people) but 21.6% 2006-2015 (4,500 people) see 1.3
- The trend in the number of live births is a result of trends in the fertility rate (the number of live births per 1,000 women ages 15-44 years) and the population of women ages 15-44 years. Following a downward trend in the number of births in Gateshead in the second half of the 1990's the number of births has risen since 2001 and the projected trend is a rise of 7% by 2010 and 18% by 2015, see 1.5
- Violence against the person 13.9 offences per 1,000 population ranking 3rd lowest in the region see 1.24
- homelessness is low (.2 use of temporary accommodation per night per 1000 households)(*1.26*).

5.2 Vulnerable groups

Key points:

- There are 69 children per 10,000 in looked after care in Gateshead, ranked 5th highest in the region see 1.6, however educational attainment in this group is comparatively good see 2.4 (65% obtained GCSEs at grade A*-G)
- There are 16.5% households in Gateshead occupied by single older people ranked 3rd highest in the region see 1.7.
- Black and ethnic minority populations are increasing but are still in relatively small numbers in specific parts of the Borough see 1.10
- 23.9% of the population have a limiting long term illness see 3.1
- 47.1 per 1,000 working age population claiming benefits or allowances for mental or behavioural problems ranked 4th highest in the region see 1.14
- Numbers of people with physical and learning disabilities are not all collected systematically but some estimates are available in 1.17 to 1.21. Currently the total number of people with a learning disability known to services is 632. The number of people aged 50 or more with learning disability is expected to rise by 30 by 2020. In the case of other disabilities (physical, sensory and mental health other than dementia), the Projecting Adult Needs and Service Information System suggests only small increases. However the ageing population also implies an increase in sensory disabilities as indicated in the linked *Briefing on sensory impairment*.
- Of claimants of disability living allowance who are aged up to 24 years, those with learning difficulties amount to 15% of that total and those with

'other mental health causes' amount to 10 % of that total (Disability Living Allowance)

- There is expected to be a considerable increase in the number of households with people aged over 65 receiving intensive home care (Client Group Population Projections – Older People)
- Of the 239 people who live with family carers, 54% live with a carer over the age of 60 and 16% live with a carer over the age of 75. (Learning Disability Age)
- Excess seasonal deaths - there were 300 excess winter deaths in South of Tyne and Wear in 2006/07. (Excess seasonal deaths)
- 5.1% of children aged 5 to 10 years (976 children) experience mental health disorders. This rises to 11.7% of children aged 11 to 15 years (1382 children).(The mental health needs of children and young people in Gateshead Children's Trust)
- In 2008, 10% of secondary school pupils said they felt afraid to go to school because of bullying 'often or every day'.(an increase from 5% in 2004) (*2008 Exeter Health Related Behaviour Questionnaire, Director of Public Health Annual Report*)
- In 2008, 22% of Year 8 boys said they had been a victim of violence or aggression in the area where they live (an increase from 15% in 2004) (*2008 Exeter Health Related Behaviour Questionnaire, Director of Public Health Annual Report*).

5.3 Social, cultural and economic issues

Key points:

- 3.1% of the population of working age are claiming Job Seekers Allowance ranked 4th lowest in the region see 2.10
- there are an estimated 1484 problematic drug users of whom 78.1% are in treatment see 3.83
- an analysis of the 7 domains of the Index of Multiple deprivation shows that Gateshead has 61.1% of Super Output Areas in the worst 20% nationally for the health domain, compared with 44.4% for the Index of Deprivation overall, 38% for education and 42% for income. Employment is also poor with 58.7% in the worst 20% nationally. Health is therefore one of the two issues making Gateshead's overall ranking on the Index worse, whereas barriers to housing and services, crime, and living environment score relatively well (1.25)
- 1250 males aged 16 or under claim disability living allowance, 340 because of learning difficulty or other mental health causes. Corresponding figures for females aged 16 or under are 630 in total, with 110 because of learning difficulty or other mental health causes. (Disability Living Allowance)

5.4 Current known health status

Key points:

- chronic disease levels are high see 3.39 to 3.46: coronary heart disease, chronic obstructive pulmonary disease, cancers are all higher than the rate for England; asthma prevalence is also higher than for Sunderland or South Tyneside; diabetes is of particular concern rising from 6717 (04/05) to 7862 (06/07), with a continuing upward projection.
- 58% of year 10 boys and 38% of year 10 girls recorded a high self-esteem score in 2008 in response to a question about well-being.
- 21.6% of Gateshead's primary school age children in year 6 were obese in 2008 (as compared to 18.3% in England) (3.31).
- 11.9 % of Gateshead's primary school age children in reception were obese in 2008 (as compared to 9.6% in England) (3.30).

5.5 Neighbourhoods

There is to be special focus on the five neighbourhood planning areas with the lowest life expectancy in Gateshead Discussions in November 2008 showed that alcohol issues were regarded as a priority in more than one area. For information on the wards with the lowest life expectancy, see Lowest life expectancy neighbourhoods. Further discussion on this is in section 8 (community engagement in health).

5.6 Lifestyle

Key points:

- teenage conceptions have fallen by 25.8% since 1998 see 3.2 although there is some evidence this is reaching a plateaux and other aspects of sexual health such as sexuality transmitted infections remain a cause for concern
- There were 733 hospital admissions from self-harm in 2006/07, compared with only 448 in 2002/03 (Annual Reports of the Directors of Public Health for South of Tyne and Wear 2007/08)
- 44% of men regularly drink 8 or more units of alcohol on one occasion, 21% of women 6 or over (Annual Reports of the Directors of Public Health for South of Tyne and Wear 2007/08)
- 7% of year 10 boys (aged 14 or 15) and 12% of Year 10 girls had eaten no breakfast on the day of a 2008 survey.

5.7 Education

Key points:

- The proportion of Gateshead school children at Key Stage 4 achieving 5 or more GCSEs at grades A* -C is significantly higher (at 74%) than that of the North East as a whole (66%) and that of England (65%). (see 2.16).
- There is wide variation across the district, with significantly lower proportions gaining these grades in both the south west and the north east of the district. (see 2.17)
- 14.5% of Gateshead's working age population have degrees or higher, compared to 20.4% of England's.

6 Current met needs of the population

The **data annex** contains information on the numbers of people taking up services already provided (and some waiting time information), including social care, immunisations, health checks for looked after children, drug service or mental health services.

Benchmarking according to regional and national performance is uneven because different indicators are published at different times of the year. There are also sometimes changes in the way an indicator is measured. Sections 6.1 and 6.2 discuss two particular areas where at first glance the data suggest there might be a problem. Section 6.3 is concerned with inequalities in the take-up of cervical screening.

6.1 People with mental health needs supported to live at home

In 2007/8 the Gateshead value was 2.95; in 2005/6 it was 6.45 After 2005/6, CBS activity was disaggregated from PCT activity data, hence there appears to be a reduction between these two years.

6.2 Number of carers receiving services

The19% increase between 2006/7 and 2007/8 should be seen alongside the *Number of adults supported by services commissioned by Gateshead Council - CBS 65+*. Here there is a 16% reduction between 2006/7 and 2007/8, which is not what would be expected given an ageing population. Staff are now more rigorous about identifying services that are for the carer rather than the person being cared for. In the past an elderly person might be referred to a day centre primarily to give the carer a break for example, but that would be recorded as a service for the elderly person. Now it would be recorded as a carer service.

6.3 Uptake of cervical screening, particularly among learning disabled women

One of the principles of the Gateshead, South Tyneside and Sunderland Cervical Screening Programme is to ensure that it is:

"equally accessible to all women aged 25-64 years without geographical, cultural, linguistic or organisational barriers."[1]

To assess how much the programme fulfils this principle a Health Equity Audit was proposed. The purpose of a Health Equity Audit (HEA) is to:

"identify how fairly services or other resources are distributed in relation to the needs of different groups and areas, and the priority action to provide services relative to need" [2] (p2)

An HEA is not complete until the changes have been implemented. Therefore the objective of this audit (Cervical Screening Coverage for Gateshead, South Tyneside and Sunderland as of 31st March 2007) was to understand the profile of patients who are not accessing screening services across the South of Tyne and Wear. This will then direct work to increase the cervical screening rates across the Sunderland, South Tyneside and Gateshead.

Equitable health care for people with learning disabilities is an issue currently receiving attention nationally and locally. People with learning disabilities have poorer access to health services, which could leave them vulnerable to poor health and wellbeing both in the short and long term. National evidence suggests that breast and cervical screening are used less by women with learning disabilities. A local study, on which a report was produced in October 2008 (Cancer screening uptake within the female learning disabled population in Gateshead), aimed to identify measures to increase uptake of screening services within the learning disabled population, so that future rates of breast and cervical cancer are reduced in this population. The study was conducted in two parts. The first was a health equity audit, where the non-attendance data for breast and cervical screening were compared between learning disabled and non-learning disabled populations in Gateshead. The second part consisted of discussion groups with learning disabled women, their parents/carers and learning disabled staff.

