Northumberland

Joint Strategic Needs Assessment
Baseline Position

2008/09

CONTENTS

FOREWORD

Northumberland Care Trust and Northumberland County Council have worked together to produce this baseline position document as the first resource for the Northumberland Joint Strategic Needs Assessment (JSNA). Joint Strategic Needs Assessment aims to provide a detailed picture of the health and wellbeing needs of the people of Northumberland.

This baseline position document looks at a wide range of health and care issues and highlights where we need to do more to improve people's health and wellbeing. It examines existing and future demographic trends, key issues such as health inequalities, and social and environmental context. It systematically reviews existing knowledge about health and wellbeing, as well as health needs, health and social care and clinical quality. It identifies gaps to be addressed and identifies key issues for commissioning.

We have put together this assessment based on available data. This is our first JSNA and so we have made a real effort to provide a good overview of health and wellbeing needs in Northumberland across health, adult care and children's services. As a result there is some degree of repetition between the sections; where this occurs we have endeavoured to provide cross reference on the first occasion that a topic appears. Also, because the document has been pulled together over a number of months some data will swiftly be superseded by new releases; we have therefore attempted to be as clear as possible about data sources so that readers should be able to access more up-to-date data if they wish.

The needs assessment has informed:

- The negotiation and agreement of the Northumberland Local Area Agreement 2008-2011[1];
- The implementation of the current Children & Young People Plan 2006-2009[2];
- The development of 5 year commissioning outcomes for Northumberland within the forthcoming NHS North of Tyne Strategic Plan[3];
- The developing service commissioning plans for the range of client groups within adult social care.

This document does not replace on-going public health surveillance to address new and emerging issues in improving population health and reviewing the effectiveness of existing and future treatments.

We will endeavour to develop and improve this source of evidence into the future. We hope you enjoy reading this document and find it useful.

Dr Sue Gordon Acting Director of Public Health	Daljit Lally Executive Director of Adult Care	Trevor Doughty Executive Director of Children's Services

1. INTRODUCTION

BACKGROUND

The statutory partners

Northumberland Care Trust is responsible for planning, delivering and purchasing the right health and social care for local residents. The Care Trust pays for services provided by hospital trusts and the ambulance trust and has contracts with GPs, pharmacists, dentists and opticians to make sure adequate services are in place for local people. The Care Trust also commissions adult social care services, in partnership with the County Council, and works in close partnership with the Council to commission children's services.

Care Trusts bring together responsibility for health services and adult social care services, in particular:

- Working actively to help local communities improve their health, for example by offering: stop smoking services, screening services for things like breast cancer, advice about healthy eating and lifestyles, checks for things like blood pressure and sexual health services.
- Providing a range of community health services, through an integrated adult provider directorate which also provides a care management service on behalf of the Council, supporting older people and adults with physical or learning disabilities, and manages some residential, day care and home care services on behalf of the Council.
- Acting as partners in the Families and Children's Trust (FACT), which provides integrated services to support children and their families.

Northumberland County Council Children's Services Directorate is responsible for planning and commissioning effective services for children and young people; it does this by overseeing the Families and Children's Trust (FACT) arrangements for the county. Children's Trusts bring together local organisations to improve children's and young people's lives by delivering better services, in particular:

- Identifying children and young people at risk of failure or harm, and intervening early to make sure children are safe and can thrive.
- Narrowing the gap – especially in educational attainment – between vulnerable children and young people and others, while also improving the lives of all children.
- Reducing child poverty.

The legal duty

The requirement for Joint Strategic Needs Assessment (JSNA) was created in the Local Government and Public Involvement in Health Act, 2007[4]. This places a duty upon upper tier local authorities and PCTs to undertake JSNA.

Guidance on Joint Strategic Needs Assessment[5] states that the process will lead to:

- Stronger partnerships between communities, local government and the NHS; and
- A firm foundation for commissioning that improves health and social care provision and reduces inequalities.

JSNA aims to:

- Identify areas for priority action through Local Area Agreements (LAAs) and Community Strategies;
- Help commissioners to specify outcomes that encourage local innovation; and
- Help providers shape services to address needs.

The key focus of JSNA includes:

- Understanding the current and future health and wellbeing needs of the population over both the short term (three to five years) to inform Local Area Agreements, and the longer term future (five to ten years) to inform strategic planning;
- Commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

In particular, JSNA will address those outcomes described in both the National Indicator Set for local authorities and local authority partnerships[6], and the "vital signs" referred to in the Operating Framework for 2008/09[7].

JSNA is seen as a continuous process underpinned by strong elements of:

- Partnership working;
- community engagement;
- Evidence of effectiveness.

Over time, evidence will be sought to demonstrate where commissioning decisions have been informed by JSNA.

Links to World Class Commissioning

The aim of world class commissioning[8], and therefore the ultimate test of its success, will be an improvement in health outcomes and a reduction in health inequalities. It will have a direct impact on population health and will significantly reduce inequalities between the areas with the worst health and the population as a whole.

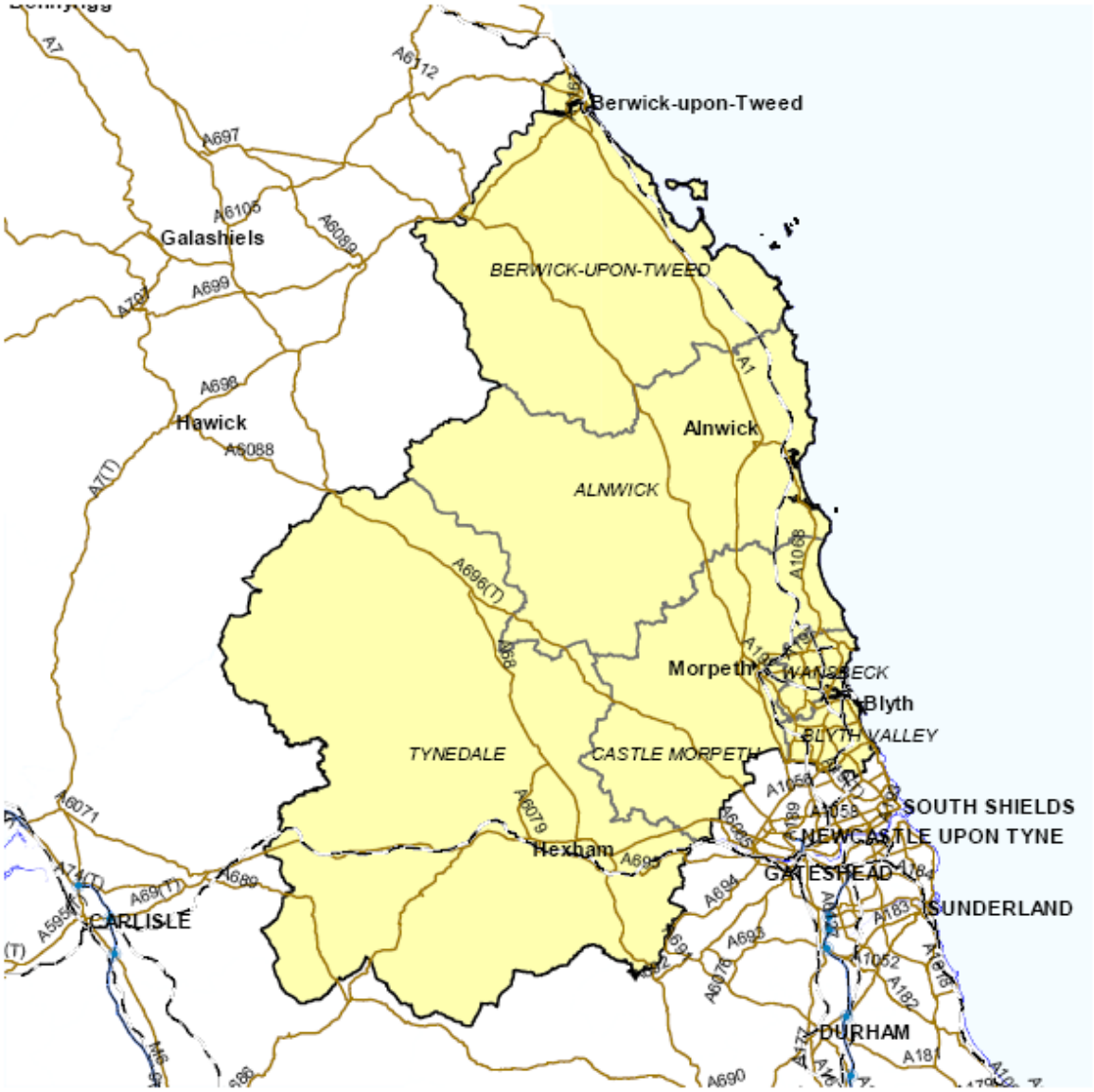
The assurance process for world class commissioning[9] provides a clear link between JSNA and strategic planning. Consistency between the JSNA, the strategic plan vision, the population context and the stated health improvement initiatives will be assessed through the assurance process and will inform the rating of the PCO. Aggregated assessments of need performed by the PCO and local authorities, in the form of JSNA, are required to be submitted as evidence for the self assessment against a number of commissioning competencies as follows:

- **Competency 2** - Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities;
- **Competency 5** – Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements;
- **Competency 6** – Prioritise investment according to local needs, service requirements and the values of the NHS;
- **Competency 7** - Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes.

2. DEMOGRAPHY

GEOGRAPHY

Figure 1: Map of Northumberland



SOURCE: APHO and Department of Health. From 'Health Profile for Northumberland 2008 © Crown Copyright 2008. Map is based on Ordnance Survey material © Crown Copyright. All rights reserved. DH 100020290 2008.

Northumberland is England's most northerly county. The county is made up of three distinct types of area based on their demographic, geographic, cultural, and heritage differences, and the varying influence of their neighbouring communities. Within each area the constituent communities share similar socio-economic characteristics that are discrete from each other as follows:

The **north of the county** is distinctly open and sparse. Rich archaeological features reflect its troubled borderland past. The principal towns of Alnwick, Berwick and Morpeth serve large catchments that are also partially influenced by both Edinburgh to the north and Tyneside to the south. Many of the communities living in this area are characterised by physical remoteness and rural disadvantage.

The **west of the county** is distinctly rural, albeit split by major road and rail transport corridors running into Newcastle and Gateshead. The towns of Ponteland and Hexham are desirable places to live and visit, placing considerable demands on their services and infrastructure. Many of the communities living in this area are characterised by an economic and cultural interdependence with the Tyneside conurbation.

The **southeast corner of the county** is a compact coastal lowland intersected by several river estuaries; its natural landscape has been substantially changed by extensive mining activity. It is distinctly built up with the county's largest settlements of Ashington, Blyth and Cramlington sited in protected corridors on the northern fringe of Tyneside. Many of the communities living in this area are characterised by high levels of multiple deprivation following the decline of coal mining industries.

The county's demographic profile - with very distinct settlements - means that one size does not fit all. It is therefore vital that services are customised to local needs.

Currently, local government in the county is organised in two tiers; one county council and six district or borough councils provide the council services to the people of Northumberland. In response to the Government's White Paper *Strong and Prosperous Communities*[1], the proposal for one new single authority covering the whole of Northumberland was accepted. Elections for the new council were undertaken in May 2008 and the new authority will be formally established on 1st April 2009.

POPULATION STRUCTURE

The most recent official estimates of population produced by the Office for National Statistics are those for mid-2006. These show the population of Northumberland to be around 310,000.

Table 1: Mid Year Population Estimate, local authorities in Northumberland compared to England, 2006

	Alnwick	Berwick	Blyth Valley	Castle Morpeth	Tynedale	Wansbeck	Northumberland	ENGLAND
Males								
0-4	818	499	2,278	1,155	1,470	1,733	7,953	1,513,100
5-14	1,783	1,354	4,979	2,900	3,467	3,545	18,028	3,099,578
15-24	1,714	1,413	5,085	3,149	3,340	4,005	18,706	3,432,304
25-44	3,609	2,593	10,443	5,767	6,779	7,904	37,095	7,227,836
45-64	4,781	3,935	11,201	7,439	9,113	8,270	44,739	6,159,175
65-74	1,728	1,541	3,300	2,551	2,774	2,742	14,636	1,980,818
75-84	993	897	1,757	1,542	1,605	1,582	8,376	1,189,891
85&+	244	256	402	387	436	394	2,119	323,680
Total	15,670	12,488	39,445	24,890	28,984	30,175	151,652	24,926,382
Females								
0-4	644	487	2,207	1,068	1,493	1,589	7,488	1,442,362
5-14	1,730	1,281	4,805	2,676	3,349	3,404	17,245	2,951,678
15-24	1,510	1,260	4,983	2,474	2,910	3,566	16,703	3,263,706
25-44	3,865	2,848	10,998	5,524	7,036	8,409	38,680	7,273,041
45-64	4,986	4,079	11,613	7,347	9,288	8,389	45,702	6,314,462
65-74	1,830	1,675	3,668	2,788	3,191	2,994	16,146	2,190,433
75-84	1,289	1,275	2,503	2,015	2,242	2,268	11,592	1,669,685
85&+	520	574	982	713	1,010	859	4,658	731,196
Total	16,374	13,479	41,759	24,605	30,519	31,478	158,214	25,836,563
Persons								
0-4	1,462	986	4,485	2,223	2,963	3,322	15,441	2,955,462
5-14	3,513	2,635	9,784	5,576	6,816	6,949	35,273	6,051,256
15-24	3,224	2,673	10,068	5,623	6,250	7,571	35,409	6,696,010
25-44	7,474	5,441	21,441	11,291	13,815	16,313	75,775	14,500,877
45-64	9,767	8,014	22,814	14,786	18,401	16,659	90,441	12,473,637
65-74	3,558	3,216	6,968	5,339	5,965	5,736	30,782	4,171,251
75-84	2,282	2,172	4,260	3,557	3,847	3,850	19,968	2,859,576
85&+	764	830	1,384	1,100	1,446	1,253	6,777	1,054,876
Total	32,044	25,967	81,204	49,495	59,503	61,653	309,866	50,762,945

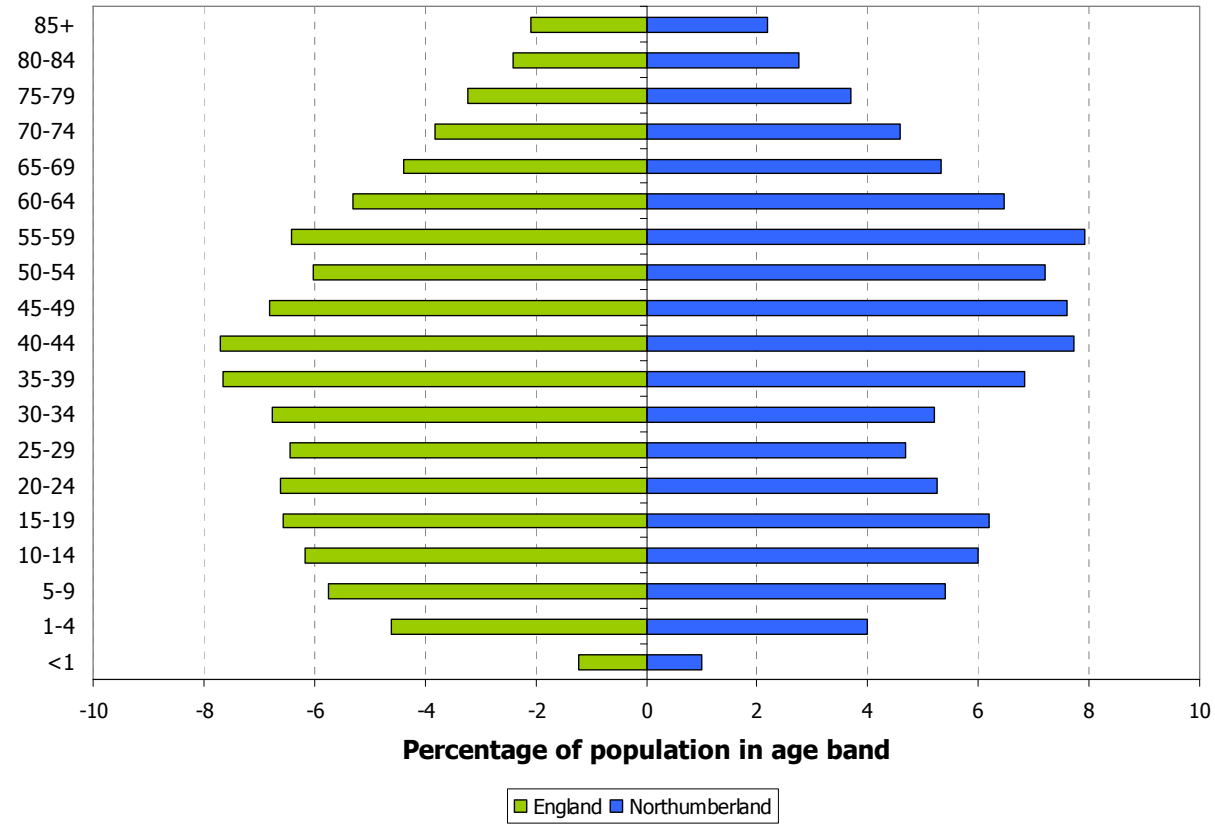
SOURCE: 2006 Mid-Year Population Estimates, ONS, 2007 © Crown copyright

Table 2: Percentage of Mid Year Population Estimate by age band, local authorities in Northumberland compared to England, 2006

	Alnwick	Berwick	Blyth Valley	Castle Morpeth	Tynedale	Wansbeck	Northumberland	ENGLAND
Males								
0-4	5.2	4.0	5.8	4.6	5.1	5.7	5.2	6.1
5-14	11.4	10.8	12.6	11.7	12.0	11.7	11.9	12.4
15-24	10.9	11.3	12.9	12.7	11.5	13.3	12.3	13.8
25-44	23.0	20.8	26.5	23.2	23.4	26.2	24.5	29.0
45-64	30.5	31.5	28.4	29.9	31.4	27.4	29.5	24.7
65-74	11.0	12.3	8.4	10.2	9.6	9.1	9.7	7.9
75-84	6.3	7.2	4.5	6.2	5.5	5.2	5.5	4.8
85&+	1.6	2.0	1.0	1.6	1.5	1.3	1.4	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Females								
0-4	3.9	3.6	5.3	4.3	4.9	5.0	4.7	5.6
5-14	10.6	9.5	11.5	10.9	11.0	10.8	10.9	11.4
15-24	9.2	9.3	11.9	10.1	9.5	11.3	10.6	12.6
25-44	23.6	21.1	26.3	22.5	23.1	26.7	24.4	28.2
45-64	30.5	30.3	27.8	29.9	30.4	26.7	28.9	24.4
65-74	11.2	12.4	8.8	11.3	10.5	9.5	10.2	8.5
75-84	7.9	9.5	6.0	8.2	7.3	7.2	7.3	6.5
85&+	3.2	4.3	2.4	2.9	3.3	2.7	2.9	2.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Persons								
0-4	4.6	3.8	5.5	4.5	5.0	5.4	5.0	5.8
5-14	11.0	10.1	12.0	11.3	11.5	11.3	11.4	11.9
15-24	10.1	10.3	12.4	11.4	10.5	12.3	11.4	13.2
25-44	23.3	21.0	26.4	22.8	23.2	26.5	24.5	28.6
45-64	30.5	30.9	28.1	29.9	30.9	27.0	29.2	24.6
65-74	11.1	12.4	8.6	10.8	10.0	9.3	9.9	8.2
75-84	7.1	8.4	5.2	7.2	6.5	6.2	6.4	5.6
85&+	2.4	3.2	1.7	2.2	2.4	2.0	2.2	2.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

SOURCE: 2006 Mid-Year Population Estimates, ONS, 2007 © Crown copyright

Figure 2: Percentage of Mid Year Population Estimate by age band, Northumberland compared to England, 2006



SOURCE: 2006 Mid-Year Population Estimates, ONS, 2007 © Crown copyright

Tables 1 & 2 and Figure 2 show that:

- The percentage of the population in younger age bands (from <1 to 35-39) is lower for Northumberland than for England; and
- The percentage of the population in older age bands (from 40-44 to 85+) is higher for Northumberland than for England.

