North Tyneside Director of Public Health Annual Report
2012-13
Addressing Health Inequalities

Foreword

2012-13 was a significant year in terms of the major reorganisation of the NHS and public health system. Responsibility for local delivery of a range of public health duties, and transforming health improvement interventions (Appendix One) was given to local authorities with Public Health England being established to work with national and local government, industry, and the NHS, to protect and improve health and support healthier choices. Clinical Commissioning Groups were established to purchase local health care services including; hospital care, rehabilitation care, urgent and emergency care, most community health services and mental health and learning disability services. Health and Wellbeing Boards were formally established at the end of 2012-13 with the responsibility to improve integrated working between local health care, social care and public health.

My annual report for 2012-13 focuses on a number of **key factors that impact significantly on health inequalities** in North Tyneside – particularly in relation to life expectancy and healthy life expectancy. The report assesses the progress we are making locally in relation to reducing health inequalities and makes recommendations with regard to further focussed action. Through the development of Joint Strategic Needs Assessment understanding of local health needs is improving and enabling more targeted, outcome based approaches.

Moving forward the focus needs to be very clear in terms of understanding who experiences the most significant health inequalities and ensuring that services currently funded to address heath needs as well as providing a universal 'offer' to all in the population, are **focussed on and reach those most in need** and are producing the desired outcomes. This may be achieved through the development of entirely different models of service provision. We therefore need to tackle the root causes of ill health as

well as providing interventions early once people have been identified as needing further help or have been diagnosed with a disease for example.

The government's vision for public health is 'To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest'[1]. There are two high level outcomes around supporting people to lead healthier and longer lives;

- Increased healthy life expectancy - taking account of the health quality as well as the length of life

- Reduced differences in life expectancy and healthy life expectancy between communities - through greater improvements in more disadvantaged communities

The government recognises that it will take years – even decades – to see major changes and any significant impact at a local level. It is the responsibility of the Health and Wellbeing Board to ensure that local health needs are being addressed through commissioning of services and also to ensure that the social determinants of health are being systematically addressed. However, all agencies from the public, private and community and voluntary sectors need to take responsibility for seeking and maximising opportunities to improve the health of local people.

The key to embracing these changes and challenges is around working together, doing things differently and **integrating local provision** to maximise the opportunity for local people to maintain their health, wellbeing and independence and to be able to access the appropriate services if they need further help.

Marietta Evans
Director of Public Health October 2013

[1] The Public Health Outcomes Framework for England, 2013-2016 DH 2013

Background and Context

Health inequalities are unjust disparities in health outcomes between individuals or groups. They arise from differences in social and economic conditions that influence people's behaviours and lifestyle choices, their risk of illness and actions taken to deal with illness when it occurs. Inequalities in these social determinants of health are not inevitable, and are therefore considered avoidable and unfair[2].

The Marmot Review into health inequalities in England 'Fair Society, Healthy Lives' was published in 2010. It proposed an evidence-based strategic direction to address the social determinants of health, including poor housing and unemployment, which can lead to health inequalities. Central to the review is the recognition that disadvantage starts before birth and accumulates throughout life. This is reflected in the 6 policy objectives with the highest priority being given to the first objective:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all
5. Creating and developing sustainable places and communities
6. Strengthening the role and impact of ill-health prevention.

The Marmot Review of health inequalities demonstrates very clearly the relationship between social circumstances and health. There is a considerable and significant difference in life expectancy between people living in the richest and poorest neighbourhoods nationally as well as locally, and an even greater difference in disability free life expectancy. Thus, people in more deprived areas not only die sooner, but can expect to live more of their shorter lives with illness or disability. This difference is not just between the richest and poorest in our society however, but is a graded relationship across all social positions.

[2] London Health Observatory

'These serious health inequalities do not arise by chance and they cannot be attributed simply to genetic makeup, 'bad' unhealthy behaviour or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect and are caused by social and economic inequalities in society'[3].

The key message from Marmot and from much of the government policy and health researchers over the past fifteen years or so is that the key to tackling health inequalities lies in tackling social inequalities and the disadvantages that families and individual experience. The most emphasis is placed on the early years as this is the foundation for future health and wellbeing. Interventions need to be provided at a universal level or as a 'universal offer' but where needs are greater a more targeted intensive or progressive approach is required. Working in partnership to agree evidence based high impact interventions and joint investment is key to local success.

Our North Tyneside Plan

In terms of North Tyneside Council and its partners the 'Our North Tyneside Plan identifies a key goal and outcome in relation to supporting local people to lead healthier and longer lives. It sets out a number of key objectives in relation to service delivery that will contribute to this goal.

Joint Strategic Needs Assessment (JSNA)

An annual cycle now exists of refreshing the Joint Strategic Needs Assessment, developing a Joint Health and Wellbeing Strategy (in partnership with local people and organisations), consulting on those strategic priorities, and ensuring that they are reflected in the plans of commissioners and generating interventions to improve health and wellbeing outcomes.

The JSNA for North Tyneside was refreshed during 2012-13 and presented to the Health and Wellbeing Board as well as being disseminated out to a wide range of

[3] Fair Society Healthy Lives Marmot Review Executive Summary 2010

commissioners and key stakeholders. Key messages coming out of the 2012-13 JSNA include;

- The population is projected to grow by nearly 10% by 2030 with an **increasingly ageing population**. The number of people aged 85 and over is projected to increase in North Tyneside by 46% by the year 2030 creating additional demand for social care, housing, support, and health services

- Inequalities persist within the borough in relation to income, unemployment, health and educational attainment and poor mental health and wellbeing in parts of the borough are linked to socio-economic deprivation and vulnerability

- People are living longer in the borough however the gap in life expectancy within North Tyneside is wide and has remained constant throughout the last two decades. The principal cause of premature death is cancer, followed by cardiovascular disease

- At 65 years disability free life expectancy is **significantly lower** compared to England, in addition DFLE is significantly lower in our most economically deprived and vulnerable populations. Long term conditions and dementia will be **among our biggest challenges** going forward and the proportion of people with a disability is also likely to increase with an ageing population creating additional demands for service provision

- 1 in 5 children and young people still live in poverty and vulnerable children and young people in the borough suffer from poorer outcomes socially, educationally and economically

- North Tyneside has the third highest rate of emergency admissions in England. The rate of emergency admissions is much greater in the very young (0-4yrs) and in the elderly (65+ yrs). Acute hospital admissions of people aged 85 years and over are almost six times higher than those aged under 65 years

Development of the Health and Wellbeing Strategy

The Health and Wellbeing Strategy for North Tyneside was developed during 2012-13 and signed off by the Health and Wellbeing Board. The Health and Wellbeing Strategy was based on the JSNA findings, partner and stakeholder consultation and community consultation. Issues raised by local communities include;

- Children and young people's concerns include mental health, self harm, sexual health, access to employment, alcohol and drug use and relationships
- Local concerns from more socially deprived communities and older people include; welfare benefits and income, employment, antisocial behaviour, mental health problems, alcohol and drug problems, social isolation, access to fruit and vegetables, transport and access to local services and activities.
- On a positive note local people talk about a sense of community and good relationships as being important and being able to access very local community services
- People with disabilities talk about the lack of advocacy available to them and transport costs to services; also the need for services that support healthy lifestyles to be more inclusive
- Carers raise issues in relation to mental and physical health, especially stress, stigma and isolation
- People who are homeless have difficulties registering with a GP and talk about mental health and physical health problems
- Ex Armed Forces residents raise issues around mental health problems in particular and also difficulties with employment

The focus of the Health and Wellbeing Strategy is on joint key priorities and challenges going forward. The key priorities are as follows;

Improving the Health and Wellbeing of Families: Focusing on supporting families with complex and challenging needs and working to provide better integration of services and maximizing opportunities of prevention and early intervention

Improving Mental Health and Emotional Wellbeing: Focusing on maximizing opportunities to promote positive mental health, wellbeing and recovery through accessible services and community support

Addressing Premature Mortality to Reduce the Life Expectancy Gap: Focusing on key interventions at a community and primary care level to reduce the difference in life expectancy within the borough

Improving Healthy Life Expectancy: Focusing on key interventions at a community and primary care level to reduce the difference in life expectancy within the borough

Reducing Avoidable Hospital and Care Home Admissions: Focusing on interventions in primary care, community and hospital settings to improve self management, personalised support and independence