6.4 Immunisation

Although Gateshead has a higher than the England average uptake rate for immunisation against diphtheria, polio, pertussis and haemophilus influenza B (94.5% as compared to 93.6%), the rate is lower than that for the North East as a whole (95.8%) (See data annex 4.17)

The rate of uptake of meningitis C immunisation at 24 months is 91.3%, compared to England's 93.2% and the North East's 95.9%

The uptake rate for measles, mumps and rubella at 24 months (87.5%), although higher than that for England (84.6%), remains lower than that for the North East (88.5%). The rate at 5 years old is also lower than the North East (71.6% as compared to 82.4%).

7 Related strategies and agreements

There are many strategies that are related to the Joint Strategic Needs Assessment but space precludes detailed descriptions of all of them. Some of the main ones are outlined below. Others to which reference might be made include Financial Strategies and Transport Strategies.

7.1 Spatial Planning

Gateshead's Unitary Development Plan (UDP) is up-to-date, having been adopted by the Council in July 2007. Key components linking to health – housing development, open space provision, encouraging walking and cycling and ensuring adequate community facilities – are considered on a topic chapter basis within the document. Development locations are identified on the accompanying proposals map.

The UDP will remain in force until it is replaced by a new kind of development plan – the Local Development Framework (LDF). This will encompass all Council Plans and Strategies with spatial outcomes within a Core Strategy backed up with more detailed local development documents and area action plans.

The first stage of bringing this document together – the issues and options consultation- was undertaken in 2008 and the outcomes of this will be fed into a preferred options document that will be consulted upon towards the end of the year. It is recognized that the spatial development and design of development has a key role to play in improving the health of Gateshead's population by encouraging walking, cycling and outdoor pursuits and ensuring development occurs in sustainable locations. The JSNA will be one of the documents that informs this process.

7.2 Vision for Adult Social Care

The Government policy statement on the future of community services *Our Health, Our Care, Our Say* provided an opportunity to establish a vision of social care in Gateshead. An extensive consultation *Your Life, Your Way* was carried out on the vision. The action plan to implement the vision and the consultation

priorities was developed by Gateshead Health and Social Care Partnership and agreed by the Council Cabinet in March 2008. In brief, aims include:

- Provision of support and opportunities for individuals, groups and communities to have more control and influence over their health and emotional well-being. A focus on prevention will be central.
- Helping more people, including family carers, to participate in their communities, have work and leisure and the opportunity to feel fulfilled and valued.
- Enabling people, including the most vulnerable adults, to contribute to their community, family and friendships.
- Ensuring availability of accessible information and support to help people to make informed decisions about how their care can best be delivered.
- Promoting equality through showing respect for all, providing personalised services and promoting the equalities agenda for everybody.
- Enabling individuals, family carers and communities to experience standards of care that respect them and allow them to make choices and take decisions.
- Increasing opportunities for people to improve their financial circumstances.

7.3 Local Area Agreement.

The LAA Strategic Implementation Group on the 11th January 2008 reviewed Gateshead's selection of indicators with the Joint Strategic Needs Assessment in mind. Mental health has been added as an indicator partly in response to the JSNA priorities.

7.4 PSA targets and national indicators

There exist many Relevant Public Service Agreements and National Indicators that can affect the choice of priority areas and actions.

7.5 Gateshead Homelessness Strategy

The Council is consulting on a homelessness strategy (2008-13). The strategy has an emphasis on prevention and eradication of homelessness, a reduction in the use of temporary accommodation and working in partnership to help vulnerable households by providing tailored support to enable them to sustain accommodation in the longer term.

7.6 Gateshead Housing Strategy

The Council's Housing Strategy (2007-12) sets out the long term overall vision for housing in the borough. It states that housing has a key role to improve

people's health. Objectives include ensuring the type and mix of new housing that provides choice, supports economic growth and meets housing needs and demand. It also aims to address specific community and social needs. Priorities linked to health and social care include:

- Providing more affordable housing (direct link to National Indicator 155 in the Local Area Agreement);
- Enabling people to remain in their own home by arranging appropriate support and care, carrying out adaptations and ensuring access to a wide range of assistive technology;
- Providing more specialised accommodation to meet the needs of an aging population, those with long term illnesses, and those with learning and/or physical disabilities.

There is also a housing and health direct link to the Gateshead's Local Area Agreement in connection with NI 155 net additional homes provided (the overall supply) and tackling fuel poverty (NI 187) which helps to reduce seasonal deaths in older people.

The link between housing and health is well recognized (Housing and Health). A stable, well maintained home underpins general health and well being. Housing which meets needs and aspirations is more likely to support long sustainable communities.

Housing implications will be considered as a specific aspect of any priority areas as these are taken forward for commissioning. For example, improved dementia care at home is likely to involve assistive technology.

As part of the evidence base to inform Gateshead Council's Local Development Framework, a study of housing needs (The Strategic Housing Market Assessment) will be undertaken this year considering housing requirements for the borough and the Tyne and Wear sub region over the next 20 years.

A review of Council owned sheltered housing schemes is considering the future sustainability of 11 schemes comprising over 300 units of accommodation. The review is taking into account factors which mean the accommodation is not fit for purpose due to size, location, facilities and aspirations. It is likely some schemes will have to be decommissioned. It is also likely there will be a time delay before all of the schemes can be reprovided which will impact upon the ability to meet older persons' housing needs.

7.7 "Being Healthy in Gateshead"

This is a locally developed strategy, supported by the "Being Healthy" group, a local group of people with a learning disability. It addresses health issues for people in Gateshead with a learning disability.

8 Community engagement in health

Indicators of Health Status, Lifestyle Behaviours and Uptake of Services for Focus Neighbourhood Planning Areas has been prepared in order to assist a programme of community engagement roll out in those 5 areas, focussing on health related issues; and to generate learning about the way that we can use data as a stimulus to community based action, as well as to monitor problems.

The document provides detailed information about the way the 5 Neighbourhood Planning Areas selected for this work over the next 18 months have been chosen. All have life expectancy significantly below that for Gateshead as a whole (except Highfield); and all have been chosen through the relevant Area Forum (*Lowest life expectancy neighbourhoods link to doc of same name*). There is one in each Area to maximise the learning. Most of them align with the next iteration of either the Neighbourhood Plan or a Best Value Review which should provide a way of taking issues forward.

A subset of the indicators has been chosen to give a visual profile of the 5 Areas. The spider diagrams spokes have been selected aligned with the Annual Reports of the Directors of Public Health for NHS South of Tyne and Wear 2007/2008 sections: Driving up Life Expectancy (all age all cause Mortality – persons, proportion of the population diagnosed with diabetes, and immunisation rates); Choosing Health (smoking prevalence among adults, and proportion of adults that eat 5 portions of fruit and vegetables a day); and Investing for Health (educational attainment at 16, and car ownership). This work is pilot work about ways to present the differences between neighbourhoods visually and so provide intelligence that inspires and underpins activity at a local level.

Social marketing tools can also be applied at the Neighbourhood Planning Area level. Social marketing analysis splits the population into groups with similar social and demographic characteristics: age, occupation, income, patterns of expenditure and pastimes. MOSAIC is the commercial name of the commercial product used to do this work across SOTW. It generates 12 groups, shown in comparison with the proportion in the English population. (See Table 1 below for an example of its use with regard to stop smoking services.)

Indicators of Health Status, Lifestyle Behaviours and Uptake of Services for Focus Neighbourhood Planning Areas shows its MOSAIC profile, using postcoded data. These maps are not intended to stereotype but add a new sort of information about the preferences and lifestyle of people living there which may give rise to fresh questions, interventions and ideas about the way they may engage with issues around their health and wellbeing. Central to social marketing

is matching service delivery to identified and perceived need in line with what the service user wants and sees as attractive or useful.

Table 1: MOSAIC Types Under-Represented in the Stop Smoking Service User Profile

Type	Pop	%	Index of uptake	Index of pre-valence	Description
8	1073	0.6	48	166	Families and singles living in developments built since 2001
49	4410	2	70	120	Low income older couples renting low rise social housing in industrial regions
39	7952	4	94	144	Older people living in crowded apartments in high density social housing
38	4540	2	102	163	Singles, childless couples and older people living in high rise social housing
25	1329	1	122	177	Centres of small market towns and resorts containing many hostels and refuges

Indicators of Health Status, Lifestyle Behaviours and Uptake of Services for Focus Neighbourhood Planning Areas also includes a map showing the GP surgeries, and an indication of which practices serve that particular population. Primary care is essential in addressing the needs of people at high risk of illness and early death through screening and prompt treatment. The new 'GP-led practice' will also be commissioned to set a gold standard in these preventive services. A map showing other community facilities is also included to help initiate full discussion about the resources available in that neighbourhood planning area.

The community engagement roll out follows a Service Improvement Plan produced as a result of the Overview and Scrutiny Committee Review of Inequalities. The process involves the Community Network, all the agencies involved in the Gateshead Strategic Partnership at both front line and senior management levels, and local residents. The principles follow those set out in the *Community Development Strategy*, applied to health and wellbeing, in particular:

- Communities that are active in identifying needs and opportunities for change and are committed to developing solutions and improving their local area.