Ethnicity

Culture and ethnicity may influence health beliefs and behaviours, and may therefore impact on health and wellbeing. The most set of population estimates produced by ethnic group are those for mid 2005. These suggest that around 1.8% of Northumberland residents are from BME groups.

Table 3: Estimated resident population by ethnic group, mid-2006, (experimental statistics)

	White	Mixed	Asian or Asian British	Black or Black British	Chinese or other	Total†
Males						
Northumberland	148,400	800	1,300	400	700	151,700
Alnwick	15,500	0	0	0	0	15,700
Berwick	12,200	0	0	0	0	12,500
Blyth Valley	38,700	200	300	100	200	39,400
Castle Morpeth	24,000	100	300	100	200	24,900
Tynedale	28,400	100	200	0	200	29,000
Wansbeck	29,600	0	300	0	200	30,000
NORTH EAST	1,190,500	10,100	28,100	8,000	10,800	1,247,400
ENGLAND	22,000,100	415,400	1,427,200	688,500	357,600	24,926,400
Females						
Northumberland	155,000	800	1,200	400	700	158,200
Alnwick	16,100	0	0	0	0	16,400
Berwick	13,400	0	0	0	0	13,500
Blyth Valley	41,000	200	300	0	200	41,800
Castle Morpeth	23,800	100	300	100	200	24,600
Tynedale	29,900	100	200	100	200	30,500
Wansbeck	30,900	100	200	0	200	31,500
NORTH EAST	1,259,200	9,400	24,400	6,100	9,300	1,308,300
ENGLAND	22,980,400	414,100	1,359,400	714,600	368,200	25,836,600
Persons						
Northumberland	303,400	1,600	2,700	900	1,300	309,900
Alnwick	31,500	100	200	100	200	32,000
Berwick	25,500	0	100	0	100	26,000
Blyth Valley	79,600	400	700	200	200	81,200
Castle Morpeth	47,800	300	800	300	500	49,500
Tynedale	58,300	300	400	200	200	59,500
Wansbeck	60,500	300	500	100	200	61,700
NORTH EAST	2,449,700	19,500	52,600	14,000	20,000	2,555,700
ENGLAND	44,967,800	829,500	2,786,600	1,403,000	725,700	50,762,900

SOURCE: 2006 Mid-Year Estimate of Resident Population by Ethnic Group, ONS (Experimental Statistics), 2008 © Crown copyright

NOTES:
† - estimated population presented rounded to the nearest hundred; figures may not sum due to rounding.

PROJECTED POPULATION CHANGE

Table 4: Population projections (and % population change) for Northumberland and its six districts for 2011, 2016 and 2021 compared to 2006

	2006		2011			2016			2021		
	Number	% of Total	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†
Northumberland											
0-4	15,441	5.0	16,400	5.2	6.2	16,400	5.1	6.2	16,300	5.0	5.6
5-14	35,273	11.4	33,600	10.7	-4.7	34,600	10.8	-1.9	36,100	11.0	2.3
15-24	35,409	11.4	34,400	10.9	-2.8	31,800	9.9	-10.2	30,400	9.3	-14.1
25-44	75,775	24.5	71,100	22.6	-6.2	69,400	21.7	-8.4	71,300	21.8	-5.9
45-64	90,441	29.2	94,700	30.1	4.7	93,100	29.1	2.9	90,100	27.5	-0.4
65-74	30,782	9.9	34,600	11.0	12.4	41,500	13.0	34.8	43,600	13.3	41.6
75-84	19,968	6.4	21,200	6.7	6.2	23,700	7.4	18.7	27,600	8.4	38.2
85&+	6,777	2.2	8,300	2.6	22.5	9,700	3.0	43.1	11,900	3.6	75.6
Total	309,866	100.0	314,400	100.0	1.5	320,400	100.0	3.4	327,100	100.0	5.6

SOURCE: Mid-2006 Population Estimates and 2006 based Sub National Population Projections, ONS, 2008 © Crown copyright

NOTES:
‡ - population projections are presented rounded to the nearest hundred; figures may not sum due to rounding.
† - the percentage change is for the age strata from the 2008 projection (i.e., 3.4% means that the number is 1.034 x the number for the same strata in 2006; -14.1% means that the number is 0.859 x the number for the same strata in 2006).

Table 4 (continued): Population projections (and % population change) for Northumberland and its six districts for 2011, 2016 and 2021 compared to 2006

	2006		2011			2016			2021		
	Number	% of Total	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†
Alnwick											
0-4	1,462	4.6	1,500	4.5	2.6	1,500	4.4	2.6	1,500	4.3	2.6
5-14	3,513	11.0	3,300	10.0	-6.1	3,400	10.0	-3.2	3,500	10.0	-0.4
15-24	3,224	10.1	3,200	9.7	-0.7	3,000	8.8	-6.9	2,900	8.3	-10.0
25-44	7,474	23.3	6,900	20.9	-7.7	6,600	19.4	-11.7	6,900	19.7	-7.7
45-64	9,767	30.5	10,500	31.8	7.5	10,600	31.2	8.5	10,400	29.6	6.5
65-74	3,558	11.1	4,100	12.4	15.2	5,000	14.7	40.5	5,300	15.1	49.0
75-84	2,282	7.1	2,600	7.9	13.9	2,900	8.5	27.1	3,400	9.7	49.0
85&+	764	2.4	900	2.7	17.8	1,100	3.2	44.0	1,300	3.7	70.2
Total	32,044	100.0	33,000	100.0	3.0	34,000	100.0	6.1	35,100	100.0	9.5
Berwick											
0-4	986	3.8	1,100	4.2	11.6	1,000	3.7	1.4	1,000	3.6	1.4
5-14	2,635	10.1	2,400	9.1	-8.9	2,300	8.5	-12.7	2,300	8.3	-12.7
15-24	2,673	10.3	2,500	9.4	-6.5	2,300	8.5	-14.0	2,100	7.6	-21.4
25-44	5,441	21.0	5,000	18.9	-8.1	4,700	17.3	-13.6	4,800	17.3	-11.8
45-64	8,014	30.9	8,400	31.7	4.8	8,300	30.6	3.6	8,100	29.2	1.1
65-74	3,216	12.4	3,700	14.0	15.0	4,500	16.6	39.9	4,700	17.0	46.1
75-84	2,172	8.4	2,400	9.1	10.5	2,600	9.6	19.7	3,100	11.2	42.7
85&+	830	3.2	1,100	4.2	32.5	1,300	4.8	56.6	1,600	5.8	92.8
Total	25,967	100.0	26,500	100.0	2.1	27,100	100.0	4.4	27,700	100.0	6.7

SOURCE: Mid-2006 Population Estimates and 2006 based Sub National Population Projections, ONS, 2008 © Crown copyright

NOTES:
‡ - population projections are presented rounded to the nearest hundred; figures may not sum due to rounding.
† - the percentage change is for the age strata from the 2008 projection (i.e., 3.4% means that the number is 1.034 x the number for the same strata in 2006; -14.1% means that the number is 0.859 x the number for the same strata in 2006).

Table 4 (continued): Population projections (and % population change) for Northumberland and its six districts for 2011, 2016 and 2021 compared to 2006

	2006		2011			2016			2021		
	Number	% of Total	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†
Blyth Valley											
0-4	4,485	5.5	4,800	5.9	7.0	4,800	5.8	7.0	4,700	5.6	4.8
5-14	9,784	12.0	9,200	11.3	-6.0	9,400	11.4	-3.9	9,800	11.7	0.2
15-24	10,068	12.4	9,700	11.9	-3.7	8,900	10.8	-11.6	8,400	10.1	-16.6
25-44	21,441	26.4	20,400	25.0	-4.9	20,000	24.2	-6.7	20,400	24.4	-4.9
45-64	22,814	28.1	23,400	28.7	2.6	22,300	27.0	-2.3	21,200	25.4	-7.1
65-74	6,968	8.6	8,000	9.8	14.8	9,800	11.9	40.6	10,500	12.6	50.7
75-84	4,260	5.2	4,500	5.5	5.6	5,200	6.3	22.1	6,100	7.3	43.2
85&+	1,384	1.7	1,700	2.1	22.8	2,000	2.4	44.5	2,400	2.9	73.4
Total	81,204	100.0	81,600	100.0	0.5	82,500	100.0	1.6	83,500	100.0	2.8
Castle Morpeth											
0-4	2,223	4.5	2,400	4.8	8.0	2,500	4.9	12.5	2,500	4.8	12.5
5-14	5,576	11.3	5,400	10.8	-3.2	5,700	11.2	2.2	6,000	11.5	7.6
15-24	5,623	11.4	5,400	10.8	-4.0	5,100	10.0	-9.3	5,000	9.6	-11.1
25-44	11,291	22.8	10,700	21.3	-5.2	10,500	20.6	-7.0	10,900	20.9	-3.5
45-64	14,786	29.9	15,500	30.9	4.8	14,900	29.2	0.8	14,500	27.8	-1.9
65-74	5,339	10.8	5,700	11.4	6.8	6,500	12.7	21.7	6,800	13.1	27.4
75-84	3,557	7.2	3,800	7.6	6.8	4,100	8.0	15.3	4,500	8.6	26.5
85&+	1,100	2.2	1,400	2.8	27.3	1,600	3.1	45.5	2,000	3.8	81.8
Total	49,495	100.0	50,200	100.0	1.4	51,000	100.0	3.0	52,100	100.0	5.3

SOURCE: Mid-2006 Population Estimates and 2006 based Sub National Population Projections, ONS, 2008 © Crown copyright

NOTES:
‡ - population projections are presented rounded to the nearest hundred; figures may not sum due to rounding.
† - the percentage change is for the age strata from the 2008 projection (i.e., 3.4% means that the number is 1.034 x the number for the same strata in 2006; -14.1% means that the number is 0.859 x the number for the same strata in 2006).

Table 4 (continued): Population projections (and % population change) for Northumberland and its six districts for 2011, 2016 and 2021 compared to 2006

	2006		2011			2016			2021		
	Number	% of Total	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†	Number‡	% of Total	% Change†
Tynedale											
0-4	2,963	5.0	3,100	5.1	4.6	3,100	5.0	4.6	3,100	4.9	4.6
5-14	6,816	11.5	6,600	10.9	-3.2	6,900	11.1	1.2	7,100	11.1	4.2
15-24	6,250	10.5	6,100	10.1	-2.4	5,500	8.9	-12.0	5,400	8.5	-13.6
25-44	13,815	23.2	12,800	21.1	-7.3	12,500	20.1	-9.5	13,100	20.5	-5.2
45-64	18,401	30.9	19,500	32.2	6.0	19,200	30.9	4.3	18,700	29.3	1.6
65-74	5,965	10.0	6,900	11.4	15.7	8,300	13.4	39.1	8,800	13.8	47.5
75-84	3,847	6.5	4,100	6.8	6.6	4,700	7.6	22.2	5,600	8.8	45.6
85&+	1,446	2.4	1,700	2.8	17.6	1,900	3.1	31.4	2,300	3.6	59.1
Total	59,503	100.0	60,600	100.0	1.8	62,100	100.0	4.4	63,900	100.0	7.4
Wansbeck											
0-4	3,322	5.4	3,600	5.8	8.4	3,600	5.7	8.4	3,500	5.4	5.4
5-14	6,949	11.3	6,700	10.7	-3.6	7,000	11.0	0.7	7,300	11.2	5.1
15-24	7,571	12.3	7,500	12.0	-0.9	6,900	10.8	-8.9	6,700	10.3	-11.5
25-44	16,313	26.5	15,600	24.9	-4.4	15,200	23.9	-6.8	15,400	23.7	-5.6
45-64	16,659	27.0	17,600	28.1	5.6	17,800	27.9	6.8	17,300	26.7	3.8
65-74	5,736	9.3	6,300	10.1	9.8	7,300	11.5	27.3	7,600	11.7	32.5
75-84	3,850	6.2	3,800	6.1	-1.3	4,200	6.6	9.1	4,800	7.4	24.7
85&+	1,253	2.0	1,500	2.4	19.7	1,800	2.8	43.7	2,200	3.4	75.6
Total	61,653	100.0	62,600	100.0	1.5	63,700	100.0	3.3	64,900	100.0	5.3

SOURCE: Mid-2006 Population Estimates and 2006 based Sub National Population Projections, ONS, 2008 © Crown copyright

NOTES:
‡ - population projections are presented rounded to the nearest hundred; figures may not sum due to rounding.
† - the percentage change is for the age strata from the 2008 projection (i.e., 3.4% means that the number is 1.034 x the number for the same strata in 2006; -14.1% means that the number is 0.859 x the number for the same strata in 2006).

Figure 3: Projected structured of Northumberland Population, 2011

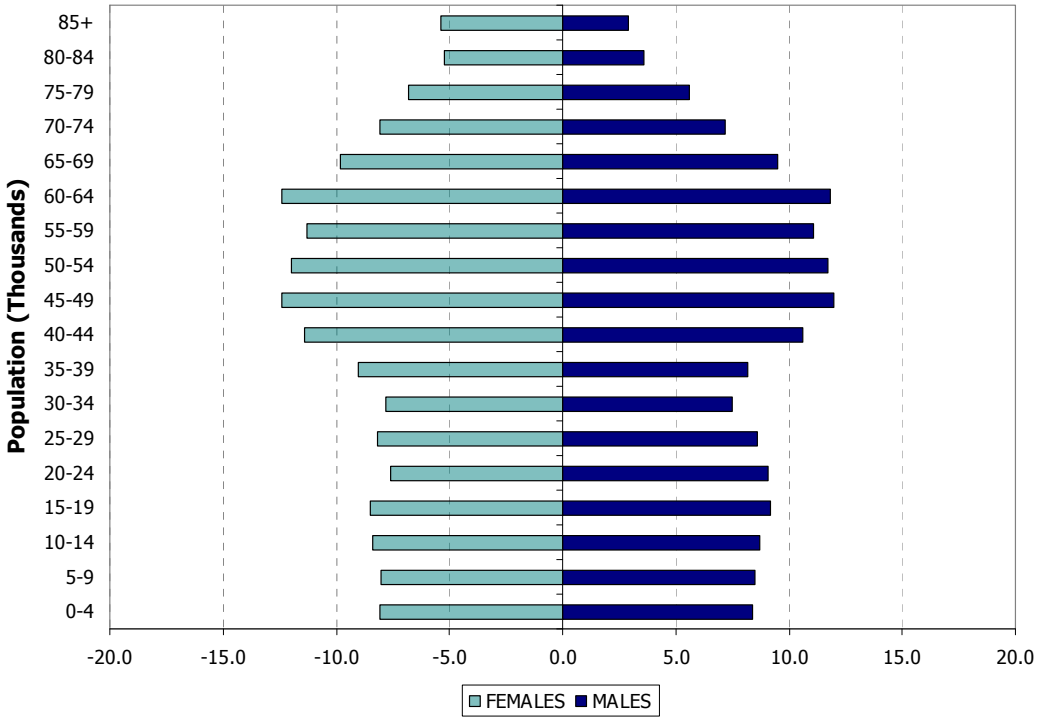


Figure 4: Projected structured of Northumberland Population, 2016

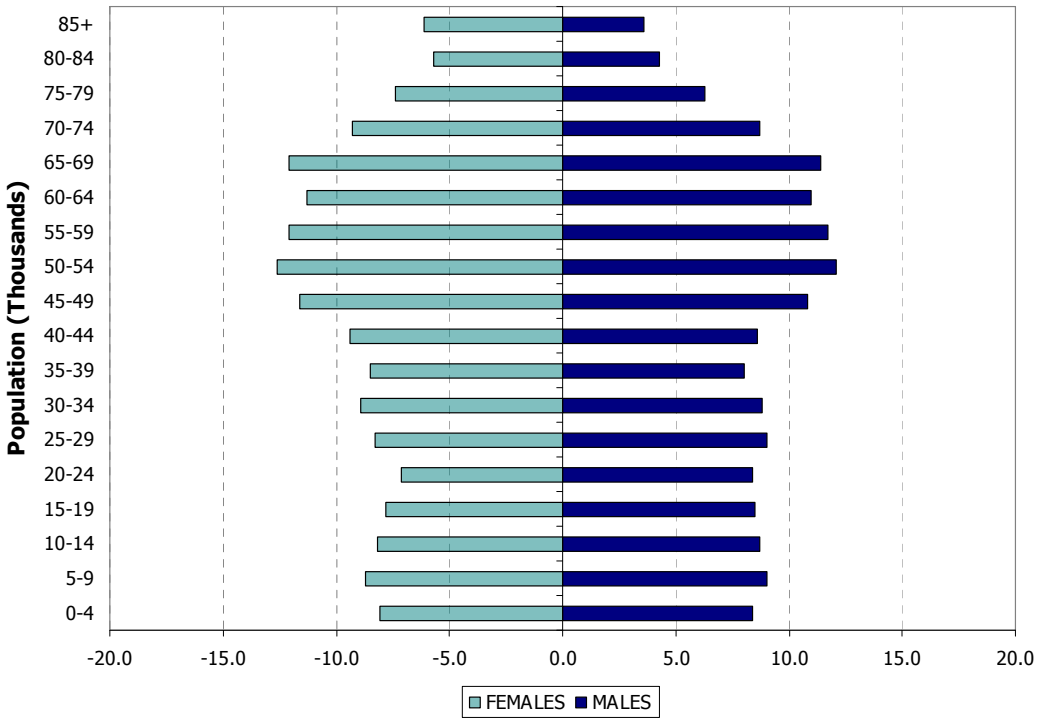


Figure 5: Projected population for Northumberland, by sex and age group 2006-2021

SOURCE: Mid-2006 Population Estimates and 2006 based Sub National Population Projections, ONS, 2008 © Crown copyright

The most recent set of population projections are those based on the 2006 Mid-Year Population Estimates. These suggest that the total population of Northumberland will increase over the next 10 years by 3.4% from 309,866 in 2006 to around 320,400 in 2016.

The most notable feature is the predicted increase in the population aged 65 years and over. The number of persons aged 65 and over will increase from 57,527 in 2006 to around 74,900 in 2016. As a percentage of the total population, older people (i.e., those aged 65 and over) constituted 18.6% of the population in 2006; by 2016 it is predicted that they will represent 23.4% and by 2021 25.4%.

In contrast, the number of children and young people resident in Northumberland is expected to be fairly static over the same period. The number of persons aged under 15 will increase from 50,714 in 2006 to around 51,000 in 2016. As a percentage of the total population, children and young people (i.e., those aged under 15) constituted 16.4% of the population in 2006; by 2016 it is predicted that they will represent 15.9% and by 2021 16.0%.

The population aged 15-64 is predicted to fall over the same period. The number of persons aged 15-64 will decrease from 201,625 in 2006 to around 194,300 in 2016. As a percentage of

the total population, they constituted 65.1% of the population in 2006; by 2016 it is predicted that they will represent 60.6% and by 2021 58.6%.

There is more information about the predicted demographic changes and their impact on the need for care services on pages 116-119.

