INEQUALITIES

‘It never rains but it pours’

Gateshead Director of Public Health
Annual Report 2017
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from the Director of Public Health Gateshead  

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I feel incredibly privileged to be presenting my second annual report as Director of Public Health for Gateshead.

The annual report is a statutory function. It is required to be independent, in that it doesn’t represent an organisational or political perspective, but instead sets out my professional view of the health and well-being of our communities in Gateshead.

This year’s report, ‘It never rains but it pours’, focusses on inequality. The report describes how disadvantage can cluster and accumulate across the life-course. It explores how inequalities are experienced through the eyes of people in Gateshead and it attempts to give a platform for those people whose voices are often not heard loudly enough. Poor health outcomes are significantly more prevalent in communities that experience other hardships (e.g. poverty). These patterns of illness highlight that health is considerably more complex than individual behaviour choices.

I know many of you reading this will agree that it is completely unacceptable that:

Two babies, born on this day in Gateshead, could have as much as a 10 year difference in life expectancy due entirely to the circumstances into which they are born.

If you look beyond Gateshead those same babies could have as much as a 15 year difference in life expectancy when compared to the most affluent area in Britain.

| Baby boy born in the most deprived communities in Gateshead can expect to live on average | 73.2 years |
| Baby boy born in the least deprived communities of the English borough with the highest life expectancy can expect to live on average | 88.3 years |
| Baby girl born in the most deprived communities in Gateshead can expect to live on average | 76.9 years |
| Baby girl born in the least deprived communities of the English borough with the highest life expectancy can expect to live on average | 90.8 years |
It is not fair that life chances are marked before these babies have even taken their
first breath. The burden of ill-health falls hardest and fastest on those from low income
backgrounds.

‘Poverty is not an accident. Like slavery and apartheid, it is man-made
and can be removed by the actions of human beings.’
(Nelson Mandela)

Once born into this cycle of disadvantage, a person is more likely to experience, and
accumulate, a range of poor outcomes over the course of their life, with those experiencing
multiple difficulties often suffering unthinkable adversity, stigma and isolation.

Despite much amazing work over recent decades, to improve health, inequalities in entirely
preventable disease remain stubbornly persistent. In fact, in recent years inequalities in
Gateshead appear to be growing.

Slope Index of Inequality in life expectancy at birth, based on local deprivation deciles: range in
years of life expectancy across the social gradient within each local authority, from most to least
deprived, Gateshead compared to LA with lowest range.
Would it surprise you if I told you that health care only accounts for around 10% of a population’s health?¹

There is increasing evidence that the current system is severely limited by its disproportionate focus on treating ill-health when it occurs rather than investing in the conditions and qualities that support health over a lifetime.

‘Why treat people and send them back to the conditions that made them sick?’²

This report considers the inequalities that are visible through a range of very different lenses. However, regardless of the lens you are looking through, the overwhelming message is the impact of economic disadvantage. In this context health is broadly shaped by political, social, economic, environmental and cultural factors which in turn are affected by the distribution of power, money and resources including: family circumstances, personal and family wealth, social opportunities, housing, education, individual health status, environment and employment, amongst others. Of course inequalities are not inevitable but it is important to recognise particular life experiences that increase someone’s likelihood of disadvantage.

The moral case is strong but beyond this there is also a clear economic case for being concerned about inequalities in health. Being in good health is not just important to an individual but it is also important to the economy. The ‘poor health poor wealth cycle’ outlined in the report ‘Health and Wealth – Closing the Gap in the North East’ (North East Commission for Health and Social Care Integration) illustrates how ill-health drives poor productivity and vice versa.

‘The ultimate source of any society’s wealth is its people. Investing in their health is a wise choice in the best of times, and an urgent necessity in the worst of times’.³

My report aims to extend our understanding of the way health outcomes are shaped so we can consider whether there are more effective ways to tackle health inequalities. If we continue to address inequalities through existing approaches we will continue to see the same outcomes. Adopting this perspective characterises a healthy person:

‘not as someone free from disease but as someone with the opportunity for meaningful work, secure housing, stable relationships, high self-esteem and healthy habits.’¹
'There is no greater inequality than the equal treatment of unequals.'
(Felix Frankfurter)

It is really important that I acknowledge the work that has already started in some parts of Gateshead, recognising the need to address these growing injustices. It’s not going to be easy. We are battling a tide of both uncertainty, particularly with finance, alongside the local impact on inequalities of national policies. The combination of these provides a perfect storm where, without concerted action, outcomes for the most disadvantaged in our community are set to get progressively worse.

In order to equalise outcomes it is also important that we consider our approach to how existing resources (people, time, money) are distributed, so that those communities experiencing the greatest disadvantage receive the greatest level of resource.

To respond to these challenges, work to address inequalities, using a social determinants approach, needs to be jointly owned and collaboratively designed.

As I entered my second year in this role, and was choosing the focus of this years report, I spent time reflecting on what motivated me to choose a career in Public Health. The memory that stands out most was being driven by an enthusiasm and passion (in sometimes unsophisticated ways) to redress these injustices.

And one of the reasons I love working in Gateshead is that I know people here really care and share this aspiration.

Therefore, I am appealing to your sense of justice, your compassion, your purpose, the reason you chose your role (or it chose you). I’m asking you to think even more deeply and carefully about how we do more, systematically, to mitigate the negative impact of inequalities that are disproportionately experienced by some of our communities.

**Strategic recommendations**

1. The Health and Wellbeing Strategy should be renewed, adopting a much longer term approach, with a strengthened vision to address inequalities. This needs to include measures to address the social determinants of health alongside prevention and early intervention at every level.

2. Partners in Gateshead should shift the focus from managing the burden of ill-health to promoting actions that create the right conditions for good health through the employment of a robust Health in all Policies approach.

3. The Council and its partners should target resources to those individuals and communities most in need. Robust evaluation of reach and impact should be undertaken regularly using a Health Equity Audit approach.
“Of all of the forms of inequality, injustice in health is the most shocking and the most inhumane”. 

Martin Luther King, Jr

HELLO BABY!

You take your first breath.

Where you are from in Gateshead determines how long you will live.....
In Gateshead two babies born on the same day at the Queen Elizabeth Hospital can have a 10 year difference in life expectancy. While we would never seek to justify it, how can we explain this? Is it based on geographical location or is it much more than that?

Inequalities can begin well before a baby is born, with factors such as the mother’s access to healthcare, her living environment and what she eats and drinks. However, what is even more important is that doesn’t have to be the case.

With this in mind, tackling inequalities should begin before a person is born and carry on through their life. This is an approach we are passionate about in Gateshead.

As our two babies grow up, they are faced with opportunities and challenges that can take them in many different directions. But the resulting impact on their lives is not set in stone and although inequalities do exist in Gateshead, the different outcomes of these are not inevitable and can be challenged if we work together across all sectors for all people in our borough.

What do we mean by ‘health inequalities’?

Health inequalities are: “differences in health between people or groups due to social, geographical, biological or other factors.”

The kind of life a person is born into, where they live, the environment they live in, where they go to school and work, can affect both their life chances and in turn their health.

Addressing these inequalities requires a move away from a medical model of public health to a broader, all-encompassing approach.

The Gateshead population is made up of many diverse groups who all have different health risks, opportunities and life experiences.
Inequalities in health are not a new concern for Gateshead, with some inequalities having been deep rooted for a long time. These inequalities are something that we all need to be thinking about so we can help make them a thing of the past.

A report published in 2010 by Professor Sir Michael Marmot stated: “Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people from different socio-economic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unjust.”

His report identified **SIX** goals to tackle inequalities:

1. **Give every child the best start in life**
2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**
3. **Create fair employment and good work for all**
4. **Ensure a healthy standard of living for all**
5. **Create and develop healthy and sustainable places and communities**
6. **Strengthen the role and impact of ill-health prevention**

Local authorities together with their partners (e.g. health and the voluntary and community sector) are ideally placed to take action to achieve these goals as their roles touch on all these aspects.

Gateshead Council aims to improve the well-being and equality of opportunity for everyone living in Gateshead and recognises that health inequalities are: “Unjust, unacceptable and avoidable”.

It is our belief that things can and should be done to tackle these inequalities and improve the quality of life for everyone in Gateshead – starting from the day they are born.

**What do we mean by ‘health inequalities’?**

Many factors have an effect on health inequalities ranging from whether you are a man or a woman, the state of the economy, where you live, the kind of house you live in, whether you are in a job or not, the local environment, your lifestyle and behaviour patterns.
The social determinants of health are all interconnected - how old you are, whether you’re male or female, what kind of house you live in, how well you did at school, if you have a job and what kind of a job it is, how active you are and the quality of the environment around you.
So, you are born in Gateshead.....that means:

- you live in the 73rd most deprived area out of the 326 local authorities in England.
- you could be one of more than 23,600 people who live in a neighbourhood with deep levels of deprivation.
- you are more likely to experience poor health outcomes compared to people living in the South of England.
- you are more likely to die sooner and experience more illness or disability than people living in the South of England.
- you feel the burden caused by austerity and welfare reforms which have been greater in the North than the South of England – exacerbating further the difference in health outcomes.

Life and Death  Gateshead v England

Where you are born in Gateshead also makes a difference

- A man living in the Bridges area on average lives 9.3 years less than a man in Whickham South and Sunniside.
- A woman living in Felling lives on average 7.7 years less than a woman in Whickham South and Sunniside.

Men:
(England average is 79.3 years)

Women:
(England average is 83.1 years)
Healthy life expectancy  Gateshead v England

A Gateshead man can expect to have 57 years of life in good health compared to the England average of 63.4 years. This is 6.4 years less. Within Gateshead a man living in the most deprived communities will live on average 13.8 years less in good health than a man in the most affluent.

A Gateshead woman can expect to have an average of 59.1 years of life in good health compared to the England average of 64.1 years. This is five years less. Within Gateshead a woman living in the most deprived communities will live on average 12.8 years less in good health than a woman in the most affluent.

Deaths from preventable causes

Each year 233 people per 100,000 in Gateshead die from causes that are considered preventable compared to the England average of 185 per 100,000.

That means there are more than 462 deaths in Gateshead every year that could be prevented.

WHAT CAN WE DO to reduce the INEQUALITIES gap?

THREE things we could do:

1. We need to continue to move away from the historical medical model of public health to a broader, all-encompassing approach addressing the wider determinants.
2. Inequalities begin well before a baby is even born and early intervention should be a key factor from the start.
3. We need to understand the difference between equality and equity and use this to create a fairer Gateshead for all.
“The difference between rich and poor is becoming more extreme, and as income inequality widens the wealth gap in major nations, education, health and social mobility are all threatened.”