Where we are concerned to address differences in life expectancy of 6-7 years for men and women within Gateshead, communities actively identifying the opportunities for change is central to the task. This may also generate opportunities for engaging with services, working with employees and organisations, and sharing skills, knowledge and resources in a co-ordinated way.

9 Process for prioritising commissioning priorities: defensible decision-making

A set of Criteria for Decision-Making was developed following discussion with the Children and Young People Improving Health and Wellbeing Board, the Planning function in Economy and Enterprise, and the Housing Strategic lead.

The principle is not to convert this list into a scoring system, but to ensure that issues are consistently addressed so that the rationale for decisions is clear.

The questions have been designed based on (the Health Needs Assessment Workbook by Judith Hooper and Phil Longworth 2002, Health Development Agency www.nice.org.uk), a standard framework for health needs assessment, to help us focus on those elements of commissioning that will best place services to face demographic trends, and consumer expectations, using technological developments to the maximum.

There are three main stages to the approach, each with a specific set of questions. The stages are:

- Stage 1: analysis and rationale for service improvement (public health lead). This concentrates on impact and effectiveness.
- Stage 2a: change management. This concentrates on acceptability.
- Stage 2b: public views (Community Care Forum and Community Empowerment Network led). This considers public views, carers and patient empowerment.
- Stage 2c: resource feasibility. This looks at identified resources and alternatives, needs and finance.
- Stage 3: commissioning intentions (Commissioner-led). This considers implementation issues.

Following these stages and considering the questions within them allowed a set of priorities (2008 JSNA priorities) to be developed for the 2008 JSNA. This formed the basis for the 2009 JSNA refresh, which was amended in the light of

new information and data analysis (discussed in section 5 above) and the wide range of consultations with users, carers, providers and local residents discussed in section 4 above.

10 Key issues and priorities for Gateshead in 2009

The following table details the priorities identified for the 2009 JSNA, based on the 2008 priorities and augmented by further consultation and accumulation of additional data. Its three main sections (driving up life expectancy; choosing health; and investing in health) are in line with those in the Annual Reports of the Directors of Public Health for NHS South of Tyne and Wear 2007/2008

Column headings in the table reflect the questions considered in assessing the priorities and show how each priority was assessed according to the same criteria: health impacts, including mortality and morbidity as well as health and social services; socio-economic effects, including both education and employment; prevalence or incidence and forecast trends; health inequalities; effective interventions and rationale for action, the latter section referring, where appropriate, to the evidence, to the concerned consultation group or to an existing target or indicator.

The main issues identified, prioritised and included in the table are:

Part 1: Driving up life expectancy

1.1 Screening and early years

Antenatal, newborn and developmental screening
Breastfeeding
Immunisation
Cancer screening in people with learning disability

1.2 Illness and chronic conditions

Respiratory conditions (asthma & COPD)
Excess winter deaths
Circulatory diseases/stroke
Musculo-skeletal conditions

Part 2: Choosing health

2.1 Mental health and emotional well-being

General mental health and emotional well-being
Child and young person emotional health and well-being
Dementia

2.2 Lifestyle

Substance misuse (drugs & alcohol and tobacco)
Sexual health
Under 18 conceptions
Parents, carers and families
Childhood obesity

Part 3: Investing in health

3.1 Poverty and exclusion

Reducing isolation and loneliness in older people
Children living in poverty
Poverty of aspiration and educational attainment
Educational standards at primary school and secondary school
Children missing from education
Engagement in further education, employment or training on leaving school
Provision of decent homes
Neighbourhoods with the lowest life expectancy

3.2 Violence

Victims of domestic violence including especially children
Bullying and discrimination
Crime and anti-social behaviour

3.3 Services for specific groups

Services for disabled children
Young carers
Older family carers of people with learning disabilities
Looked after children
Reducing vulnerability to poor health through identifying needs of vulnerable individuals and groups
Ex-prisoners

Key issues and priorities for Gateshead

Part 1: Driving up life expectancy

1.1 Screening and early years					
	Direct impacts on health and on health and social services. Socio-economic impact (employment/qualifications)	**Prevalence, trends and projections**	**Health inequalities**	**Effective interventions**	**Other rationale for action**
1.1.1 Antenatal, newborn and developmental screening					
	Antenatal screening is a way of assessing whether the unborn baby (foetus) could develop or has developed an abnormality or other condition during pregnancy. If problems are identified early health professionals and parents can plan accordingly – including provision of services. Planning to ensure implementation of a wide range of extended and partnership services and support to meet complex needs	Over 95% of pregnancies result in the birth of a healthy baby. Gateshead's infant mortality rate (5.5) is higher than national average (5.0) and NE average (4.9). Infant mortality is a sensitive measure of the overall health of a population. It reflects apparent association between causes of infant mortality and other factors likely to influence the health status of whole populations, such as general living conditions, economic development, social well-being, rates of illness and quality of the environment.	Pregnancy and the first years of life are most important – this is when the foundations of future health and wellbeing are laid down. There is good evidence that outcomes for both children and adults are influenced by the factors that operate during pregnancy and the first years of life. Improving socio-economic conditions and obstetric care can make significant contribution to reducing maternal and infant mortality	Implementation of the *Child Health Promotion Programme* which is the early intervention and public health programme. At a crucial stage of life, the *Child Health Promotion Programmes* Universal reach provides an invaluable opportunity to identify families in need of additional support and children at risk of poor outcomes.	*Every Child Matters* *National Service Framework* *The Child Health Promotion Programme* NICE guidelines CG62
1.1.2 Breastfeeding					
	Research[31] demonstrates that breastfeeding has a major role to play in public health, promoting health in both the short and long term for baby and mother. Breastfed babies have lower incidence of gastric, respiratory and urinary tract infections and allergic diseases. Breastfeeding mothers have a reduced risk of pre-menopausal breast cancer and ovarian cancer.	The method of feeding at the 6-8 week check is now the primary measure of infant feeding. From 2003/04, breastfeeding initiation rates have steadily increased to 59.6% in 2007/08. These rates are higher than the North East average (52.4%). However, they remain lower than the England average (70.0%).	Research[3] concludes that breastfeeding has a key role to play in tackling the fundamental policy goal of addressing inequalities in health in the UK. Despite overwhelming health benefits and cost savings associated with it, breastfeeding rates remain low. Mothers more likely to initiate breastfeeding include: first-time mothers, older mothers, mothers working within a managerial or professional background, mothers with higher levels of education and mothers of black/ ethnic	A Gateshead Public Health Midwife will take a lead role in the promotion of breastfeeding across the borough and will take a lead in the preparation for achievement of Unicef Baby Friendly initiative. Messages will continue to normalise breastfeeding. (Links with the regional infant feeding co-ordinator to ensure consistency.) Breastfeeding champions to be identified within each of the five localities. Training packages available for group work and one to one support.	*Every Child Matters* *NSF for Children, Young People and Maternity Services* *The Child Health Promotion Programme* *DH guide to maternal and infant nutrition*

			minorities.	Mapping of rates across the 5 localities. Identify opportunities for voluntary and community groups to promote and support breastfeeding.	NICE guidance on maternal & child nutrition
1.1.3 Immunisation					
	Immunisation is the most effective public health intervention in the world for saving lives and promoting good health. Childhood immunisation has been singly effective in wiping out key infectious diseases. Unimmunised people are at risk from catching the disease and rely on other people being immunised to avoid becoming infected.	Uptake rates: Diphtheria, polio, pertussis, haemophilus influenza immunisation B: 94.5% Meningitis C immunisation at 24 months: 91.3% Measles, mumps and rubella: at 24 months 87.5%; at 5 years 71.6%	There is considerable variation in immunisation uptake rates between wards	Continue to implement strategies to improve uptake of vaccination in GP practices.	*Every Child Matters* *NSF for Children, Young People and Maternity Services*
1.1.4 Cancer screening in people with learning disability					
	Cancer mortality will be higher among population groups with lower uptake of health screening programmes. In medium to long term (10 to 20 years) hospital admissions will be reduced if uptake of cervical, breast and bowel cancer screening can be increased now.	Quality Outcomes Framework (QOF) now includes Learning Disability as a key indicator, measuring prevalence in primary care. In Gateshead 450 people ages 18 and over (0.3%) have been diagnosed with a learning disability (similar to England). Estimates of prevalence nationally [4]from Valuing People report suggest that 650 people in Gateshead ages 18 and over have a severe learning difficulty. These are people who will need support to live independently. Gap of 200 between GP records and suggested prevalence may be due to data quality or unmet need. It is not possible to look at trends in prevalence of learning disability as there is currently a measure at only one point in time (2006/07) from QOF system that measures prevalence in primary care. It will take a number of years before data quality will be consistent at practice level.	Strong evidence[2,5,6] that uptake of cancer screening services among people with a learning disability is lower than uptake among the population as a whole. Recording of learning disability is now established within primary care among adults, so it is possible to begin to monitor health status of this group compared to the population as a whole, using simple measures such as prevalence of chronic disease e.g. CHD or diabetes among people with a learning disability against overall prevalence. Comparative screening programme uptake rates may still be difficult.	Person-centred Health Action Planning4 at the following life stages: • Transition from secondary education with a process for ongoing referral; • Leaving home to move into residential service; • Moving home from one provider to another; • Moving to an out of area placement; • Changes in health status, e.g. period of out-patient care or in-patient treatment; • On retirement; • When planning transition for those living with older family carers. Department of Health guidance document "Equal access to breast and cervical screening for disabled women" sets out good practice for screening services.	A small but specific development for screening services, which will need to be reviewed once adequate baseline data are available. Added value to screening services could be spin off in terms of communicating with people with other forms of cognitive impairment, e.g. dementia. Issue emerged in health equity audit.
1.2 Illness and chronic conditions					
1.2.1 Respiratory conditions (range of conditions, including asthma & Chronic Obstructive Pulmonary Disease (COPD))					