Table 5: Selected Elements of Population Change between 2006 and 2016, local authorities in Northumberland compared to England

	Alnwick	Berwick	Blyth Valley	Castle Morpeth	Tynedale	Wansbeck	Northumberland	ENGLAND
Total Population								
2006	32,044	25,967	81,204	49,495	59,503	61,653	309,866	50,762,945
2016†	34,000	27,100	82,500	51,000	62,100	63,700	320,400	54,724,200
% change‡	6.1	4.4	1.6	3.0	4.4	3.3	3.4	7.8
Population aged under 15								
2006	4,975	3,621	14,269	7,799	9,779	10,271	50,714	9,006,718
2016†	4,900	3,300	14,200	8,200	10,000	10,600	51,000	9,701,900
% change‡	-1.5	-8.9	-0.5	5.1	2.3	3.2	0.6	7.7
Population aged 15-64								
2006	20,465	16,128	54,323	31,700	38,466	40,543	201,625	33,670,524
2016†	20,200	15,300	51,200	30,500	37,200	39,900	194,300	35,135,500
% change‡	-1.3	-5.1	-5.7	-3.8	-3.3	-1.6	-3.6	4.4
Population aged 65 and over								
2006	6,604	6,218	12,612	9,996	11,258	10,839	57,527	8,085,703
2016†	9,000	8,400	17,000	12,200	14,900	13,300	74,900	9,887,000
% change‡	36.3	35.1	34.8	22.0	32.4	22.7	30.2	22.3

SOURCE: 2006 Mid-year Population Estimates, ONS, 2007; 2006-based Sub National Population Projections, ONS, 2008 © Crown copyright

NOTES:

† - projected figure for 2016 are presented rounded to the nearest hundred; figures may not sum due to rounding.
‡ - percentage change figures need to be interpreted with caution since figures for 2016 are rounded.

Table 6: Actual live births and deaths for 2006 compared to projected live births and deaths for 2016, local authorities in Northumberland compared to England

	Alnwick	Berwick	Blyth Valley	Castle Morpeth	Tynedale	Wansbeck	Northumberland	ENGLAND
Live Births								
2006	301	192	933	393	509	669	2,997	635,748
2016†	300	200	900	400	500	700	3,100	685,000
% change‡	-0.3	4.2	-3.5	1.8	-1.8	4.6	3.4	7.7
Deaths								
2006	354	286	813	518	620	692	3,283	470,326
2016†	400	400	800	500	700	700	3,400	451,400
% change‡	13.0	39.9	-1.6	-3.5	12.9	1.2	3.6	-4.0

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development; 2006-based Sub National Population Projections, ONS, 2008 © Crown copyright

NOTES:

† - projected figure for 2016 are presented rounded to the nearest hundred; figures may not sum due to rounding.
‡ - percentage change figures need to be interpreted with caution since figures for 2016 are rounded.

Within Northumberland, crude birth rates and fertility rates fell between 1997 and 2002, but have risen again between 2002 and 2006. This has been against a backdrop of increasing total population, but a falling child bearing population (females aged 15-44). As a result, rising from a baseline of 2,997 in 2006 to around 3,100 by 2016 (a rise of around 3%).

Table 7: Historic fertility: Selected fertility measures for local authorities in Northumberland, 1997-2006

	Number of live births	Population		Crude Birth Rate†			General Fertility Rate‡			Total Period Fertility Rate¥		
		Persons all ages	Females aged 15-44	Rate	95% LL	95% UL	Rate	95% LL	95% UL	Rate	95% LL	95% UL
Northumberland												
1997	3,158	306,756	59,517	10.29	9.94	10.66	53.06	51.23	54.94	1.61	1.55	1.66
1998	3,199	307,241	59,434	10.41	10.05	10.78	53.82	51.98	55.72	1.68	1.57	1.80
1999	3,077	307,490	58,565	10.01	9.66	10.37	52.54	50.70	54.43	1.67	1.57	1.79
2000	2,798	307,348	58,183	9.10	8.77	9.45	48.09	46.32	49.91	1.55	1.45	1.67
2001	2,881	307,363	57,635	9.37	9.03	9.72	49.99	48.18	51.85	1.62	1.51	1.74
2002	2,762	307,811	57,362	8.97	8.64	9.31	48.15	46.37	49.98	1.58	1.47	1.70
2003	2,934	308,487	56,959	9.51	9.17	9.86	51.51	49.66	53.41	1.70	1.59	1.82
2004	2,952	309,222	56,426	9.55	9.21	9.90	52.32	50.45	54.24	1.73	1.62	1.86
2005	3,024	309,841	56,063	9.76	9.42	10.11	53.94	52.03	55.90	1.79	1.68	1.92
2006	2,997	309,866	55,383	9.67	9.33	10.02	54.11	52.19	56.09	1.81	1.69	1.94

SOURCE: Mid Year Population Estimates, ONS; Live Births, Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development © Crown copyright

NOTES:

† - crude birth rate is the number of live births per 1,000 population.
‡ - general fertility rate is the number of live births per 1,000 females aged 15-44 years.
¥ - total period fertility rate is the average number of children that would be born to a woman experiencing the fertility rates of the calendar year in question, throughout her childbearing years.

Table 7 (continued): Historic fertility: Selected fertility measures for local authorities in Northumberland, 1997-2006

	Number of live births	Population		Crude Birth Rate			General Fertility Rate			Total Period Fertility Rate		
		Persons all ages	Females aged 15-44	Rate	95% LL	95% UL	Rate	95% LL	95% UL	Rate	95% LL	95% UL
Alnwick												
1997	321	30,887	5,702	10.39	9.29	11.59	56.30	50.31	62.80	1.74	1.42	2.16
1998	336	30,768	5,610	10.92	9.78	12.15	59.89	53.66	66.65	1.90	1.56	2.34
1999	309	31,314	5,654	9.87	8.80	11.03	54.65	48.73	61.10	1.74	1.41	2.17
2000	265	30,955	5,644	8.56	7.56	9.66	46.95	41.47	52.96	1.54	1.22	1.95
2001	290	31,069	5,550	9.33	8.29	10.47	52.25	46.41	58.63	1.73	1.40	2.16
2002	270	31,134	5,434	8.67	7.67	9.77	49.69	43.94	55.98	1.71	1.36	2.15
2003	275	31,422	5,449	8.75	7.75	9.85	50.47	44.68	56.80	1.67	1.34	2.10
2004	281	31,649	5,453	8.88	7.87	9.98	51.53	45.68	57.92	1.74	1.39	2.18
2005	296	31,955	5,474	9.26	8.24	10.38	54.07	48.09	60.60	1.85	1.49	2.31
2006	301	32,044	5,375	9.39	8.36	10.52	56.00	49.85	62.70	1.97	1.60	2.44
Berwick upon Tweed												
1997	194	26,412	4,783	7.35	6.35	8.45	40.56	35.05	46.69	1.26	0.98	1.66
1998	196	26,236	4,723	7.47	6.46	8.59	41.50	35.89	47.73	1.35	1.04	1.77
1999	217	26,167	4,616	8.29	7.23	9.47	47.01	40.96	53.70	1.50	1.17	1.95
2000	165	25,971	4,535	6.35	5.42	7.40	36.38	31.04	42.38	1.22	0.92	1.65
2001	180	25,959	4,447	6.93	5.96	8.02	40.48	34.78	46.84	1.37	1.03	1.82
2002	175	25,959	4,382	6.74	5.78	7.82	39.94	34.24	46.31	1.37	1.04	1.82
2003	200	25,902	4,318	7.72	6.69	8.87	46.32	40.12	53.20	1.60	1.24	2.08
2004	176	26,129	4,280	6.74	5.78	7.81	41.12	35.27	47.67	1.40	1.06	1.86
2005	194	25,975	4,201	7.47	6.45	8.60	46.18	39.91	53.16	1.60	1.24	2.09
2006	192	25,967	4,108	7.39	6.39	8.52	46.74	40.36	53.84	1.63	1.27	2.13

SOURCE: Mid Year Population Estimates, ONS; Live Births, Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development © Crown copyright

Table 7 (continued): Historic fertility: Selected fertility measures for local authorities in Northumberland, 1997-2006

	Number of live births	Population		Crude Birth Rate			General Fertility Rate			Total Period Fertility Rate		
		Persons all ages	Females aged 15-44	Rate	95% LL	95% UL	Rate	95% LL	95% UL	Rate	95% LL	95% UL
Blyth Valley												
1997	928	80,402	16,918	11.54	10.81	12.31	54.85	51.38	58.50	1.67	1.48	1.89
1998	921	81,065	17,091	11.36	10.64	12.12	53.89	50.46	57.48	1.64	1.45	1.86
1999	921	80,575	16,689	11.43	10.70	12.19	55.19	51.68	58.87	1.72	1.52	1.95
2000	866	81,154	16,705	10.67	9.97	11.41	51.84	48.45	55.41	1.61	1.42	1.83
2001	883	81,334	16,588	10.86	10.15	11.60	53.23	49.78	56.86	1.65	1.46	1.88
2002	807	81,563	16,599	9.89	9.22	10.60	48.62	45.32	52.09	1.52	1.34	1.74
2003	868	81,556	16,438	10.64	9.95	11.38	52.80	49.35	56.44	1.65	1.46	1.88
2004	865	81,301	16,236	10.64	9.94	11.37	53.28	49.78	56.95	1.67	1.47	1.90
2005	975	81,474	16,178	11.97	11.23	12.74	60.27	56.54	64.17	1.88	1.68	2.13
2006	933	81,204	15,981	11.49	10.76	12.25	58.38	54.70	62.25	1.85	1.64	2.09
Castle Morpeth												
1997	463	49,342	9,053	9.38	8.55	10.28	51.14	46.59	56.02	1.63	1.38	1.94
1998	429	49,090	8,909	8.74	7.93	9.61	48.15	43.70	52.93	1.56	1.30	1.87
1999	407	49,439	8,781	8.23	7.45	9.07	46.35	41.96	51.08	1.54	1.29	1.85
2000	372	49,429	8,644	7.53	6.78	8.33	43.04	38.77	47.64	1.45	1.20	1.76
2001	378	49,000	8,428	7.71	6.96	8.53	44.85	40.44	49.61	1.55	1.29	1.87
2002	382	49,172	8,468	7.77	7.01	8.59	45.11	40.70	49.87	1.58	1.31	1.90
2003	379	49,274	8,359	7.69	6.94	8.51	45.34	40.89	50.14	1.59	1.33	1.92
2004	396	49,413	8,187	8.01	7.24	8.84	48.37	43.72	53.38	1.71	1.43	2.05
2005	368	49,611	8,132	7.42	6.68	8.22	45.25	40.75	50.12	1.58	1.31	1.92
2006	393	49,495	7,998	7.94	7.17	8.77	49.14	44.40	54.24	1.73	1.45	2.08

SOURCE: Mid Year Population Estimates, ONS; Live Births, Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development © Crown copyright

Table 7 (continued): Historic fertility: Selected fertility measures for local authorities in Northumberland, 1997-2006

	Number of live births	Population		Crude Birth Rate			General Fertility Rate			Total Period Fertility Rate		
		Persons all ages	Females aged 15-44	Rate	95% LL	95% UL	Rate	95% LL	95% UL	Rate	95% LL	95% UL
Tynedale												
1997	533	57,920	10,719	9.20	8.44	10.02	49.72	45.59	54.13	1.54	1.31	1.82
1998	565	58,436	10,865	9.67	8.89	10.50	52.00	47.80	56.47	1.63	1.39	1.91
1999	537	58,502	10,640	9.18	8.42	9.99	50.47	46.29	54.93	1.68	1.43	1.97
2000	506	58,587	10,524	8.64	7.90	9.42	48.08	43.98	52.46	1.58	1.34	1.87
2001	522	58,867	10,509	8.87	8.12	9.66	49.67	45.50	54.12	1.67	1.43	1.97
2002	512	58,935	10,444	8.69	7.95	9.47	49.02	44.87	53.46	1.65	1.40	1.95
2003	531	59,030	10,345	9.00	8.25	9.79	51.33	47.06	55.89	1.78	1.52	2.09
2004	562	59,332	10,288	9.47	8.71	10.29	54.63	50.20	59.34	1.92	1.66	2.23
2005	516	59,258	10,093	8.71	7.97	9.49	51.12	46.81	55.73	1.78	1.52	2.09
2006	509	59,503	9,946	8.55	7.83	9.33	51.18	46.83	55.82	1.80	1.54	2.11
Wansbeck												
1997	719	61,793	12,342	11.64	10.80	12.52	58.26	54.08	62.67	1.78	1.55	2.06
1998	752	61,646	12,236	12.20	11.34	13.10	61.46	57.14	66.01	1.91	1.66	2.20
1999	686	61,493	12,185	11.16	10.34	12.02	56.30	52.16	60.67	1.76	1.52	2.04
2000	624	61,252	12,131	10.19	9.40	11.02	51.44	47.48	55.64	1.62	1.40	1.89
2001	628	61,134	12,113	10.27	9.48	11.11	51.85	47.87	56.06	1.62	1.40	1.89
2002	616	61,048	12,035	10.09	9.31	10.92	51.18	47.22	55.39	1.62	1.40	1.89
2003	681	61,303	12,050	11.11	10.29	11.98	56.51	52.35	60.92	1.81	1.57	2.10
2004	672	61,398	11,982	10.94	10.13	11.80	56.08	51.92	60.49	1.82	1.57	2.10
2005	675	61,568	11,985	10.96	10.15	11.82	56.32	52.15	60.73	1.84	1.60	2.13
2006	669	61,653	11,975	10.85	10.04	11.71	55.87	51.71	60.27	1.81	1.57	2.10

SOURCE: Mid Year Population Estimates, ONS; Live Births, Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development

IMPLICATIONS OF POPULATION CHANGE ON KEY CONDITIONS

Long term conditions are those that cannot, at present, be cured, but can be controlled by medication and other therapies. These include:

- Coronary heart disease;
- Heart failure;
- Stroke and transient ischaemic attack;
- Hypertension;
- Diabetes;
- Chronic obstructive pulmonary disease;
- Epilepsy;
- Cancer;
- Severe mental health conditions (includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses);
- Asthma;
- Arthritis;
- Chronic kidney disease;
- Dementia;
- Depression;
- Multiple sclerosis; and
- Parkinson's disease.

People with long term conditions are intensive users of health and social care services, including community services, urgent and emergency care and acute services. They use disproportionately more primary and secondary care services, and this pattern will increase over time with an ageing population[10]. Information from the General Household Survey for 2005[11] suggests that this group accounts for:

- 52% of all GP appointments;
- 65% of all outpatient appointments; and
- 72% of all inpatient bed days.

There is no single factor that has a significant correlation with prevalence, suggesting that there are a number of factors driving the variations, including age, socio-economic status, lifestyle choices and rurality. However, age is the most significant driver of prevalence of long term conditions. According to the General Household Survey for 2005[11]:

- Overall, over 30% of all people said that they suffer from a long term conditions.
- Some 17% of those aged under 40 said they have a long term condition.
- Some 60% of those aged 65 and over said they have a long term condition.

Numbers are predicted to increase due to factors such as an ageing population and lifestyle choices. Better long term conditions management, including improvements in clinical care and support for self care, should lead to reductions in the proportion of services used (see also pages 116-119).

North of Tyne is one of three pilot sites in England for the Year of Care project examining care planning and macro commissioning. The Department of Health is due to publish guidance for commissioners on long term conditions during 2008.

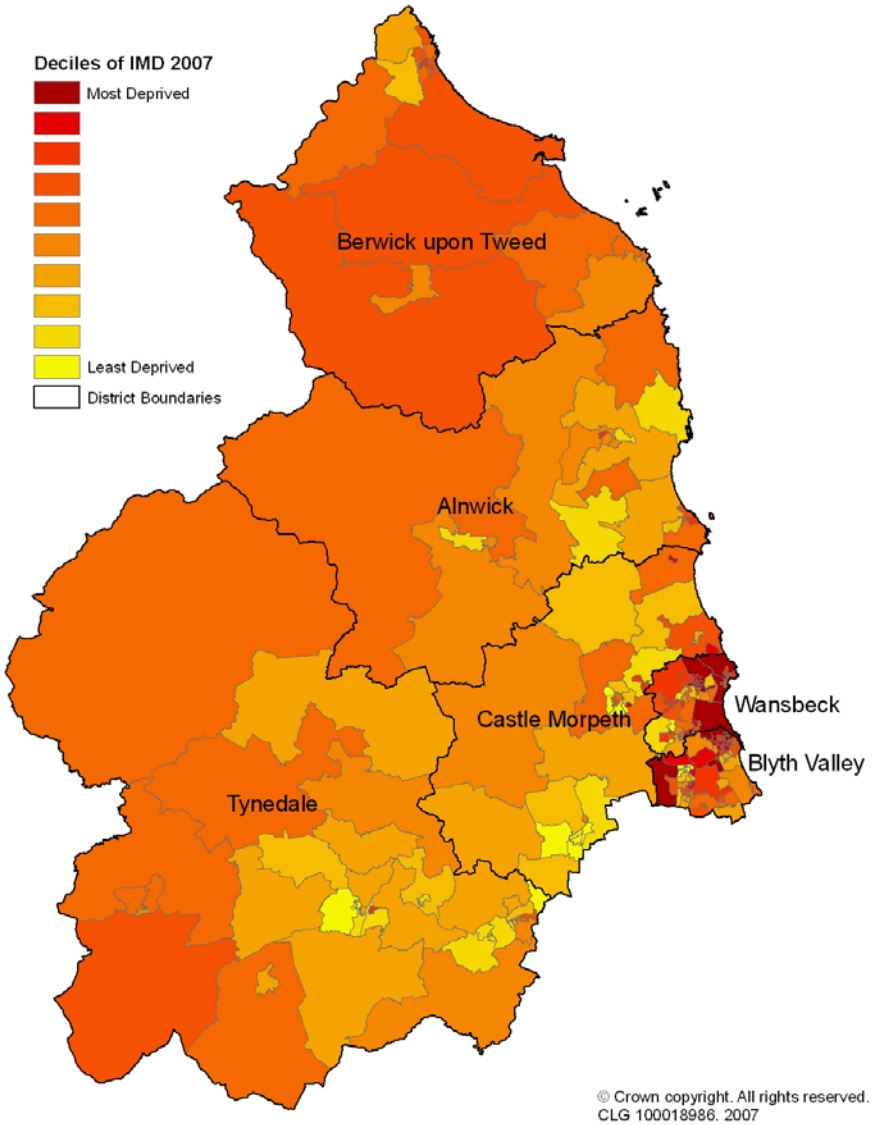
As the process of Joint Strategic Needs Assessment develops in Northumberland, more work will be done to model the implications of the changing demographic profile on long term conditions.

3. SOCIAL AND ENVIRONMENTAL CONTEXT

DEPRIVATION (USING IMD 2007)

The link between social and economic deprivation and poor health has long been recognised. The Index of Multiple Deprivation (IMD) 2007[12] provides an overall deprivation score for local authorities and smaller areas known as 'lower layer super output areas' (SOAs).

Figure 6: IMD 2007 for Super Output Areas in Northumberland, by decile



SOURCE: Department of Communities and Local Government, Indices of Deprivation 2007. The IMD 2007 map image was produced by the Strategy, Policy and Performance Unit, Government Office for the North East. The image is used with their permission.

The pattern of deprivation is complex. The vast majority of the most deprived communities in Northumberland are in Blyth Valley and Wansbeck, although there are pockets of deprivation elsewhere particularly in Berwick-upon-Tweed and Castle Morpeth.

According to the IMD 2007, Wansbeck is the 46th most deprived district of the 354 districts in England. Together with Blyth Valley at 80th place, these districts are Spearhead local authorities - because they fall into the "fifth of areas with the worst health and deprivation indicators". In these areas, Government policy requires faster than national average progress on key mortality measures in order to reduce health inequalities.

Table 8: Percentage of SOAs in the most and least deprived quintiles nationally using IMD 2007, local authorities in North of Tyne compared to the North East and England

Local Authority	SOAs in area	SOAs in the 20% most deprived in England		SOAs in the 20% least deprived in England	
		No.	%	No.	%
Northumberland	199	31	15.6	32	16.1
Alnwick	18	0	0.0	4	22.2
Berwick upon Tweed	17	0	0.0	0	0.0
Blyth Valley	52	14	26.9	4	7.7
Castle Morpeth	33	3	9.1	11	33.3
Tynedale	38	0	0.0	10	26.3
Wansbeck	41	14	34.1	3	7.3
NORTH EAST	1656	566	34.2	165	10.0
ENGLAND	32482	6496	20.0	6497	20.0

SOURCE: Department of Communities and Local Government, Indices of Deprivation 2007 © Crown copyright

If deprivation was evenly distributed across all local authorities, then each local authority would be expected to have 20% of its super output areas in the 20% most deprived super output areas in England. The table above shows that deprivation is not evenly distributed and that Blyth Valley and Wansbeck areas within Northumberland have more than a "fair share" of their SOAs experiencing levels of deprivation which place them amongst the 20% most deprived SOAs in England.