Helene D. Gayle

And so the vicious circle of inequalities begins

Poverty in childhood results in fewer opportunities making it harder to move out of poverty as an adult
Like father, like son, like mother, like daughter

The link between a person’s economic status and their health is well known and documented. Put simply, the lower down the social and economic scale you are, the poorer your health will be.

Some key findings set out in the Marmot Review summed up the situation as follows:

“Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one’s economic and social status.”

The review found that:

- people living in poorer areas not only die sooner, but spend more of their lives with disability.
- the lower one’s social and economic status, the poorer one’s health is likely to be.

The experience of poor life circumstances associated with poverty, especially in early childhood, can cause biological changes in individuals. These changes can lead to increased risk of harm in later life.

This chapter will therefore focus on the significance of economic inequalities and health in Gateshead.

What is ‘economic disadvantage’?

Or put more simply how do we define and measure poverty? Let’s look at the three key interpretations of this much-debated issue:

1 **Relative poverty** generally means that a person can’t afford an “ordinary living pattern” - that is, they’re excluded from the activities and opportunities that the average person enjoys. A household is in relative poverty (also called relative low income) if its income is below 60% of the median household income.
2 Absolute poverty is slightly trickier. The definition used by a number of international organisations (such as the UN and the World Bank) is that you can’t afford the basic needs for life, food, clothing and shelter and so on.

3 Whilst these definitions are widely used, a more recent definition from the Joseph Rowntree Foundation (2016) defines poverty as:

“Not being able to heat your home, pay your rent, or buy the essentials for your children.

“It means waking up every day facing insecurity, uncertainty, and impossible decisions about money. It means facing marginalisation – and even discrimination – because of your financial circumstances. The constant stress it causes can lead to problems that deprive people of the chance to play a full part in society.”

However it’s defined, poverty reduces an individual’s capacity to engage in those activities enjoyed by others in more advantaged circumstances.

There is also evidence that the experience of poverty itself impacts upon individuals at a biological level, explaining why the poorer you are, the harder it is to make what seem to be rational decisions over healthy behaviour and other decisions that affect your health.3

The local picture

In 2014, the ‘Due North’ report, commissioned by Public Health England, confirmed that not only is there a North South divide with respect to health in general, but that poverty is disproportionately concentrated in the North compared to the rest of the country.

People in those neighbourhoods experiencing poverty in the North tend to suffer from worse health than places with similar levels of poverty elsewhere in the country. Further, the gap in health between advantaged and less advantaged groups is greater in the North than elsewhere.

The numbers of individuals in relative and absolute poverty had been falling in the North East, with especially sharp reductions amongst those in absolute poverty. The reduction has stopped more recently with slight increases in the numbers of those in relative poverty, showing that, after housing costs around 22% of individuals in the North East, around 600 000 people live in relative poverty.4
Children and poverty

Children living in poverty do not have the same opportunities and life chances as their peers. Evidence indicates that child and family poverty often leads to cycles of disadvantage, with poor children becoming poor adults who then go on to experience poverty as a parent themselves.\(^5\)

Poverty often results in: \(^6\)

- less success at school
- a greater likelihood of poor health
- less opportunity to secure a good job
- increased risk of offending
- limited access to cultural and leisure opportunities
- increased risk of being taken into care

In Gateshead, after housing costs, more than one in four children (26.7%) live in poverty. And there are stark inequalities within the borough. In Low Fell, 6.2% of children live in poverty, while 43.5% of children in Felling live in poverty.\(^7\) A fuller picture across Gateshead’s 22 wards is shown below.

**Percentage of children living in poverty in Gateshead: Oct–Dec 2015**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Under 20%</th>
<th>Over 20%</th>
<th>Over 30%</th>
<th>Over 40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birtley</td>
<td></td>
<td>27.75%</td>
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<tr>
<td>Blaydon</td>
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<td>28.34</td>
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<td>Bridges</td>
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<td>Chopwell and Rowlands Gill</td>
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<td>Chowdene</td>
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<td>24.07</td>
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<tr>
<td>Crawcrook and Greenside</td>
<td>18.29</td>
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<tr>
<td>Deckham</td>
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<td>38.18</td>
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<tr>
<td>Dunston and Teams</td>
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<td>34.57</td>
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<td>Dunston Hill and Whickham East</td>
<td>12.70</td>
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<tr>
<td><strong>Felling</strong></td>
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<td>43.49</td>
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<td>High Fell</td>
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<td>36.31</td>
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<tr>
<td>Lamesley</td>
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<td>26.77</td>
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<tr>
<td>Lobley Hill &amp; Bensham</td>
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<td>Low Fell</td>
<td>6.24</td>
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<tr>
<td>Pelaw &amp; Heworth</td>
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<td>Ryton, Crookhill and Stella</td>
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<td>Saltwell</td>
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<td>29.21</td>
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<td>Wardley and Leam Lane</td>
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<td>Whickham North</td>
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<td>Whickham South and Sunniside</td>
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<td>Windy Nook and Whitehills</td>
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<tr>
<td>Winlaton and High Spen</td>
<td>16.75</td>
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</table>
Employment and Economic Inactivity

The conditions in which we work have a large impact on our health: good quality jobs can be protective of health, whereas poor quality work can be adverse for health. Features commonly associated with good jobs include:

- adequate pay
- protection from physical hazards
- job security and skills training with potential for progression
- a good work–life balance
- the ability for workers to participate in organisational decision-making

Inequalities exist even if you find work, and having a job in itself is not a guarantee of financial security. Over the last five years, the average weekly pay of full time workers in Gateshead has been consistently lower than England levels. In 2016, the gap in pay compared to England was £56 lower. And there are numerous factors that impact upon a person’s ability to work and the quality of work they find.

These include:

- skills level (low or no skills)
- physical and mental health and well-being
- access to affordable childcare
- caring responsibilities
- transport costs
- changes to in work benefits (such as tax credits)
- lack of internet access and low levels of digital literacy

All of the above impacts on the quality of the job people can do – with skilled work typically having more protective elements and less health–adverse conditions, while routine and manual work are more likely to have more health–adverse conditions.

In addition to entering employment, supporting residents to understand and manage finances is key, as it can increase financial capacity, raise household income and encourage and establish preventative measures to reduce financial hardship.
Economic reality check

1 in 4 children in Gateshead live in poverty

The highest levels of child poverty in the borough can be found in three wards:

- Deckham 35.6%
- High Fell 34.7%
- Felling 44.9%

More than 14,000 people in Gateshead claim some out of work benefit

- 24% claim benefits in Felling
- 2% claim benefits in Crawcrook and Greenside

29,000 people of working age are not in work, with 9,600 economically inactive due to long-term sickness

10,000 (11.2%) of Gateshead households are fuel poor, compared to the national average of 10.6%

Around £70 million per year will be lost from Gateshead residents as a result of welfare reforms.

Almost 2,500 households are affected by the Under Occupancy charge, reducing benefit by £14 per household/per week for the first bedroom and £25 for the second.

1,811 foodbank parcels were issued in 2016 compared to 1,698 in the previous three years
Debt and credit

“Annual income twenty pounds, annual expenditure nineteen pounds nineteen shillings and six pence, result happiness. Annual income twenty pounds, annual expenditure twenty pounds ought and six, result misery.”
Mr Mcawber from Charles Dickens’ novel David Copperfield, written in 1850.

167 years later and the pain and misery of getting into debt and not having enough money to live on has not changed – nor it seems has our ability to intervene and prevent further escalation when it comes to the residents who most need our help most – with debt levels at record highs across the UK.

CASE STUDY: Family intervention success

Who are we?
We are the Families Gateshead Employment Team and this is one of our cases

We were approached by a family with two children for support with their benefits, to resolve a complex financial issue.

Both the mum and her two children live with sensory impairments, with mum also having a chronic mental health problem. Due to her caring responsibilities, mum has not been able to work.

A change in her personal circumstances resulted in the family’s tax credits being stopped. This had an effect on her other benefits, as the family was no longer eligible for Housing Benefit, putting her and her family at risk of losing their home.

The Families Gateshead Employment Team worked with the family, giving them guidance and support to take them through the processes required to get their benefits reinstated.

In the meantime, to ensure the family did not suffer any further hardship, we issued foodbank vouchers so that the family would not be without food. We also contacted the family’s landlord to explain the complex situation and to come to an agreement, preventing the family from eviction and homelessness.

We also worked with the organisations responsible for administering the family’s benefits to have them reinstated. This involved support from a local MP. The resolution of the situation took over three months and significant input from the team but the family are now securely housed and receiving additional benefits to help with their children’s disabilities. The Families Gateshead Team are also providing extra support to help the father find work.
WHAT CAN WE DO to reduce the POVERTY inequalities gap?

THREE things we could do:

1. Complete the Poverty Commission for Gateshead which will include:
   a. Action to mitigate any potential negative impact of universal credit
   b. Robust support to help people remain in and get back to work where needed
   c. Identification of goals and policy changes that are needed to reduce the impact of poverty for people in Gateshead

2. Maximise the take up of the 2 year old free education entitlement to ensure children have the best start in life and are supported to be ready for school.

3. Develop and implement a multi-agency Team Around the School (TAS) approach to ensure children and families who experience problems have early and effective support.
“Reducing stigma against mental health and providing more support would have prevented me from becoming homeless and losing my job in the first place but I was seen as ‘fine’ as I was working. I had to lose my job and everything before anyone even tried to listen.”

A Gateshead resident

Homelessness is not inevitable and is rarely a housing issue alone
Going Underground

This section aims to shed a light on the experience of deep exclusion and inequality in Gateshead, through the lens of homelessness.

**What do we mean by social exclusion?**

Social exclusion is the process which affects individuals, groups or communities who lack or are denied resources, opportunities, rights, goods and services that are available to the majority of the population.\(^1\)

Social exclusion is widely acknowledged to be multi-dimensional and interactive in nature.\(^2\)

**Key drivers of social exclusion include:**

- poverty
- lower levels of educational attainment
- unemployment
- ill health
- poor housing or homelessness
- poor transport access
- increased levels of crime
- limited social support

A working framework of individual social exclusion has been developed by MacLeod et al (2016). The framework identifies three key domains that can result in someone suffering from social exclusion which are:

- your environment
- your social/economic situation
- your health issues

These three issues are characterised by different levels of inequality and discrimination, and it is a combination of these factors, as well as your own personal make-up, that determines your level of social exclusion in relation to how you:

- access relevant services;
- participate in community and civic life; and
- develop your social relationships and support network.
This framework emphasises later life, but social exclusion can occur at any time, and can have a long lasting effect on the health and quality of life for those affected as well as the equity and cohesion of society.