	Gateshead average, 135 deaths a year due to COPD, including bronchitis and emphysema, which constitutes 7% of all deaths. All age SMR between 2004 and 2006 was 156 (95% CI, 141/172) so mortality rate is 1.5 times that of England as a whole and is significantly higher than the England rate (95% CI). Only 30% of deaths occur under age 75, so impact in terms of years of life lost is not likely to be greater than that of mortality. Nationally, admissions due to all respiratory diseases (J00-J99) constitute 5% of all hospital admissions. This increases to 11% among 0-14 year olds and 9% among people ages 75+. In Gateshead there were 4,100 hospital admissions in 2006/07. Responsible for significant proportion of sickness absence.	Currently 4,600 people on GP registers in Gateshead diagnosed with COPD (local prevalence 2.2% compared to 1.4% for England) and 13,100 people diagnosed with asthma (local prevalence 6.4% compared to 5.8% for England). As with hospital admissions, this is likely to be a relatively more important condition among children than among adults. Local data on variations in prevalence have been mapped at GP practice level from QOF data. Asthma prevalence is falling slowly (6.6% in 2004/5, 6.4% in 2006/07) as is prevalence of COPD (2.3% in 2004/05 to 2.2% in 2006/07). Prevalence of smoking, a major risk factor for COPD, is falling nationally but there is limited evidence to determine whether this is local trend.	In the two wards that were the focus of the OSC Health Inequalities Review, there were 76 hospital admissions due to respiratory disease among the population of Whickham South and Sunniside (lowest number among the 22 wards) compared to 254 among the population of Lobley Hill and Bensham (2nd highest number among the 22 wards).	NICE guidance on COPD.[7] Local initiatives include: • Pulmonary Rehabilitation Group (NICE CG12 – 1.2.10, 1.2.10.4) a multi-disciplinary rolling programme including coping strategies, anxiety management, relaxation and patient education. • Domiciliary OT assessment and rehabilitation (NICE CG12 – 1.2.18, 1.2.18.5, 1.2.18.14, 1.3.4, 1.3.4.2.) for over 18s. • Expert patient programmes • Clinical management plans implemented by Community Matrons Further evidence required linking good practice to local initiatives	An important issue currently without a strategic lead
1.2.2 Excess winter deaths					
	300 excess winter deaths in South of Tyne and Wear 2006/07.	This problem is likely to increase for two reasons: • increases in fuel costs force more households into fuel poverty and • rise in proportion of the population over 60.	Fuel poverty is also linked with heart attacks, strokes, respiratory conditions and mental problems. This area of work is specifically targeted to disadvantaged groups: those in fuel poverty, many elderly and alone, often in old and poorly heated homes.	Affordable warmth schemes and Decent Homes requirements. Warm zone and Anchor staying put. Improved chronic disease and self-care management. Flu vaccine. Decent homes programmes for public and private sector stock.	Specifically asked by NST to include this. Tackling fuel poverty LAA NI 187
1.2.3 Circulatory diseases/stroke					
	Premature (under 75 years) mortality rate in Gateshead due to all circulatory disease (CHD, stroke and related diseases) has fallen by 38% since 1996, ahead of the schedule required to meet the "Our Healthier Nation" target of a 40% reduction by 2010. However gap between Gateshead and England (25% higher than England in 1996, 22% higher in 2004) is not narrowing. Because of high number of deaths due to	10,000 people in Gateshead are currently diagnosed with Coronary Heart Disease. Average prevalence is 4.9% in Gateshead compared to 3.5% across England. Prevalence in Gateshead is typical of average prevalence across the North East (rates much higher across the North East than in other regions.. Prevalence of CHD in Gateshead has fallen from 5.1% in 2004/05 to	London Health Observatory life expectancy gap tool demonstrates that 19% of the life expectancy gap between Gateshead and England for males and 32% for females is a result of higher rates of mortality due to all circulatory disease.	London Health Observatory life expectancy gap tool demonstrates that for the most disadvantaged fifth of Local Authority areas as a whole (the Spearhead group) primary and secondary prevention of CVD (a range of effective measures are specified in the model) could reduce the life expectancy gap by 6% for males and 7% for females. Doubling the capacity of smoking cessation clinics could	Key issue from *DsPH Annual Report* and PCT Operational Plan, which will require interagency support.

	circulatory disease (37% of all deaths in 2004 in Gateshead were due to CHD, stroke or related diseases), number of years of life lost is also high. Many emergency and planned hospital admissions each year in Gateshead due to CHD, MI and stroke. Major cause of premature death (31% of all deaths under 75 years in 2004 in Gateshead were attributable to circulatory disease) so any reduction in mortality and morbidity will have a positive effect on size of economically active population which is a key issue for Gateshead, which will have a higher dependence ratio than England in coming years.	4.9% in 2006/07. This means that 500 fewer people are now living with this chronic condition. Trend is consistently downward over three years. An additional 4.400 people have been diagnosed as having had a stroke. Prevalence of stroke is 2.1% in Gateshead compared to 1.6% across England.		reduce the gap by a further 1% for both males and females. The model, however, assumes that rates of intervention will remain the same in other areas. Increasing the coverage of effective interventions will have implications for the PCT's prescribing budget. Rapid access chest pain clinic at Queen Elizabeth hospital established within past five years.	
1.2.4 Musculo-skeletal conditions					
	Falls: a leading cause of mortality in those aged over 75; 56% of deaths from falls and 57% of hospital admissions for falls in Gateshead are in those aged 65 and over. Road traffic accidents: a major cause of injury and death among young adults. Accidents occur disproportionately among children and young people. Accidents are a leading cause of death in children. Osteoarthritis: knee and hip replacements are a significant cause of hospital admissions. Musculoskeletal conditions are one of the top three conditions associated with worklessness.	Musculoskeletal problems account for 1 in 10 new consultations, 18% of these for arthritis. 10-25% of people over 55 have osteoarthritis of the hip and 14-34% over 45 have osteoarthritis of the knee.[8] Fractures are likely to involve fewer young people and more old people but remain steady.[9] Age specific fractured neck of femur is likely to increase. Hip and knee replacements are likely to increase, and NICE guidance estimates revision at 10 years.	Accidents are strongly associated with socio-economic group. Pedestrian injuries are 5 times higher in social class 5 than in social class 1.	Good evidence base for prevention of fractured neck of femur involving: regular exercise; reducing smoking before the menopause in women; increasing vitamin D intake to maintain bone density; falls reduction programmes. Reduction of osteoarthritis includes reduction of obesity and managing occupational risks. Healthy Communities Collaborative work has been successful in Gateshead in relation to falls. The Falls Team based in Queen Elizabeth hospital carries out preventive work. Musculoskeletal conditions are the focus of Rapid Improvement Pathway work led by the PCT Directorate of Strategic Commissioning and Reform.	Fractured neck of femur and osteoarthritis are both conditions with major implications for independent living, primary and social care. *Every Child Matters*