EDUCATION

Tables 9 and 10 show data for attainment at GCSE or equivalent level for the academic year 2006/07. Table 9 assigns results to districts on the basis of the geographic location of schools within the district boundaries. Table 10 assigns individual children to districts on the basis of the geographic location of their home address. Differences in the numbers of pupils between the tables reflect children travelling out of their district of residence to attend school in another district; there will also be some children who cross county boundaries. Differences between general attainment rates and those including maths and English reflect the drive to broaden the

Key Stage 4 curriculum to include a wide range of vocational qualifications. Improvements in overall attainment rates, for example in Berwick upon Tweed, have not been accompanied by corresponding increases in basic skills of literacy and numeracy. (See pages 99-107 for Key Stage 2 achievement targets).

Table 9: Secondary School (GCSE and equivalent) attainment, by location of school, local authorities in Northumberland compared to the North East and England, 2006/07

	Pupils at the end of Key Stage 4	% Pupils achieving at least 5 A*-C grades	% Pupils achieving at least 5 A*-C grades including maths and English
Northumberland	3,896	58.7	46.3
Alnwick	425	54.4	42.6
Berwick upon Tweed	203	72.9	36.0
Blyth Valley	1,005	59.7	41.8
Castle Morpeth	605	73.9	63.3
Tynedale	725	73.4	57.0
Wansbeck	933	47.4	35.9
NORTH EAST	32,570	60.6	41.9
ENGLAND	649,159	62.0	46.7

Table 10: Secondary School (GCSE and equivalent) attainment, by location of pupil residence, local authorities in Northumberland compared to the North East and England, 2006/07

	Pupils at the end of Key Stage 4	% Pupils achieving at least 5 A*-C grades	% Pupils achieving at least 5 A*-C grades including maths and English
Northumberland	3,768	61.5	46.1
Alnwick	364	62.1	48.9
Berwick upon Tweed	264	70.1	38.3
Blyth Valley	1064	61.2	42.7
Castle Morpeth	550	66.9	56.7
Tynedale	722	72.0	55.7
Wansbeck	804	45.9	36.2
NORTH EAST	32,427	60.6	42.0
ENGLAND	666,247	60.4	45.5

SOURCE: GCSE and Equivalent Results and Associated Contextual Value Added Measures for Young People by Gender in England 2006/2007, Neighbourhood Statistics © Crown copyright
NOTE: Local and regional figures are for schools maintained by a Local Authority; England average figures include results from Independent schools that have agreed to participate.

EMPLOYMENT

There are a number of factors that may directly or indirectly influence mental health and wellbeing; rates are shown for incapacity benefit claims below.

Table 11: Claimants of incapacity benefit and/or severe disablement allowance, quarter ending 31st March 2008

Area	Number	working age population	% of working age population
Northumberland	14,390	187,570	7.67
Alnwick	1,060	18,921	5.60
Berwick upon Tweed	1,010	14,818	6.82
Blyth Valley	4,550	50,838	8.95
Castle Morpeth	1,900	29,468	6.45
Tynedale	1,880	35,687	5.27
Wansbeck	3,970	37,838	10.49
NORTH EAST	157,360	1,585,541	9.92
ENGLAND	2,118,120	31,626,651	6.70

SOURCE: Work and Pensions Longitudinal Study, Department of Work and Pensions, taken from NOMIS – Official Labour Market Statistics © Crown copyright

Information about older workers and the implication for public services can be found on pages 116-119 and the impact of worklessness on children and families can be found on pages 114-115.

FINANCIAL EXCLUSION

Financial exclusion is the experience of poverty affecting people who have low incomes, and who may have no access to affordable credit, bank accounts, savings, insurance cover, or impartial debt advice, and who may pay more for utilities[13]. Financial strain can affect relationships, families, children, health, and the ability to contribute and participate fully in society and local communities. Financial exclusion and debt are barriers to employment and entrench social exclusion. Causes of financial exclusion are interlinked and include[14]:

- Geographical exclusion, e.g. resulting from branch closures;
- Condition exclusion, e.g. the failure to qualify because of minimum deposit required, poor credit history or identity requirements;
- Price exclusion, e.g. the relative cost of financial products and services such as unauthorised overdrafts;
- Marketing exclusion, i.e. some less profitable groups of customers are not targeted by providers and so they are unaware of the financial services available;
- Self-exclusion, i.e. cultural and psychological barriers – financial services as 'not for people like us'.

Current needs

Financial exclusion adversely impacts upon the most vulnerable in society, including people with mental health and/or physical health problems, children, lone parents, people on pensions, and poorer people living in rural areas. In Northumberland, during 2007, the Financial Inclusion Funded (FIF) debt advisers based in Citizen's Advice Bureaux saw 1,439 clients, with debts totalling £21,426,517 (an average debt of £14,890 for each person seen)[13].

Of these clients:

- 15.9% had a disability and 13.6% a long term illness (self-report);
- 9.3% were in receipt of Job Seekers Allowance (income and contribution based);
- 13.3% claimed Income Support;
- 22.2% received Housing Benefit;
- 24.8% received Council Tax Benefit;
- 14.3% claimed Working Tax Credit;
- 18.1% claimed Child Tax Credit;
- 22% were buying their own home and had a mortgage;
- 16.3% were private tenants and 32.7% lived in social housing;
- 33.4% had priority debts (those where the creditor's ultimate sanction may result in the client losing her/his liberty, home, essential supplies, e.g., gas or electricity, or essential goods);
- 60.8% had an income of less than £14,500.

These figures outline the situation for those experiencing financial exclusion who have accessed support through the FIF debt advisors. It is difficult to quantify the extent of unmet need in the community i.e., other people who are facing financial exclusion and who require advice and support. However, given the current harsh financial climate and the context of socioeconomic deprivation experienced in parts of the county (see information on employment, housing and fuel poverty in this section), addressing financial exclusion is a clear priority in Northumberland.

Financial inclusion

To combat exclusion, financial inclusion approaches have been developed. Financial inclusion has two elements, as follows:

- Promoting good financial decision-making; and
- Developing financial capability (that is, the skills and motivation to plan ahead, to find information, and to know when to seek advice)[14].

Eleven approaches to promote financial inclusion have been identified[13]:

1. Setting strategic priorities nationally and locally which enable a multi-agency approach to prevent and address hardship and financial exclusion;
2. The expansion of credit unions and not for profit lending;
3. Financial awareness raising and debt management;
4. Independent and impartial financial advice;
5. Accessible banking facilities;

6. Free accessible welfare rights advice;
7. Innovative saving schemes;
8. Affordable warmth;
9. Tax and benefit changes so that the value of benefits and tax credits rise above the rate of the fastest growing prices or earnings;
10. Soft regeneration such as literacy and numeracy schemes;
11. Additional support for people with physical and mental health problems and their carers.

Recommendations were made to the Northumberland Strategic Partnership in 2008 for action based on current evidence and practice to promote financial inclusion within Northumberland[15]:

- The development of a multi-agency working group to establish anti-poverty objectives and to inform policy, debate and discussion locally and nationally.
- Set targets for tackling financial exclusion and poverty at a strategic level (e.g., uptake of benefits, full use of financial services, increased use of credit unions and/or community based lenders, access to impartial advice and guidance, reduce numbers of people in fuel poverty).
- Encourage partnership working between the whole range of agencies providing services for people who are financially excluded.
- Engage communities in initiatives to tackle financial exclusion and poverty.
- Prevent and reduce financial difficulties by developing the awareness, understanding and skills of the public and all who work with people who may be experiencing poverty and debt (e.g. staff in health and social care; education; local government; employment).

In response a Northumberland Financial Inclusion Partnership (NFIP) has been set up to be the vehicle for effective working on issues affecting financial inclusion by bringing together and co-ordinating the activities of partners from the statutory, private and voluntary and community sector across the county of Northumberland. The five main strands of work for this partnership are[15]:

- Developing partnership working;
- Increasing Credit Union capacity;
- Helping people develop their own skills and confidence to avoid financial crisis;
- Informing policy, debate and discussion at a local level;
- Identifying resources to take forward the work of the partnership and those organisations providing services that promote financial inclusion.

HOUSING

Annually, a large amount of data covering a wide range of housing issues are collected from local authorities (unitaries and districts); the two current collections are known as the Housing Strategy Statistical Appendix (HSSA) and the Business Plan Statistical Appendix (BPSA). The HSSA is collected from all local authorities, as they are all required to publish a housing strategy. However, local authorities that do not own any housing stock, because they have undertaken large scale voluntary transfer (LSVT) do not need a Business Plan and therefore do not submit data through the BPSA. This has implications for the completeness of data on issues such as non-decent housing. To address this, another large scale housing statistics data

collection relating to local authority and Registered Social Landlords (RSLs) is being planned which will include some of the data collected in HSSA and BPSA.

There is a mixture of provision across Northumberland encompassing private and social housing. The social housing provision is moving towards complete adoption of the Choice Based Letting system, but currently not all Local Authorities in Northumberland are running the scheme. There are some supported housing schemes, e.g., for stable drug service users who are in treatment. Many of these schemes are fairly new, but initial evaluation shows that the partnership and co-operative work surrounding the schemes is very successful.

It has been identified nationally that the majority of failures on both Housing Health and Safety Rating System (HHSRS) and Decent Homes relate to the inadequate thermal comfort aspect of the regulations. Those most at risk of ill health from conditions that are exacerbated by cold and damp are also more likely to be found living in homes that fail the Decent Homes Standard.

Decency calculations use the properties total at the start of the financial year as a baseline, assessing progress in making them decent through the year.

Table 12: Number and percentage of council owned dwellings that are non-decent, year ending 1st April 2008

Area	Council owned dwellings at 1st April 2008	Non-decent dwellings			
		No. at 1st April 2006	No. at 1st April 2007	No. at 1st April 2008	% unfit at 1st April 2008
Northumberland	18,239	5,615	4,661	148	0.8
Alnwick	1,764	2	0	0	0.0
Berwick	1,913	77	77	77	4.0
Blyth Valley	6,763	1,585	165	71	0.1
Castle Morpeth	LSVT	1,688	1,688	LSVT	N/A
Tynedale	LSVT	LSVT	LSVT	LSVT	N/A
Wansbeck	LSVT	2,263	2,731	LSVT	N/A
NORTH EAST	139,643	88,683	75,947	55,579	39.8
ENGLAND	1,837,490	725,095	617,614	489,448	26.6

SOURCE: 2007, Department for Communities and Local Government © Crown copyright

Housing for people with alcohol problems is a problem and there is no wet hostel provision across Northumberland. Data from supported housing sector show that in 2006 a total of 468 (22%) of their clients were considered to have a significant alcohol problem. Alcohol use is a contributory factor in domestic violence for both perpetrator and victim. Victims of domestic violence are particularly vulnerable to using alcohol as a coping strategy and as a result alcohol misuse often acts as a barrier to accessing services.

Housing related support needs

The Supporting People programme, managed by the Care Trust on behalf of the County Council, provides a range of housing-related support services to help people to remain independent.

Currently these services focus particularly on supporting older people at risk of losing their independence and people with a learning disability. One third of the Supporting People budget is spent on older person's services, one third on people with learning disabilities, and the remaining one third across the 19 other Supporting People client groups. The relatively low level of Government grant for the programme in Northumberland, based on historical levels of service, imposes some constraints on our ability to broaden its focus.

There is currently no specialist provision for refugees, people with HIV/AIDS, gypsies and travellers, mentally disordered offenders, or older people with mental health problems though they may access services in other categories. The potential value of services for these groups will be reviewed in the light of the data about local needs in this document and of other information.

A more detailed analysis of current needs and services is included in the updated Northumberland Supporting People Strategy[16] published in October 2008.

Fuel Poverty

Fuel poverty arises from the combination of low incomes, poorly insulated housing and expensive or inadequate heating systems; people who are least able to afford the cost of heating tend to live in houses that are hardest to heat.

The government defines fuel poverty as where a household spends more than 10% of income, after housing costs have been met, in order to achieve a heating regime adequate for health and comfort. The 'fuel poor' tend to be:

- Single pensioners;
- Families on low incomes;
- Disabled people.

HOMELESSNESS

Table 13: Households accepted as homeless and in priority need by the local authority, 2007/08

Area	Local No	Number of households	Rate/%
Northumberland	208	14,000	1.55
Alnwick	18	12,000	1.29
Berwick	32	35,000	2.67
Blyth	41	21,000	1.17
Castle Morpeth	43	25,000	2.05
Tynedale	31	27,000	1.24
Wansbeck	43	134,000	1.59
NORTH EAST	3,600	1,095,000	3.29
ENGLAND	63,170	21,062,000	3.00

SOURCE: Statutory Homelessness Statistical Release, Department for Communities and Local Government © Crown Copyright

TRANSPORT

Within Northumberland in particular, access to health services can be hampered by transport issues – this is partially because of the problems of rurality, with a sparsely populated county of 200 square miles. However the local review carried out on the Darzi proposals shows that some areas in the rest of North of Tyne also experience transport problems.

CRIME

Table 14: Numbers and rates (per 1,000 population) of police recorded crimes by selected main offence group, local authorities in Northumberland compared to the North East and England, 2006/07

	Total Recorded Crime		Violence against the person		Burglary		Offences against vehicles		Other theft offences		Criminal damage	
	No.	**Rate**	**No.**	**Rate**	**No.**	**Rate**	**No.**	**Rate**	**No.**	**Rate**	**No.**	**Rate**
N'land	19,735	63.7	4,149	13.4	2,249	7.3	1,843	5.9	3,920	12.7	5,493	17.7
Alnwick	1,596	49.8	363	11.3	162	5.1	146	4.6	310	9.7	478	14.9
Berwick upon Tweed	1,576	60.7	422	16.3	160	6.2	105	4.0	290	11.2	382	14.7
Blyth Valley	5,913	72.8	1,268	15.6	547	6.7	484	6.0	1,218	15.0	1,827	22.5
Castle Morpeth	2,472	49.9	521	10.5	298	6.0	260	5.3	535	10.8	585	11.8
Tynedale	2,381	40.0	499	8.4	359	6.0	235	3.9	484	8.1	544	9.1
Wansbeck	5,797	94.0	1,076	17.5	723	11.7	613	9.9	1,083	17.6	1,677	27.2
NORTH EAST	250,695	98.1	48,194	18.9	28,724	11.2	30,973	12.1	49,285	19.3	71,100	27.8
ENGLAND	5,093,395	100.3	976,638	19.2	594,329	11.7	719,031	14.2	1,101,086	21.7	1,106,614	21.8

SOURCE: 2006 mid-year population estimates, ONS, 2007; Police Recorded Crime Statistics 2006/07 by Crime and Disorder Reduction Partnership, Home Office, 2007 © Crown copyright

4. HEADLINE HEALTH INEQUALITIES

NATIONAL PROGRAMME TO TACKLE HEALTH INEQUALITIES

Over the last decade, the developing mission of the national programme to tackle health inequalities has been to:

- Reduce unjustified gaps in health status;
- Provide fair access to NHS services for everyone; and
- Promote good outcomes of care for all.

In June 2008, the Department of Health has published a document outlining progress and next steps for health inequalities[17]. This outlines a new vision for health inequalities as follows:

> *"In a fair and prosperous society, everyone should have the same chance to lead a long and healthy life and enjoy the same opportunities for education, employment, recreation and fulfilment that good health brings."*

It describes actions over two timescales as follows:

- The period up to 2010 – focussed on meeting the current targets and redoubling efforts to prevent avoidable deaths; and
- Beyond 2010 – developing new ambitions for health inequalities and the structure and systems that support delivery and sustainable improvements.

In 2007, the Department of Health agreed a new Departmental Strategic Objective and Public Service Agreement structure with HM Treasury as part of the *2007 Spending Review*[18]. The existing health inequalities national target[15] was reaffirmed as part of PSA Delivery Agreement 18. The Health Inequalities National Target is to:

> *"Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth."*

National target for life expectancy

This national health inequalities target is underpinned by two more detailed objectives, one of which relates to life expectancy at birth. This is as follows:

> *"Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group[16]) and the population as a whole."*

Following a review of the life expectancy target undertaken by the Prime Minister's Delivery Unit in 2006, the Department of Health announced that progress against the life expectancy target should be monitored at local level using an 'equivalent' all age all cause mortality rate.

Within the Vital Signs process for the Annual Operational Plan[17], trajectories for male and female all age all cause mortality are set for Northumberland and Northumberland's Spearhead area (i.e., Blyth Valley and Wansbeck together).

High impact changes

The following high impact changes have been identified for the NHS and for local government to tackle health inequalities[19]:

For the NHS …	**For local government …**
1. Know your gaps in life expectancy and infant mortality and develop a health inequalities strategy and programme of sufficient scale to make a strong impact on the gap.	1. Know your gaps in life expectancy and infant mortality and develop a health inequalities strategy and programme of sufficient scale to make a strong impact on the gap. 2. Maximise use of Local Area Agreements and other local plans to focus on health inequalities. 3. Use the duty of wellbeing to improve the quality of life, opportunity and health in local communities.
2. Reduce smoking prevalence and target cessation services and campaigns in deprived areas and groups. 3. Target prevention of cardiovascular diseases using prevalence models to identify areas of unmet need alongside a case finding strategy. 4. Improve detection of cancer in local communities.	
5. Ensure the quality of primary care in disadvantaged communities is sufficient to address need and is of high quality. Focus Health Trainers and Life Check programmes on tackling health inequalities.	4. Focus Health Trainers and Life Check programmes on tackling health inequalities. 5. Use the powers of Scrutiny Committees to reduce health inequalities.
6. Empower disadvantaged communities to aspire to good health.	6. Empower disadvantaged communities to aspire to good health.

What works locally

Health inequalities are deep-rooted and driven by a complex interplay of factors. Local action must be evidence-based, strategic and of sufficient scale to make a difference at population level. The Government reviewed the evidence base for the life expectancy target in 2006 and the infant mortality target in 2007. Current best understanding of what will work to narrow health inequalities rapidly, based on these reviews and the work of the National Support Team

for Health Inequalities with Spearhead communities, is set out within the progress and next steps policy document[17] and summarised below. Not surprisingly, there is a degree of overlap with the high impact changes.

What works locally ...	**Summary**
1. A strategic, evidence-based approach	Underpinned by a rigorous analysis of local data to understand the gap and what is causing it. Considering the drivers and establishing which organisation has the levers to address them, with a focus on the longer-term causes as well as the immediate needs of those already experiencing the effects of health inequalities. Ensuring NHS actions are consistent with other strategic actions, e.g. economic regeneration.
2. Scaling action to the size of the problem locally	Developing an action plan based on the analysis set out in the Joint Strategic Needs Assessment and evidence based interventions derived from the Health Inequalities Intervention Tool, with local measures and monitoring built into operational plans and local area agreements.
3. Leading from the top	Chief Executives and Directors of Finance, Commissioning and Primary Care, Clinical Leadership, Housing, Planning, etc. need to play their part. Public Health can advise but cannot deliver alone.
4. Ensuring that the quality and quantity of primary care in disadvantaged areas meets local needs and is well organised	Proactive development support should be both generic (e.g. strengthening practice management) and focused on specific priorities (e.g. managing CVD, diabetes and Chronic Obstructive Pulmonary Disease programmes).
5. Actively seeking out people who already have a disease or are at high risk but are not accessing services early enough	Ensuring that those with multiple needs are not being 'exception reported' for the Quality and Outcomes Framework (QOF). Using a variety of local data – including the QOF, prevalence models and risk-scoring – to ensure that the health needs of disadvantaged populations are being met. Working with other services to reach vulnerable groups.