Current Inequalities in relation to Life Expectancy

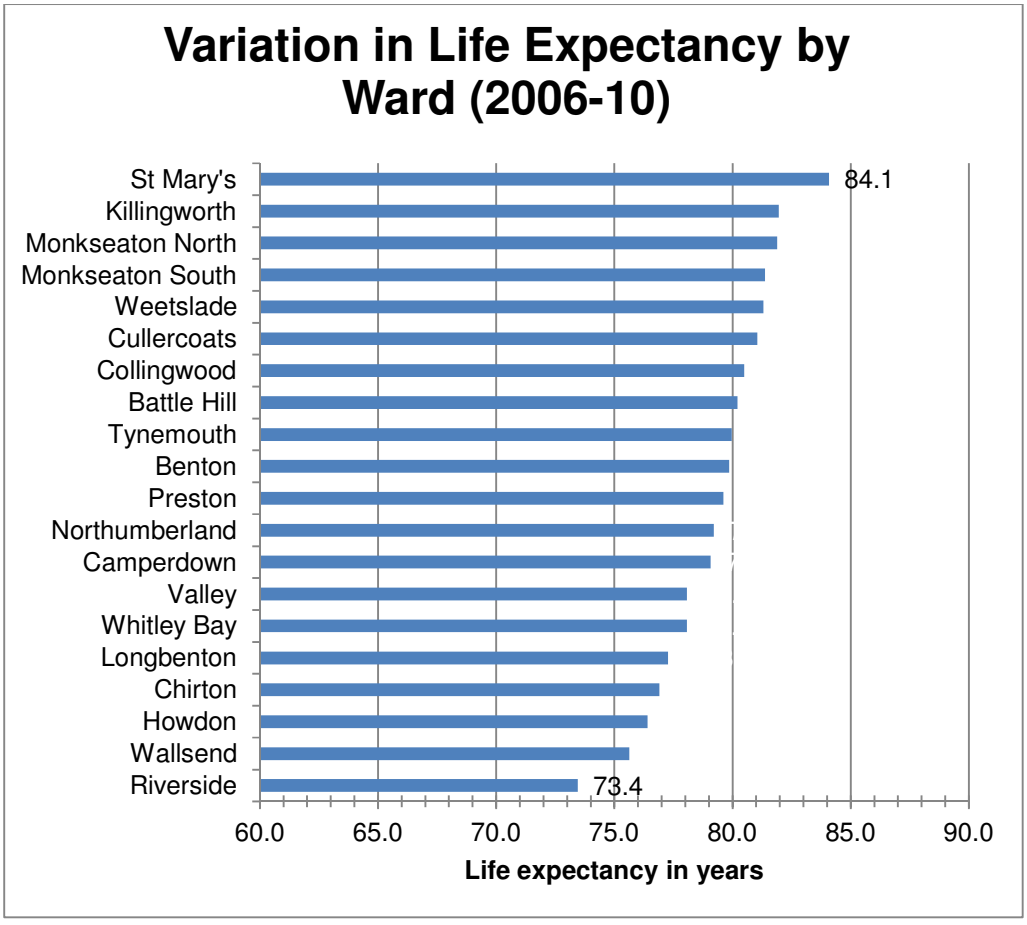
The borough of North Tyneside as a whole is now one of the least deprived areas in the North East of England. However, significant inequalities persist within the borough in relation to income, unemployment, health and educational attainment.

Key disease and factors (or combinations of factors) that reduce life expectancy include;

- Cardiovascular disease
- Cancer
- Respiratory disease
- Liver disease
- Mental illness and poor mental health
- Learning disability
- Low income
- Unemployment
- Poor housing

- Loneliness and isolation

On average people are living longer with the average life expectancy for North Tyneside being 79 years (77 years for males and 81 for females). **However the difference in life expectancy** between the most affluent areas and least affluent areas in North Tyneside is wide (11.6 years for males and 9.2 years for females) and has remained constant throughout the last two decades. The graph below shows the specific average life expectancy by ward for the borough; it can clearly be seen that people living in Riverside have a significantly average shorter lifespan that people living in St Mary's Ward.

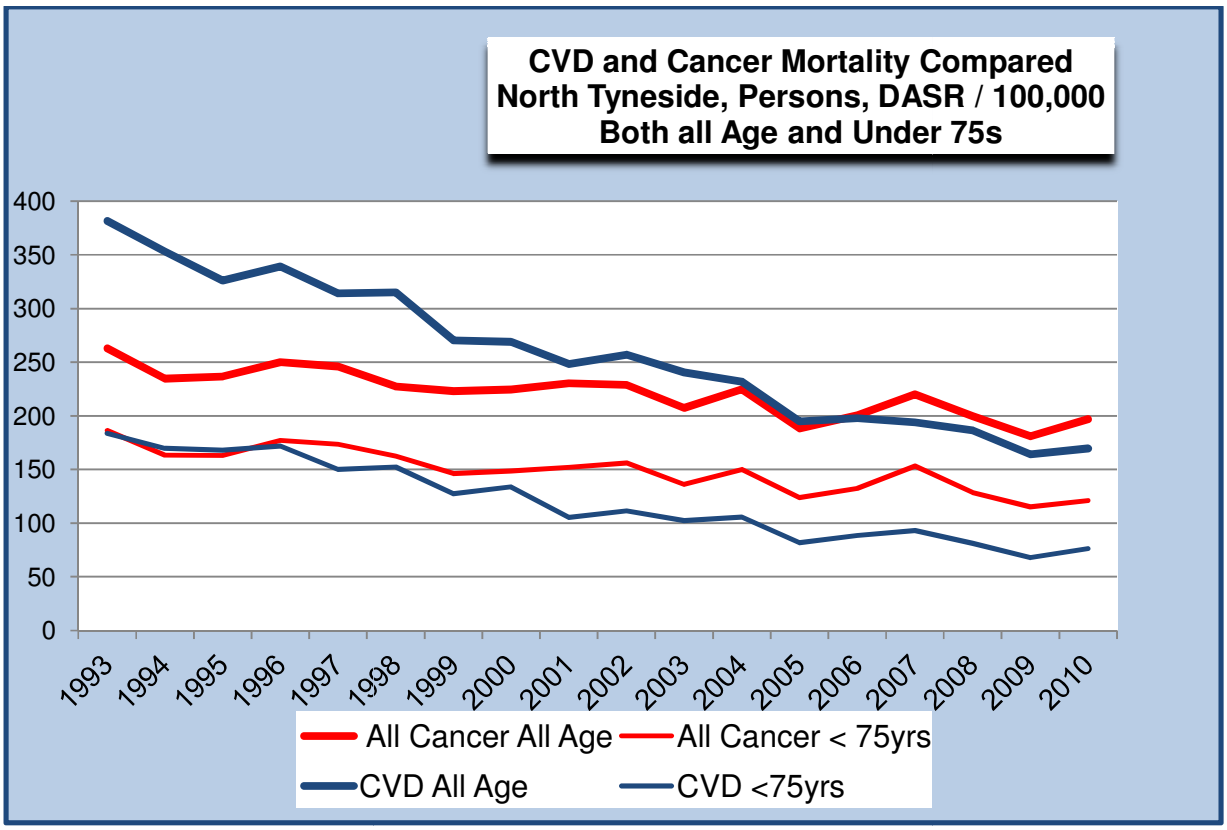


In terms of premature mortality (deaths under 75 years of age) in 2010 North Tyneside ranked 97th out of 150 local authorities in the country with an overall premature death

rate of **300** per 100,000 compared with the local authority with the lowest rate – Wokingham - with a rate of 200 per 100,000.

The principal causes of premature death in North Tyneside are cancer, followed by cardiovascular disease and respiratory disease. **Smoking** is the major contributor to cancer, cardiovascular disease (CVD) and respiratory disease mortality and morbidity and accounts for **half the gap in life expectancy between the most and least affluent groups in the borough.**