Part 2: Choosing health

2.1 Mental health and emotional well-being					
	Direct impacts on health and on health and social services. Socio-economic impact (employment and/or qualifications)	**Prevalence, trends and projections**	**Health inequalities**	**Effective interventions**	**Other rationale for action**
2.1.1 General mental health and emotional well-being					
	Mortality from suicide – average 15 deaths per year, majority male. Years of life lost – comparatively high due to young (20-45) age of most suicides. age-standardised years of life lost rate 27 per 10,000 population, (2003-05) (England 28) Hospital admissions mainly for severe and enduring mental health problems. High impact on primary care, with depression a major reason for visits to GP. Drugs budgets very high. Rate of claiming benefits for mental or behavioural problems per 1,000 people of working age is significantly higher in Gateshead (47.1 per 1,000) than NE (41.4) and England (27.4). Population projections show that Gateshead's dependence ratio (ratio of older people to people of working age) will be higher than England's in future so the effect of common mental health problems on employability and time lost due to sickness absence is more important for Gateshead.	Suggested prevalence for neurotic disorders (depression, anxiety and others) among people of working age is 16%[10]. This suggests around 20,000 adults of working age suffer from these conditions in Gateshead. Highest prevalence is among the 40-55 age band with prevalence higher among females compared to males, from the national evidence. Estimated 10-15% of people 65+ years suffer from depression nationally[11]. Between 3,400 and 5,000 older people suffer from this condition. By 2015 this will rise to 3,700-5,600 (+10%) if prevalence remains the same. Figures for severe depression are between 1,000 and 1,700 older people 65+ suffering now, increasing by 10% by 2015 to between 1,100 and 1,900 (+10%). Comparative rates of benefit claimants due to mental and behavioural problems suggest that local prevalence is significantly higher than regional and national average prevalence. QOF introduced depression measures in 2007 (but only relating to people with a chronic condition). "Mental Health" indicator measures the prevalence of severe and enduring mental health conditions. 1,700 people suffer from these in Gateshead (0.8%, 0.7% for England). NE rates of prescribing antidepressants are higher than national. In 05/06 Gateshead had 2nd highest rate of antidepressant prescribing among 6 local PCT areas. Trends in benefit claimants misleading – number eligible for benefits changed in recent years with changes to administrative systems.	*Gateshead Overview and Scrutiny Committee Review of Health Inequalities* (June 2007 to March 2008) has identified mental health as a particular priority. A map of the rate of claiming benefits for small areas in Gateshead in 2005 and estimates of prevalence of depression in Gateshead by ward in 2002 both show higher rates of prevalence in areas of Central and East Gateshead where levels of socio-economic disadvantage are highest. Gateshead has been a pathfinder for Targeted Youth Support. This work has identified a level of unmet mental health needs amongst young people which impacts of outcomes for those individuals.	NICE says choice of pharmacological or psychosocial treatment (cognitive behavioural therapy) should be offered to service users when presenting with anxiety or depression after a period of watchful waiting (NICE guides ref CG22 and CG23). No evidence to say what appropriate balance between therapies is and currently no easy way of measuring what the balance is in practice. Layard Report[12] nationally called for an increase in availability of psychosocial therapies but noted that they were no cheaper than pharmacological interventions. Government Green Paper "In work, better off" notes the effectiveness of the Pathways to Work initiative which provides tailored support for disabled people seeking work and has been piloted in Gateshead. Clients in the pilot areas have been 7% more likely to have found a job after 18 months. The paper contains a proposal to roll out the programme nationally.	Major issues for Gateshead, affecting significant numbers, with a developing evidence base and high policy profile. Features in the OSC Inequalities Review. Features in many consultations, including voluntary/ community sector

2.1.2 Child and young person emotional health and well-being					
	At any time, one in ten children and young people have a mental health problem, the majority of which are either emotional disorders (depression or anxiety) or conduct disorders. Inter-relationship with risk behaviours and physical health: poor mental health is often the underlying factor behind risk behaviours (including smoking, risky sexual activity, substance abuse) and health outcomes (including injuries, teenage pregnancy, eating disorders, bullying and violent behaviour). Poor emotional health and well being affects educational achievement: poor mental health is associated with low educational performance and absenteeism; additionally, conduct and hyperkinetic disorders disrupt the educational environment for other children. This may have a long term impact on employability. Increased offending and anti-social behaviour: conduct disorders in particular are associated with anti-social and offending behaviour which impact on the safety and well-being of the wider community. The average cost to society of an individual with untreated conduct disorder is £70k.	Using the Gateshead CAMHS HNA risk factors which impact on the prevalence of mental health problems are identified within three categories: • risk factors in the child, for example language and related problems, • risk factor in the family, for example parental criminality, alcohol or personality disorder and • risk factors in the community, for example homelessness. Boys more likely to have a mental disorder than girls. Amongst 5-10 year olds, 10% of boys and 5% of girls have a mental disorder; amongst 11-16 years olds, 13% of boys and 10% of girls. Estimated numbers of children and young people (aged 5 – 16 years) in Gateshead experiencing an emotional health disorder include: • 1600 diagnosed with a conduct disorder • 1000 experiencing an emotional disorder • 410 being hyperactive • 350 with a less common disorder Results from the 2008 Health Related Behaviour Questionnaire include: • 58% of Year 10 boys and 38% of Year 10 girls (aged 14 or 15 years) reported a high self esteem score. These figures are slightly above the England average for boys and below the England average for girls. • 51% of Year 8 boys and 33% of Year 8 girls (aged 12 or 13 years) reported a high self esteem score. Both figures are below the England average • 10% of pupils in secondary schools reported that they felt afraid to go to school because of bullying 'often or every day'. (Increased since 2004.)	High proportion of children & young people affected by financial hardship, 62% of all 0 to 18 year olds (38,000) live in households where either no adults work, or where earnings are sufficiently low to warrant state financial assistance Such financial circumstances can be both cause and consequence of challenging family or household circumstances and impair children and young people's outcomes. 49% of children in Gateshead are in low income families (49% across NE, 42% England. ONS (2000) The mental health of children and adolescents in Great Britain report concludes: • Children of lone parents are twice as likely to have a mental health problem as those living with married or cohabiting couples. • Children from lower socio economic background more likely to have mental health problems than those from higher socio-economic background.	Gateshead has successfully secured a Pathfinder Mental Health in Schools project from April 08 Range of services from one-to-one work to group work within schools to improve self-esteem[13] Measures to ensure good mental health of children and adolescents include providing the following: • Universal services should promote positive mental health within community settings. • Accessible early intervention and prevention services delivering support to children, their families and professionals to meet social, emotional and/or behavioural difficulties. • specialised service for severe and complex mental health problems and neuro- development disorder.	National priority (PSA 12) *Every Child Matters* *National Service Framework for Children, Young People and Maternity Services* NICE: PH12 Social and emotional well being in primary education Promoting emotional health and well being through the *National Healthy Schools Standard* NICE guidance CG28: Depression in Children and Young People National CAMHS review Mental health needs of children and young people assessment (including views of stakeholders)
2.1.3 Dementia					
	10% of deaths in men over 65 and 15% of deaths in women over 65 may be attributed to dementia. Admissions to hospital where dementia is the primary diagnosis	Prevalence increases with age. Dementia is more prevalent among women than men in same age band. Estimates[14] suggest that in 2005 in Gateshead, 2,300 people aged 60 years and over suffer from dementia. Gateshead appears to have a higher prevalence of	With many long-term conditions such as cancer or heart disease the state, through the NHS, pays for a high proportion of the	NICE guidance[15] gave approval for certain prescription drugs within clinical guidelines. Result has been rapid increase in dispensing of these drugs[16]. Guidance recommends the	A specific aspect of care with evidence for local growth as an issue, and

	account for only a small proportion of the estimated total number of people who suffer from the condition. These are the most severe cases. There is a rising trend in admissions: 42 admissions to Northumberland Tyne and Wear Mental Health Trust with a primary diagnosis of Alzheimer's in 2003/04, 53 in 2004/05 and 62 in 2005/06. Generally affects people 65+ years although there are some working age adults affected. An increase in the number of sufferers will mean a larger number of people of working age who will have full or part-time caring responsibility.	vascular dementia than elsewhere in the country, probably reflecting the high rates of risk factors. This might increase the overall numbers of people with dementia with a significant minority under 65. By 2010 the number of people suffering from dementia in Gateshead will increase by 1% to 2,400 and by 2015 it will increase by 14% to 2,600. The small increase between now and 2010 is due to a small increase in the total older population (1.5% increase between 2006 and 2010) and this is in common with other local areas such as South Tyneside (1.5%) and Sunderland (2.2%) compared to the North East as a whole (3.9%) and England (6.2%). This is less than the Alzheimer's Society estimate of 38% increase nationally over the by 2022. If life expectancy is increased by reducing the prevalence of some illnesses, then the prevalence of dementia may increase. Difficult to predict prevalence as diseases that kill people in Gateshead early, e.g. CHD/ stroke are also risk factors for dementia.	care needs of sufferers whereas people who suffer from Alzheimer's are supported by social care rather than health care and means tested for the services they receive, instead of receiving free NHS care. Probable inequalities for people with dementia include increased isolation, poorer access to mainstream services, e.g. physical healthcare, impact on carers, less consultation and involvement in services than others.	following therapies and treatments other than prescription drugs: • structured group cognitive stimulation programmes • alternative therapies such as aromatherapy, multi-sensory stimulation or music/dance therapy • cognitive behaviour therapy for people with dementia who additionally suffer from depression or anxiety. This may include their carers • Sensory stimulation therapies for anxiety e.g. reminiscence therapy or animal-assisted therapy New housing models of care based on extra care are needed.	national priority.
2.2 Lifestyle					
2.2.1 Substance misuse (drugs and alcohol)					
	The National Treatment Agency defines harm as a result of substance misuse as that which significantly disrupts the young person's functionality. Substances are defined as illegal drugs, illicit prescription drugs, alcohol, and volatile substances (NTA 2007). Between 1991 and 2005 across England the rate of alcohol related death among men doubled. Rates of alcohol-related deaths among males are significantly higher in Gateshead than across England and higher than NE average. Gateshead among 10% of local authorities with the highest rates. Around 55 deaths each year in Gateshead attributable to alcohol. If all alcohol-related deaths under 75 years in Gateshead were avoided this would increase local average life expectancy by 1 year.	Estimates of binge drinking show most of Gateshead's population live in wards among the 10% of areas across England where average prevalence of heavy drinking on a single occasion is highest. Need more information on alcohol use by older people and consequences, e.g. falls. The impact of alcohol misuse on the lives of children and young people is well documented. It is a major feature in the rate of Child Protection registrations and in the incidence of Domestic Abuse. Marked upward trend in alcohol-attributable hospital admission rates among both males and females. 2003/04 around 3,400 alcohol-related hospital admissions in Gateshead, increasing to 4,000 in 2005/06. Need more work regarding dual diagnosis (people with drug/alcohol misuse and a mental health problem) in older people. 56% of Year 10 boys and 57% of Year 10 girls (aged 14 or 15 years) reported consuming alcohol within 7 days of a questionnaire being carried out. (Both figures above the England average)[17] 22% of Year 8 boys and 22% of Year 8 girls (aged 12 or 13 years) reported consuming alcohol within 7 days of a questionnaire being carried out.	Although there are variations within Gateshead in the proportion of adults binge drinking weekly or more often, most of the 22 electoral wards are among the 10% of all wards in England with the highest estimated rates of binge drinking.	Range of evidence-based interventions should be commissioned by PCTs to address alcohol misuse at varying levels of severity, from brief interventions by GPs and other health professionals to community or inpatient detoxification[19]. Integrated specialist substance misuse services. Screening of those truanting or excluded from school[13] Harm reduction to children from maternal substance misuse[13]	Issue which is significant for Gateshead, features in the OSC Inequalities Review, and links with PCT Local Delivery Plan. National priority (PSA 14) *Every Child Matters* *NSF for Children, Young People and Maternity Services* *National Treatment Agency: Young People's Substance Misuse*