What works locally …		Summary
6.	Capitalising on neighbourhood and community infrastructures to engage individuals, families and communities, particularly those 'seldom seen, seldom heard' in services	Use them to ensure services are responsive to needs. Use them to help motivate and support appropriate health-seeking behaviour.
7.	Ensuring that partnerships are effective	Partnerships need to work effectively for middle management and frontline staff, not only at board level. Different organisations should agree priorities, explicitly share leadership and responsibility, and take concerted action.
8.	Considering and addressing workforce implications	Understanding what needs to be done locally, by whom, and the resources needed, taking into account the necessary scale of activity and balancing the skill mix to obtain cost-effectiveness and sustainability of systems.
9.	Innovating	Always look for new ways to understand problems and deliver solutions.

Where are we now?

Targets and trajectories

Life expectancy is a good summary measure of health outcome, reflecting a broad range of activities within and outwith the NHS. All age all cause mortality is used as a proxy measure for life expectancy at local level because it is easier to measure and better understood than life expectancy; the two measures are highly correlated. Target activity is focused on reducing the gap between the Spearhead group of local authorities[20] – the fifth of authority areas with the worst health and deprivation – and the England average.

Nationally, life expectancy is increasing for both men and women, including in the Spearhead areas; but it is increasing more slowly in the Spearhead areas, so the gap continues to widen. The gap is widening more for women than men. In 2004-2006, for males the gap (between England and the Spearhead group) was 2% wider than at baseline, while for females it was 11% wider.

There is a great deal of local variation within the Spearhead group. To meet the Health Inequalities life expectancy national target, we will need to reverse a long-term trend; the target remains a challenging one.

Graphical summaries of progress toward the original life expectancy (LE) targets for the spearhead local authorities are shown in Figures 7-10. This analysis is based on the assumption that for England male life expectancy at birth would reach 78.6 years by 2010 and female life expectancy at birth would reach 82.5 years by 2010. The "gaps" in projected life expectancy for local Spearhead areas are therefore based on these values for England.

Figures 7-10 show that:

- For England, male life expectancy at birth is on track to reach the target figure of 78.6 years by 2010.
- For England, female life expectancy at birth not improving rapidly enough to stay on track to reach the target figure of 82.5 years by 2010.
- Blyth Valley is on track to meet the 10% gap reduction in life expectancy at birth for males and females.
- Wansbeck is on track to meet the 10% gap reduction in life expectancy at birth for males, but off track for females.

Figures 11-14 shows similar summaries for the PCO Spearhead areas in relation to the life expectancy targets translated into targets for all age all cause mortality (AAACM), as set through the Vital Signs process. It should be noted that the trajectories set through this process are more challenging than the original life expectancy targets, since they allow for the 'shifting goal posts' that result from comparing the Spearhead group with England as a whole (which includes the Spearhead group).

Figures 11-14 show that:

- For Northumberland as a whole, current performance is in line with the required trajectory.
- For the Northumberland Spearhead area, there is a need to improve performance to reach trajectory for both males and females.

Figure 7: LE at birth for Blyth Valley – males

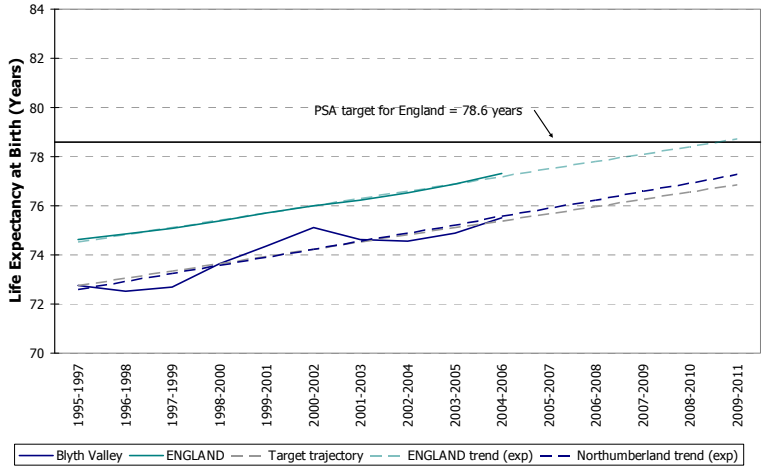


Figure 8: LE at birth for Blyth Valley - females

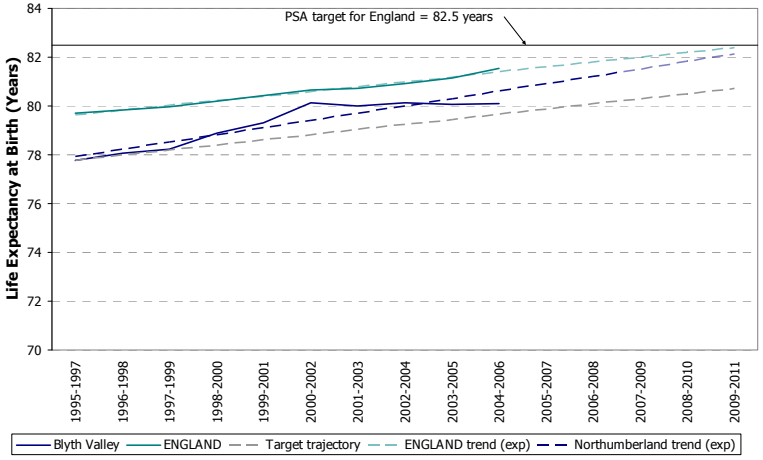


Figure 9: LE at birth for Wansbeck – males

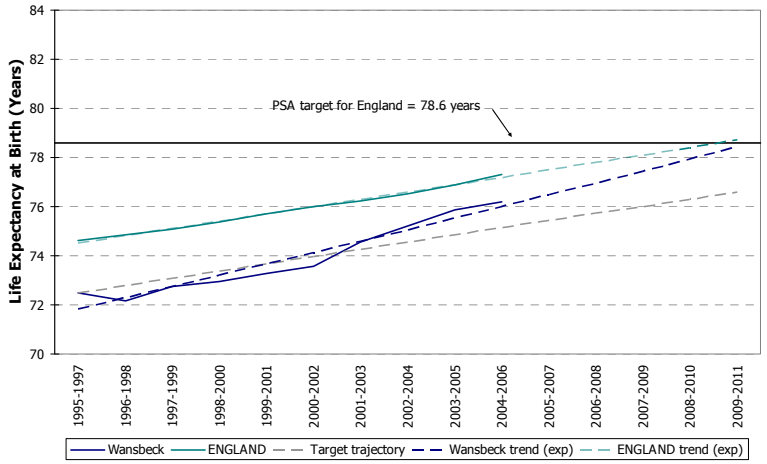


Figure 10: LE at birth for Wansbeck - females

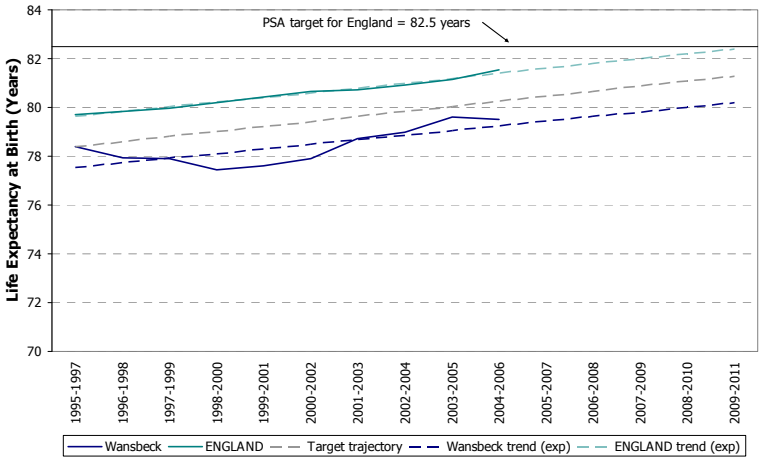


Figure 11: AAACM for Northumberland – males

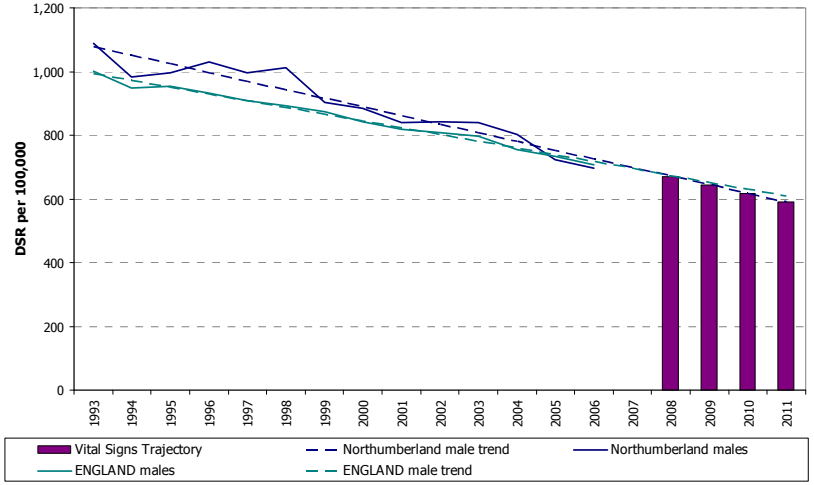


Figure 12: AAACM for Northumberland - females

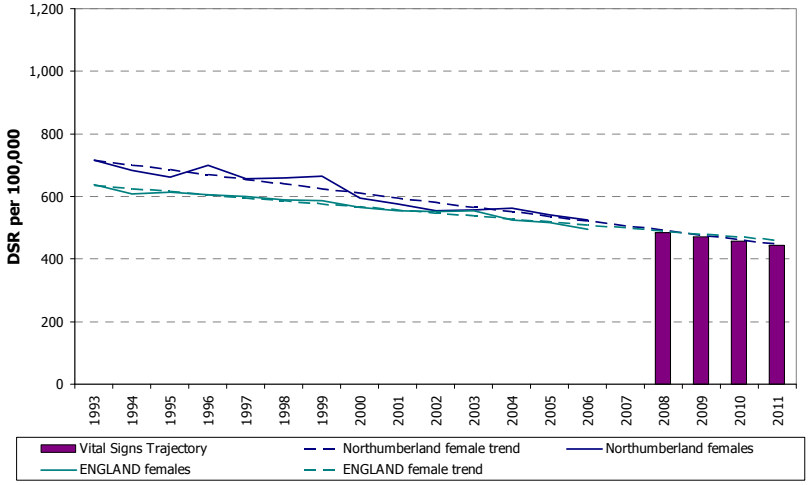


Figure 13: AAACM for Northumberland Spearhead (Blyth Valley & Wansbeck) - males

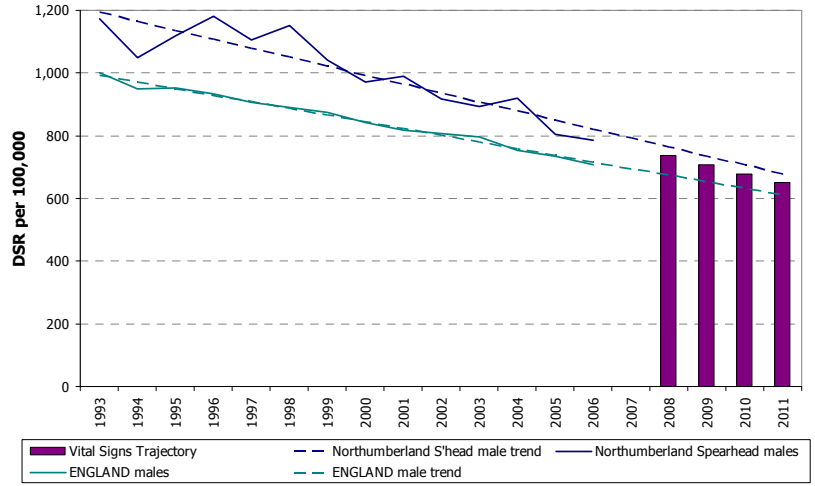
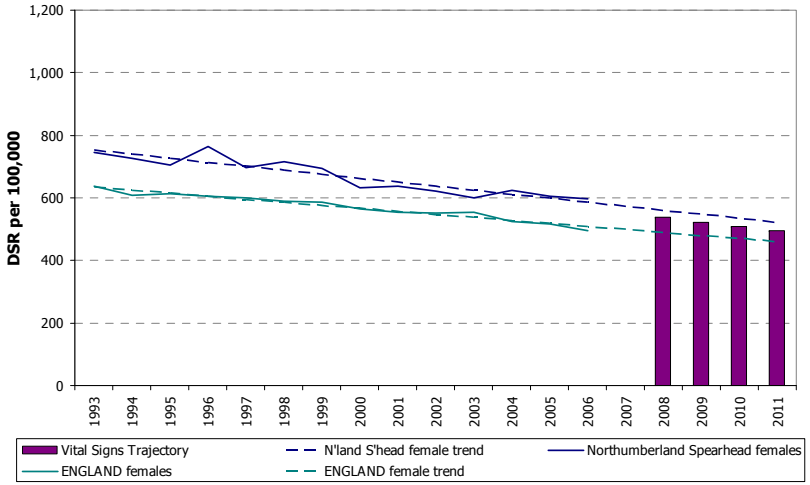


Figure 14: AAACM for Northumberland Spearhead (Blyth Valley & Wansbeck) - females



Comparative performance

Life expectancy at birth for men and women in Northumberland is increasing, but remains lower than the English average.

Table 15: Life expectancy at birth for males, local authorities in Northumberland compared to the North East and England, 2001-2003 to 2004-2006

	2001/03	2002/04	2003/05	2004/06
Northumberland	75.9	76.1	76.7	77.2
Alnwick	76.9	76.5	76.7	78.3
Berwick	77.3	77.7	78.4	79.8
Blyth Valley	74.6	74.6	74.9	75.5
Castle Morpeth	77.3	77.4	78.1	78.2
Tynedale	76.7	76.5	77.5	78.1
Wansbeck	74.5	75.2	75.9	76.2
NORTH EAST	74.7	74.9	75.4	75.8
ENGLAND	76.2	76.5	76.9	77.3

SOURCE: Sub National Life Tables, Office for National Statistics, 2008 © Crown copyright

Table 16: Life expectancy at birth for females, local authorities in Northumberland compared to the North East and England, 2001-2003 to 2004-2006

	2001/03	2002/04	2003/05	2004/06
Northumberland	80.9	80.8	80.9	81.1
Alnwick	83.3	82.7	82.5	81.3
Berwick	82.0	82.4	83.0	83.7
Blyth Valley	80.0	80.1	80.1	80.1
Castle Morpeth	81.0	81.1	80.9	82.0
Tynedale	81.3	81.4	81.4	81.8
Wansbeck	78.7	79.0	79.6	79.5
NORTH EAST	79.5	79.6	79.8	80.1
ENGLAND	80.7	80.9	81.1	81.6

SOURCE: Sub National Life Tables, Office for National Statistics, 2008 © Crown copyright

There is wide variation in levels of deprivation at ward and local authority district level within Northumberland, and this is reflected in significant within area variation of life expectancy.

Figure 15: Life Expectancy at Birth, 2004-2006

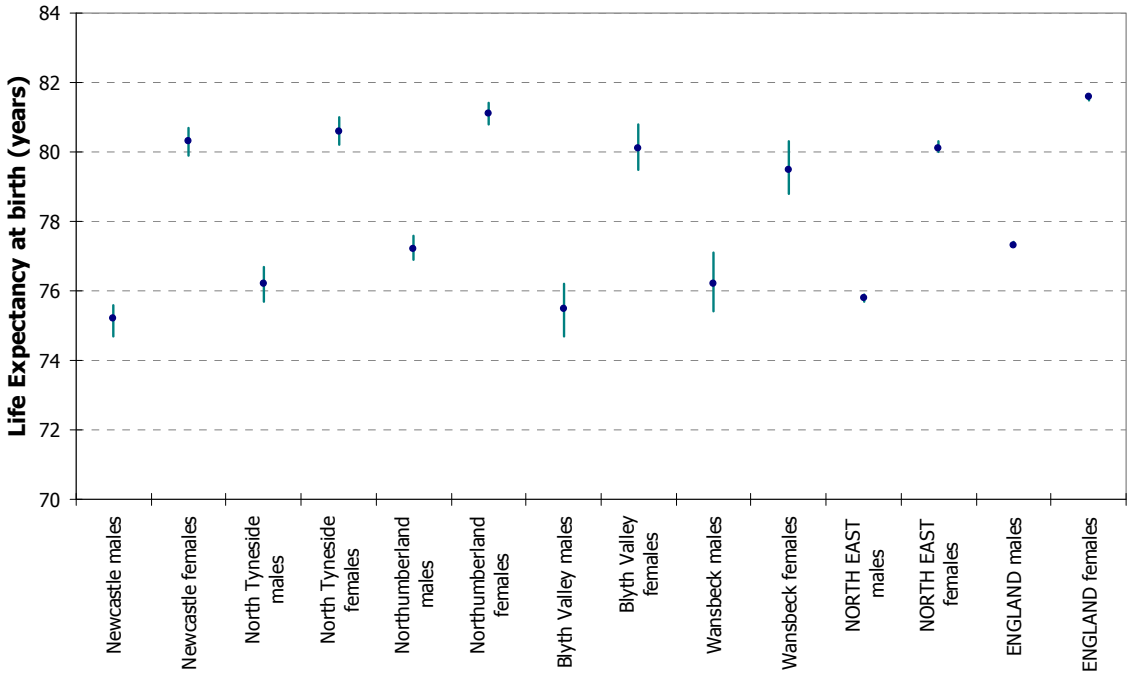


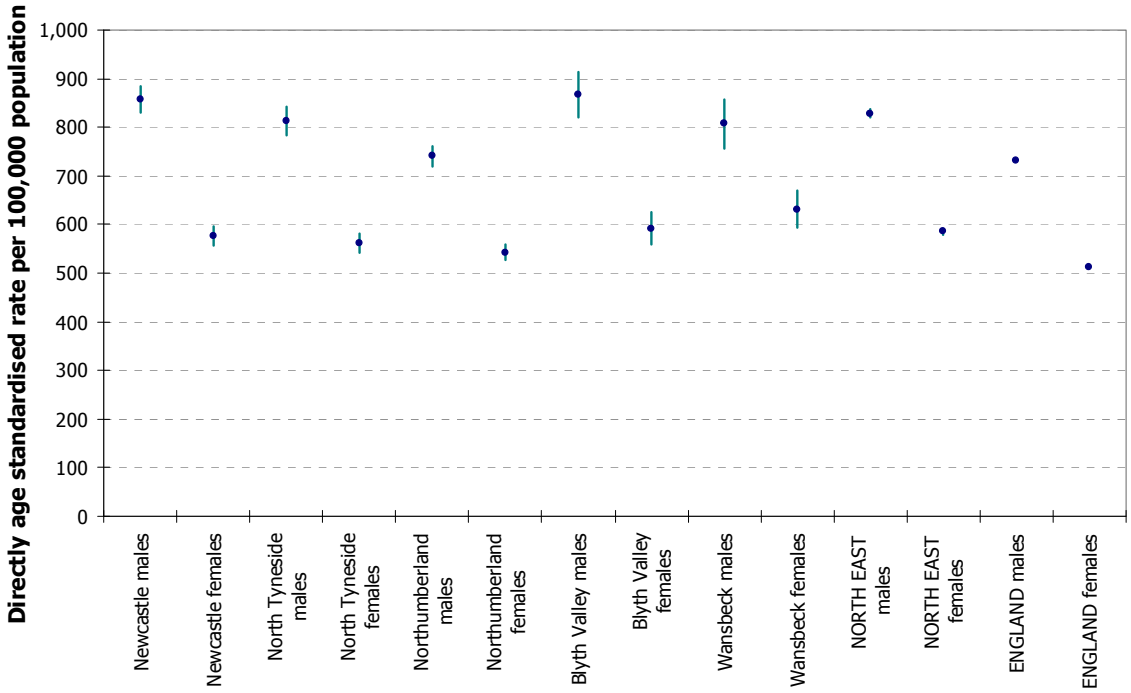
Table 17: Directly age standardised rate for all age all cause mortality (per 100,000 population), local authorities in Northumberland compared to the North East and England, 2001-2003 to 2004-2006

	2001/03	2002/04	2003/05	2004/06
Northumberland	684.2	677.3	659.5	633.3
Alnwick	592.4	618.2	620.9	603.2
Berwick	596.5	573.2	548.3	503.2
Blyth Valley	738.9	737.2	731.0	712.4
Castle Morpeth	645.2	636.2	622.5	587.3
Tynedale	656.9	654.5	626.9	591.2
Wansbeck	777.0	754.8	723.6	712.7
NORTH EAST	751.0	739.1	719.2	694.2
ENGLAND	664.3	650.6	633.9	610.5

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright

Although all age all cause death rates are worse than the average for England, they have been steadily decreasing over the past ten years (1995-1997 to 2004-2006). Over that time the gap between England and Northumberland has narrowed from 76 per 100,000 to 8 per 100,000 for males and from 401 per 100,000 to 229 per 100,000 for females.