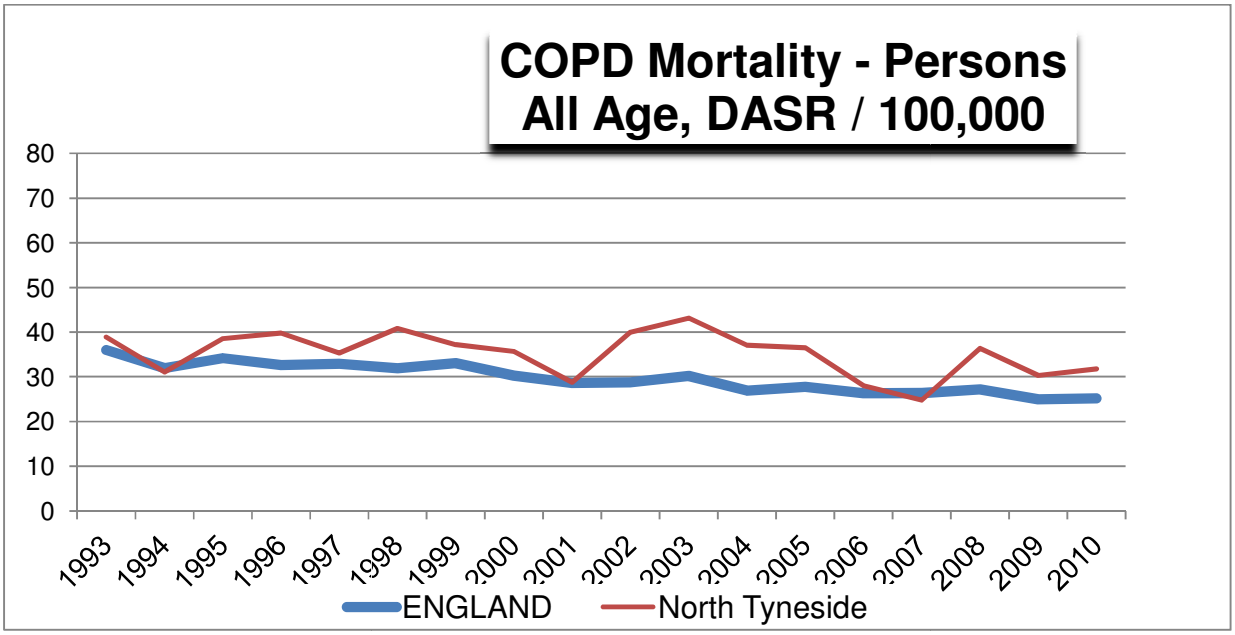
The graph below shows the trend in premature mortality (under 75 years) for CVD and cancer between 1993 and 2010. The graph illustrates that while there have been significant improvements over time with premature mortality due to CVD reducing most dramatically.



In order to continue to reduce premature mortality from cardiovascular disease preventative interventions in terms of stop smoking services and physical activity need to be accessible for individuals most at risk. Other cardiovascular disease risk factors including high blood pressure and diabetes need to be identified early through targeted NHS health checks and treated.

Chronic Obstructive Pulmonary Disease

As shown in the graph below there has been a variable but slowly decreasing trend in premature deaths due to Chronic Obstructive Pulmonary Disease (COPD). Between 2005 and 2009 there were nearly **4 times more deaths** attributable to COPD in the most deprived quintile compared to the least deprived quintile. Smoking is the most important factor in determining respiratory mortality and morbidity. There is also a strong link with seasonal excess mortality with up to a third of excess winter deaths being from respiratory disease.

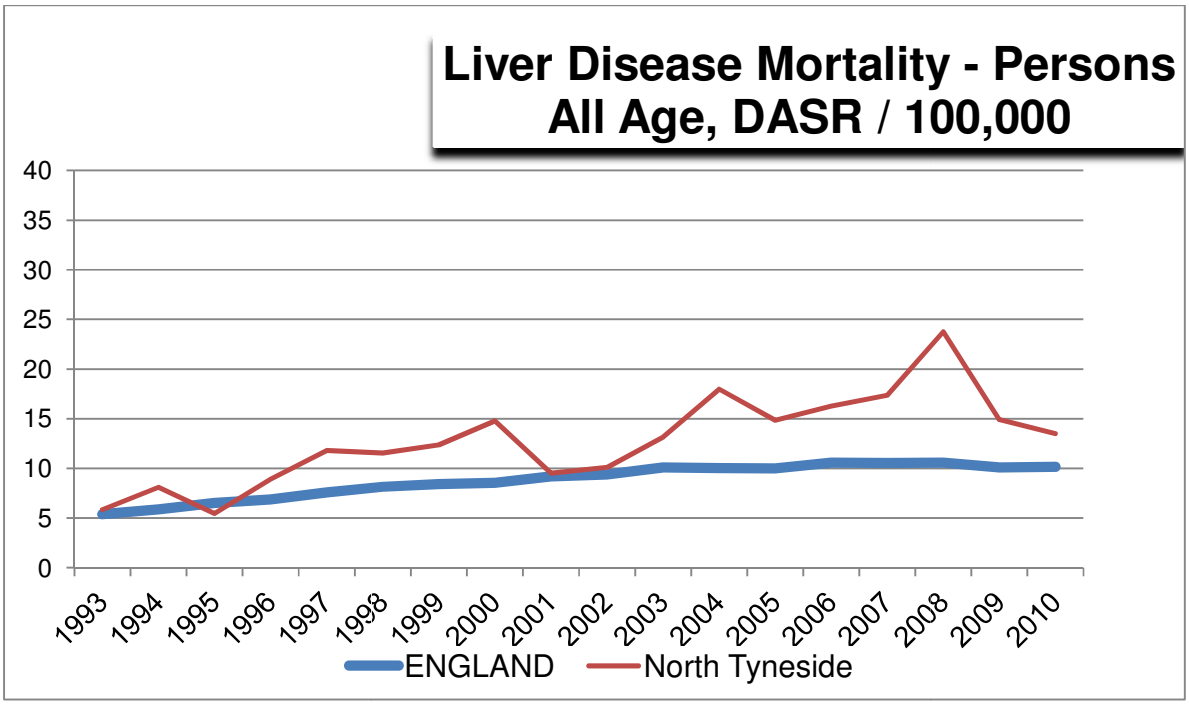


It is estimated that there are **significant numbers of people** with COPD who remain undiagnosed. Awareness raising and testing for COPD needs to be carried out in local

communities where individuals are most at risk so that those testing positive can receive the appropriate treatment.

Chronic Liver Disease

The mortality rate from chronic liver disease in North Tyneside is **significantly higher** than those of both the North East and England (2008-10 North Tyneside value 17.4, North East 14.0, England 10.3, all age DASR). The graph below shows the trend between 1993 and 2010 and shows a fluctuating but gradually **increasing trend**.



Recent data from 2011 shows that the rate of deaths from liver disease for females in North Tyneside is the highest in the North East and the 6th worst in England. The rate of deaths for males in North Tyneside is also higher than the North East average and significantly higher than the England average.

Common risk factors for liver disease include excessive alcohol consumption, obesity and hepatitis. It is estimated that over half of liver disease that develops is due to alcohol

consumption. Alcohol and weight management services need to be accessible and appropriate to need (see below). People at risk of Hepatitis A and B should be offered immunisation and those at risk of Hepatitis C (mainly injecting drug users) need to be offered testing.

Common Risk Factors in relation to Premature Mortality

As outlined above there are common risk factors and behaviours associated with premature mortality. These include;

- smoking
- poor diet
- physical inactivity
- alcohol misuse
- high blood pressure
- diabetes

Local data demonstrates inequalities in relation to these risk factors in the population. Evidence also shows that whilst the number of people overall who engage in multiple risky health behaviours, such as excessive drinking or smoking or having a poor diet has reduced, people from poorer backgrounds and the most vulnerable are still more likely to undertake three or more of these behaviours[4].

Smoking prevalence

Smoking is the major contributor to cancer, cardiovascular disease and respiratory disease mortality and morbidity and accounts for **half the gap in life expectancy** between the most and least affluent groups.The percentage of adults in the borough who smoke was estimated at 23.4% in 2010/11; this is higher than the average for England (20.7%). However, the prevalence in routine and manual workers in the borough is 34.6%. Smoking in pregnancy still persists with around 15% of women still smoking at time of delivery.

[4] Clustering of Unhealthy Behaviours Over Time, Buck & Fonseci The King's Fund, 2012

Interventions and services to support people to stop smoking must be effective, accessible and available to those who need most support. This means that support must be available within local communities and within the context of supporting people to maintain and improve their physical and mental wellbeing.

Alcohol Consumption

Alcohol misuse is a major problem within North Tyneside in terms of the health, social and economic consequences which affect a wide cross section of the borough at a considerable cost. Recent data shows that liver mortality is increasing which is related largely to alcohol consumption and also obesity.

North Tyneside has the **4th highest rate in the UK for binge drinking** (29.9%) and the highest rate in the North East for dependent drinkers (8.6%). It is estimated that only 2.8% of dependant drinkers are in contact with treatment services.

Alcohol Related Hospital Admissions are particularly high in the borough compared with the average for England. The rate of alcohol related hospital admissions increased by 139% between 2002/3 and 2010/11. These are highest in Chirton, Riverside, Wallsend and Howdon wards. During quarter 3 and quarter 4 of 2012 there was a decrease in alcohol related admissions which suggests that measures put in place to support people who are drinking excessively are starting to have some impact.

Services to support people with alcohol problems need to be of sufficient scale and appropriate to level of need. Services also need to be focussed on recovery and must aim to address some of the underlying factors in relation to excessive alcohol consumption.