Experiencing any of the areas of social exclusion can be very isolating; however some individuals, groups and communities in Gateshead experience more than one area, resulting in severe and negative disadvantages. This form of social exclusion can be described as deep exclusion.

The local picture

A recent Health Needs Assessment (HNA) was undertaken on behalf of Gateshead Health and Well-being Board, the focus of which was on vulnerable, homeless adults (18 years and over) who had repeated experiences of homelessness or vulnerable housing as well as a wide range of other vulnerability including:

- substance misuse
- physical and mental health issues
- chronic poverty
- social exclusion
- cycles of physical and emotional abuse
- involvement with the criminal justice system

The HNA sought to identify the scale, nature and impact of these vulnerabilities by considering them through the lens of homelessness. However, it was recognised that this group could have been viewed through any of the vulnerability domains because the common thread that emerged was a picture of deep exclusion and inequality.
Headlines from the HNA

3,325 people in Gateshead are either homeless, living with substance misuse or involved in crime

245 of these people in Gateshead experience all three – with a cost to the public purse annually of around £5.58 million

- Homelessness is not inevitable and is rarely a housing issue alone.
- Homelessness is evidence of inequalities and is a late marker of exclusion and disadvantage.
- Local and national evidence demonstrated an engrained overlap between homelessness and other support needs such as substance misuse, physical and mental ill health, cycles of physical and emotional abuse and involvement with the criminal justice system.
- Current evidence suggests that homelessness results from the impact of structural, institutional, relationship and personal risk factors and triggers which have a cumulative impact, and are often underpinned by poverty and structural inequalities.
- Our current system is weakest where it needs to be strongest. The way services are funded, commissioned, monitored and measured often means homeless, vulnerable individuals with multiple and complex needs to navigate a complicated system that requires them to engage and manage relationships with numerous different agencies in order to address their needs.
- The HNA identified evidence locally and nationally of significant and long-standing health inequalities faced by people experiencing homelessness. Gaps in our understanding of how local health services are accessed by homeless groups is a barrier to tackling health inequalities that could be addressed. Mental health is a cause and consequence of homelessness and the significant barriers faced in trying to get the right help and support, particularly for individuals with multiple needs, emerged across a number of local data sources.

Personal insight

“I am not a bad person, but people think I am straight away because of my past and drugs and criminal record”

Peer Research with 27 people in Gateshead with experience of homelessness and multiple and complex needs identified a number of factors that contributed to their homelessness experiences. These included:

- not being heard in childhood
- childhood trauma
- mental health
- substance misuse
- debt
- job loss
Respondents identified missed opportunities to intervene, particularly between the ages of 16 and 20, and they talked about the impact of being provided with accommodation and/or support that was sometimes inadequate and even detrimental to their health and well-being. Gaps in support were identified across housing, physical, social and mental health. They also highlighted a need to listen to people earlier and to listen well, to address issues around transitions and how appropriate help and support can be accessed, to remove postcode barriers and to ensure staff are appropriately trained to recognise and support multiple and complex needs.

CASE STUDY: The reality of living with multiple needs and issues

Who am I?
This is the story of Ben (not his real name)

Gateshead resident, Ben is supported by local charity Fulfilling Lives. When referred, he had multiple issues – he was homeless, misusing substances, had a history of offending and a history of suicide attempts.

He has significant physical health and mobility issues following an accidental fall. He has been subjected to physical assaults, often resulting in him being hospitalised and is engaged in risky drug taking behaviour. He is also vulnerable to financial abuse. Ben is currently living in a more rural Gateshead area, but is not managing his tenancy and has significant rent arrears. Mobility issues mean he finds it hard to get around or keep appointments and this isolation has sometimes stopped him staying on prescription for methadone. Ben’s Fulfilling Lives navigator has been encouraging him to engage with therapeutic interventions around his drug use, which he has previously stated he did not want to access.

WHAT CAN WE DO to reduce the HOUSING inequalities gap?

THREE things we could do:

1. Public sector partners should agree that people will not be excluded from services due to the complexity of their needs and ensure the whole workforce are commissioned, equipped and encouraged to effectively understand and support multiplicity of need.

2. Tackle the root causes of homelessness within all policy areas.

3. Establish system-wide leadership and governance of homelessness prevention and early intervention.
“The strongest predictor of unhappiness is anyone who has had a mental illness in the last 10 years. It is an even stronger predictor of unhappiness than poverty – which also ranks highly.”

Polly Toynbee

Living with poor mental health is hard when you’re just a kid 😞

Half of all mental illness starts by the age of 14

Mental health issues can affect your whole life, not just your health.
Mind, body and soul

Half of all mental illness starts by the age of 14 and can impact on a person’s education, job prospects and relationships – and that’s before you factor in the health problems associated with mental health issues.

Any actions and interventions to strengthen well-being can therefore positively influence life expectancy and importantly, the proportion of this that is spent in good health.

Greater levels of well-being will improve employment rates and efficiency as well as reducing risky behaviours such as smoking and the over consumption of alcohol.

**Impact and consequences**

Mental health problems in childhood and adolescence can set the course of someone’s life. It can lead to:

1. Reduced educational achievement and employability
2. Increased risk of impaired relationships, drug and alcohol misuse, violence and crime

And the poorer you are the more likely you are to develop a mental illness, with people from manual backgrounds at higher risk than those from non-manual backgrounds.¹

**The work factor**

Whether you’re in work or not is a huge factor when it comes to explaining the differences in prevalence rates of all psychiatric disorders in adults. Unemployed people are:

- **FOUR** times likely to be dependent on drugs
- **THREE** times more likely to suffer from phobia and functional psychosis
- **TWO** times more likely to have a depressive episode, generalised anxiety disorder and obsessive–compulsive disorder.¹

Mental ill health is both a cause and a consequence of unemployment
National picture

One in four adults and one in 10 children are likely to have a mental health problem in any given year. This can have a profound impact on the lives of tens of millions of people in the UK, thousands of people in Gateshead, and can affect their ability to sustain relationships, work, or just get through the day.

People with poor mental health are shown to die 10 to 25 years earlier than people in the general population.²

The cost of mental ill health to the economy in England has been estimated at £105 billion (of which £30 billion is work related), and is the single largest area of spend in the NHS, accounting for 11 per cent of the NHS secondary health care budget. Furthermore it is predicted that treatment costs will double in the next 20 years.³

The current economic down turn will also impact. The strongest negative effect of an economic downturn is on mental health. People suffering from financial strain and job insecurity are at risk of mental health problems.

Local picture

At first glance the picture of mental health in Gateshead doesn’t appear to be too bad, with proxy measures of well-being and happiness, as collected by the Office of National Statistics (ONS), similar to national figures, our regional neighbours and similar authorities across England.

There has been progress in the right direction for all four indicators of the short Warwick Edinburgh Mental Well-being Scale (WEMWBS) between 2011/2012 up to 2015/2016.

The table below shows this progress:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011/2012</th>
<th>2015/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported well-being – People with Low satisfaction score</td>
<td>9.4%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Self-reported well-being – People with Low worthwhile score</td>
<td>6.7%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Self-reported well-being – People with Low happiness score</td>
<td>13.7%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Self-reported well-being – People with High Anxiety score</td>
<td>24.3%</td>
<td>21.3%</td>
</tr>
</tbody>
</table>

Source: Public Health Outcomes Framework ⁴
Despite this, Gateshead exhibits higher levels of estimated common mental health disorders and high levels of anti-depressants prescribing when compared to regional and national figures.

**What we are doing?**

The need for prevention is clear as the current economic downturn and the roll out of Universal Credit from October 2017 onwards will continue to challenge the resilience of Gateshead residents over the coming years.

A preventative approach is important with the focus on promoting wider public mental health through a range of programmes to help give people the skills to deal with life when times become harder. Gateshead, working in partnership with Newcastle, will use Time to Change and Connect® as the medians to educate and engage the public.

There will be focussed work with groups who face inequalities in health including:

- People with dual needs, i.e. mental health and substance misuse
- People on benefits moving over to Universal Credit
- People facing social isolation
- People furthest away from the jobs market
- People at risk of suicide

**Future developments**

There will be an increased focus on mental health promotion in line with ‘Making Every Contact Count’ (MECC). This will enable delivery of a range of community initiatives and training in community settings to increase knowledge and skills relating to supporting people with mental health issues.

This will include a focus on increasing physical activity which is known to have a positive impact.
CASE STUDY: Making a difference

Who am I?
I’m a female professional, aged 40, and I suffer from mental illness. This is my story.

Like so many others I suffer from general anxiety disorder and fear pretty much everything and everyone which in turn has resulted in low self-esteem. I believe I have suffered with this for a very long time although not really accepting it until two years ago when things just got too difficult to manage on my own. I have sought help from Talking Therapies on two separate occasions and recently completed an eight-week group session regarding depression and low self-esteem. For me, my road to thriving with good mental health included:

Accepting who I am and how certain situations make me feel, understanding those triggers and how my body responds and not being ashamed about myself, but feeling proud that I took a step to ask for help.

Talking to my therapist about the difficulties I encounter helped me realise how I made things more difficult for myself. I beat myself up on a daily basis, blaming myself for anything and everything. I talked to my manager and a work colleague to make them aware of how I find certain situations extremely difficult. This helped me immensely as it was another means of support and helped me come to work knowing I had support and help if needed.

Practicing techniques given to me by Talking Therapies which include how to deal with challenging situations, ending the day on a positive note and not worrying about what could have been or about things I have no control over, whether it’s in the past or the future.

I also love being outdoors and I also run – something that has brought me some wonderful friends who have touched my heart in more ways than they will ever know.

“It hasn’t been an easy road, I wear my mask well and there are many people, who probably would not believe how I feel on a daily basis, but I am thriving and I will get there in time. I picture myself as a happy individual, the confidence will come with time but it is certainly becoming brighter for me.”

WHAT CAN WE DO to reduce the inequalities gap for people with MENTAL HEALTH CONDITIONS

THREE things we could do:
1. Improve the support offer for people who experience dual need, e.g. mental health and substance abuse
2. Provide support for working aged people moving onto Universal Credit
3. Build on the pilot Social Isolation Programmes to engage more with communities
“If I had known I was going to live this long, I would have taken better care of myself.”

Mae West

‘One size fits all’ just won’t cut it when it comes to improving and raising the quality of life for older people in the area.

Lose track of the person and you lose track of the problem.

People with dementia often suffer from increased inequalities such as increased isolation and poorer access to mainstream services.
Casting a long shadow

Someone once said, “It’s not how old you are, it’s how you are old.”¹ And ‘how you are old’ depends on lots of things.