Figure 16: All Age All Cause Mortality Rate per 100,000, 2004-2006



Cross-cutting health indicators across Northumberland

Table 18 presents common indicators from the Health Profile for Northumberland, as follows:

- Early deaths from smoking;
- Hospital stays related to alcohol;
- Breast feeding initiation;
- Smoking in pregnancy.

Table 18: Selected health indicators from Health Profiles, Northumberland compared to England

Indicator/condition	Northumberland	England
Early deaths from smoking†	244.5	225.4
Early deaths from cancer	120.3	117.1
Early deaths from heart disease and stroke	83.6	84.2
Hospital stays related to alcohol†	350.0	260.3
Breast feeding initiation†	50.8	69.2
Smoking in pregnancy†	19.1	16.1

SOURCE: APHO and Department of Health, Health Profile for Northumberland, 2008 © Crown copyright

NOTE: † - These figures are statistically significantly worse than the England average.

Mortality from causes considered amenable to healthcare

This indicator has been established to help reduce deaths from causes considered amenable to health care. Causes of death are included 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 age groups specified. The indicator includes:

- Intestinal infections (ICD-10 A00-A09) at ages 0-14 years;
- Tuberculosis (ICD-10 A15-A19, B90) at ages 0-74 years;
- Diphtheria, tetanus, and poliomyelitis (ICD-10 A36, A35, A80) at ages 0-74 years;
- Whooping cough (ICD-10 A37) at ages 0-14 years;
- Septicaemia (ICD-10 A40-A41) at ages 0-74 years;
- Measles (ICD-10 B05) at ages 1-14 years;
- Malignant neoplasm of colon and rectum (ICD-10 C18-C21) at ages 0-74 years;
- Malignant neoplasm of skin (ICD-10 C44) at ages 0-74 years;
- Malignant neoplasm of female breast (ICD-10 C50) at ages 0-74 years;
- Malignant neoplasm of cervix uteri (ICD-10 C53) at ages 0-74 years;
- Malignant neoplasm of unspecified part of the uterus and body of the uterus (ICD-10 C54-C55) at ages 0-44 years;
- Malignant neoplasm of testis (ICD-10 C62) at ages 0-74 years;
- Hodgkin's disease (ICD-10 C81) at ages 0-74 years;
- Leukaemia (ICD-10 C91-C95) at ages 0-44 years;
- Diseases of the thyroid (ICD-10 E00-E07) at ages 0-74 years;
- Diabetes mellitus (ICD-10 E10-E14) at ages 0-49 years;
- Epilepsy (ICD-10 G40-G41) at 0-74 years;
- Chronic rheumatic heart disease (ICD-10 I05-I09) at ages 0-74 years;
- Hypertensive disease (ICD-10 I10-I13) at ages 0-74 years;
- Ischaemic heart disease (ICD-10 I20-I25) at ages 0-74 years;
- Cerebrovascular disease (ICD-10 I60-I69) at ages 0-74 years;
- Respiratory diseases excluding pneumonia, influenza and asthma (ICD-10 J00-J09, J20-J44, J47-J99) at ages 1-14 years;
- Influenza (ICD-10 J10-J11) at ages 0-74 years;
- Pneumonia (ICD-10 J12-J18) at ages 0-74 years;
- Asthma (ICD-10 J45-J46) at ages 0-44 years;
- Peptic ulcer (ICD-10 K25-K27) at ages 0-74 years;
- Appendicitis (ICD-10 K35-K38) at ages 0-74 years;
- Abdominal hernia (ICD-10 K40-K46) at ages 0-74 years;
- Cholelithiasis & cholecystitis (ICD-10 K80-K81) at ages 0-74 years;
- Nephritis and nephrosis (ICD-10 N00-N07, N17-N19, N25-N27) at ages 0-74 years;
- Benign prostatic hyperplasia (ICD-10 N40) at ages 0-74 years;
- Maternal deaths (ICD-10 O00-O99) at ages 0-74 years;
- Congenital cardiovascular anomalies (ICD-10 Q20-Q28) at ages 0-74 years;
- Perinatal deaths (all causes excluding stillbirths) at ages 0-6 days;
- Misadventures to patients during surgical and medical care (ICD-10 Y60-Y69, Y83-Y84) at ages 0-74 years.

Healthcare intervention includes preventing disease onset as well as treating disease. Age limits are applied to this data as listed above; rates are age standardised and presented per 100,000 population aged under 75 years.

Table 19: Directly age standardised death rate from causes considered amenable to healthcare, local authorities in Northumberland compared to the North East and England, 2004-2006

	Number	Rate	95%LL	95%UL
Northumberland	1251	109.58	103.40	115.75
Alnwick	126	99.17	81.23	117.12
Berwick	105	89.97	72.34	107.60
Blyth Valley	321	117.40	104.49	130.32
Castle Morpeth	183	97.91	83.20	112.61
Tynedale	213	96.22	83.04	109.39
Wansbeck	303	139.88	123.95	155.81
NORTH EAST	11,187	131.00	128.54	133.46
ENGLAND	176,733	111.75	111.23	112.28

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright

Northumberland's rate is lower than the average for England.

Indicators of health inequalities

Relationship with multiple deprivation

Figure 17 shows that, in general, areas with higher levels of deprivation suffer from higher mortality rates. This is true for Northumberland as a whole, but also for each of the six districts within Northumberland.

Understanding the gap in all age all cause mortality

During 2007, a *Health Inequalities Intervention Tool* [22] was published to present key data and modelling aimed at helping Spearhead Local Authorities improve life expectancy quickly. The analysis was based on mortality data for 2003-2005, and the tool presents the percentage of the positive mortality gap due to a range of causes of death. The positive mortality gap is calculated by applying England's age sex specific death rates for specified causes of death to the local population structure and subtracting the resultant estimates of "expected deaths" from observed deaths for the local area. Only those which give positive results are included in the calculation of total excess deaths. Table 20 and Figure 18 provide a summary of the percentage of positive excess mortality by cause for the Northumberland Spearhead local authorities.

Figure 17: All Age All Cause Mortality vs IMD2007 score: Northumberland Lower Super Output Areas (plotted as a separate series for each district), 2002-2006 pooled data

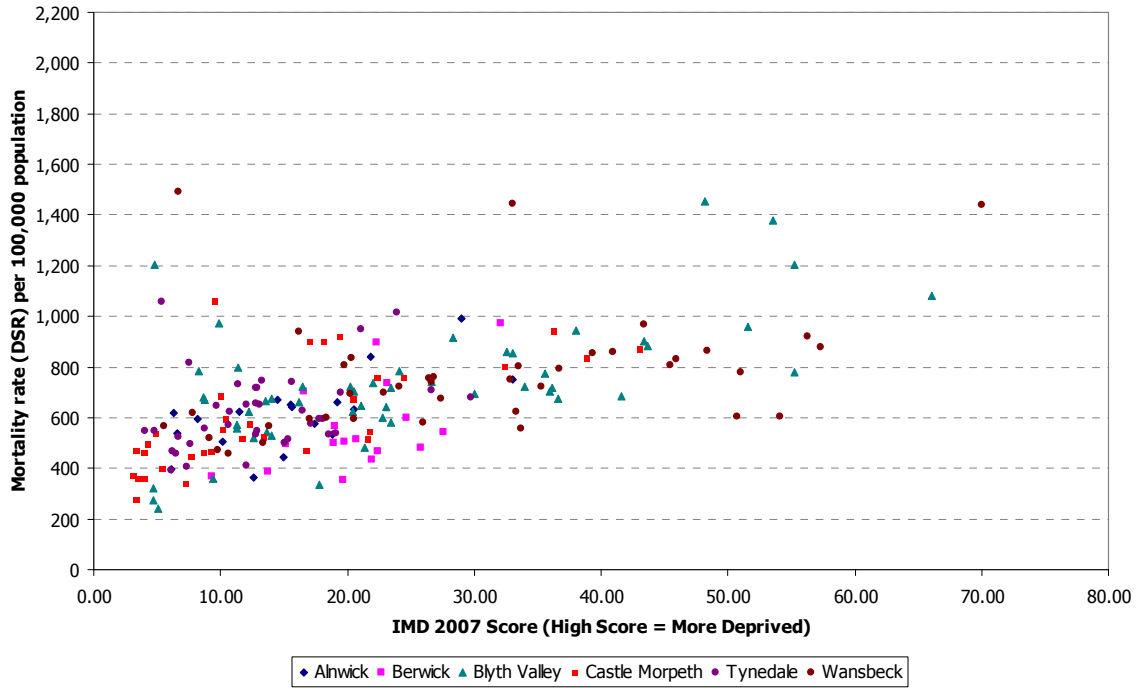


Figure 18: Percentage of positive excess mortality by sex and cause: North Tyneside, 2003-2005

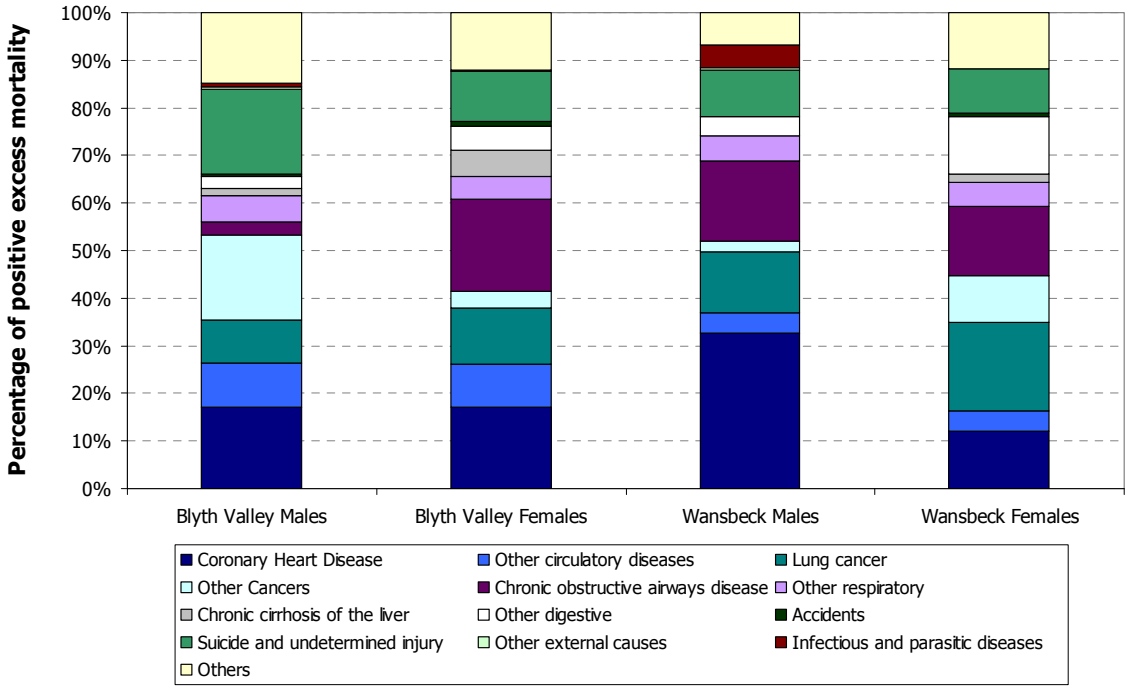


Table 20: Number of deaths and percentage of positive mortality gap by cause, 2003-2005

	No. of deaths	% Excess deaths	
		Males	Females
Blyth Valley			
Coronary Heart Disease	488	17.2	17.1
Other circulatory diseases	433	9.3	9.0
Lung cancer	180	8.9	11.9
Other Cancers	483	17.8	3.4
Chronic obstructive airways disease	146	2.9	19.4
Other respiratory	225	5.4	4.7
Chronic cirrhosis of the liver	36	1.5	5.6
Other digestive	98	2.6	4.9
Accidents	59	0.4	1.1
Suicide and undetermined injury	43	17.8	10.6
Other external causes	<5	0.7	0.0
Infectious and parasitic diseases	26	0.6	0.2
Others	325	14.9	12.0
TOTAL	2542	100.0	100.0
Wansbeck			
Coronary Heart Disease	410	32.6	12.0
Other circulatory diseases	356	4.4	4.4
Lung cancer	168	12.8	18.7
Other Cancers	397	2.1	9.7
Chronic obstructive airways disease	163	16.9	14.6
Other respiratory	181	5.3	5.1
Chronic cirrhosis of the liver	20	0.0	1.6
Other digestive	106	4.0	12.2
Accidents	38	0.0	0.7
Suicide and undetermined injury	27	9.9	9.4
Other external causes	<5	0.5	0.0
Infectious and parasitic diseases	30	4.8	0.0
Others	244	6.7	11.8
TOTAL	2140	100.0	100.0

Cardiovascular disease (mainly coronary heart disease), cancer and respiratory disease (particularly chronic obstructive airways disease) account for about two-thirds of the gap between Spearhead areas and England. Locally they account for:

- For Blyth Valley – 62% of the gap for males and 66% of the gap for females;
- For Wansbeck – 74% of the gap for males and 65% of the gap for females.

National modelling has been undertaken to identify interventions to narrow the life expectancy gap. These include smoking cessation, secondary prevention of CVD, early identification of cancer, and action to reduce deaths from respiratory diseases.

Tackling health inequalities successfully and sustainably means local service providers working in partnership to address the wider determinants of health such as poverty, employment, poor housing and poor educational attainment. Primary Care Trusts and Local Authorities are the key partners leading and driving change locally.

The 2010 target, and the analysis shown above, gives a shorter term focus on preventing the early deaths of people who already have disease or are at high risk of developing disease. Reducing the prevalence of smoking will impact on all three causes.

Based on the national modelling of the key contributory causes of death, the Department of Health has suggested the following interventions are being those that could potentially narrow the life expectancy gap; these need to be interpreted locally in the light of demographics, existing performance and other local factors. They are listed below:

Key suggested **targeted** interventions[19] are as follows:

- Smoking cessation clinics - double capacity in Spearhead areas for 2 years.
- Secondary prevention of cardiovascular disease - additional 15% coverage of effective therapies in Spearhead areas for persons aged 35-74 years.
- Primary prevention of cardiovascular disease in people with hypertension aged under 75 years:
    - 40% coverage for antihypertensives; and
    - Statin therapy.
- Primary prevention of cardiovascular disease in people with hypertension aged 75 years and over:
    - 40% coverage for antihypertensives; and
    - Statin therapy.
- Other interventions for local determination, including:
    - Early detection of cancer;
    - Respiratory diseases;
    - Alcohol related diseases; and
    - Reducing infant mortality.

Key suggested **universal** interventions[19] are as follows:

- Smoking reduction in clinics – as at present.
- Secondary prevention of cardiovascular disease - 75% coverage of effective therapies for persons aged 35-74 years.
- Primary prevention of cardiovascular disease in people with hypertension aged under 75 years:
    - 20% coverage for antihypertensive; and
    - Statin therapy.

Plans in place

Northumberland's Health and Well-being Strategy[22] sets out the vision for 2010 where:

- Life expectancy for all areas of Northumberland has increased to at least the same level as the rest of the country by 2010.

This overall vision is underpinned by two main priorities to:

- Improve the health of children in the early years and through school; and
- Prevent the avoidable deaths from heart disease and stroke in middle aged people.

The Strategy includes programmes which aim to:

- Give children the best start for a healthy life;
- Encourage young people toward healthier lifestyle choices;
- Prevent avoidable death and disability in adults with an emphasis on risk of heart disease and stroke;
- Promote an active and independent life for older people;
- Promote mental health and emotional well-being; and
- Recognise diversity – including tackling multiple deprivation with the Spearhead areas of the county and rising to the challenges of health problems in rural areas.

Objectives for health improvement and reducing inequalities are also strongly reflected in the Sustainable Community Strategy[23] and Local Area Agreement[7]. Health is one of the Strategy's seven themes and links to health objectives are apparent in all themes; these are cross referenced within the Health and Well-being Strategy. The Local Area Agreement includes targets on all age all cause mortality, cardiovascular disease mortality, stopping smoking, affordability of housing and tackling fuel poverty within its designated list of 35 indicators.

Progress on the key health issues are reported within the Director of Public Health's Annual Report[24].

Engagement arrangements

Partnership arrangements

The Northumberland Strategic Partnership (NSP) co-ordinates the efforts of all organisations with an interest in regenerating Northumberland. Its aim is to help to ensure that the economic, social and environmental needs of the county are achieved. The Strategic Partnership works through a system of partnership structures designed to ensure that all interests are covered and that opportunities can be developed quickly and efficiently for the benefit of Northumberland; these are: the NSP Board, the NSP Executive and six Sector Boards, including a Sector Board for Health, Care and Well-being.

Public engagement

The Sustainable Community Strategy[23] recognises the need to have in place interactive channels of communication and dialogue that go beyond decision makers simply "consulting" on a prescribed way forward. Plans for the developing new single unitary council for Northumberland[25] include clear plans for improved community engagement by bringing together community interests and decision makers at a geographical scale that broadly respects the distinct parts of Northumberland whilst being manageable for taking effective decisions.

Development of the new Local Area Agreement[7] has involved processes of engagement with elected members, voluntary and community sector organisations, and the private sector. The input of residents was through the consultative and perception-based elements of the evidence base. Information was provided to all households to keep the public informed of progress.

There is a commitment within the Health Strategy that all partner organisations should involving local communities, service users and carers in the development and evaluation of health programmes. The Director of Public Health report describes a number of health programmes with where there is active engagement with particular communities, young people and the general public.

5. LIFESTYLE FACTORS

TOBACCO CONTROL AND STOP SMOKING

Smoking remains the greatest contributor of premature death and disease across Northumberland. It is estimated that up to half the difference in life expectancy between the most and least affluent groups is associated with smoking. It is estimated that 87% of deaths from lung cancer are attributable to smoking, as are 73% of deaths from upper respiratory cancer and 86% of chronic obstructive lung disease. Smoking is also a major factor in deaths from many other forms of cancer and circulatory disease.

Northumberland has rates of smoking attributable mortality statistically significantly higher than the England rate; during 2003-2005, it was estimated that 1,996 of the 10,260 or 19.5% deaths occurring in persons aged 35 and over were due to smoking.

Table 21: Smoking Attributable Mortality in persons aged 35 and over, 2003-2005

	No. of deaths	Rate†	95% LL	95% UL
Northumberland	1,996	254.4	243.4	265.7
Alnwick	191	208.8	180.9	240.2
Berwick	168	202.5	173.4	234.8
Blyth Valley	510	295.9	271.2	322.6
Castle Morpeth	312	233.4	208.6	260.4
Tynedale	345	218.5	196.6	242.8
Wansbeck	469	315.3	288.0	345.1
NORTH EAST	16,996	296.0	291.6	300.5
ENGLAND	260,988	234.4	233.5	235.3

SOURCE: APHO and Department of Health. 'Health Profiles Interactive (www.healthprofiles.info) 2008 © Crown Copyright 2008

NOTE: † Directly age standardised rate per 100,000 population aged 35 years and over

Synthetic estimates based on the Health Survey for England compare smoking prevalence in adults at small area level. The smallest geography for which estimates are available is at the level of Middle Layer Super Output Areas (MSOAs). Within Northumberland, there is a four fold difference between the estimated smoking prevalence in the best performing (10% for Castle Morpeth 007) and worst performing (43.7% in Blyth Valley 001) MSOAs in Northumberland.