Obesity

In 2011 the estimated the prevalence of obesity for adults was 26.6%, **significantly higher** than the prevalence for England (24.2%). In terms of children the most recent

data for 2012/13 (provisional) indicates that we have not seen a sustained rise in the Year 6 obesity prevalence. The previous year's figure of 22.0% had been the highest ever figure but this year's figure has reduced to 18.6%. Local mapping also shows a higher prevalence of obesity in children living in deprived areas of the borough compared with those in less deprived or more affluent areas.

Services to address obesity need to be of sufficient scale and evidence based. The aim should be to intervene as early as possible; in particular with families, so that locally available support can be provided around healthy eating, cooking and physical activity.

Healthy Eating

The percentage of adults eating healthily is estimated to be **significantly worse** than the figure for England. The Health Survey for England 2006-08 estimated that 20% of the adult population in North Tyneside consume 5 or more portions of fruit and vegetables per day. A local survey carried out in 2012 suggests that people on low incomes are less likely to eat fruit and vegetables, less likely to cook food from raw ingredients and more likely to eat ready meals and takeaways on a regular basis.

Support in relation to healthy eating and improving access to fruit and vegetables for example needs to be provided locally and must be sustainable in terms of local communities learning and sharing new skills and also taking responsibility for maintaining food growing initiatives.

Physical Activity

In terms of physical activity the proportion of adults who are physically active in North Tyneside is estimated to be similar to the England average and has improved gradually over the past 10 years. The Active People Survey for 2012/13 reported that in North Tyneside 56.2% adults had participated in sport at least once in the last 4 weeks, 26.3% had participated in 30 minutes of moderate intensity sport at least three times in the last week and 44.6% participated in 30 minutes of moderate intensity sport at least once in the last week. However local surveys suggest that people living in more economically

deprived areas of the borough are less likely to take part in the weekly recommended levels of physical activity.

The evidence above therefore suggests that we need to do more to engage with and motivate people from our more deprived neighbourhoods and more vulnerable individuals to be more physically active. Interventions and activities also need to be affordable and accessible.

Hypertension

Hypertension is one of the major modifiable risk factors for stroke and coronary heart disease. Physical activity, healthy eating (particularly reducing salt intake) and medication can all help control and reduce blood pressure levels.

The prevalence of hypertension in North Tyneside identified on general practice registers is 15.4% which amounts to 33,054 people (2011/12). Predictive models for hypertension suggest that **levels may be as high as 32.6%** (52,871 people). Being on a general practice register increases the likelihood of the better management of that condition and reducing the potential risks from high blood pressure. Evidence suggests that undiagnosed hypertension may more likely be present in people who smoke, are overweight and between the ages of 45 – 54.

Public awareness in relation to high blood pressure needs to be improved. The NHS Health Checks Programme running in the borough is designed to identify risk factors for cardiovascular disease including high blood pressure but needs to be delivered in ways which engage with people most at risk.

Diabetes

Diabetes is a chronic and progressive disease that impacts upon almost every aspect of a person's life. Evidence shows that people with diabetes which is either not diagnosed or poorly managed can have their lifespan reduced by up to 10 years. Predictive models for diabetes suggest there is a significant gap between actual and measured (or

diagnosed) prevalence levels in North Tyneside. They suggest a potential deficit of 2000 patients missing from practice register. The North Tyneside prevalence of diabetes based on the practice registers in 2011/12 was 6.2% which is 10,781 people. The estimated prevalence for people aged 16 years or older who have diabetes (diagnosed and undiagnosed) is 7.7% which is 12,755 people.

Public awareness in relation to diabetes needs to be improved The NHS Health Checks Programme running in the borough is designed to identify risk factors for cardiovascular disease including diabetes but needs to be delivered in ways which engage with people most at risk.

Other factors that Impact on Premature Mortality

There are a range of factors that contribute to premature mortality. Evidence suggests that adults who are disadvantaged are most likely to be at risk of premature mortality[5]. These include (but are not limited to) people in the following circumstances;

- those on a low income and/or benefits
- those living in poor quality or social housing
- some members of black and minority ethnic groups
- those with a mental health problem
- those with a learning disability
- those who are institutionalised (including those serving a custodial sentence)
- those who are homeless

Issues in relation to wider determinants of health are addressed further on in my report. Falls in people aged over 65 years also have a significant impact on life expectancy and healthy life expectancy.

[5] Identifying and supporting people most at risk of dying prematurely NICE September 2008

People with Mental Health Problems

Poor mental health and wellbeing in parts of the borough are linked to socio- economic deprivation, vulnerability and premature mortality. People suffering from serious mental illnesses like schizophrenia or bipolar disorder have a life expectancy that can be 10 to 15 years lower than the average in the local population. The excess under 75 mortality rate in adults with serious mental illness in 2010/11 was 1,275 in North Tyneside compared to an England average of 921. In terms of suicide North Tyneside has a higher rate than the England average - the indirectly standardised mortality rate for suicide and undetermined injury in 2010/11 was 142 per 100,000 compared with the England average of 100 per 100,000.

A more strategic approach to mental health and suicide is required in the borough to ensure that needs are being addressed through appropriate services. Services to improve mental wellbeing need to be accessible to individuals who are in greatest need. This includes social prescribing services and health improvement services generally.

People with Learning Disabilities

Life expectancy for people with learning disabilities is lower than for the rest of the population. Evidence shows that people with learning disabilities are 2.5 times more likely to have health problems than other people but are less likely to receive regular health checks. There are over 1,000 adults aged over 18 years known to GP practices in North Tyneside. Currently around 53% of these people have had a health check.

Work to improve uptake in relation to health checks needs to continue and services and interventions to support children and adults with learning disabilities to be more healthy need to engage better with potential clients and offer more inclusive programmes with support where required.

People from Black and Minority Ethnic (BME) Populations.

Evidence shows that people from Black and Minority Ethnic (BME) communities tend to have poorer health, a shorter life expectancy and have more difficulty in accessing health

care than the majority of the population. The BME population in North Tyneside is currently estimated at 5.9% and has almost doubled since 2001. The main communities within this are 'other white' (for example from elsewhere in Europe) at 3.2%, Indian at 1.1%, Chinese at 1% and 0.6% other groups.

Work to improve uptake in relation to health screening and services needs to continue and interventions to support children and adults from BME populations to be more healthy need to engage better with potential clients and offer more inclusive programmes with support where required.

Falls Prevention in Older People

The Royal Society for the Prevention of Accidents (ROSPA) estimates that one in three people aged 65 years and over experience a fall at least once a year – rising to one in two among 80 year-olds and older. Approximately 5% of older people in the community who fall in a given year experience a fracture or require hospitalisation. The impact of falls, and particularly recurrent falls, include reduced life expectancy, reduced quality of life, increased hospitalisation rates and loss of independence. In 2012-13 around 1,437 people aged 65 and over suffered a fall in North Tyneside which is equivalent to a rate of 3,873 per 100,000. This is **significantly higher** than the England average.

A more strategic approach is required in relation to falls prevention in the borough to ensure that evidence based falls prevention programmes are provided at a sufficient scale and are accessible to older people most at risk. This includes lower level privative services as well as more clinical assessments.

Reducing Premature Mortality from Causes Amenable to Healthcare

Measures of avoidable mortality are used to gauge the extent to which healthcare services save lives and contribute to population health.

Avoidable mortality is the number of deaths that should not take place in the presence of effective and timely healthcare and prevention. Causes of death are included in this

indicator if there is evidence that they are amenable to healthcare interventions and – given timely, appropriate, and high quality care – death rates should be low among the population under 75 years of age. Healthcare interventions include those aimed at preventing the onset of diseases such as circulatory disease and cancer where these are caused by lifestyle choices, as well as treating disease.

Mortality from causes considered amenable to health care in essence is looking at how well health services are doing at preventing deaths that could have been avoided through the application of appropriate health care measures. The NHS leads on reducing premature mortality that is amenable to health care interventions.

Potential Years of Life Lost (PYLL) from causes amenable to healthcare is an estimate of the average years a person would have lived if he or she had not died prematurely from a cause that was amenable to healthcare. There has been a downward trend in PYLL for amenable causes in England. There has been a similar decline in North Tyneside however the PYLL for both males and females is higher than that for England as shown in figure 1 and 2 below.

This is unsurprising given that CVD, cancer, respiratory and liver disease amenable aspects account for **82%** of all amenable PYLL and death rates for all are higher in North Tyneside than in England.