It has been suggested that inequalities decrease with age but this effect may largely be due to the fact that people who are able to be sampled in older age were often the healthiest to start with—i.e. the “survivor effect”.²

Being healthy in later life goes far beyond looking at the services provided through health and social care, and needs to take into account issues such as housing, income, transport and social relationships.

There is currently no accepted definition of older people or ‘old’ age. Some services cater for those aged over 50, whereas people may traditionally think of older people as those who are retired from paid work or are over the age of 65.

Older people in Gateshead are not a homogeneous group and they represent a huge array of different life experiences, circumstances, challenges and opportunities and therefore a “one size fits all” approach will not adequately address their issues.

Older people also make a significant contribution to informal care, voluntary organisations and community engagement. However, becoming older brings with it many challenges some of which give rise to significant public health issues.

Although some of this vulnerability can be to some extent offset by secondary prevention, lifestyle and access to services, this is not true for all people. Many of these public health issues are experienced disproportionately by older people and these will be the focus of this chapter.
National picture

Across the UK there are many common issues that affect older people including:

- dementia
- vulnerability to severe weather conditions
- income deprivation
- loneliness and social isolation
- frailty and falls
- housing issues
- mental health and well-being
- long-term conditions e.g. diabetes

The key is to focus on what it is to age well and increase positive outcomes for older people in order to tackle these issues.

There are many protective factors as well as risk factors for older people’s health and well-being. And as we get older we’d hope to tick more of the protective factors, but inequalities cast a long shadow and for more and more of us, the reality of old age tells a different story.

<table>
<thead>
<tr>
<th>Protective Factor</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence</td>
<td>Poverty</td>
</tr>
<tr>
<td>Self confidence</td>
<td>Caring responsibilities</td>
</tr>
<tr>
<td>Health literacy</td>
<td>Loss</td>
</tr>
<tr>
<td>Good coping mechanisms</td>
<td>Loneliness</td>
</tr>
<tr>
<td>Physically active</td>
<td>Financial pressures</td>
</tr>
<tr>
<td>Support</td>
<td>Isolation</td>
</tr>
<tr>
<td>Companionship</td>
<td>Poor physical health</td>
</tr>
<tr>
<td>Cognitive capacity</td>
<td>Poor mental health</td>
</tr>
<tr>
<td>Involved in community life</td>
<td>Poor living/housing circumstances</td>
</tr>
<tr>
<td>Wealth</td>
<td>Advanced older age</td>
</tr>
</tbody>
</table>
Our Gateshead Population

Gateshead has more people of pensionable age than it has children.³

19.1% of the population are over the age of 65. This is higher than the England average of 17.7%⁴

Every year, data is reported about excess winter deaths in the over 85 age group. In winter 2014–2015 there were 173 excess deaths in Gateshead.⁴

22.1% of older people in Gateshead experience income deprivation compared to 16.2% nationally.⁴

6.14% of people aged over 75 live alone.⁴
Dementia

More than \textbf{2,500} people over \textbf{65} in Gateshead are currently living with dementia

Falls

- In 2015, \textbf{1,312} per 100,000 people were admitted for emergency hospital admissions due to falls in the \textbf{65–79 years age group}. This compares badly to the England average of \textbf{1,012} per 100,000.\textsuperscript{4}

- Falls account for more than \textbf{50\% of injury-related hospitalisations} among people over \textbf{65 years and older}.\textsuperscript{6}

- A Gateshead resident over \textbf{65 years of age} is \textbf{26.7\%} more likely to be admitted to hospital or suffer injury because of a fall and \textbf{24.2\%} more likely to suffer a hip fracture when compared to the national average for England.\textsuperscript{6}

- Falls are currently estimated to cost the NHS \textbf{£2.3 billion per year}\textsuperscript{7} nationally

Social isolation and loneliness

Tackling loneliness and social isolation is seen as a key priority in older people’s health and well-being as well as having implications for the provision and cost of health and social care services.

More than two million people over the age of 75 live alone.\textsuperscript{2} In Gateshead there are around 9,000 people aged over 75 who live alone. In addition to this, more than half of older people living alone nationally say they speak to someone else less than once a month; this includes neighbours, family and friends.\textsuperscript{7}

There are many reasons why an older person may become isolated such as bereavement, their family moving away, medical issues, disability or simply by leaving the workplace.
Retirement

One major change during older age is retirement. Retirement can have a negative impact on people due to the loss of role and routine but it can also be positive by providing new opportunities such as volunteering and community work.\(^2\)

However, the route taken into retirement is key and this is where your background, type of job you do and economic situation all impacts on health. For example those who retire wealthy have better mental health than those who continue working, whereas those who retire on average or low incomes have poorer mental health.\(^2\)

Digital exclusion

For many of us the use of new technology – smart-phones, laptops and social media - is a positive experience. However many older people not only find it daunting but it can compound their feeling of social isolation – especially if family and friends have moved away. Again, background, income, access to learning opportunities and support is key if this is to be addressed.

Community connections

It has been shown that there is a strong relationship between social class, wealth and social roles and engagement in leisure activities in older age. Older people with caring commitments often experience a poorer quality of life, especially if they feel they are not adequately rewarded for their time.\(^2\)

Feeling that you are able to positively contribute to your community has a positive effect on mental health and well-being. However, there is a strong link between social class and wealth when it comes to taking part in community life and activities – which can be a lifeline in reducing loneliness and improving older people’s quality of life.

What are we doing?

Helping to bridge this gap and bring people together is a vital part of many local voluntary groups and organisations. A locally based charity called Equal Arts has developed a ‘Creative Friends’ project which supports older people in our community who are at risk of loneliness. The project brings people together to enjoy creative activities such as music, dance and painting with the aim of developing old interests, sparking new ones and building friendships.

Age UK Gateshead provides a huge range of community-based services and independent advice on benefit, housing and advocacy advice, and the Gateshead Older People’s Assembly aims to give older people a voice, offering them the support and help they need to improve their lives and be more independent.
Future developments

It’s very difficult to accurately predict the future issues and needs in our older population. We know that the size of this population is increasing year on year, and that people are living for longer with more and more complex needs. Consequently more work is needed to address the inequalities currently experienced by this group.

Below we show the kind of conditions people aged 65+ living in Gateshead are likely to face in 2030 compared with figures from 2015. As you can see, every area of need is expected to increase adding weight to the need to act now if older people are to be supported in a positive and sustained way.

### Number of people aged over 65 years in Gateshead

<table>
<thead>
<tr>
<th>Condition</th>
<th>2015</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disabilities</td>
<td>795</td>
<td>1,014</td>
</tr>
<tr>
<td>Moderate or severe learning disabilities</td>
<td>108</td>
<td>133</td>
</tr>
<tr>
<td>Autistic spectrum disorder</td>
<td>355</td>
<td>457</td>
</tr>
<tr>
<td>Depression</td>
<td>3,316</td>
<td>4,185</td>
</tr>
<tr>
<td>Severe depression</td>
<td>1,051</td>
<td>1,350</td>
</tr>
<tr>
<td>Dementia</td>
<td>2,603</td>
<td>3,735</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>3,380</td>
<td>4,381</td>
</tr>
<tr>
<td>Moderate or severe hearing impairment</td>
<td>16,164</td>
<td>21,600</td>
</tr>
<tr>
<td>Falls</td>
<td>10,142</td>
<td>13,295</td>
</tr>
<tr>
<td>Mobility</td>
<td>6,905</td>
<td>9,347</td>
</tr>
</tbody>
</table>

In time of increasing austerity, more and more support and services will be provided by voluntary and community groups.

It is important that public sector organisations maintain and nurture a relationship with this important sector, building on the positive steps already made.

A co-ordinated response is needed from all services to further develop community capacity for helping older people. We need to intervene now to create a healthier and more independent old age for the people of Gateshead.
CASE STUDY:
Mixing up the ages is a recipe for success and transformation

Who am I?
I’m a worker at Age UK Gateshead. This is my story.

Or rather, it’s the story of how social isolation can be tackled amongst older people for whom loneliness is the norm.

Many of the people I and my colleagues work with live alone and as a result can suffer from low moods and depression – notwithstanding the other complex medical conditions they may have. But our monthly Monday intergeneration session which sees older people coming together at a day centre in Gateshead with a mother and toddler group, has been a revelation for everyone taking part.

The laughter and song that fills the room is contagious and very moving. The mums and their children really look forward to it and the older people love getting stuck in with story-telling, nursery rhymes and even magic tricks! They all watch CBeebies together – and have given the thumbs up for the ‘Night Garden’ – a key topic of conversation at the event!

It’s hard to quantify the impact of the activity as it is so wide reaching, children reach out to clients and do not see age – they see a friend, a playmate – and this in itself is transformational. The activity is heavily staffed but the outcomes more than equate the resource.

WHAT CAN WE DO to reduce the inequalities faced by older people?

THREE things we could do:

1. Reduce social isolation and loneliness for older people by early identification of people at risk.
2. Increase life and healthy life expectancy and closing the gaps between different wards in Gateshead
3. Increase community capacity and cross sector working to provide better support through preventative activities.
“We reserve the right to smoke for the young, the poor, the black and the stupid.”

US Tobacco Company RJ Reynolds

If smokers were helped to stop, it would lift around 4,434 families in Gateshead out of poverty.
Tobacco use remains the main cause of preventable ill health and premature death in the borough and is the single most important driver of health inequalities.\(^1/2\)

Every 21 hours someone in Gateshead dies as a result of smoking and more than half of all smokers die early from a smoking-related disease. That’s around nine people every week and more than 460 residents a year.\(^1\)

Illness and the inequalities arising from smoking also fall disproportionately on some of the poorest and most vulnerable people in our community.\(^3\)

**Socio-economic status**

Smoking rates are much higher amongst the less advantaged in society. Smoking is responsible for half the difference in life expectancy between the rich and the poor.\(^1\)

There are strong and persistent links between poverty, smoking rates and the rates of tobacco-related disease.\(^4\)

These links are particularly strong in Gateshead. Residents with good jobs are almost half as likely to smoke as the borough average of 17.9%. In contrast, almost one in three of those in routine and manual jobs smoke.

The highest rates of smoking are seen amongst those people who have never worked or are long-term unemployed – more than one in three of those without a job smoke.\(^5\)

**9.5% of managers/professionals smoke**
**33.5% of people who’ve never worked/long term unemployed smoke**

The ‘knock-on’ effect of this means that exposure to second hand smoke is higher in less affluent households. Smoking in the home increases the rates of childhood asthma by up to 50%.

Sadly, children with a parent who smokes are up to three times more likely to go on to smoke.\(^6\)

This is why reducing smoking amongst adults remains one of the most effective ways to reduce smoking amongst children and young people.
Smoking and money

People on low incomes also spend a higher proportion of their income on tobacco. That means they have less money to spend elsewhere.