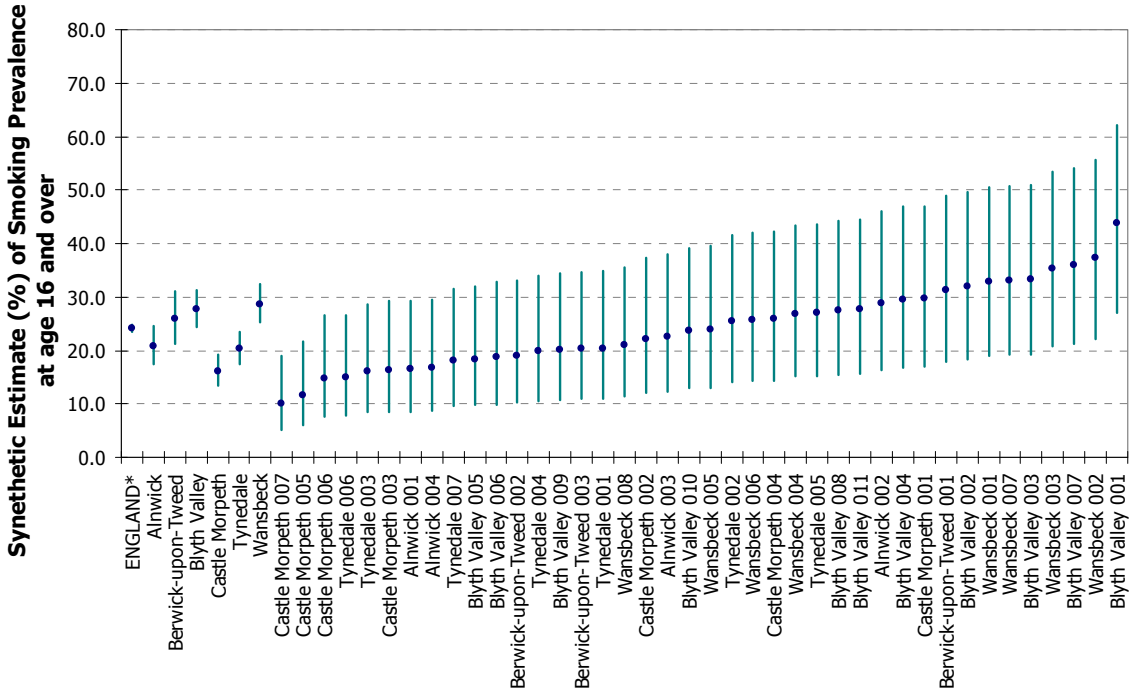
Table 22: Estimated Smoking Prevalence in persons aged 16 and over

	Estimated Prevalence (%)	95% LL	95% UL
Northumberland	23.5	22.0	25.0
Alnwick	20.7	17.4	24.5
Berwick	25.9	21.2	31.1
Blyth Valley	27.7	24.4	31.3
Castle Morpeth	16.2	13.4	19.3
Tynedale	20.4	17.5	23.5
Wansbeck	28.7	25.2	32.5
ENGLAND‡	24.7	23.4	24.1

SOURCE: Synthetic Estimates of Smoking Prevalence 2003-2005, Neighbourhood Statistics © Crown copyright

NOTE: ‡ England data is a direct estimate from Health Survey for England data.

Figure 19: Estimated Smoking Prevalence in persons aged 16 and over: Northumberland MSOAs, 2003-2005



SOURCE: Synthetic Estimates of Smoking Prevalence 2003-2005, Neighbourhood Statistics © Crown copyright.

NOTE: ‡ England data is a direct estimate from Health Survey for England data.

Figure 20: Map of Estimated Smoking Prevalence in persons aged 16 and over: Northumberland MSOAs, 2003-2005

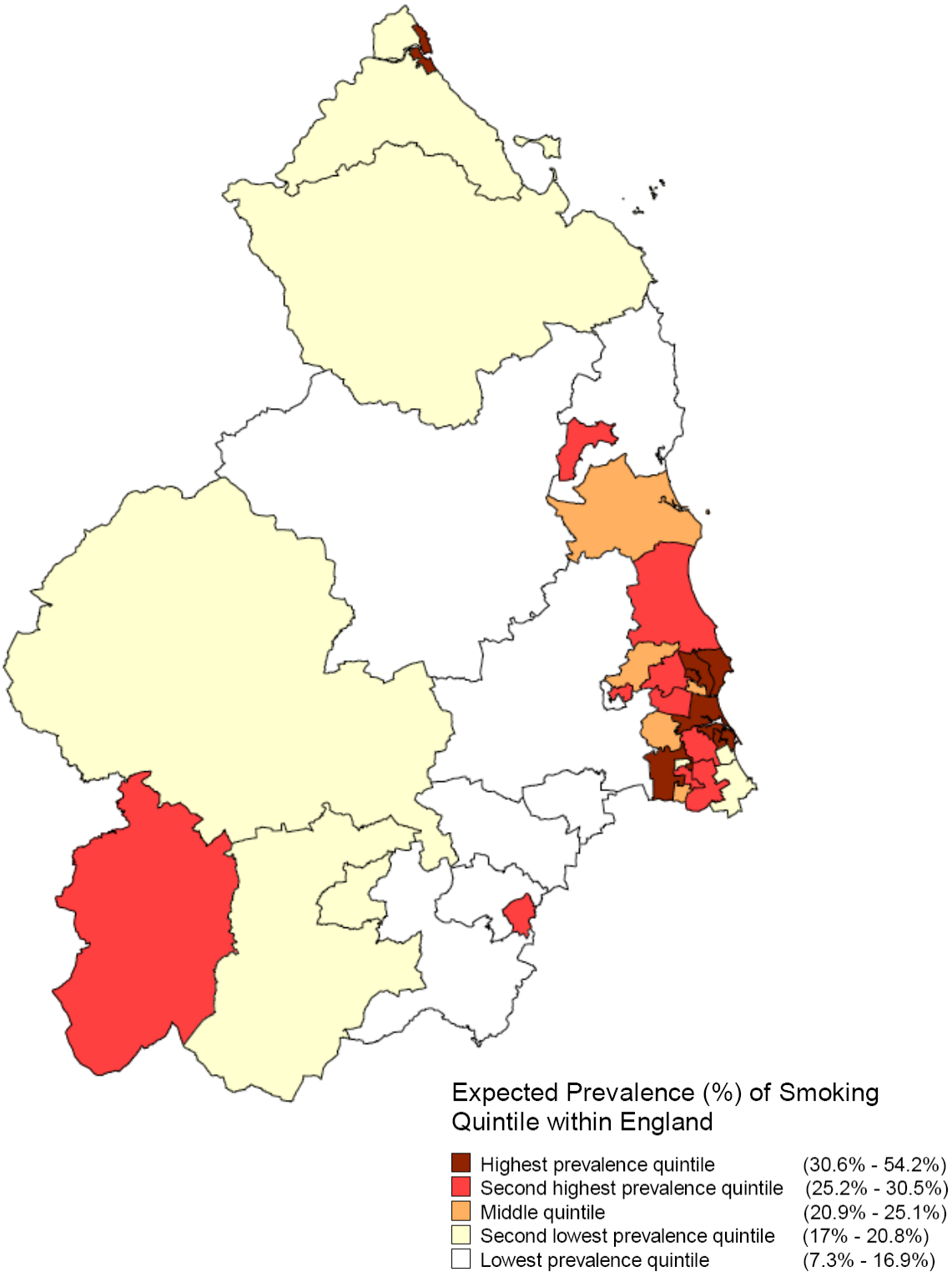


Table 23: Number and rate (per 100,000 population aged 16 and over) of self-reported 4 week smoking quitters, 2003/04 onwards, plus 2008/09 targets

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09 target†
No. of quitters	2,156	2,355	2,399	2,411	2,414	**2,455**
Rate per 100,000	865	932	942	942	941	**952**

SOURCE: Statistics on NHS Stop Smoking Services, Information Centre © Crown Copyright

NOTE: † - Vital Signs target for 2008/09.

Smoking in pregnancy is of particular concern, highlighted by area health profiles. Smoking during pregnancy is estimated to contribute to 40% of all infant deaths. The Priorities and Planning Framework 2003-2006[26] contained a target of delivering a reduction each year in the proportion of women continuing to smoke throughout pregnancy from 23% in 1995 to 18% by 2005 and then to 15% by 2010.

Table 24: Mothers known to be smoking at the time of delivery

	2003/04	2004/05	2005/06	2006/07	2007/08
No. of maternities	3,044	2,911	3,016	3,015	3,076
No. smoking§	731	602	657	561	566
% mothers smoking§	24	21	22	19	18

SOURCE: Data submitted for LDP Returns, Northumberland Care Trust

NOTE: § - Cells shaded in blue are where data failed to reached the Department of Health's quality standard of < 5% of records with smoking status unknown

Reducing smoking rates in deprived communities is one of the greatest challenges in health improvement, but is vital to closing the health inequalities gap. A health equity audit in 2006[27] examined prevalence and outcome (4 week quit rate). This made several recommendations about how smoking-related inequalities might be addressed.

Service developments include:

- Improving the accessibility of the service out of hours by increasing the number of sessional advisors, greater use of pharmacy with extended opening hours, and using a wide range of venues;
- Earlier access to stop smoking services for pregnant smokers by having the pregnancy specialist advisor at early pregnancy sessions;
- Raising awareness of the dangers of second hand smoke through changes to the Child Health booklet and by promoting the National Clean Air Award for child minders; and
- Developing a training aid for those supporting smokers with mental health issues;
- Establishing the POINT - a young people's project for advice and support on quitting smoking which has been accessed by over 70 young people.

Work includes supporting smokers to quit; reducing exposure to second hand smoke; running effective communications and education campaigns; reducing tobacco advertising, marketing and promotion; regulating tobacco products; and reducing the availability and supply of tobacco products.

On-going support for the tobacco control agenda is evident within Northumberland's Health Strategy[22] and Local Area Agreement[7]. Northumberland Care Trust makes a financial contributions to FRESH (the regional office for a Smoke Free North East), but there needs to be a robust service level agreement for the North of Tyne that ensures this provides value for money. Smoking clearly makes a significant contribution to the area's mortality gap. It is therefore necessary to ensure that tobacco control and stop smoking approaches are included in a robust Health Gain Schedule so that key messages are systematically delivered through frontline staff. This will require effective connections between public health, commissioning and providers.

There is a need for more robust data about smoking including local prevalence data about young people and longer-term quit rates.

The Department of Health's National Support Team for Health Inequalities suggested that the stop smoking service specification should be refocused to ensure a systematic approach in meeting the needs of prioritised groups of smokers. It is recognised that an exclusive focus on achieving 4-week quit targets may be detrimental to support for the more vulnerable smokers who find it harder to quit. Services must ensure that they support people to stop smoking and stay stopped. Those in "greatest need" should be targeted, recognising the multiplicity of risk (e.g., those with CVD, those who are obese) and interventions should be targeted where they will have the biggest returns. National policy emphasises the need to target routine and manual workers rather than focusing on area-based approaches to tackling inequalities, conflicting with local programmes, such as Neighbourhood Renewal or Spearhead initiatives.

It recommended that there is great potential in working with primary care performance management and development teams to improve validation of Quality and Outcome Framework (QoF) smoking indicators and effectiveness of brief interventions and referral by GPs. Some excellent work has been done to target patients on primary care long–term condition registers. This work should be developed into a systematic menu-based system of customer access strategies linked to patient segmentation.

ALCOHOL

The North of Tyne scoping review of adult alcohol treatment services identified significant crossover in terms of gaps and weaknesses in local alcohol treatment service delivery. The three PCO areas have converged on a number of alcohol treatment priorities, which they agree would need to be delivered across North of Tyne if adult alcohol treatment service provision was to improve, and if alcohol related harm was to be reduced. The identified gaps in adult alcohol treatment provision are set out below under Tier 1/Tier 2 Interventions and Tier 3/Tier 4 Interventions.

As part of the review process, the PCTs have sought to identify the number of people with alcohol use disorders (AUD) within each PCT area. At present, there is a shortage of reliable alcohol consumption data available to the PCTs; however some crude figures give us an indication of the number and type of people with an alcohol problem, as follows:

- The Alcohol Needs Analysis Research Project (ANARP)[28] concluded that 26% of people in the North East have an alcohol use disorder (i.e., they consume alcohol at hazardous, harmful or dependent levels). Applying this percentage to the Northumberland population of persons aged 15 years and over gives an estimate of around 67,400 people with alcohol use disorders. It must be noted however that these figures were considered to be an underestimate.
- The synthetic estimates of binge drinkers, published by the North West Public Health Observatory in 2006, suggests that 23% of the population is binge drinking. Applying this percentage to the population of Northumberland gives an estimate of the number of binge drinkers in the locality as around 59,700.

Table 25: Rate of hospital admission for alcohol related harm per 100,000 population in persons of all ages, local authorities in Northumberland compared to the North East and England, 2004-2006

	2004/05		2005/06		2006/07	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Northumberland	4,196	1,143.7	5,806	1,567.9	6,580	1,723.9
Alnwick	389	1,029.8	560	1,448.3	652	1,631.6
Berwick	298	921.1	342	973.1	431	1,171.6
Blyth Valley	1,140	1,260.2	1,630	1,781.8	1,748	1,869.3
Castle Morpeth	710	1,119.6	955	1,515.5	1,073	1,653.8
Tynedale	691	938.2	892	1,216.8	1,040	1,384.6
Wansbeck	962	1,365.3	1,424	2,002.3	1,605	2,196.0
NORTH EAST	43,328	1,509.3	50,439	1,738.8	55,904	1,903.5
ENGLAND	720,583		828,411		904,034	

SOURCE: North West Public Health Observatory, based on Hospital Episode Statistics, Department of Health © Crown copyright

Table 26: Directly age standardised mortality rate per 100,000 population from chronic liver disease, including cirrhosis (ICD-10 K70, K73-K74) in persons of all ages, local authorities in Northumberland compared to the North East and England, 2004-2006.

	Number	Rate	95% LL	95% UL
Northumberland	110	9.64	7.79	11.48
Alnwick	8	6.61	1.97	11.25
Berwick	9	6.96	2.22	11.69
Blyth Valley	37	13.33	8.99	17.67
Castle Morpeth	18	8.75	4.60	12.89
Tynedale	14	6.40	2.82	9.98
Wansbeck	24	11.56	6.87	16.25
NORTH EAST	1,112	13.24	12.45	14.03
ENGLAND	16,779	10.20	10.04	10.35

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright

Alcohol–related hospital admissions, chronic liver disease and alcohol-related deaths are all higher in Northumberland than the average for both the North East and England. The hospital admission figures do not include statistics for Accident and Emergency units and would be much higher if these were also included.

Excessive and inappropriate drinking leads to crime and social disorder - particularly youth disorder - with increased demand on Police and other support services. Hazardous and harmful drinking in the home is widespread and damaging to the health and wellbeing of individuals and families and needs to be better understood.

A pilot study looking at the use of brief interventions will shortly be completed and initial results look positive and cost-effective. In Wansbeck, a pilot alcohol project is currently underway where joint working between a host GP practice and a voluntary organisation provides nurse-supervised home detoxification for people with alcohol problems and also provides group and one to one counselling and complementary therapy sessions for people.

Many people with drink problems remain in work, which is positive, but this may mean that they are not receiving any help or treatment.

OBESITY, DIET AND PHYSICAL ACTIVITY

Obesity

In England in 2005, 22.1% of men and 24.3% of women were classified as obese and almost two thirds of all adults were either overweight or obese. Indeed the levels of obesity in England have trebled since the 1980s. The Foresight Report 2007[29] indicated that most adults in the UK today are overweight and that without action, by 2050, 60% of men and 40% of women could be obese, and obesity related diseases will cost an extra £45.5 billion per year.

It is estimated from this report that the costs to Northumberland for morbidity caused by obesity will escalate from £25.9 million to £38.9 million by 2015 if the current trend in obesity prevalence continues. Obesity impacts on cardio vascular disease, diabetes, some cancers and many other conditions.

Table 27: Overweight and obese school children in Reception and Year 6, local authorities in Northumberland compared to the North East and England, 2007/08

	Reception class			Year 6		
	No. of children	**Prevalence %**	**95% CI ± %**	**No. of children**	**Prevalence %**	**95% CI ± %**
Obese†						
Northumberland	289	10.1	-1.1 to 1.1	546	17.9	-1.4 to 2.2
ENGLAND	46,020	9.6	-0.1 to 0.1	90,735	18.3	-0.1 to 0.9
Overweight‡						
Northumberland	429	14.8	-1.3 to 1.3	435	14.3	-1.2 to 1.2
ENGLAND	61,913	13.0	-0.1 to 0.1	70,732	14.3	-0.1 to 0.1

SOURCE: National Child Measurement Programme Results 2007/08, The Information Centre, © Crown copyright

NOTES: † -% of children obese as defined according to the UK90 95th percentile.
‡ - % of children overweight as defined according to the UK90 85th percentile.

Table 28: Estimated number of obese children (>95th centile) by age group for Northumberland

	0-3	**4-11**	**12-15**	**Totals**
Northumberland	2,950	7,550	5,510	16,010

SOURCE: North East Obesity Review of Need and Capacity. Executive Directors of Public Health Briefing Paper 18 July 2008

NOTES: Estimates are calculated from the Health Survey for England and the data from the National Child Measurement Programme.

Also see pages 91 for information about tackling childhood obesity.

Physical activity

Table 29: Measures of physical activity in adults aged 16 years and over for 2005/06 and in children aged 5-16 years in 2006/07, local authorities in Northumberland compared to the North East and England

	Adults		Children	
	%	Significance	%	Significance
Northumberland	12.5	better	81.7	worse
Alnwick	15.8	better	88.4	better
Berwick	11.3	none	90.0	better
Blyth Valley	11.4	none	72.7	worse
Castle Morpeth	14.7	better	88.0	better
Tynedale	13.4	none	84.1	worse
Wansbeck	10.0	none	80.6	worse
NORTH EAST	11.4	none	87.0	better
ENGLAND	11.6		85.7	

SOURCE: Adult physical activity taken from Sport England's Active People Survey, 2005/06; child physical activity taken from the Annual Survey of School Sport Partnerships for DCFS 2006/07 © Crown copyright

The table above provides the a measure of the percentage of adults aged 16 years and over who reported participating in moderate intensity sport and active recreation on 20 or more days in the previous 4 weeks (averaging 5 or more times per week) in the Active People Survey for 2005/06[30]. When compared to England, Northumberland has a higher rate of physical activity among adults. Rates of participation in Alnwick and Castle Morpeth are also better than national average.

The table above also provides a measure of the percentage of children attending state schools belonging to a School Sport Partnership who were reported as participating in at least 2 hours of high quality PE and school sport within and beyond the curriculum in a typical week of the academic year in the Annual Survey of School Sport Partnerships for 2006/07[31]. Blyth Valley, Tynedale and Wansbeck have rate of participation that are significantly better than the England average, whilst Alnwick, Berwick and Castle Morpeth have rates that are significantly better.

There is a clear need for better data about obesity prevalence, as well as the lifestyle choices people make about diet and activity levels across Northumberland. Accessible and effective activities promoting healthier food and physical activity choices should be commissioned to improve Northumberland population's health.

Prevention and treatment

A range of interventions to increase physical activity levels and improve nutritional knowledge are currently commissioned. These range from general advice and information to drug prescribing and surgery, which is the last line of intervention in weight management.

The Healthy Living Centre (HLC) in Wansbeck offers general weight management advice and individual weight management and fitness programmes. All clients have their blood pressure, body mass index (BMI) and waist circumference recorded regularly.