	Around 4,000 alcohol attributable hospital admissions each year (distinct from A&E attendance) in Gateshead, with two thirds among men. Gateshead is among the 5% of English local authorities with the highest male and female alcohol attributable admission rates. Unsafe alcohol consumption will have an effect on employability and this is of particular importance to Gateshead because the dependence ratio (ratio of people of working age to people who have retired) which will be higher in future years than it is now and will be higher than the comparative rate for England as a whole. Rates of binge drinking are highest among young adults.	(Both figures above the England average)[17]. The Hidden Harm Report calculated that for every problematic drug user, one child under 16 is likely to be affected. More work needs to be undertaken to identify the known numbers of children and young people affected through adult treatment figures, social care and those in specialist services. All young people are potentially at risk of misusing drugs and alcohol but there are several key risk groups. These include children in care, persistent absentees, excludees, young offenders and children affected by parental use. Children whose parents misuse drugs/ alcohol are at increased risk of negative outcomes, including SIDS, emotional/ behavioural problems and own substance use. Likelihood of using an illegal substance in children under 16: nine times higher for frequent truants (45%), five times higher for young people who have been arrested (27%) and excluded (26%) than for non-vulnerable young people (5%).[18]			*Needs Assessment and Treatment Plan* Voluntary and community sectors concern re 1. young people who have mental health problems related to alcohol. 2. older people, as people aged 55-74 have highest rates of alcohol related deaths *local community safety strategic assessment* and indicative weighted place survey
2.2.2 Substance misuse – tobacco					
	Smoking is still a leading cause of premature death and disease (particularly stroke and lung cancer). Smoking in pregnancy poses serious health risks to the unborn child (including respiratory problems, low birth weight, increased risk of cot death) Local smoking prevalence was mapped at electoral ward level, allowing comparison with educational attainment. Although no causal relationship can be inferred, there is a strong correlation between areas of high smoking prevalence and areas of low educational attainment.	Within the North East region, around a quarter of babies are born to mothers who have smoked throughout pregnancy[20]		Intensive stop-smoking support for pregnant women Pre-operative smoking cessation leads to shorter length of hospital stay; smoking cessation leads to fewer emergency admissions for acute cardiovascular events (Dept of Health)	Regional strategy, smoking in pregnancy. National and LAA targets around reduction of smoking rates. Regional Public Health Strategy – *Better Health, Fairer Health* Raised in voluntary and community consultation
2.2.3 Sexual health					
	Mortality due to cervical cancer is	The number of people within the old Northumberland,	Incidence of STIs at PCT	National screening programme for	Incidence of STIs

	low (average of less than five deaths per year in Gateshead over the past five years). However, there is a screening programme in place so mortality is monitored as an outcome measure showing effectiveness of the programme. Gateshead's 2004-06 SMR: 111 (95% CI 55,199) but not significantly different to 100. Low level of total years of life lost compared to other diseases. 2005/06 at Gateshead Health, 98 admissions, 548 bed days (total admissions in 05/06 55,000). This compares to 2002/03, 90 admissions, 614 bed days. STIs will not affect employability except in terms of absenteeism. However, this may be significant as most STIs occur among adults in the 16-44 years age band.[21]	Tyne and Wear SHA (NTWSHA) area diagnosed with HIV/Aids increased in actual numbers from 167 to 507 between 1999 and 2005. In 2005 88 people with HIV/Aids were resident in Gateshead (116 including estimate of undiagnosed disease).[22] Gateshead prevalence higher than South Tyneside or Sunderland. Incidence of Chlamydia across NTWSHA also rose between 2001 and 2005 from 112 to 243 per 100,000 population all ages. Rates of incidence of gonorrhoea and syphilis across NTWSHA also rose in this period. Trends in incidence of Chlamydia, gonorrhoea and syphilis across NTWSHA are all increasing although syphilis may have peaked in 2004. No data currently available from the Health Protection Agency for PCT level populations. Nationally, incidence of gonorrhoea now in decline so this may be an area of local concern. The NE is not a hotspot in relation to rates of incidence for any of the key STIs[23]. The fall in the uptake of the cervical screening programme is of concern. Uptake rate is now falling towards the PCT's target minimum uptake rate of 80%.	level is not available and this makes an accurate assessment of health inequalities difficult.	cervical cancer is ongoing. Coverage in Gateshead has fallen slightly between 2002 and 2006 from 82.1% to 80.7% but this has been mirrored by a parallel fall in coverage regionally and nationally. In 2006 coverage across England was 79.5%. Ways of increasing uptake of cervical screening should be considered. Chlamydia screening important,, especially for under 25s. Since 2003 a national screening programme for Chlamydia among young adults has been introduced. Continued efforts needed to increase promotion of programme and numbers screened. Some STIs are diagnosed within traditional primary care settings e.g. GP surgeries. Better access to information	within the NE is not among the highest nationally *Every Child Matters* *NSFfor Children, Young People and Maternity Services* National priority (PSA 14) Chlamydia incidence identified as a priority area for young people under 25 years in the 2007 APA
2.2.4 Under 18 conceptions					
	Direct impact on health. Higher risks of complications. Almost a third of domestic violence begins with pregnancy. Repeat teenage pregnancies carry increased risk of preterm delivery and mental health problems. Risk of social isolation, particular with repeat teenage pregnancies. Can lead to exclusion from education or the labour market	The teenage conception rate is falling in Gateshead. Although the 2004 milestone of a 15% reduction was achieved (22% actual reduction), it will be more challenging to achieve the main target of a 50% reduction in the rate between 1998 and 2010. Conception rates were better than target for some years but rose again in 2006 (48.4 per 1000 females aged 17-19)	Gap between Gateshead and England narrowed since 1998. Strong link incidence & socioeconomic disadvantage. Higher rates in deprived areas. Long lead-time for DH collection and distribution of ward level rates (26 months from end of period) mean these are less useful in considering inequalities.	Contraception /sexual health services for 16-19 year olds. Better access to information The Contraception and Sexual Health service in Gateshead has grown between 2003 and 2006 and local access rates among young people in the 16-19 age group have also risen. Assessment of living arrangements and provision of suitable housing	National priority (PSA 14) *Every Child Matters*
2.2.5 Parents, carers and families					
	Child health directly influenced by actions and behaviour of parents, carers and families	n/a		Family support services along with parenting offer. Single point of referral to ensure choice of appropriate course of action [13]	*Every Child Matters*
2.2.6 Childhood obesity					
	Treating children for overweight or	The local 2007 survey showed a high level of childhood	Obesity an increasing	Availability of nutritionally balanced	(PSA 12)

	obesity may stigmatise them and put them at risk of bullying, which in turn can aggravate problem eating. Confidentiality and building self-esteem are particularly important if help is offered at school. Interventions to help children eat a healthy diet and be physically active should develop a positive body image and build self-esteem.	obesity: • In Reception (ages 4-5), 11.9% of children are recorded as obese; • In Year 6 (ages 10-11), 21.6% of children are recorded as obese These results are higher than the England and SHA NE average. In 2006/07 81% of schoolchildren aged 5-16 years were participating in a minimum of 2 hours of high quality PE within school. This figure is lower than the England average and lower than statistical neighbours.	problem nationally & locally. Obesity closely linked to deprivation and Gateshead therefore has high levels of overweight and obese children. The rise in obesity is due to a number of interlinking factors and thus is challenging to tackle. Evidence of effectiveness of interventions to tackle obesity is lacking and more research is required.	school meals through implementation of nutrient based standards.[13] Provision of good dietary and nutritional information for young people in schools and colleges[13]. Needs Partnership approach at earliest possible opportunity to promote physical activity, healthy, nutritionally adequate diet and positive self esteem. Following NHS SoT&W National Support Team visit for Childhood Obesity (Jan 2009), Gateshead childhood obesity strategy group will contribute to the development of a local strategy and action plan - in line with the regional vision. Will contribute to LAA target. Family based interventions must be developed alongside adult obesity strategy to tackle inter- generational aspect of obesity. Additional capacity within the existing tier 3 services is being explored to ensure overweight and obese children can be supported with their families to make healthy changes to lives.	NICE guidance CG43: Guidance on prevention , identification, assessment and management of overweight and obesity in adults and children *National Child Measurement Programme* *National Healthy Schools Standard* *NSF for Children, Young People and Maternity Services* *National Child Health Promotion Programme* *Healthy Weight: Healthy Lives*

Part 3: Investing in health

<table>
<tr><th colspan="6">3.1 Poverty and exclusion</th></tr>
<tr><th></th><th>Direct impacts on health and on health and social services. Socio-economic impact (employment/qualifications)</th><th>Prevalence, trends and projections</th><th>Health inequalities</th><th>Effective interventions</th><th>Other rationale for action</th></tr>
<tr><td colspan="6">3.1.1 Reducing isolation and loneliness in older people</td></tr>
<tr><td></td><td>Isolation may lead to malnutrition and health problems, including depression and dementia. Contact with health and social care systems is delayed until a crisis is reached. Data to pinpoint this problem are not currently available.