The facts speak for themselves

- **24,000 households** in Gateshead have at least one smoker
- **1/3 of families** are below the poverty line in homes where there is a smoker
- **2,600 households** and more than **4,000 people** would be lifted out of poverty if smokers quit

Estimates of poverty in England adjusted for expenditure on tobacco, Action on Smoking and Health, 2015

Smoking and mental health

Smoking causes people with serious mental illnesses to suffer years of poverty, disability and a premature death. This is a tragic, preventable and unacceptable inequality. 

The facts speak for themselves

- **More than 40%** of adults with a serious mental illness smoke
- **This group will die on average 10–20 years earlier than the general population.**
- **1/3 of all cigarettes smoked** in England are smoked by people with a mental health condition.
People with mental health conditions are no less motivated to quit than other smokers, but evidence has suggested that health professionals may not offer them the same support as others.

Some professionals think that stopping smoking could worsen their patients’ conditions, when the evidence suggests that stopping smoking can reduce anxiety and depression.3

Northumberland Tyne and Wear NHS Foundation Trust (NTW) provides secondary care services to working age adults in Gateshead. NTW went ‘smoke free’ in March 2016. This means that smoking is no longer permitted anywhere on its premises, and both patients and staff are supported to stop smoking.

Patients’ smoking status is now recorded and inpatients are offered support to quit smoking during their time in Trust premises, with referral to local stop smoking services upon discharge.

This is a significant step in creating a “Smokefree NHS”, and an important part of improving health inequalities for people with mental illnesses.

**Smoking and pregnancy**

Persuading mums-to-be to stop smoking is the single most effective way to improve the health and well-being of the baby. Smoking causes harm to the baby even before they are born, with potentially devastating consequences for both mother and baby.

**The facts speak for themselves**3/8

- 5,000 miscarriages
- 300 stillbirths
- 2,200 premature babies
- 19,000 babies to be born with low birth weight
- Infants are four times more likely to die suddenly if the mother smokes when pregnant
- Smoking among pregnant women in more disadvantaged groups and those aged under 20, is considerably higher than in older and more affluent groups.
- Mothers in routine and manual occupations are five times more likely to have smoked throughout pregnancy compared to women in managerial and professional occupations.
Making a difference

There are things happening that help and influence pregnant women to stop smoking. NICE guidance on smoking amongst pregnant women contains a range of evidence-based recommendations that can help women to stop smoking. These include regularly using Carbon Monoxide (CO) monitors to assess whether women are smoking and requiring pregnant smokers to opt-out of stop smoking support. The latter has been shown to double quit rates in pregnant women who smoke.\(^3\)

Monitoring data from Fresh North East – the Regional Office for Tobacco Control – suggests that in Gateshead the four-week quit rate for pregnant women has risen from 25.5% in the first six months of 2015/16 to 37.1% in the same period in 2016/17.

This is a significant rise and shows that with the right support people do change their behaviour helping the mother and baby.

Smoking and long term conditions

Long-term conditions (LTCs) are those that can be controlled but not cured. Smokers are more likely to live with a long-term illness and many LTCs are either caused or exacerbated by smoking.\(^9\)

People with a LTC tend to be heavy users of healthcare resources, accounting for nearly 70% of all inpatient bed days. Smokers living with an LTC face increased health risks and complications.

Smoking both causes and exacerbates long-term conditions:

- Chronic obstructive pulmonary disease (COPD) causes 24,000 deaths in England every year
- In Gateshead COPD is the single, largest reason for unplanned hospital admissions
- People with asthma who smoke are more likely to suffer worse symptoms and more rapid decline in lung function than those with asthma who don’t smoke
- Smokers are 2–4 times more likely to have a stroke
- Smokers with diabetes have increased risks of complications and premature death
- People with a LTC account for 50% of GP appointments
Smoking also doubles the risk of developing social care needs. Research undertaken in 2016 by Action on Smoking and Health shows that for local authorities in the North East in 2015/16:

- Smokers are likely to need care on average nine years earlier than non-smokers.
- Councils across the UK spend an additional £44 million/year on social care for smokers aged 50+. In Gateshead this is estimated to cost around £6 million a year.
- Smokers across the region aged 50+ also faced a bill of over £36.6 million to cover the cost of their own care.
- In addition, a further 13,595 individuals receive informal care from friends and family.

**Smoking and the LGBT Community:** Data from the Integrated Household Survey shows that lesbian and gay people are much more likely to smoke than the general population.10

Whilst there is a lack of research on smoking among bisexual and trans people, surveys do show both bisexual and trans people are more likely to smoke. Young LGBT people are also more likely to smoke, to start smoking at a younger age and smoke more heavily.

People from LGBT communities also experience additional health risks resulting in the potential for significant health inequalities:

**Mental Health:** LGBT people are more likely to suffer from mental ill health. Stopping smoking is associated with reduced depression and improved quality of life.

**HIV:** Men who have sex with men are most at risk of acquiring HIV in the UK. Around 47% of HIV positive men smoke, and they are more likely to develop cancers of the lung, anus, mouth and throat and are more likely to suffer from respiratory disease.

**Gender identity related surgeries:** Smoking is a significant risk factor during and after any surgery. Smokers are 38% more likely to die after surgery and more likely to experience wound infection.
CASE STUDY:
Smoking, saving and improving your life

Who am I?
I am a Gateshead resident in my 50s and have quit for life. This is my story.

I started smoking when I was 15. It was just something you did, all my friends smoked and it was just part of growing up. I’ve smoked for nearly 40 years and it was when a friend’s husband, also a smoker, was diagnosed with cancer, that I decided enough was enough and I didn’t want to put myself at risk.

So I arranged to see a stop smoking advisor. He recommended that I tried a medicine called Champix that would make it easier for me to stop smoking. We agreed a date when I would quit and though I was nervous about it all, my advisor reassured me this was normal and gave me some help and advice on how to deal with the cravings and anxieties I would feel once I stopped smoking. With his support, I’m pleased to say I have successfully given up cigarettes, a decision I don’t regret at all.

Plus as someone who had always lived in rented accommodation, I never thought I’d be able to afford my own home. But stopping smoking was such a confidence boost to me, and such a huge achievement, I decided to look for my own place. Using the money I saved from smoking, I was able to save up for a deposit and now two years on from quitting cigarettes, I have bought my own home. Giving up smoking can be life changing and I’m proof of that!

WHAT CAN WE DO to reduce the inequalities caused by smoking?

THREE things we could do:

1. Continue to implement a comprehensive approach to tobacco control supported by regional work and a committed local Smokefree Alliance
2. Increase the number of quit attempts amongst groups and communities particularly at risk from harm due to tobacco
3. Build public health capacity in community-based organisations to reduce inequalities arising from tobacco use.
“We can all agree that government can’t solve the obesity crisis alone. It’s an ongoing issue that will require a collaborative effort across private and public sectors if we want to see some long-term success.”

Marcus Samuelsson

Reducing weight is not a matter of looking good – it’s a matter of life and death

By 2050, 50% of women and 60% of men in the UK will be obese. In the future being overweight will be the norm.

Foresight, 2007
A weighty issue

Being overweight or obese both influences and reinforces health inequalities, and can lead to a vicious cycle of health inequalities continuing across the generations. And the problem is getting worse.

There are clear links between health inequalities and where people are born, where they grow up, their age and where they live and work.¹

The problems around obesity start at an early age and are more marked with girls than boys. Today nearly a third of children aged two to 15 are overweight or obese and the younger generations are becoming obese at earlier ages and staying obese for longer.

Children living in the 10% most deprived areas are twice as likely to be obese as those children living in the 10% least deprived areas.²

Reducing obesity levels will save lives as obesity doubles the risk of dying prematurely. Obese adults are seven times more likely to become a type 2 diabetic (which may cause blindness or limb amputation) than adults of a healthy weight.

The economic costs are great too. We spend more each year on the treatment of obesity and diabetes than we do on the police, fire service and judicial system combined.³

It is estimated that the NHS in England spent £5.1 billion on overweight and obesity-related ill-health in 2014/15.

National picture

Again, and this is a recurring theme in this report, the burden falls hardest on those from low-income backgrounds.

Obesity rates are highest for children from the most deprived areas and the situation shows no signs of improving. Children aged five and from the poorest income groups are twice as likely to be obese compared to their most well off counterparts – and by age 11 they are three times as likely.⁴

Income related differences in physical activity and consumption of fresh fruit and vegetables and sugar persist amongst children.⁵ This suggest that the socio-economic differences in the prevalence of obesity is set to continue unless more preventative initiatives are put in place.⁶
The problem of obesity and being overweight also changes with age. Prevalence of obesity is lowest in the 16-24 year age group, and generally higher in the older age groups among both men and women. There is a decline in the oldest age group, which is particularly apparent in men. This pattern has remained consistent over time.

Overall, for women obesity prevalence increases with greater levels of deprivation, regardless of the measure used. For men, only occupation-based and qualification-based measures show differences in obesity rates by levels of deprivation.

**Obesity and activity levels**

A number of common inequalities exist in the likelihood of participating in the recommended levels of physical activity. These include:

- 37% of long-term unemployed people do no physical activities
- Young people aged 16-24 are more active
- Older people aged 75+ are most likely to be inactive
- Activity rates can be reduced as a result of increase work commitments and parenthood

**39% of adults from higher income households played sport once a week**

Compared to:

**26% from lower income households**

(and this participation gap has increased in recent years)

Participation in sport is often limited by income, access and time barriers.

These factors should be taken into consideration when designing interventions to promote physical activity so that the most vulnerable groups are prioritised.
Disability and obesity

Whilst data on disability and obesity is limited, it is known that people with disabilities are more likely to be both overweight and have lower physical activity levels than the general population.

Children who have a limiting illness are more likely to be obese or overweight, particularly if they also have a learning disability. Both underweight and obesity are an issue for people with learning disabilities. This relationship varies according to age and gender.

Disabled people are half as likely as non-disabled people to be active, and inactivity is shown to increase as the number of impairments an individual has increases.\(^6\)

Also only one in four people with learning disabilities take part in physical activity each month compared to over half of those without a disability.

A view from Gateshead

Almost two in every three adults are overweight and around one in four are obese.

One in four children aged four to five are overweight.

In the most deprived area of Gateshead the proportion of obese adults is almost double that in the least deprived areas.

Adults most likely to be obese are - 55-64 years

Adults least likely to be obese are - 18 to 24 years\(^9\)
How active are we in Gateshead?