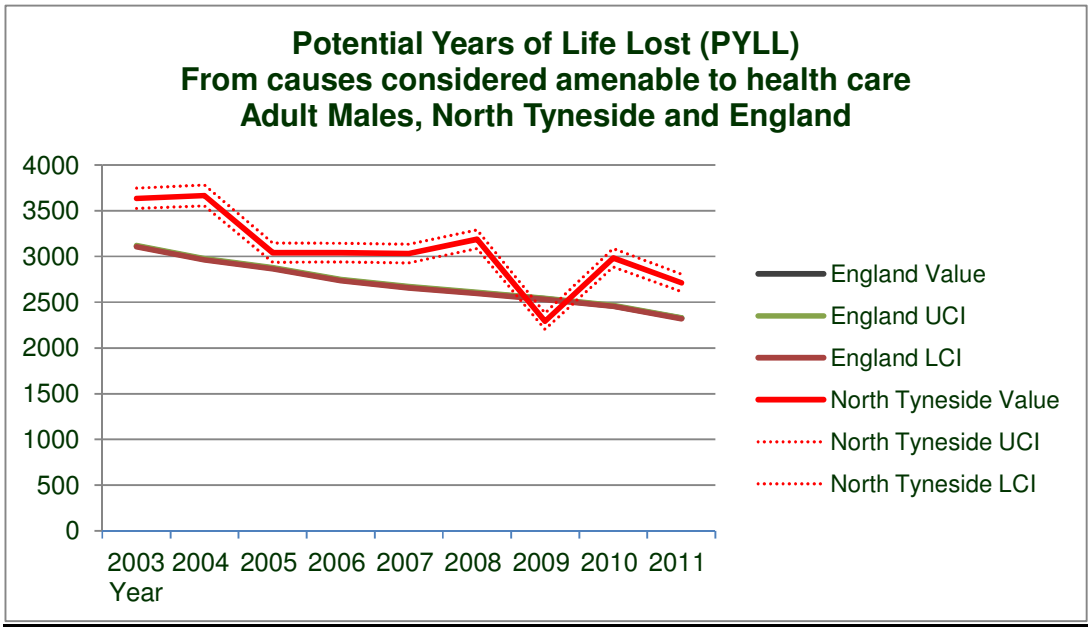


Figure 1: PYLL from causes amenable to healthcare for males

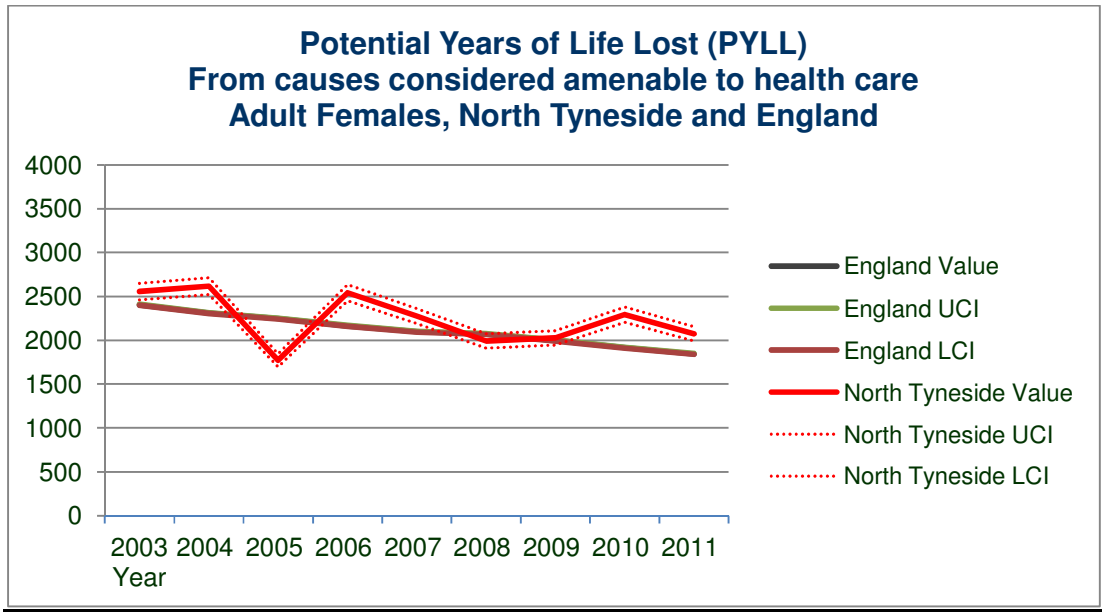


Figure 2: PYLL from causes amenable to healthcare for females

Healthy Life Expectancy

In terms of understanding **healthy life expectancy** the best measure we have currently is Disability Free Life Expectancy which measures the number of years a person can

expect to live free from a limiting persistent illness and disability. Disability-free life expectancy measures disability by looking at self reported limitations in day to day activities such as work, school and leisure activities.

At 65 years the disability free life expectancy (DFLE) in North Tyneside is **significantly lower** compared to England and in addition DFLE is significantly lower in the most deprived populations of North Tyneside. For England DFLE at 65 yrs is 10.8 years for men but only 7.7years for men in NT and for women the figures are 11.4years (England) and 8.7yrs (North Tyneside).

The main causes of years lived with disability are **mental health and musculoskeletal conditions** (these two account for half of the total).

However there are limitations with this measure as the self-reported health questions do not distinguish between types of health problem. For instance, they do not distinguish between long-term conditions such as diabetes, which can be managed and need not always cause disability, and severe health impairments such as Alzheimer's and other dementias that often require nursing and residential care. Most people fear losing their independence and dependence is also associated with high health service usage and associated economic costs. Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life.

Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources

of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities[6].

Some research evidence suggests that life expectancy is increasing more quickly than disability-free life expectancy[7]. Therefore there will be an increase in the prevalence of ill-health and disability in the older population if age-specific prevalence rates remain constant as the population ages. For healthy life expectancy to increase faster than life expectancy we need to delay the onset of disabling diseases so that the period of time when someone experiences poor health is reduced or compressed.

Approximately 30 per cent of the population has one or more long-term condition[8]. This includes people with a range of conditions that can be managed but often not cured.

Key conditions that reduce healthy life expectancy in the borough include;

- Depression and anxiety
- Dementia
- Musculoskeletal disorders
- Cardiovascular disease including heart disease and stroke
- Cancer
- Diabetes
- Respiratory disease
- Arthritis
- Neurological conditions

There are three ways to achieve an increase in life expectancy and healthy life expectancy if the scale of interventions meets local need and also if the population groups or individuals most at risk or in need are identified early given additional support to maintain them in good health as long as possible;

[6] Long-term conditions and mental health: The cost of co-morbidities. Kings Fund 2012
[7] Increasing life expectancy and the compression of morbidity: a critical review of the debate Howse K. Oxford Institute of Ageing 2006
[8] Department of Health 2011

- Delay the onset of disease, achieved by improved primary prevention through supporting healthy lifestyles – particularly in those most at risk of disease
- Delayed progression of disease as a result of improved secondary prevention which is achieved by identifying onset of disease as early as possible and providing treatment and support for behaviour change
- Increased survival once disease has progressed to a more complex or advanced level, achieved through improved tertiary prevention which involves managing the disease symptoms and supporting with rehabilitation

What are the key challenges for North Tyneside?

Historically in terms of improving health in the borough the focus has been on providing services that tackle symptoms of poor health and/or health behaviours such as health checks, smoking, obesity or excessive alcohol consumption to the population as a whole. This approach can be successful for some people who are motivated and supported to change. However for people who experience a range of social problems they are both more likely to have poorer health due to poor health behaviours, which are often coping mechanisms and are less likely to be motivated or equipped with the necessary skills to change and equally least likely to seek out services and support to help them make changes.