If 'older people' is defined as 50+, isolation may be a factor contributing to worklessness.</td><td>Gateshead has a high proportion of households occupied by single older people (60+F/65+M, 16.5%, 3rd highest LA rate within NE) compared to NE (15.6%) and England (14.4%). Total number of households in Gateshead with this characteristic is 14,000.

Older population 65+) will grow by 1.5% in Gateshead by 2010 (6.2% across England). By 2015, comparative increase will be 10.1% in Gateshead, 19.6% across England. This implies an extra 200 single older people by 2010 and 1,400 extra by 2015. However, greater proportion of single older people will be in the oldest old (85+ age bands) and 85+ population will increase by 8.1% by 2010 and 21.6% by 2015 (similar to England, but less than average increase across NE).</td><td>The distribution of single older people in Gateshead is distinct from the distribution of socioeconomic deprivation. Areas such as Pelaw and Heworth and Winlaton are not the most disadvantaged.

Areas with the highest concentration older people living alone are Pelaw and Heworth, Winlaton, Chopwell and Rowlands Gill, High Fell, Low Fell and Bensham. There are other indices of deprivation which relate to social isolation e.g. poor mental and physical health, financial circumstances, ethnicity, fear of crime, poor transport.</td><td>Literature review [24] found that nine of ten effective interventions involved educational or support input. Six of the eight non-effective interventions involved one to one social support, information, advice, health needs assessment. Review suggests that educational and social activity group interventions that target specific groups can alleviate social isolation and loneliness among older people.

Access to services and activities addressing social isolation and loneliness is variable[25] ; services are often not tailored to the needs of the most lonely and isolated; older people are rarely involved at the design stage. These issues need to be addressed.

Meeting older peoples' housing needs and aspirations by providing a choice of affordable, community located homes for life with support packages to maintain independence.</td><td>A specific aspect of prevention, meeting the needs of this growing section of the population, with an evidence base for action. Links with mental illness.

Serious concern for many consultees, including voluntary and community sectors</td></tr>
<tr><td colspan="6">3.1.2 Children living in poverty</td></tr>
<tr><td></td><td>Poverty is linked with a wide range of health inequalities, including reduced life expectancy, greater prevalence of chronic conditions and higher incidence of heart disease, respiratory diseases and most cancers.

Deprivation & avoidable injury clearly linked:
• Children whose parents have never worked, or are long-term unemployed are</td><td>49% of children in Gateshead (15,600 children) are in low income families (compare 42% for England as a whole).

Within small areas, the proportion of children living in families receiving workless benefits or tax credits varies from under 5% to over 70%</td><td>Highest proportions of children in low income families occur in certain wards (data annex 2.2)

Children born into poverty are more likely to:
• die in the first year of life
• be born small, be born early, or both</td><td>Provision of free school meals

Adequate income, affordable child care, adult employment opportunities, an inclusive education system and accessible health, leisure and transport facilities are essential for the prevention and eradication of inequalities in child health[26].</td><td>Government target

Local mental health needs assessment of children and young people raised concerns because of link</td></tr>
</table>

	thirteen times more likely to die from avoidable injury than children of parents in higher managerial and professional occupations. • Children in the most deprived 10% of wards in England are three times more likely to be hit by a car than children in the 10% least deprived wards Educational qualifications significantly affect an individual's position in the labour market.		• be bottle fed; • die from an accident in childhood • smoke and have a parent who smokes • have poor nutrition • become a lone parent • have or father children younger • die younger.		of poverty with mental disorders in children
3.1.3 Poverty of aspiration and educational attainment					
	Better general health and better mental health experienced by those with higher level of education. A region's economic success is partly determined by the skills and education of its workforce.	Only 14.5% of Gateshead's working age population have degree or higher	Job opportunities and hence economic potential greater for those with higher qualifications	Increasing opportunities for things to do & places to go for young people. Access to schemes to gain recorded and accredited outcomes through use of Asdan, Duke of Edinburgh's awards etc in informal setting, e.g. youth clubs[13] Young apprenticeships and off-site vocational learning options [13]	Government target Regional Economic Strategy. Important to economic well-being of region
3.1.4 Educational standards at primary school and secondary school					
	Strong correlation between educational achievement and life expectancy Educational qualifications significantly affect an individual's position in the labour market.	Proportion of Gateshead school children achieving Key Stage 2 Level 4 in English and mathematics is equal to or greater than the proportion across England. 74% at Key Stage 4 achieve 5 or more GCSEs at grades A* -C.	Wide variation across the district, with significantly lower proportions gaining these grades in both the south west and the north east of the district – links between educational attainment and health status	In and out of school support services, including homework clubs, use of support workers and nurture groups.[13]	Government target. Important to economic well-being of region
3.1.5 Children missing from education and children who are home educated					
	Links with low self-esteem and mental health problems. Educational qualifications significantly affect an individual's position in the labour market.			Monitoring of children missing from education. Multi-agency collaboration[13]	*Every Child Matters*
3.1.6 Engagement in further education, employment or training on leaving school					
	Links with low self-esteem and mental health problems Educational qualifications significantly affect an individual's position in the labour market.		Unemployment is linked with poverty.		Important to economic well-being of region
3.1.7 Provision of decent homes					

	Poor housing can exacerbate or cause respiratory diseases. Heating costs, particularly for the elderly on low incomes, can lead to poverty and associated problems. Elderly people can suffer or die from hypothermia.	n/a		Warmzone. Decent Homes requirements in public and private sectors	Concern of voluntary and community consultees LAA NI 187
3.1.8 Neighbourhoods with the lowest life expectancy					
	Lower life expectancy	Gateshead generally has lower life expectancy than England as a whole (males 75.8, England 77.5; females 80.4. England 81.7)	Lowest life expectancy areas have been identified as targets for specific action.	Collection and analysis of small area statistics to monitor and identify target areas. Identification essential prerequisite to service development.	Government targets to reduce inequalities
3.2 Violence					
3.2.1 Victims of domestic violence including especially children *NB Violent offences include homicide, serious wounding, less serious wounding and common assault (in descending order of severity) but also sexual offences and robbery. Domestic violence is a subset of violent offences and can fall into any of the aforementioned categories. Rate of violent offences per 1,000 population (incidence) is an indicator of violent crime in the Community Health Profiles[27].*					
	2005: 325 deaths due to homicide in England & Wales (636 including verdicts pending and injury undetermined). Of these, it is estimated that 100 deaths per year are the direct result of domestic violence[28], which is also a prime cause of miscarriage or stillbirth[29]. This suggests figures <5 for the Gateshead population if local and national mortality rates are similar. Actual homicides in Gateshead (excluding deaths due to dangerous driving) have been <5 each year from 2004/05 to 2006/07. Ambulance attendance following assault between 2001/02-2005/06 has decreased by 35.3% (-347), from 982 to 635 Around 20 emergency admissions due to violence in the home in Gateshead each year at a cost to the NHS of £20,000[30]. There will be many additional attendances at A&E that are not admitted. Domestic violence can have both short-term and long-term effects on physical and mental health, leading to acute and chronic physical injury, loss of hearing and vision, physical disfigurement, depression, alcoholism and sometimes suicide[31].	England rate of violent offences 2005/06 was 20 per 1,000 population all ages. Comparative rates are NE 18, Sunderland 19, S Tyneside 17 and Gateshead 14. Gateshead rate based on 2,655 offences. Rate in previous year was 16 per 1,000. Although violent crime remains a serious problem, Gateshead trends in recent years are downward. 3,600 incidents of domestic violence reported to Gateshead police each year. "Violent offences" indicator captures only a small proportion of all incidents, as many are never brought to prosecution. Steady trend in number of domestic violence incidents (neither increasing nor decreasing) over time. Women account for 80% of all reported domestic violence victims in UK. Number of children on Child Protection Register in Gateshead due to physical or sexual abuse increased sharply (by over 200%) between 2005/06 and 2006/07.	Evidence from the US has shown an inverse social gradient in the relationship between violent crime and socioeconomic status[32] Groups particularly vulnerable to domestic violence include: • older people (mainly in the form of neglect3); • pregnant women (30% cases begin in pregnancy); • women fleeing violence (women are at greatest risk of homicide at the point of separation or after leaving a violent partner)[33].	Repeat incidents of domestic violence have been reduced in Gateshead as a result of the Multi-agency Risk Assessment Conference process. Specialist Domestic Violence Courts started in Gateshead in 2008. An evaluation of 7 early courts showed positive results for the victim and for appropriate sentencing[34]. Probation and voluntary perpetrator programmes are available. Evidence suggests that completing a course will stop violence for a period, but may be replaced by verbal or psychological[35]. Voluntary programmes are more effective at stopping violence than compulsory programmes. An intensive home visiting programme may have the potential to improve parenting and increase identification of children at risk of abuse or neglect [36]	Domestic violence is a hidden crime. Already high prevalence may be under-estimated. Cost to NHS as a whole estimated at £1.2b for physical injuries and £176m for mental health issues.[37] Domestic violence particularly affects vulnerable adults, and is strongly linked to child protection referrals. *Every Child*