The Active Lives survey (2015/16) gives us some insight into adult activity levels in Gateshead. 501 people responded with the following results. Of those who responded:

- 23.2% described themselves as ‘inactive’ compared to 22.3% nationally, and 24.6% regionally.
- 61.8% of Gateshead respondents are ‘active’ compared to 64.9% nationally, and 62.8% regionally
- 76.5% participated in sport and physical activity (not including gardening) at least twice in the previous month. This compares to a national rate of 77.2% and a regional rate of 74.7%

The way forward

Although we are beginning to better understand what works to reduce levels of obesity overall, there is very little accessible evidence available on what works to reduce inequalities or differences in obesity levels between social groups.

The Foresight review of obesity stressed the importance of a “whole systems” approach to tackling the ‘obesity epidemic’.

It highlighted the need to bring together stakeholders, gather data, complete analysis of existing actions and consider the resources available to local authorities in order to put in place the pre-systems and processes needed to tackle and prevent obesity.

What we do know is that unless action such as this is taken in the coming years, more people in Gateshead will be overweight or obese with all the problems and issues that involves. Ultimately we need a fundamental change in attitude and culture (such as happened with smoking and wearing seat belts) if progress is to be made in this area - this has started but will take time.
Who am I?

Who am I? As an embedded researcher, I was asked to explore community-led initiatives to tackle childhood obesity in partnership with a voluntary organisation in one of the wards in Gateshead with high levels of health inequalities. Local community members identified their priorities for action, including initiatives to promote healthy eating and physical activities for adults and children. Early findings from the research show that:

- Meaningful community-led initiatives require long term investment, a positive organisational ethos and non-judgmental approaches, recognising the grinding effects of poverty and social isolation.
- The effects of welfare reform and austerity are having a significant negative impact on health and wellbeing, increasing stress and anxiety.
- A welcoming, inclusive approach can reduce social isolation, improve social support, community connectedness and cohesion and enhance a sense of belonging.
- Coming together to cook, eat, create, learn, laugh, socialise and have fun are effective ways to engage community members in health and wellbeing activities, alongside the provision of activities for children and young people.
- Opening doors to try out sports activities in a safe, familiar environment, recognising the social, financial and environmental barriers people face in using formal leisure services.
- The stigma associated with being overweight and the effects of bullying because of body size and shape can have deep and long lasting effects on an individual’s mental health and emotional wellbeing.

THREE things we could do:

1. Establish a long term approach with a shared commitment across a range of partners, focusing not just on the individual contributions of each organisation, but on how the whole system works together. Recognise the complex web of causes and influences on obesity and inequalities.

2. Consider a more holistic, social model of health. Obesity can’t be tackled without consideration of the social determinants of health including employment, financial inclusion, housing, complex family issues, and much more.

3. We need to listen more to people/children within communities so that they are engaged in the process and feel part of the solution. Engaging with people experiencing health inequalities is important if we are to fully understand and address the barriers created by poverty and discrimination.
“Drugs ruin peoples’ lives, break up families and have disastrous effects on our communities.”

Adam Rickett, actor

SEX, DRUGS AND ROCK AND ROLL.....don’t believe it.
Highs and lows: Drinking and drugs

Substance misuse causes a wide range of social and health harms and costs. It is both a cause and consequence of other aspects of disadvantage including physical and mental ill-health problems relating to employment, housing, family life and crime issues.

The number of people accessing Gateshead’s treatment and recovery service for alcohol and drugs related conditions is increasing. In 2015-16, there were 1,989 clients compared to 1,826 in 2014-15. 69.6% are male, with one in five of these aged between 30-34.

Cheers?

Evidence suggests that while drinking alcohol is most common among many of our more affluent communities, those who experience the greatest levels of alcohol related harm live in some of the borough’s most deprived neighbourhoods. However even if people in our most deprived communities consume less alcohol, they are more likely to suffer greater harm than those in more affluent communities.

Chronic health conditions caused by drinking alcohol increase with both the amount and number of years someone has been drinking. But other harms such as accidents, crime and the loss of productivity - are associated with other patterns of consumption including binge drinking.

The lows of being high

While drug misuse can be found across all sectors of society, problematic use is concentrated in the communities who experience the greatest economic disadvantage. From heroin and crack use among adults, to cannabis and legal highs use amongst young people, it’s the more vulnerable parts of our society who are affected most.

The harms caused by drugs are wide-ranging. Drug misuse may cause or exacerbate existing problems, its harms may be acute or chronic, and issues may arise from recreational use as well as dependency or problematic use. Drug misuse is strongly associated with a range of other poor outcomes including homelessness, sexual exploitation and mental illness.

Whilst drug dependence can affect anyone, we know that those in our society with a background of childhood abuse, neglect, trauma or poverty are more likely to be affected. And the children of those dependent on drugs have to cope with the impact on their own lives with some ending up in care as a result. Another area of increasing concern is the use of the internet to buy drugs - which appears to becoming more common.
Severe and multiple disadvantage

When we take a closer look at the individuals affected by substance misuse – it soon becomes apparent that drugs and alcohol aren’t the only issues they have to deal with.

Recent research entitled ‘Hard Edges’\(^3\) published by the Lankelly Chase Foundation differentiates between various categories of severe and multiple disadvantage (SMD). This means that individuals face at least one of three issues of homelessness, substance misuse and crime. The report found that poverty and mental health problems were nearly universally present.

In Gateshead the following figures tell their own story – the numbers represent the number of people in the working age population.

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse only</td>
<td>1,130</td>
</tr>
<tr>
<td>Substance misuse + homeless</td>
<td>260</td>
</tr>
<tr>
<td>Substance misuse + offending</td>
<td>660</td>
</tr>
</tbody>
</table>

Out of 151 local authorities, Gateshead was ranked 28th highest for cases with multiple disadvantage, with an estimated rate of 26 per 1,000 of the working age population.

Local picture: alcohol

As alcohol plays a significant role in our society and economy, universal actions across the whole population need to focus on promoting safe, sensible and sociable alcohol consumption. Targeted actions focus on groups where alcohol causes most harm, in particular alcohol-related violence, problem hot spots, young people at risk of hazardous and harmful drinking and older age.

Alcohol and under-18s

Whilst alcohol consumption by under-18s continues to fall, evidence suggests that those who do drink, drink at excessive and harmful levels.

Alcohol-related hospital admissions (over 18 years)

2016-17 figures show that Gateshead has the 2nd highest rate of alcohol-related admissions to hospital in England.

- The number of men admitted to hospital with alcohol-related conditions has increased by 23.62% since 2008-09 - the highest in the North East.
- The number of women admitted to hospital with alcohol-related conditions has increased by 34.33% since 2008/09.
Drugs and young people
Of the 145 young people being treated for drugs misuse in 2015-16:

- 66% were male
- 75% of young people in treatment were classed as living with parents or other relatives.
- 71% of young people listed alcohol and cannabis as the primary substance they need help with.
- 12% were looked after children
- 29% disclosed domestic abuse
- 31% disclosed self-harm
- 20% were not in education, employment or training
- 35% had been involved in anti-social behaviour or criminal acts

Drug related deaths
The local picture is reflective of the national picture. Deaths in Gateshead have more than tripled since 2012. In 2016 there were 19 deaths that were categorised as drug related. The characteristics of the deceased remain similar – with the majority of deaths continuing to be male, white, aged 25-34yrs and male. A number of other trends have also been identified:

- mental illness
- living alone
- single
- unemployed
- in substance misuse treatment
- using a cocktail of drugs
- poor access to mental health services
- previous overdoses
- complex/chaotic lifestyle

To address this worrying trend we need to make sure that the right services are available based on local need. This is underpinned by the development of new data collection systems and remodelling the services to facilitate more efficient and equitable local service provision across the whole population.

We need to intervene early with key at-risk groups, who are particularly susceptible to drug use and are more likely than others to experience adverse outcomes. These would include:

- children from households where there is drug use;
- looked after children;
- offenders;
- people with mental health problems; and
- people from deprived neighbourhoods.
Key findings from the Lankelly Chase ‘Hard Edges’ report are especially pertinent to those experiencing poverty, deprivation and limited social support. It highlights that:

- These journeys are difficult and relapse or setbacks are common. But many people can and do overcome deeply entrenched problems;
- Finding meaningful opportunities and roles helps to build a positive self-image; and
- Supportive friends and family play a key role in sustaining these journeys, while discriminatory attitudes and labels can hold people back.

Successful recovery from substance misuse, while facing a number of other disadvantages, is dependent on issues such as personal skills and capabilities, support networks, self-confidence and location. For example, recovery from drug misuse may require building up a new community of supportive friends, and moving away from contacts who encourage using. Indeed, recovery and cessation happen largely outside formal treatment settings and support services.

Drug use can affect anyone, problematic heroin and opiate use is concentrated in areas of deprivation, where residents tend to have lower levels of recovery capital (supportive friends, family, educational qualifications, resilience, money, employment, and so on).
CASE STUDY: Breaking the cycle of alcoholism

Who am I?
I am a husband and dad – I’m also a recovering alcoholic.

This is Craig’s story

I was introduced to Gateshead Evolve* by my family. I was going through a bad patch. I lost my job, my house and had split up with my partner.

I started drinking a lot and before I knew it I was drinking six litres of strong cider a day, hiding it from everyone.

Then one day I had a withdrawal fit and ended up in hospital for eight days. When I got out, I admitted to my family I was an alcoholic.

I started going to Gateshead Evolve about six months ago. My worker was great. She put me on a reduction plan and within three months I was down to three litres a day.

I go to a lot of groups. I find it helps to talk to people with similar problems as myself. I started an eight day home detox in November last year and have not had a drink since. I also started Foundations of Recovery in the New Year as part of my recovery plan.

I feel great at the minute, I know I will have bad days but it’s worth it. I am spending a lot more time with my little girl. I feel like a dad again. It’s great.

*Gateshead Evolve is a single, integrated drug and alcohol recovery service for all adults in Gateshead.

WHAT CAN WE DO to reduce the inequalities caused by drinking and drugs?

THREE things we could do:

1. The Council, with its partners, should agree measures aimed at reducing the availability, affordability and promotion of alcohol in order to protect those who are most vulnerable.

2. Gateshead’s Substance Misuse Strategy Group should prioritise preventative activity with those groups most at risk of poor outcomes. This will include; children and young people, residents in our most deprived communities, adults with multiple and complex needs, those experiencing dual diagnosis (addiction and mental illness), offenders and people who are homeless or vulnerably house.

3. The Council, with its partners, should ensure that recovery is visible bringing about enduring change to local communities, particularly focusing on those in most need.
“Young people should have the skills, confidence and motivation to look after their sexual health and delay parenthood until they are in a better position – emotionally, educationally and economically – to face its challenges.”