The key challenges in terms of addressing the difference in life expectancy and healthy life expectancy include;

- Tackling the root causes of ill health rather than dealing with the symptoms – this includes educational attainment, income, employment, housing condition, homelessness and environment
- Working with local people to build on local assets and develop health promoting communities where better access to shops and affordable facilities, services and activities make it easier for people to make healthy choices.
- Engaging with and empowering local people to lead change

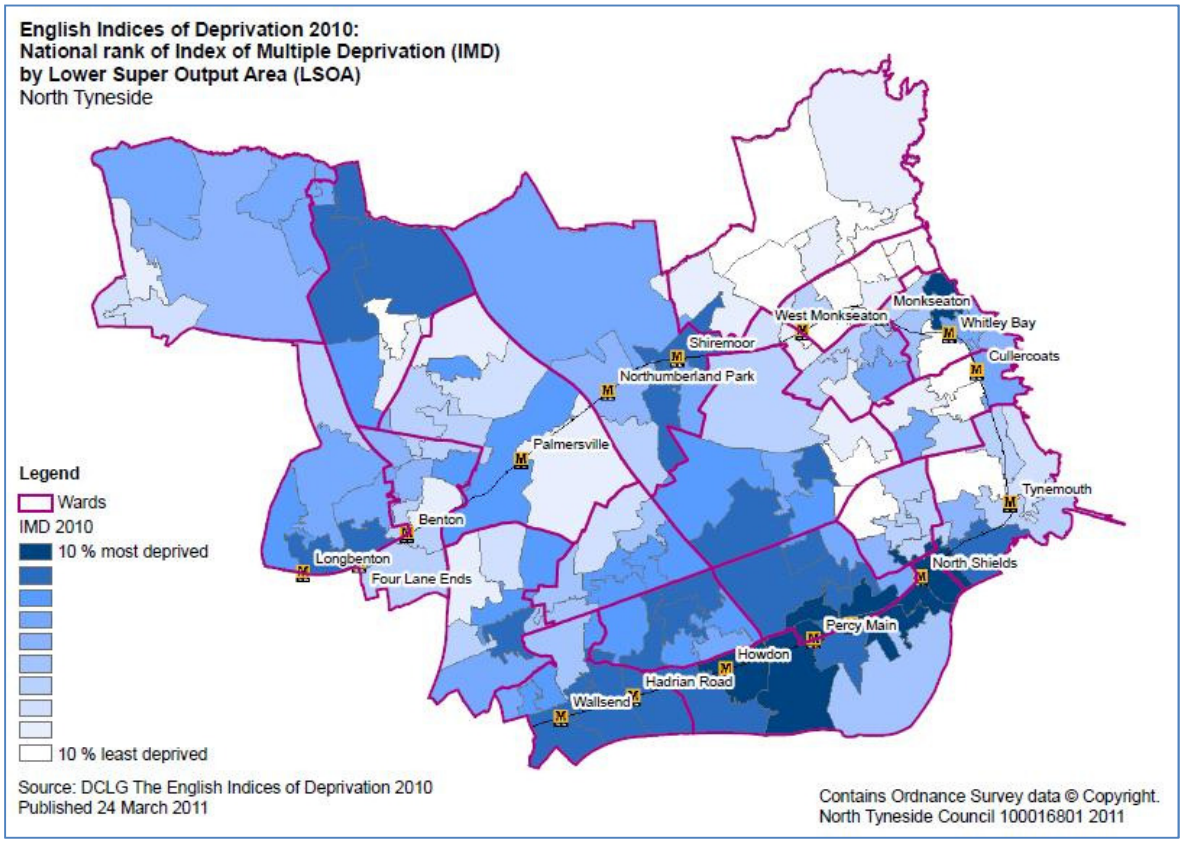
- Working with families and a range of local people and organisations to build resilience in individuals and communities
- Ensuring that preventative interventions and services to support local people to make changes are of a sufficient scale to make an impact on levels of need and are sustainable going forward
- Ensuring that services designed to support people to maintain their health and wellbeing engage with and take into account the needs of people who are most vulnerable and who may face the greatest difficulties accessing the services
- Maintaining and where necessary improving the quality of care to ensure that services users have the best opportunity to recover and maintain their independence for as long as possible

Tackling the Root Causes of ill Health

"Deprivation *takes many different forms in every known society. People can be said to be deprived if they lack the types of diet, clothing, housing, household facilities and fuel and environmental, educational, working and social conditions, activities and facilities which are customary, or at least widely encouraged and approved, in the societies to which they belong*.[9]"

The link between social and economic deprivation and poor health has long been recognised. People living in areas with higher levels of deprivation tend to have poorer health than those living in more affluent areas. Approximately 50,000 residents in North Tyneside live in areas described as amongst the 20% most deprived in the country, with deprivation tending to be concentrated in particular neighbourhoods. Of the 326 local authorities in England, North Tyneside is 113th most deprived. This is an improvement from a national ranking of 102nd most deprived in 2007. The map below shows the areas of deprivation in the borough.

[9] Townsend, P. (1987) Deprivation *, Journal of Social Policy,* 16 (1), pp. 125-146



People who are vulnerable and/or on low incomes are more likely to live in areas where housing costs are cheaper and are likely to have a higher exposure to negative influences on health, and to lack resources to avoid some of them or their effects, than people living in less deprived circumstances. People with disabilities, mental illness and those of certain ethnic or age groups, may also experience varying exposures to these influences on health. A person's gender may influence health opportunities – this is reflected in the lower life expectancy of men.

In 2003[10] the government identified the root causes of health inequalities as;

- poverty
- poor educational outcomes,
- worklessness
- poor housing

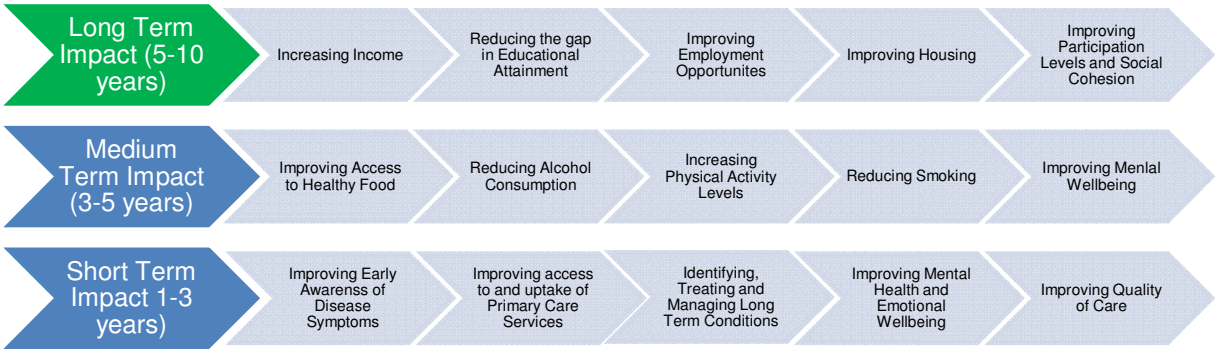
[10] Tackling Health Inequalities: A Programme for Action Department of Health 2003

- homelessness
- problems of disadvantaged neighbourhoods

While priority and funding has been directed to physical and economic change in many of the more deprived communities in North Tyneside over many years, the social change agenda from within communities has not had the same priority or emphasis.

A significant proportion of the population in North Tyneside are going to continue to experience health inequalities unless there are consistent national and local policies in place to address the root causes. Currently a great deal of emphasis and funding from the public sector is placed on addressing the 'symptoms' of deprivation in terms of ill health, crime and social care needs - dealing with the complex problems people experience - while less attention and funding is focussed on systematically ensuring that the local population is supported and empowered to improve their health and wellbeing.

What are the key factors in relation to reducing the difference in Life Expectancy and Healthy Life Expectancy?



Poverty and Income

It is widely recognised that poverty, or low income, is associated with poor health. Poor health can lead to low income as well as vice versa. Studies have shown that both individual income (in terms of poverty or material circumstances) and income inequality

(relative income) make a difference to health and social problems[11]. There is a strong relation between mortality and income inequalities. People living in countries with greater income inequality have a shorter life expectancy. Furthermore, a similar relation has been found for geographical areas within countries[12].

The Welfare Reform Act which has been agreed by parliament introduces a wide range of reforms, many of which will be introduced from April 2013 onwards. These aim to making the benefits and tax credits systems fairer, more affordable and better able to tackle poverty. However there is concern at a local level that some people may be worse off or unable to manage the new arrangements. There is also evidence that poorer families prioritise their weekly income in significantly different ways according to what they believe they need.

The Centre for Social Justice identifies five key pathways to family poverty;

- family breakdown and/or domestic violence
- economic dependency and worklessness,
- poor educational attainment of parents
- addiction and or mental ill health
- indebtedness.

Family poverty remains one of the greatest challenges facing the borough. The most recent figures show that North Tyneside has a child poverty level (19.6%) which is just below the national average (2010). However there is still considerable variation in the extent of child poverty between neighbourhoods. Child poverty levels vary from 3% in St Marys ward to 40% in Riverside. Across North Tyneside around 1 in 5 children live in poverty in North Tyneside.

[11] Does income inequality cause health and social problems? Joseph Rowntree Foundation 2011
[12] Psychosocial and material pathways in the relation between income and health Marmot M, Wilkinson RG, British Medical Journal; 322(7296): 1233–1236, May 19, 2001

Educational attainment

The educational attainment of a child's parents, particularly the mother, is recognised as one of the most powerful predictors of child health in both developed and developing countries[13]. There is also evidence of a correlation between educational attainment and current and future health status. An analysis of over 100 local education authority areas found educational attainment at age 15-16 to be **significantly associated** with both coronary heart disease and infant mortality[14].

Educational attainment could therefore be considered to be a **protective factor** in a population as long as concerted efforts are being made to narrow the gap in attainment between the most advantaged social groups and the most disadvantaged.