		Between 2003/04 & 2005/06, trends in common assault (CA), less serious wounding (LSW) and serious wounding are all downward. CA and LSW increased slightly in 2006/07 - not yet possible to say whether this is a spike or part of a longer trend.			*Matters*
3.2.2 Bullying and discrimination					
	Can be major cause of mental and emotional health problems. Can affect educational attainment, particularly if it leads to absenteeism.	In 2008, 10% of secondary school pupils said they felt afraid to go to school because of bullying 'often or every day'[38]		Anti-bullying award for schools. Monitoring bullying incidents, particularly for children from BME, those with disabilities and instances of homophobic bullying[13]	*Every Child Matters*
3.2.3 Crime and anti-social behaviour					
	Can lead to mental and emotional health problems. Can lead to social isolation.	Perception of crime and anti-social behaviour is also important (raised in community surveys)		Improvement of parks, accessible open spaces and play provision	*Every Child Matters* Issue raised in surveys
3.3 Services for specific groups					
3.3.1 Services for disabled children					
	Now very clear evidence of the changing nature of childhood disability. The report of the Prime Minister's Strategy Unit (Improving the Life Chances of Disabled People, 2005) noted that disabled children form the fastest growing group of disabled people (62% rise from 1975 – 2005). The number of children with complex health conditions has similarly increased, largely due to improvements in health care and, in particular, neo natal care. We are aware of duplication in services with both health and social care funding occupational therapy services and short breaks. Potentially: • available services do not match needs of individual children and their families, • there is a lack of clarity for providers as to which services are provided by each team for example in relation to equipment and home adaptations • there is a lack of continuity for children and families	It is difficult to ascertain the exact number of disabled children aged 0-19 years within Gateshead as there are several data sources. • The Children with Disabilities Voluntary Register hold information on 759 children and young people • The Disability Living allowance Claimants Register indicates 2370 children and young people • The 2008 school census shows a total of 5410 children and young people with school action or school action plus or a Statement of SEN *Improving the Life Chances of Disabled People* estimates that 1 in 20 children aged under 16 years has a disability. This would equate to approximately 2000 for Gateshead		Implement the recommendations from the Children with Disabilities Review (Solace Enterprise, Jan 09). Review Therapy services in line with National Reviews (e.g. Bercow[39]). Support and care: • Single placement, long-term foster carers for disabled children[13] • Local residential living support placements[13] • Targeted and flexible approach to share care[13] • Embedding in early years settings [13]of Early Support principles and practice. ' • Supported travel' or 'buddy' scheme for young people with learning disabilities[13] Increased choice of work-related learning opportunities for young people with learning difficulties or	National priority (PSA 12) *Every Child Matters* *National Service Framework for Children, Young People and Maternity Services* *Aiming High for Disabled Children (2007)* Bercow review[39]

				disabilities through the 'move Up' project[13] Direct payments to families to increase choice, control and minimise barriers to participation [13]	
3.3.2 Young carers					
	With many adult responsibilities, young carers often miss out on opportunities that other children have to play and learn. Many struggle educationally and are often bullied for being 'odd'. They can become isolated, with no relief from the pressures at home, and no chance to enjoy a normal childhood. Many young carers experience poor emotional and physical health with unacceptable levels of stress. Around one in ten young carers provide more than 50 hours of care per week. These children and young people are most likely to need services, support and assistance, to help promote their own health, well being, education, development, labour market participation and social inclusion.	In the UK there are estimated to be 139 000 children under the age of 18 years who are unpaid family carers (Census 2001). Gateshead Crossroads Macmillan Young Carers Service has an existing caseload of 290 young carers, and a throughput of 334 during 2007/08 (Gateshead Young Carers Statistics). There is still a problem in identifying and assessing young carers needs and the majority are unknown to services and agencies.		Implement the strategic objectives which have been identified within the Young Carers action plan Family Pathfinder work stream linked to the Young Carers	*Every Child Matters* *Carers at the heart of 21st Century Families and Communities – DOH 2008* *Local Survey of Young Carers*
3.3.3 Older family carers of people with learning disabilities					
	Many family carers experience poor emotional and physical health. Problems can be exacerbated when the carers are, themselves, older. Family carers cannot always take advantage of educational or job opportunities	The profile of carers shows that they are becoming older		Supported accommodation to provide independence (including aging carers) Effective housing solutions required through partnership working and commissioning tailored housing accommodation and services.	Ageing population of family carers
3.3.4 Looked after children					
	Children and young people who are looked after are amongst the most socially excluded groups. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs however, often remain unmet. As a result, many children and young people who are looked after experience significant health	OC2 data - 2007 figures indicate a total of 306 looked after children with 38.8% have statements of SEN The proportion of Looked After Children with statements of SEN has not been below 30% in recent years (2006 figure 37%) Of the current 306 looked after	Children and young people who are looked after are amongst the most socially excluded groups.	Use of screening tool (from Jan 09) for drug and alcohol use (children aged 10 years plus) to identify need and generate low level intervention into the service. Appropriate referrals into the specialist service made early Implement findings of sexual health audit (Jan 2009) to improve services.	*Every Child Matters* *DOH 2002 – Promoting the Health of Looked After Children* *National*

	inequalities and on leaving care experience very poor health, educational and social outcomes. The percentage of looked after children obtaining 5 GCSEs at grades A-G is 65% (as compared to 90% of all children)	children 16.6% are educated outside the authority		Other initiatives: • Virtual School Head for Looked After Children • Annual health and dental checks. • Family Group Conferences to prevent admissions and effective return home from care [13] • Placement dedicated therapeutic support to looked-after children[13] • One to one support from play development staff[13]. • Personal support arrangements for those aged 16-19 leaving care, including financial support[13 F]	*Service Framework for Children, Young People and Maternity Services* Emotional & Behavioural Health of Children in Care (NI 58)
3.3.5 Reducing vulnerability to poor health through identifying needs of vulnerable individuals and groups					
	Vulnerable groups tend to experience poorer health and, sometimes, poorer access to appropriate services	n/a		Gateshead has been successful in family pathfinders bid – will target the most vulnerable families	Government targets to reduce inequalities
3.3.6 Ex-prisoners					
	Physical disorders (epilepsy, asthma, diabetes, coronary heart disease, cancer) - same rate as those in equivalent population. Drug related deaths and suicide cause significant years of life lost, although numbers are small.[40] Prison population largely young, male, socially deprived, inner city. Levels of mental illness very high in prisoners. For males in remand: personality disorder (78%), functional psychosis in past year (10%), neurotic disorder in the past week (59%). 6 out of 10 prisoners are functionally illiterate, which impacts on their employability and social functioning.	The 150,000 people going through prison in a year, plus their families, make up the poorest 1% of the population in terms of overlapping forms of deprivation. In Gateshead in 2005-6 89 adults were sentenced to prison by Magistrates, occupying 10 places over the year between them, at a cost of £350,000. 13 juveniles were sent to custody in the same period, at a cost of around £200,000. Crown Court decisions placed 150 adults in prison at a cost of around £6million.[41] The prison population continues to rise as a result of policies related to criminal justice.	Prisoners have experienced very high proportions of adverse life events (e.g. 43% have been in an institution as a child, 30% have experienced violence at home, 30% bullying, 47% homelessness, 55% serious money problems). Almost a quarter of probation service clients known to the service in 2005-6 came from Dunston and Teams, and Felling. The OSC Review of Health Inequalities considered ex-prisoners as an important group although it did not rank this work in the top 8 recommendations.	The key health issue for those leaving prison is continuity of care for those leaving prison, especially where drug, alcohol and mental health problems are involved. The first few days in custody and the first few days after release are high-risk times. Re-settlement and employment are key aspects of the strategy to reduce re-offending.	Effective work with this relatively small group would focus on people with complex multiple deprivation needs, which if successful could make a significant impact on them and the community as a whole.

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