Beverley Hughes Minister for Children, Young People and Families Department for Education and Skills, 2006

“I’m only 16 – what do I know about bringing up a baby?”

Teenage mums are three times more likely to suffer from post-natal depression – as if it wasn’t hard enough.
Finding out you are pregnant is life-changing in itself and finding out you are pregnant as a teenager presents a range of additional challenges.

Without the right support teenage parents can encapsulate many of the inequalities covered in this report – from health to housing, education opportunities to employment – the life chances and opportunities open to them are often reduced and as a consequence future outcomes for young parents and their child are often poorer.

Teenage pregnancy is both a cause and consequence of health and education inequalities – with the impact on the individual and the cash-strapped organisations supporting and helping them being felt way beyond the birth of the child.

<table>
<thead>
<tr>
<th>Child health</th>
<th>Mental health and well-being</th>
<th>Economic well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teenage mums are three times more likely to smoke during pregnancy</td>
<td>Teenage mums have higher rates of poor mental health up to three years after the birth</td>
<td>Children born to teenage mums have a 63% higher risk of living in poverty</td>
</tr>
<tr>
<td>Babies have a 56% higher risk of infant mortality</td>
<td>Teenage mums are three times more likely to suffer from post-natal depression</td>
<td>One in five girls not in education, training or employment are teenage mums</td>
</tr>
<tr>
<td>Children are twice as likely to be admitted to hospital for accidental injury</td>
<td>Two in three teenage mums experience relationship breakdown in pregnancy</td>
<td>Men who are young fathers are twice as likely to be unemployed at age 30</td>
</tr>
<tr>
<td>At age five, children are 11 months behind when it comes to talking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What can be done?

Public Health England identified three key strands to improving the outcomes for young people.

1. **Prevention**: avoiding pregnancy in the first place. Unintended pregnancies can be prevented through:
   - High quality sex and relationship education
   - Early access to effective contraception
   - More intensive support for those at risk

2. **Choice**: If pregnancy does happen, the teenager needs choices through:
   - Early access to free pregnancy testing
   - Unbiased advice on pregnancy options
   - Prompt referral to abortion or early antenatal care

3. **Support**: Poor outcomes are not inevitable. When teenage mums and young dads receive the right support that is trusted by the young parents and is early, sustained and multi-agency led, the results can be positive.

The result of prevention, choice and support as outlined above can have a positive effect not only for the individuals concerned, but also from an economic perspective.

For example, for every individual who doesn’t develop a mental health issue (and we know teenage mums are at risk of this), a local authority saves £2,000 a year. And for every child prevented from going into care, social services save an average £65,000 per year.

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**New Government legislation**

In March 2017 Justine Greening, Secretary of State for Education, announced proposed legislation for statutory Relationships and Sex Education in all schools – including academies and free schools, to:

“...put relationships and sex education on a statutory footing, so every child has access to age appropriate provision, in a consistent way...all primary schools in England to teach age-appropriate ‘relationships education’; and all secondary schools in England to teach age-appropriate ‘relationships and sex education’. Schools will be required to teach this content from September 2019.”
Gateshead facts and figures

In 2015, 90 women aged between 15 and 17 years had a confirmed pregnancy test with half of them going full term to birth. In contrast in 1998 there were 199 teenagers with a confirmed pregnancy test which highlights a reduction of 54.8%. 3

While this is positive, we can’t be complacent. Looking at figures compiled between 2013-15, six wards in Gateshead - Birtley, Felling, Deckham, Windy Nook & Whitehills. High Fell, Chopwell & Rowlands Gill - had significantly higher rates of teenage pregnancies than the England Average (median).

In contrast, Dunston Hill & Whickham East, had a significantly lower rate than the England median with the remaining 15 wards similar to the England median rate. 4

A Gateshead perspective

A specialist outreach nurse, has a unique insight into the needs of these young mums. Based in Trinity Square Health Centre in the heart of Gateshead, she works with young women under the age of 18 offering them the advice and support they need to make informed decisions. She offers group work with organisations such as the Young Women’s Project in Gateshead who support a large number of women who would otherwise not engage in any services.

The way forward

Getting support right for teenage mothers and young fathers can transform their lives and those of their children, reducing the cycle of disadvantage so often linked to this group. At a strategic level, good support at the right time is:

- integral to safeguarding, the Early Help agenda and improving life chances;
- key to giving every child the best start in life;
- vital if we are to break intergenerational inequalities; and
- vital if we want to reduce future demand on health and social services.

The most important lesson from the Teenage Pregnancy Strategy (1998) is that the solution to high rates of teenage pregnancy is not in the gift of any one service.

A whole system approach is needed, with clear actions for all agencies, supported by strong leadership and accountability.
CASE STUDY:
It’s about opening doors, not putting up barriers

Who am I?
I am a worker from the Young Women’s Outreach Project

2017 is the project’s 25th anniversary and it’s great to be part of such a welcoming and nurturing place where young people choose to come – often they don’t know anyone else their age who is pregnant or who has had a baby.

I work with young mothers usually between the ages of 13-19. Together with my colleagues we offer support in a wide range of things, and if we can’t help we find someone who can. Many topics are covered, including things like relationships, body image, health, team building, and we have fantastic support from the Specialist Teenage Pregnancy Nurse.

Many of the young mums and dads we work with come to us with low self-esteem, no confidence, no skills and poor education records. Working closely with them, we aim to make a difference and give them the support they need to be good, nurturing and positive parents. I’d like the young people to speak for themselves about how they feel about the service – their comments include:

“The Young Women’s Project has been a massive part of my life both in the past and now in the present, helping me with confidence and qualifications. I have benefited from the service in many ways, my confidence and self-esteem have been massively improved and I now have the motivation to start college.”

“Amazingly helpful. Helped during pregnancy and after, and even through hard personal times. I have gained confidence and made new friends.”

“I started going to the school aged man’s group.* It helped me with my confidence and gave me experience in youth work, and I am now a volunteer at the project.”

“Talking to other young dads makes it easier.”

*The North East Young Dads & Lads Project was launched by the Young Women’s Outreach Project in October 2015.

WHAT CAN WE DO to reduce the inequalities linked to teenage pregnancy?

THREE things we could do:
1. Continue to create more opportunities and choice for young people to access high quality contraception across a range of health settings in Gateshead.
2. Invest in grass roots community support projects where young mums and dads can get practical support to be the best parent they can and share their experiences.
3. Schools should ensure all children have access to high quality relationships and sex education.
“More and more people, most of them young, are being locked out of opportunities and privileges many of us have taken for granted.”

Duncan Exley, director of the Equality Trust

“I don’t have time to eat healthily, relax or do leisure stuff – I’m too busy caring for my mum”

Gateshead Young Carer

One third of young carers in Gateshead worry all the time about their family and those they care for
Coping and caring

As with adults, children and young people most affected by health inequalities are those who also experience other aspects of disadvantage. They may be living apart from their parents, suffering abuse, neglect or exploitation, or they could be the main carer for their mum or dad. They also may not be in school, training or work as a consequence of their situation.

Once again, a household affected by economic inequalities can have a direct impact on any child living there, leading to more limited opportunities and options not faced by those in better off homes.

But it doesn’t stop there: inequalities experienced during childhood may have physical, psychological and other detrimental impacts that affect them throughout the rest of their lives.

This chapter will look at the inequalities faced by one particular group – young carers – to demonstrate how unfair and far-reaching inequalities can be when you are young and simply trying to do your best in difficult circumstances.

A young carer can be called upon to undertake many roles. From doing tasks way beyond what most young people would be asked to do, including sibling care; general care, such as administering medication or lifting a parent; interpreting/translating and helping a parent to learn English; emotional support; or intimate care, such as toileting and bathing.

Every young carer is different – some may get additional family support – others might not. Some may spend most of their free time caring, or are called upon for just a few hours a week – it all depends on the nature of the care required.

But young carers should not be forced to grow up early and instead they should have the chance to enjoy their childhood, with the same opportunities as their peers so they can thrive, develop and learn. Missing out on vital school attendance and training can result in a negative impact on their future.

While there are negatives, we shouldn’t underestimate the positive side to caring either. It can be an expression of commitment and affection, can serve to strengthen the bond between the young carer and the cared for person and give them a sense of satisfaction and the feeling that they have an important role within the family unit. There is also evidence which points towards resilience factors associated with the caring role.
National picture

According to the Children and Families Act 2014 a young carer “… becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well-being or educational achievement and life chances.”

Research has shown that young carers suffer from specific problems, which are different from those experienced by adults involved in caring. These can include:

- less time for homework/exams, not attending school or being frequently late for school
- isolation from other children and from the wider family
- limited or no time for leisure or socialising
- feeling guilty about the conflicting emotions they feel towards the person they care for
- feeling they have no one to turn to for help or support
- lack of recognition for their role
- problems as they get older in terms of further education, finding work, accommodation, and relationships

Given the amount of care some children and young people are providing, it’s no surprise they experience such specific problems.

Many young carers feel stigmatised because they are different – they do not experience the same type of childhood as other children, and their parents and siblings are in some way perceived as being different. Some young carers are likely to be doubly stigmatised – those caring for parents with mental health problems or problems of addiction or siblings of someone with a learning disability. Many feel they have no-one to turn to or that they are letting people down if they talk to someone

According to the 2011 Census,¹ there are 403,603 young people under the age of 25 providing unpaid care in England, with 1,670 in Gateshead. A comparison between England and Gateshead young carers is shown below.

<table>
<thead>
<tr>
<th>Hours of care 2015</th>
<th>England carers</th>
<th>Gateshead young carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides 1 to 19 hours unpaid care a week</td>
<td>301,032</td>
<td>1,189</td>
</tr>
<tr>
<td>Provides 20–49 hours unpaid care a week</td>
<td>58,389</td>
<td>275</td>
</tr>
<tr>
<td>Provides 50+ hours unpaid care per week</td>
<td>44,182</td>
<td>206</td>
</tr>
<tr>
<td>Is in very good or good health</td>
<td>368,573</td>
<td>1,535</td>
</tr>
<tr>
<td>Is in fair health</td>
<td>28,444</td>
<td>108</td>
</tr>
<tr>
<td>Is in bad or very bad health</td>
<td>6,586</td>
<td>27</td>
</tr>
</tbody>
</table>

¹ According to the 2011 Census, there are 403,603 young people under the age of 25 providing unpaid care in England, with 1,670 in Gateshead. A comparison between England and Gateshead young carers is shown below.
In a recent health review of young Gateshead carers (aged 18 and under) they reported that they regularly experienced a number of physical and emotional health problems including:

- **85.8%** headaches
- **70.2%** feeling very tired
- **64.3%** feeling sad or low
- **60.0%** feeling nervous
- **59.7%** not sleeping

**Tick tock**

Time, or lack of it, was also an issue for many young carers and was the key reason why they didn’t eat properly, relax or take exercise. This is compounded by a lack of sleep and an inability to switch off and relax at night.