In North Tyneside although there has been sustained improvement in educational attainment across the borough as a whole there remain **significant gaps** between children in more affluent circumstances and their lower income or more vulnerable peers;

- Looked after children continue to underperform in comparison to their peers.
- The gap at Early Years Foundation Stage between the lowest achieving 20% of children and the rest has increased
- The educational gap between those with Free School Meals (FSM) and their non-FSM peers remains
- The gap in attainment between children with Special Educational Needs and their peers need to be addressed particularly at key stage 4 as there has been a decline
- Level 3 qualifications by age 19 in North Tyneside remains below the national average, meaning fewer pupils achieve the qualifications they would need to progress to higher education and university

[13] N J Spencer, *Poverty and Child Health*, Radcliffe Medical Press, 2000
[14] HM Treasury and Department of Health, 2002

Worklessness

The Marmot Review identified that work and employment are of critical importance for population health and health inequalities[15]. Action taken to reduce health inequalities will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

In terms of adults who are unemployed there is strong evidence to suggest that adverse effects on health are most likely among those who experience long-term unemployment. In terms of moving into employment there is good evidence that overall health will improve and GP usage and other health services will reduce.

In terms of working age adults those who are to experience most inequality will be individuals who are at high risk of disease and/or premature death due to one or more risk factors and Iindividuals who are more likely to experience mental and/or physical ill health due to social exclusion, service access issues, or social problems. In terms of those adults in work, **two thirds of sickness absence and long term incapacity** is due to mild and treatable conditions, including; depression, anxiety, stress related mental health problems and musculoskeletal conditions.

- The proportion of the population aged 16-64 years estimated to be economically active in North Tyneside (April 2011 and March 2012) was 79.2%, this is higher than the figure for both the North East and Britain
- The number of people claiming Jobseekers Allowance (JSA) and National Insurance credits at Jobcentre Plus local offices in 16-64 ages (April 2011 to March 2012) was highest in Riverside ward, followed by Chirton ward and Wallsend. St Mary's ward had the lowest rate of claimants
- In 2012, 8.8% of young people aged 16-18 were classed as NEET (not in education or training) this is significantly worse than the value for England.

[15] Report on new evidence on health inequality reduction, produced by Task group 2 for the Strategic review of health inequalities post 2010

- At August 2012 North Tyneside had 11.5% of its 18-24 year old population claiming Job Seekers Allowance. This is higher than the North East (10.4%) and National (7.5%) figures.

Social Isolation and Loneliness

Loneliness is a factor associated with poor physical and mental health. Evidence suggests that it is the quality of social interaction rather than the quantity that is important. Although social isolation is most common in the elderly, younger adults (e.g. those who are housebound or disabled or single parents with young children) may also be affected by both social isolation and loneliness. Reduced social contact, being alone, isolation and feelings of loneliness are associated with reduced quality of life. Although we do not know the extent of loneliness in the local population national estimates would suggest **at least 10% of the population experiences social isolation at any one time**.

Loneliness has an impact on life span, the more frequent use of health services, the need for long term care and the quality of life.

Housing Condition

'The relationship between poor housing and ill health is a complicated one which involves many different factors. Evidence suggests that living in poor housing can lead to an increased risk of cardiovascular and respiratory disease as well as to anxiety and depression. Problems such as damp, mould, excess cold and structural defects which increase the risk of an accident also present hazards to health'[16].

Studies using population data suggest that the strongest links are for:

- Accidents - 45% of accidents occur in the home and accidents are in the top 10 causes of death for all ages
- Falls – 50 % of falls occur in the home
- Cold - cold homes are linked to increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health.

[16] Chartered Institute of Environmental Health 2011

In relation to children there is strong evidence that poor housing conditions result in educational under achievement lower literacy rates poor school attendance respiratory conditions and accidents and associated GP attendance and hospital admissions.

The Decent Homes Programme aimed to refurbish all social sector homes to a minimum standard between 2000 and 2010. The government will invest a further £1.6 billion to improve housing in the public sector. However, housing quality is poorest in the private rented sector; homes in this sector housing people on benefits are not supported under the new initiative.

There are around 94,000 homes in North Tyneside. Most (77%) are privately owned; the rest are either owned by the Council (17%) or housing associations (6%). There is a shortfall of 479 affordable homes each year in North Tyneside including; social rented housing. Approximately 97% of the social housing in North Tyneside meets the Decent Homes Standard. In contrast 35% (25,503) of homes in the private sector fail the decent homes standard and 20% (14,344) of homes in the private sector are likely to have a category 1 hazard in relation to the Housing Health and Safety Rating System.

In North Tyneside 16,996 households are fuel poor which means that in order to heat their home to an adequate standard of warmth those households needs to spend more than 10% of their income.

There are four key issues in relation to housing and health;

- Homelessness
- Access to suitable and /or supported housing for vulnerable individuals including those with mental health problems, learning disabilities and substance misuse problems
- The quality of housing available for those on low incomes and vulnerable individuals

- Poor housing condition that contributes to falls and ill health

Involving Local People in how we Deliver Services

Public sector and community and voluntary sector organisation recognise that certain areas make disproportionate demands on their services. These are normally small pockets of severe deprivation and social dysfunction. Such areas are likely to fall within the most socio-economically deprived in the borough.

Residents of such areas are likely to have poor personal support and contact networks; experience physical and mental health issues; be both victims and perpetrators of crime and disorder, and to be without work and on little more than a subsistence income. As such they make heavy demands on the services of the police and emergency services, social work, accident and emergency departments and primary care, housing providers and environmental health services among others.

In these most challenging neighbourhoods the basic principles of an alternative approach would be based on the following:

- An assets approach, implying respect and recognition of the individuals and families involved, working with them in understanding issues and developing their own solutions
- A long-term commitment to the areas - recognising that a sequence of short term projects that are the typical experience of deprived areas do not work and do not enjoy the trust or confidence of the community
- The key aims of the commitment being to build solidarity within the community, an atmosphere of attachment and cohesion, and the sense of coherence that is the foundation of a healthy and fulfilling quality of life, and the foundation of empowerment, employment and engagement in civic life
- A focus on early years and working with young people as the most critical life stages for the individuals involved and for the communities as a whole.

Building Healthier Communities

There are a number of connected key issues linked to building healthier communities;

- Empowering local people to play an active part in improving healthier opportunities in their community
- Working with families and a range of local people to build resilience in individuals and communities
- Working with local people to build on local assets and develop health promoting communities where better access to shops and affordable facilities, services and activities make it easier for people to make healthy choices

Tackling the causes of persistent health inequalities can help lessen reliance on frontline services and improve life ambitions. A growing body of evidence suggests that individuals supported by high levels of social capital tend to recover more quickly and are more resilient to disease[17]. There are parallel findings relating to mental health[18].
It is well established that the more opportunities people have to be involved and make a difference in their local community, the better they feel about facilities and services and agencies that provide those services. They are also more likely to be empowered to influence the development of new and existing services.

A Healthcare Commission study in 2009[19] showed evidence that where people are genuinely involved in developing their own and their community's health services, three things happen. First, local services become more responsive to local conditions. Second, health needs are met with fewer repeat visits to healthcare providers. Third, there is improved access to services and increased accountability and satisfaction.

In North Tyneside a range of data analysis, social marketing analysis, surveys and health equity audits have been carried out in recent years. These largely show that people living in more deprived areas of the borough and people who are more vulnerable are less likely to demonstrate positive health behaviours, access preventative healthcare

[17] Halpern, D. Social Capital. Cambridge: Polity Press. (2005).
[18] McKenzie, K. and Harpham, T. Social Capital and Mental Health. London: (2006).
[19] 'Listening, Learning, Working Together', Healthcare Commission (2009)

– for example health checks and screening programmes and are more likely to access healthcare inappropriately – for example attendance at A&E. They are also more likely to be admitted to hospital either as a planned or an emergency admission.

Summary

My review of progress made during 2012-13 demonstrates that while general improvements have been made in relation to some areas – reducing including reducing premature mortality from cardiovascular disease, a reduction in alcohol related hospital admissions and a downward trend in relation to Potential Years of Life Lost from causes considered amenable to health care there are still many areas relating to premature mortality and healthy life expectancy where North Tyneside performs significantly worse than the England average.

By taking effective action across prevention, diagnosis and treatment we will reduce the numbers of people dying prematurely, and reduce the burden of illness as a whole. If we achieve this we will not simply be supporting people to live longer - we will be supporting them to improve their quality of life – particularly if they are living with long-term conditions.

This will require sustained action across the health and social care sector as well as closer working with communities. **Integration will be key** in relation to the current financial challenges faced by the public and community and voluntary sectors and will also provide better, seamless services for local people.

Interventions and actions that will have the **greatest impact** on inequalities in health in North Tyneside include;

- A reduction in smoking in low income and vulnerable groups
- An increase the proportion of the population who are a healthy weight
- Detection and treatment of diseases earlier, such as heart disease, high blood pressure, diabetes, respiratory disease and cancers

- Providing preventive interventions for vulnerable groups with the worst mental and physical health, including those who may be at risk of domestic or sexual violence and abuse
- Supporting parents with mental health, substance misuse and relationship or domestic violence issues to ensure that impact on their children is minimised
- Investing in the health and wellbeing of all children and young people with a focus on families
- Working with communities to develop innovative approaches to improving mental health and emotional wellbeing, and preventing loneliness
- Increasing income levels and employment, and reducing poverty
- Improving the quality and condition of private landlord proprieties that do not met the Decent Homes Standard
- Developing early intervention and recovery based services to help people with drug and alcohol problems
- Scaling up community based exercise and rehabilitation programmes for people with long term conditions

Key Recommendations for 2012-13

Recommendations for Children, Young People and Families

- Commission a high-quality lifestyle survey of young people to provide a baseline for health and wellbeing improvement
- Review evidenced based school health improvement interventions to ensure quality and equity of access for all children and young people
- Review the School Nursing Service to identify and focus on health and wellbeing outcomes for children and young people
- Address some of the key disadvantage in the early years including child poverty and the gap in educational attainment through supporting families and identifying and addressing problems early
- Ensure that children with learning and/or physical disabilities are supported to be as healthy and active as possible along with their families

- Integrate NHS, public health and/or health improvement interventions with education and social care services

Public Health/Health Improvement Recommendations

- Develop community based health improvement services which are developed in conjunction with local people and are able to address multiple unhealthy behaviours in a whole person and inclusive approach
- Establish a Community Health Champions Programme
- Remodel drug and alcohol services to place a greater emphasis on early intervention and recovery
- Include the requirement to carry out health equity audit in all new provider contracts to ensure that health improvement and healthcare services are being accessed equitably
- A public mental health strategy should be developed to reflect the new local authority responsibility for public mental health.
- An evidence-based Suicide Prevention Plan should be developed reflecting local authority and clinical commission group and NHS England responsibilities
- A health equity audit of screening programmes should be undertaken to establish variation in uptake of local screening programmes and make recommendations on improving uptake – particularly in relation to more vulnerable populations.
- Widen the provision of NHS Heath Checks to included appropriate community based providers and deliver health checks in innovative ways to ensure equity of access
- Improve the range of falls prevention activities available to older people
- Review sexual health services to ensure equity of access
- Carry out awareness raising campaigns in relation to diabetes, high blood pressure and COPD to increase the number of people being diagnosed correctly

Recommendations in relation to Working with Communities

- Key front line staff need to be based within most vulnerable communities
- More focus is required on place based approaches to address a range of issues in a more intensive or co-ordinated way

- Provide funding and/or support for community led initiatives to improve health
- Work with local people to improve cooking skills and access to healthy food through community based schemes
- Improve access to free and/or low cost physical activity opportunities for people on low incomes and/or people with disabilities or mental health problems
- Strengthen community based approaches to improving mental health and wellbeing – particularly in more vulnerable and low income populations

Local Authority Recommendations

- Work within communities to build resilience and capacity and empower local people
- Carry out Health Impact Assessments and/or Equality Impact Assessments to ensure that strategic decisions and commissioning decisions do not impact adversely on health inequalities
- Develop an approach across the Council in relation to reducing inequalities
- Carry out a health impact assessment in relation to the Local Plan
- Ensure that health at work initiatives reach staff most in need

Integrated Health Service and Social Care Recommendations

- Integrate and co-locate key health and social care services particularly for more vulnerable children & adults and the elderly
- Move to a single assessment process for health and social care services
- Continue to shift investment into more upstream preventative interventions to reduce the demand on hospitals and nursing homes

Primary Care Recommendations

- Improve access to health living and self care advice and support through pharmacies
- Raise awareness and promote early diagnosis in relation to symptoms and risk factors for key conditions including diabetes, lung cancer, Chronic Obstructive Pulmonary Disease and high blood pressure

- Ensure that once diagnosed patients have access to the right treatment when they need it, including drugs and treatments recommended by the National Institute for Health and Care Excellence (NICE)
- Integrate mental health support with primary care and chronic disease management programmes
- Support more appropriate use of A&E through primary care and community services access
- Implement effective self care programmes for people with long terms conditions so that they are empowered with the personal skills and confidence to manage their own condition
- Ensure that rehabilitation programmes are of sufficient scale and quality to help people with long term conditions to maximise their health, wellbeing and independence
- Improve the uptake of seasonal influenza and pneumococcal immunisation in older people and at risk groups
- Identify people at risk of falling and refer into falls prevention services

Secondary Care Recommendations

- Ensure that 'Making Every Contact Count' is embedded in hospital policy and practice so opportunities to engage with patients to help them stay in good health are maximised
- Hospitals should make every effort through its policies, campaigns and incentive schemes to promote the mental and physical health and wellbeing of its own workforce
- Commissioners of hospital services need to ensure that interventions to engage with patients around maintaining good health are embedded into contracts
- Reduce avoidable deaths through improvements in quality of care, medicines management and a reduction in hospital acquired infections

Housing, Environment and Transport Recommendations

- Continue to support housing and environmental improvements in most economically deprived areas
- Improve the standard of non decent houses to prevent falls and reduce hospital admissions
- Influence transport co-ordination and coverage to improve access to services

Poverty and Income Related Recommendations

- Ensure that clear information is available to all partners and the public around welfare reform, the impacts and the support that is available
- Support people on low income and people who are vulnerable with budget management with appropriate encouragement to reduce expenditure on cigarettes and alcohol and increase expenditure on 'healthy' food

Community Safety Recommendations

- Commission community based violence/domestic violence prevention and perpetrator programmes.

Main Themes Going Forward;

1. Work with local communities to keep people (children and adults) as healthy and active as possible to maintain or improve wellbeing, resilience and independence for as long as possible and to **prevent or delay the onset of disease**

2. Identify people who have **early signs and symptoms of disease as soon as possible** – working within communities – so that they can receive the most appropriate treatment but also so that they can be supported to remain healthy, active and independent for as long as possible through participation in local health and wellbeing activities and self care

3. Support people with established or more advanced conditions to keep as active and independent as possible through **rehabilitation and reablement programmes** to reduce the likelihood of hospital or care home admissions

These approaches need to be underpinned with the ongoing efforts to address the wider determinants of health discussed earlier in this report.

Appendix One

Public Health Functions and Responsibilities in Local Authorities

Local authorities will be required to deliver their new public health functions to: tackle the causes of ill-health and reduce health inequalities, promote and protect health, and promote social justice and safer communities. Some of these functions are regarded as mandatory to ensure that some service areas have greater uniformity of provision especially where they are legally required (such as health protection, and the provision of contraception).

The **mandatory services** include:

- Appropriate access to sexual health services
- Duty to ensure there are plans in place to protect the health of the population
- Ensure NHS commissioners receive public health advice they need
- Deliver the National Child Measurement Programme
- Offer the NHS Health Check assessment

The elements of the Healthy Child Programme (age 5-19) previously proposed as mandated is subject to further review and will not be mandated during 2013.

Other commissioning responsibilities include:

Prevention and Lifestyle services

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services

- Public health services for children and young people aged 5-19
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long term conditions
- Local initiatives on workplace health

Health Protection

- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Local authority role in dealing with health protection incidents, outbreaks and emergencies
- Local initiatives that reduce public health impacts of environmental risks

Wider determinants of health

- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion

These functions are deemed discretionary and the commissioning of the services will be guided by the Public Health Outcomes Framework, the local Joint Strategic Needs Assessment and the joint health and wellbeing strategy.

A specific mandatory function for local authorities is to provide public health advice to NHS commissioners. The general areas of input are on:

- Strategic planning, in relation to assessing needs, reviewing service provision and deciding priorities
- Procuring services, in relation to designing shape and structure of supply, planning capacity and managing demand.
- Monitoring and evaluation, in relation to supporting patient choice, managing performance and seeking public and patient views.

For emergency planning, a Lead DPH from a local authority in the LRF will be appointed to coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area. The Lead Director of Public Health will co-chair a Local Health Resilience Partnership with a lead director appointed by the NHS Commissioning Board. The Lead DPH will have access to a health emergency planning resource.

In relation to screening and immunisation programmes, the DPH will advise on whether screening or immunisation programmes in their area are meeting the needs of the population and whether there is equitable access.