**What are we doing?**

Organisations in Gateshead have developed a way of working more closely together in a more holistic way in order to meet the needs of young carers through the provision of more joined up support.

Our health needs assessment for carers (young people and adults) was published in October 2016. It contains a number of key recommendations to improve the identification and health and well-being of carers.

Gateshead also has a young carers strategy that focusses on four key themes: identification and recognition, realising and releasing potential, a life alongside caring, and supporting carers to stay healthy.

A strategic review of all age carers’ services in Gateshead is currently taking place to help determine how future services will support carers.
CASE STUDY:
Don’t define me as just a ‘carer’

Who am I?
I am a support worker from the Young Carer’s Trust, helping Paula

Paula was only nine when she was referred to us. She cared for her mother, who had mental health problems, and her grandmother, who had cancer. The youngest of four, her siblings were all displaying behavioural problems at the time, including one who was using drugs. She was also taking significant responsibility for a young niece, as her older sister was incapable of parenting her appropriately.

This level of pressure and responsibility could have had a huge impact on Paula’s ability to achieve at school, remain emotionally healthy and enjoy the type of social life experienced by her peers. However, through a combination of Paula’s determination and ability, and our intervention at different stages in her life, Paula has been able to achieve personally, academically and professionally.

We helped her to develop a social life and make friends by helping her to attend social activities at weekends and during school holidays. These enabled Paula to develop confidence and social skills, and ensured that her time outside of school didn’t revolve solely around her caring role and that she could access social opportunities at a similar level to her peers.

Paula is now nearly 20, and is studying at college. Her achievements are the result of her diligence and hard work. However, the Carers Trust Tyne and Wear’s approach to addressing the educational, personal and social inequalities that she experienced as a young carer has made a significant difference in her aspirations and her attitude towards engaging in new opportunities. Importantly, we were able to initiate this input early in childhood, enabling us to build a relationship with Paula and provide a service that could respond to her changing needs.

WHAT CAN WE DO to reduce the inequalities faced by children and young people?

THREE things we could do:

1. Ensure the recommendations from the carers health needs assessment are implemented effectively.
2. Ensure all agencies working with young carers support them to stay healthy.
3. Following the strategic review of all age carers’ services ensure that future service provision improves outcomes for young carers.
“Health inequalities will widen if effective services are offered, or taken up, with greater frequency by wealthier than less wealthy people. The reverse is also true, however, and there is an opportunity for healthcare to reduce social inequalities if it reaches those most in need.”


“My health conditions don’t just affect me, they affect my family, my work and my future lifestyle.”

Around six in ten deaths from cardiovascular disease in Gateshead could be prevented
Double whammy

Having a long-term health condition is bad enough. Add to this the fact that you will probably live a shorter and less healthy life is a double whammy that links directly to the health inequalities faced by the poorest people in our communities.

**In Gateshead there are nearly 65,000 people living with long term health conditions – that’s around 26% of our population.**

Long Term Conditions (LTCs) are defined as diseases that cannot currently be cured, but are controlled by medication and/or other treatment. So not only are a large number of people in our borough living restricted lives, but the economic impact is also significant. With many people unable to work as a result of their illness, the days lost due to illness and the cost of this to the economy and to the health service is also a significant factor.

This chapter will focus on long-term conditions and inequalities, using cardiovascular disease (e.g. heart disease, stroke) as a specific focus.

**National picture**

More people die in the UK of Cardiovascular disease (CVD) than any other illness. It’s also one of the conditions most strongly associated with health inequalities. The burden of illness and early death from CVD is disproportionately shouldered by groups with the lowest socio-economic status.

- If you have CVD you are three times more likely to die prematurely compared to more affluent groups.
- CVD death rates are 50% higher among South Asian groups.

In Gateshead early deaths (under 75) from CVD are significantly higher than the national rate standing at 93.1 per 100,000 compared to England 74.6 per 100,000.
Risk factors

The main risk factors linked with cardiovascular disease are:

- Poor diet
- Physical inactivity
- Smoking
- Excessive alcohol consumption

CVD risk factors tend to cluster together, which has a disproportionate effect on people who are disadvantaged, further increasing inequalities. Tackling these risk factors will also help prevent other major causes of death and illness, such as type 2 diabetes and many cancers.

In order to reduce the gap between rich and poor, it’s vital to identify areas within our communities where CVD is having the greatest impact. This will then allow for preventative and treatment-focused services to be structured and delivered more effectively and to the people who need them most.

Indeed access to the right health care at the right time, for the right people, for example for hypertension and cholesterol control for those at high risk of cardiovascular disease, is probably the single quickest thing that can be done to reduce inequalities in health. But getting the delivery of health care right will not on its own solve England’s inequality problem.

Exacerbating the inequalities

There are many other issues that can impact on people with CVD - from leaving it too late to seek help from their doctor to low health literacy levels and low expectations of what they should expect in terms of treatment and support, which may be linked to their economic situation.

Compared to people who have high levels of health literacy, those from poorer backgrounds with lower health literacy levels will be more likely to have (in addition to their long term condition):

- lower uptake of screening;
- higher rates of risk-taking behaviour;
- less knowledge of diseases and self-care;
- limited self-management skills;
- lower medication compliance; and
- higher rates of hospitalisation.
Local picture

The number of people diagnosed with an LTC in Gateshead is lower than expected numbers, suggesting that not everyone has been identified. Unknown patients imply unmet need, increased use of local health services and increased chance of people suffering unnecessarily and dying early, compared to England averages.

For example, it’s estimated that there are around 20,000 people with undiagnosed hypertension in Gateshead. That means they are unaware of their high risk and are not receiving the lifestyle advice and medical treatment that we know can prevent heart attacks and strokes.

Similarly, around 4,000 people with type 2 diabetes, a condition that dramatically increases the risk of life-changing CVD, are undiagnosed or under-treated.

What we are doing?

NHS Health Check targets people who are at high risk of having a heart attack or stroke in the next 10 years. This key prevention programme can help to tackle health inequalities, as the burden of early death from CVD is three times higher in the most deprived communities compared with the least deprived.

Informing people better – part of Gateshead’s LTC Strategy— is to make sure that people living with long term conditions are well informed and supported to make effective choices to stay well and seek medical attention when required.

So while there is great work being done, it is not consistent across the borough and we still have significant variation in the detection and management of high risk conditions, including high blood pressure, type 2 diabetes and chronic kidney disease.
CASE STUDY:
Smoking, saving and improving your life

Who am I?
I am a man in my early 40s with long term-health conditions. This is my story

I am a local man, married with a young family and I am also the main carer for my father.

I have many long term conditions including diabetes type 1 (from childhood), heart disease, coeliac disease, under-active thyroid, low vision, a skin condition and have suffered a stroke.

I’m not working at the moment, but hope to go back to work in the future. If you asked me what would be helpful to me and my family, it’s simple: I want to know about and receive the care that meets both mine, and my families, needs. This means being able to get the information I need in a format I can read clearly (given my low vision problem) and written in plain English so I understand what options I have.

Having lots of long term conditions, I know I need to stay as fit and healthy as I can, but some activities that could help me are too expensive, so I have to just do what I can afford. I worry about the impact of budget cuts in healthcare and how they will affect me in the future.

WHAT CAN WE DO to reduce the inequalities faced by people with long term HEALTH CONDITIONS?

THREE things we could do:

1. Work towards improving health literacy by building on and extending targeted local strategies to improve this amongst the communities that need it most. This will not only work towards improving health outcomes more broadly, it will help reduce health inequalities.

2. A ‘whole-systems approach’ to prevention must include addressing unhealthy environments as well as interventions that spot high-risk behaviours and conditions early on and help individuals make healthier choices. This is where primary care professionals can help – with over one million conversations taking place with patients every day, the opportunity is there to engage and inform patients so they do know what’s out there and the options open to them.

3. Local strategies should embed population-wide prevention strategies at all levels. Improving outcomes is not just about reducing mortality, it is also about improving people’s quality of life. Research shows that prevention strategies that include population-wide interventions alongside NHS Health Checks have the greatest impact on reducing overall CVD burden and inequalities.
A tale of two babies

**Most affluent**

<table>
<thead>
<tr>
<th>Inequalities before birth</th>
<th><strong>Most deprived</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>47%</strong> less likely to have parents that smoke*</td>
<td><strong>30%</strong> more likely to have parents that eat 5+ fruit and veg per day *</td>
</tr>
<tr>
<td><strong>88%</strong> more likely to have parents that smoke*</td>
<td>Twice as likely to have a teenage parent*</td>
</tr>
</tbody>
</table>

**Most deprived**

<table>
<thead>
<tr>
<th><strong>Child</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>38%</strong> more likely to be overweight or obese (Reception)</td>
</tr>
<tr>
<td><strong>58%</strong> more likely to have a good level of development (age 5)</td>
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<table>
<thead>
<tr>
<th><strong>Teenager</strong></th>
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<tbody>
<tr>
<td><strong>55%</strong> less likely to be in the criminal justice system*</td>
</tr>
<tr>
<td><strong>55%</strong> more likely to have a hospital stay for self-harm</td>
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<tr>
<th><strong>Teenager</strong></th>
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<tbody>
<tr>
<td><strong>3.5 times</strong> more likely to die of Coronary Heart Disease before aged 75</td>
</tr>
<tr>
<td><strong>Twice</strong> as likely to complete suicide</td>
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<th><strong>Teenager</strong></th>
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<tr>
<td><strong>53%</strong> less likely to die from respiratory disease before 75 years old</td>
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N.B. These figures are for illustration purposes only. Calculations have been interpreted using data available in October 2017. Some variation may be partially explained by small numbers. Statements highlighted with an * have used national data as local variation wasn’t available.
A tale of two babies tells our story of inequalities.

It is vitally important to recognise that no outcome is set in stone. However the story aims to illustrate the potential variation in the opportunities and difficulties two babies might encounter throughout their life based on the circumstances into which they are born.

It highlights a demonstrable bias in the way our current systems are set up to benefit, to a greater extent, those in more affluent circumstances. With determination and collaborative effort we can reduce this injustice.
APPENDIX 1

References

Introduction


Chapter 1: Overview: Life and death, health and sickness, well-being and misery


Chapter 2: Like father live son, like mother like daughter


Chapter 3: Going underground

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APPENDIX 2

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Fulfilling Lives

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