The Food for Thought programme supports patients who are obese to make healthy lifestyle changes. The Skilled for Health[32] training programme (Phase 2) is aimed at those people with limited literacy, language and numeracy skills and helps reduce inequalities in health status. The educational support uses health topics to improve skills. Topics include alcohol, smoking, nutrition and physical activity.

Dieticians and food workers deliver nutrition and cooking skills within the community in a variety of settings and offer short sessions through to the accredited Open College Network accredited training. These sessions and courses are offered to frontline workers to build capacity and ensure consistent messages in care, and cooking skills are offered to members of the community who would benefit from additional support in these areas.

Health Trainers receive referrals from any source including self referrals. Health Trainers complete basic "health MOTs" including height, weight, blood pressure measurement, complete alcohol brief interventions and signpost to stop smoking and other relevant services.

There are specialised services run by the NHS, with partners including Local Authorities, to support weight management. These include:

- Exercise referral schemes;
- Dietetic support (including weight management), available in community, primary care and hospital based settings via General Practitioner referral;
- Specialist diabetes services are available providing a range of support to include weight management and lipid management.

Drug therapy

Anti obesity medications Orlistat and Sibutramine are available to clients through prescription from GP practices.

Table 30: Number and cost of prescriptions for anti-obesity medications across Northumberland April 2006–March 2007

	Number of prescriptions	Cost
Northumberland	5,796	£237,287

In Northumberland, between 2003/04 and 2007/08, there has been an 18.2% increase (not including Rimonabant). Audit reveals the use of Rimonabant in some practices at a cost of £5,158 in 2006/07and an additional cost of £3,575 in 2007/08.

Bariatric Surgery

There is a large mismatch between need and current capacity for prevention and treatment services for obesity including weight management programmes, drug prescribing and bariatric

surgery. There are an estimated 171,729 people who are overweight or obese in Northumberland; of these 62,999 are estimated to be obese. North of Tyne has an estimated capacity for less than 5,000 people per year on programmes, with even fewer for more targeted weight management programmes. The regional Health and Wellbeing Strategy[33] highlights the need to scale up bariatric surgery and obesity drug prescribing to meet demand. Estimated costs to the NHS for North of Tyne for obesity morbidity are set to rise from an estimated £69million in 2007/08 to £103 million in 2015 if the current trend in rise in obesity continues.

Identified needs are as follows:

- Integrated pathways and referrals across North of Tyne;
- Scale up prevention and treatment of obesity through more drugs, more surgery, more family and group interventions;
- Increase capacity across the statutory and third sectors to deal with increased demand;
- Develop more emphasis on the 'life course approach' where interventions are targeted across peoples lives, and not just focused on children; and
- Link interventions to the demand resulting from the national social marketing campaign.

BREAST FEEDING

Table 31: Percentage of infants where breastfeeding was initiated (LDPR – hospital based collection) compared to local monitoring (MEDICS – GP based collection), 2005/06 to 2007/08

	2005/06	2006/07	2007/08
Northumberland (LDPR)†	44.3	49.5	58.8
Northumberland (MEDICS)	41.2	45.4	45.3
Blyth Valley	34.7	38.6	36.7
Wansbeck	27.7	30.0	34.9

SOURCE: NHS Local Delivery Plan data monitoring line, Department of Health; NHS North of Tyne Local Performance local, 2005/06 to 2007/08

NOTE: † - ascertainment within the hospital data is better than within the MEDICS data, but cannot currently be provided below Northumberland level; lower reported rates of breastfeeding initiation within the MEDICS data are likely due to incomplete recording status.

Increasing the numbers of women who choose to breastfeed their babies remains an important priority in improving health and reducing health inequalities. The importance of improving breastfeeding rates is recognised nationally and locally. Breastfeeding contributes to several national policies and public service agreement targets. (See also page 91).

Across Northumberland, a comprehensive strategy to address inequalities and focus on encouraging maternity providers to work towards achieving the UNICEF Baby Friendly Initiative award is being developed. Activities include developing peer supporters, infant feeding coordinators and staff training. Additional support is targeted to the Spearhead local authorities of Blyth Valley and Wansbeck, where reported breastfeeding initiation rates are lower.

SUBSTANCE USE

Overall within Northumberland opiate use remains the most problematic substance in terms of treatment need, associated crime levels and impact on harm reduction services. However, use of crack cocaine is an increasing problem. Among younger people poly drug use is common amongst those using drugs and this poly use compounds the problems they experience through drug use.

Steroid use is an increasing problem, with 50% of people accessing the Harm Reduction Service in Northumberland doing so because of their steroid use. Among young men in particular, steroid use has been shown to be associated with violence. Most of the people using steroids are not in services and are only accessing the needle exchange part of the service – where they will receive safe injecting advice.

Table 32: Numbers in treatment and number of new presentations retained in treatment for at least 12 weeks, Northumberland compared to the North East and England, 2007/08

	No. in contact with structured treatment	No. of persons that presented	No. of persons retained in treatment at 12 weeks	% of persons retained in treatment at 12 weeks
Northumberland	969	296	222	75
NORTH EAST	13,623	4,991	4,048	81
ENGLAND	202,666	82,381	64,440	78

SOURCE: National Treatment Agency for Substance Misuse, 2008 © Crown copyright

NOTE: Figures include alcohol if people are in structured treatment with services.

In 2008/09, it is estimated that there are between 783 and 977 adult problem drug users in Northumberland. At present, it is not known exactly how many of these individuals have young people living with them. Of these, 716 are either in treatment or known to treatment services[34]. The majority of the in-treatment population resides in the more urban areas of the county. However, it should be remembered that Berwick upon Tweed and, to a lesser extent, Castle Morpeth, Tynedale and Alnwick all have class A drug users living within the district. Services are therefore required to be delivered across the county, with a concentration of service in Blyth, Ashington and Berwick.

SEXUAL HEALTH

Sexual health and wellbeing is a major public health challenge. Sexual ill health is increasing. The highest burden is borne by gay and bisexual men, young people and black and minority ethnic groups. Improving sexual health is a priority at both national and local level.

Sexually Transmitted Infections

Data on diagnoses of sexually transmitted infections (STIs) are collected by the Health Protection Agency from Genitourinary Medicine (GUM) services across the UK.

At England level:

- Trends over the 10 year period from 1997 to 2006 show a gradual rise in the number of new STI diagnoses and recurrent infections, while other diagnoses made in GUM clinics (e.g., candidosis & vaginosis) have remained relatively stable.
- Genital chlamydia infection is the most common STI diagnosed in GUM clinics.
- Between 2003 and 2006, diagnoses of uncomplicated chlamydia infections have increased by 25%.
- Over the same period new diagnoses of genital warts and genital herpes increased and gonorrhoea diagnoses decreased.
- Over the same period there was an increase in the number of diagnoses of infectious (primary & secondary) syphilis.

Within the North East region, the patterns are similar to these national patterns. The majority of cases of syphilis continue to occur among men who have sex with men. Enhanced surveillance of syphilis was initiated by the Health Protection Agency in the North East in 2002 when an outbreak in the population of men who have sex with men population was detected.

Chlamydia Screening

The Chlamydia Screening Office in Newcastle leads the work on Chlamydia screening across North of Tyne. The Annual Operational Plan[35] includes a target for the proportion of the population aged 15-24 years accepting a screen. The target set by the Department of Health for 2007/08 was for 15% of 15-24 year olds to be screened through the National Chlamydia Screening Programme. Although the numbers of screens undertaken are well below the local target, the programme is one of the best performing in the country. Chlamydia Screening is struggling nationally and locally to meet set targets. In order to increase uptake an innovative marketing strategy is being developed using novel techniques like 'peer to peer' marketing - where students are paid to recruit their peers to the programme.

Table 33: Number of young people aged 15-24 screened through the National Chlamydia Screening Programme, 2007/08

	Number	% of all 15-24 year olds	% of sexually active population
Northumberland	1,917	5.4	7.1
NORTH EAST	22,479	6.4	8.1
ENGLAND	319,008	4.9	6.3

SOURCE: National Chlamydia Screening Programme, NHS Local Delivery Plan data monitoring line (PSA11d), Health Protection Agency, 2008 © Crown copyright

From April 2008, all chlamydia screens/tests undertaken outside of genitourinary medicine clinics (GUM) on 15-24 year olds will count towards calculating screening coverage in residents of each Primary Care Trust (PCT). This will have an effect of increasing the numbers reported as screened as many tests are currently performed as diagnostic tests in GP practices and other clinics. Screening coverage of 35% is required to achieve the population impact on Chlamydia prevalence and a review of the sub regional delivery model is required to achieve the optimum level of service. (Also see page 92).

Access to GUM

Table 34: Percentage of patients offered an appointment with GUM within 48 hours and the percentage of patients seen within GUM within 48 hours, Northumberland, 2007/08

	Q1	Q2	Q3	Q4	Annual
Number offered	518	623	669	717	2527
Number seen	341	460	535	591	1927
First attendances	518	629	672	733	2552
% Offered	100.0	99.0	99.6	97.8	99.0
% Seen	65.8	73.1	79.6	80.6	75.5

SOURCE: NHS North of Tyne Local Performance data, 2007/08

The local targets for access to Genitourinary Medicine (GUM) services are to offer 100% of patients (first attenders) within 48 hours and for 95% of patients (first attenders) to be seen within 48 hours. Sustaining 100% of patients offered an appointment within 48 hours of contacting the GUM service will be a challenging. Problems associated with data collection are being addressed. There is a persistent gap between the percentages of patients offered and seen; this is partly due to patient choice and failure to attend appointments. It is for local determination how much we aim to narrow this gap and optimise patients seen within 48 hours.

Teenage conceptions

Rates of teenage conception are generally declining but not rapidly enough to meet existing targets. Key actions include work targeting young people in schools and communities in teenage pregnancy "hot spot" areas who are provided with an intensive programme of sex and relationship education (SRE) and increased use of long acting reversible contraception, particularly in girls who have already become pregnant once. (Also see page 92).

In order to achieve the ambitious target a much more proactive approach to performance monitoring and managing the implementation of action plans including a scaled up and systematic approach to the promotion and provision of long acting reversible contraception (LARC) will be necessary.

Table 35: Rate of conceptions to women aged under 18 (per 1,000 women aged 15-17), local authorities in Northumberland compared to the North East and England, 2001-2006,

	2001	2002	2003	2004	2005	2006	2001-2003†	2004-2006†
Northumberland	36.8	41.1	38.2	37.5	36.6	35.9	38.7	36.7
Alnwick							36.4	27.4
Berwick							32.2	24.5
Blyth Valley							47.6	51.8
Castle Morpeth							25.4	23.3
Tynedale							22.4	19.2
Wansbeck							58.2	53.9
NORTH EAST	48.3	51.1	52.2	50.8	50.0	48.3	50.6	49.7
ENGLAND	42.5	42.7	42.2	41.6	41.3	40.4	42.5	41.1

SOURCE: Every Child Matter, Department for Children, Families and Schools, 2008 © Crown copyright

NOTE: † - rates for district councils are only available for three year rolling periods.

Table 36: HIV prevalence (rate per 100,000 population), Northumberland compared to the North East and England, 2001-2005

	2001		2002		2003		2004		2005	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Northumberland	18	5.9	26	8.4	33	10.7	43	13.9	45	14.5
NORTH EAST	310	12.2	403	15.9	534	21.0	641	25.2	754	29.6
ENGLAND	24,023	48.6	28,783	58.0	33,694	67.6	38,272	76.4	43,335	85.9

SOURCE: SOPHID, Health Protection Agency, 2008

The number of new HIV diagnoses has been steadily rising in the North East since 2000, with the largest number of cases reported in 2005. Since 2005, the number of new diagnoses appears to have levelled off but this trend should be interpreted with caution since numbers for recent years may still rise as more reports are received.

MENTAL HEALTH

Northumberland's draft Mental Health Promotion Strategy[36] highlights local pockets of deprivation since factors influencing deprivation have also been shown to be associated with higher levels of poor mental health. Achievement of reduced health inequalities should therefore have a positive effect on some mental health conditions. The strategy additionally identifies binge drinking as a factor which can impact adversely on mental health.

As mentioned in the section on population trends, older people will become a larger proportion of the population. Transport and rurality issues may compound possible problems of access to services and flexibility of delivery for this group.

Table 37: Number and unadjusted prevalence (percentage) of registered patients on the practice dementia register, 2006/07

	Number on dementia register	Total of practice list populations	Prevalence (%)
Northumberland	1,427	319,959	0.45
NORTH EAST	12,128	2,654,901	0.46
ENGLAND	212,794	53,681,098	0.40

SOURCE: Quality and Outcomes Framework (QoF) 2006/07, The Information Centre, 2007 © Crown copyright

Table 38: People aged 65 and over predicted to have dementia, local authorities in Northumberland compared to England, 2008, 2010 and 2015

	2008		2010		2015	
	Number	%	Number	%	Number	%
Northumberland	4,038	6.8	4,275	6.8	4,885	6.7
Alnwick	490	7.1	496	6.8	562	6.6
Berwick	465	7.0	501	7.3	584	7.0
Blyth Valley	861	6.5	885	6.5	1,045	6.3
Castle Morpeth	701	6.8	727	6.9	807	6.7
Tynedale	833	7.1	840	6.8	978	6.7
Wansbeck	752	6.8	796	6.9	875	6.7
ENGLAND	591,284	7.1	611,205	7.1	678,461	7.0

SOURCE: Projecting Older People Population Information System, Care Services Improvement Partnership, 2008, © Crown copyright

The Projecting Older People Population Information (POPPI) tool is designed to give councils with social service responsibilities and PCTs easy access to forecasts of the numbers and characteristics of older people in their locality through to 2025. Along with the Projecting Adult Needs and Services Information (PANSI) system covering the 18-64 age groups, POPPI and PANSI bring together relevant information for council planners and commissioners of adult social care and provide a consistent starting point for Joint Strategic Needs Assessment. They provide forecasts based on applying the latest set of population projection data to current prevalence data from the Office of National Statistics. As such they provide "static projections" and do not predict 'expected' future outcomes. For more information on dementia see page 122.

Table 39: Directly age standardised mortality rate per 100,000 population from suicide and injury undetermined (ICD-10 X60-X84, Y10-Y34 excluding Y33.9) for persons of all ages, local authorities in Northumberland compared to the North East and England, 2004-2006

	Number	Rate per 100,000	95% LL	95% UL
Northumberland	125	12.79	10.45	15.13
Alnwick	12	13.15	5.28	21.02
Berwick	7	7.89	1.15	14.62
Blyth Valley	35	14.50	9.64	19.37
Castle Morpeth	22	13.09	7.21	18.97
Tynedale	21	9.10	4.98	13.22
Wansbeck	28	14.61	9.09	20.14
NORTH EAST	766	9.69	8.99	10.38
ENGLAND	13,119	8.25	8.11	8.40

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2007 © Crown copyright

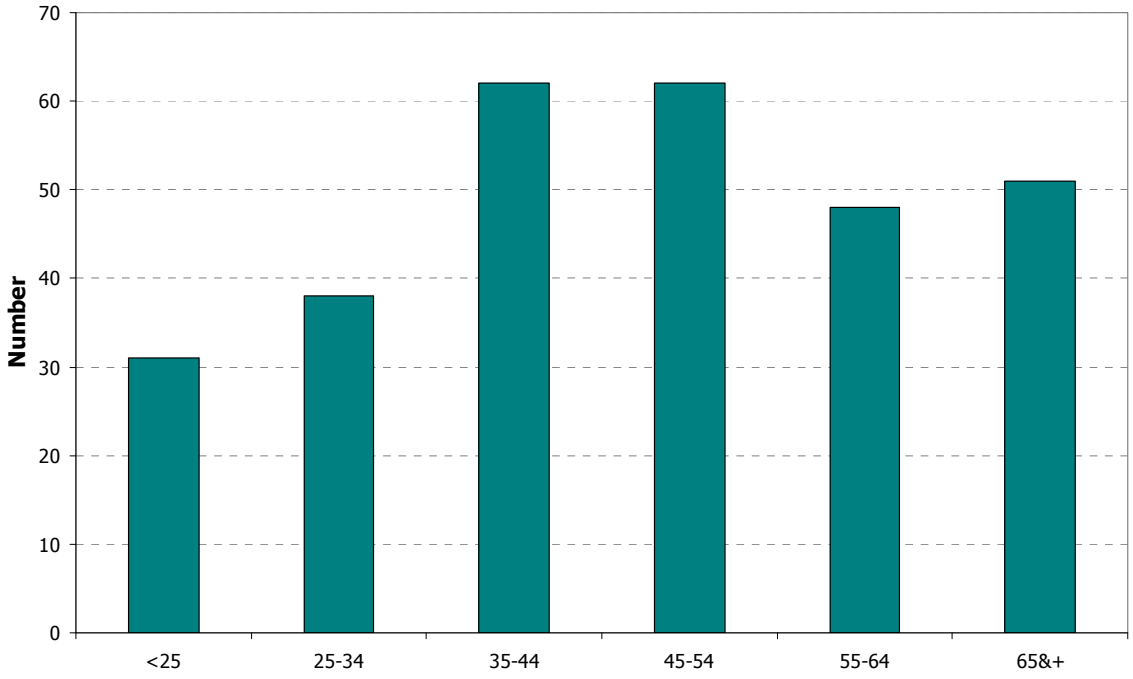
Table 40: Directly age standardised mortality rate per 100,000 population from suicide (ICD-10 X60-X84) for persons of all ages, local authorities in Northumberland compared to the North East and England,2004-2006

	Number	Rate per 100,000	95% LL	95% UL
Northumberland	78	7.87	6.05	9.68
Alnwick	7	6.85	1.58	12.11
Berwick	6	6.98	0.48	13.47
Blyth Valley	19	7.80	4.26	11.33
Castle Morpeth	16	8.90	4.25	13.54
Tynedale	12	5.78	2.32	9.25
Wansbeck	18	9.33	4.93	13.73
NORTH EAST	485	6.16	5.60	6.72
ENGLAND	9303	5.85	5.73	5.97

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright

As the table above shows suicide levels for Northumberland as a whole are appreciably above the regional average.

Figure 21: Suicides and open verdicts, by age in Northumberland 1997-2006



SOURCE: Suicide Prevention, Northumberland County Review 1997-2006, Northumberland Tyne & Wear NHS Trust

UNINTENTIONAL INJURIES

Table 40: Number and crude rate per 100,000 of road injuries and deaths, local authorities in Northumberland compared to the North East and England, 2004-2006

	2004		2005		2006	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Northumberland	234	75.7	202	65.2	205	66.2
Alnwick	32	101.1	17	53.2	36	112.3
Berwick	15	57.4	21	80.8	16	61.6
Blyth Valley	34	41.8	44	54.0	24	29.6
Castle Morpeth	43	87.0	37	74.6	37	74.8
Tynedale	66	111.2	51	86.1	69	116.0
Wansbeck	44	71.7	32	52.0	23	37.3
NORTH EAST	1,158	45.6	1,093	42.9	1,164	45.5
ENGLAND	29,771	59.4	27,945	55.4	27,551	54.3

SOURCE: Road Casualties English Local Authority Tables, Department for Transport, 2008 © Crown copyright

6. PRIMARY CARE

CHRONIC DISEASE MANAGEMENT (USING QOF)

Clinical quality

There is increasing emphasis on commissioning for quality. Work is needed to develop more useful and appropriate quality indicators, and to make better use of those already available. Often, individual indicators cannot adequately capture issues of clinical or service quality.

For example (see Example 1 below) when looking at Quality and Outcome Framework (QoF) data, we could debate whether a "high" value of diabetes prevalence is a good thing or a bad thing. If we believe that this indicator accurately describes the background disease prevalence – then a high value would be considered to be bad because it would indicate high level of disease within the population. If, however, we believe that this indicator is more likely to describe the degree of ascertainment of cases of people with diabetes on the practice register – then a high value would be considered to be a good thing since patients can only be effectively managed if we know about them.

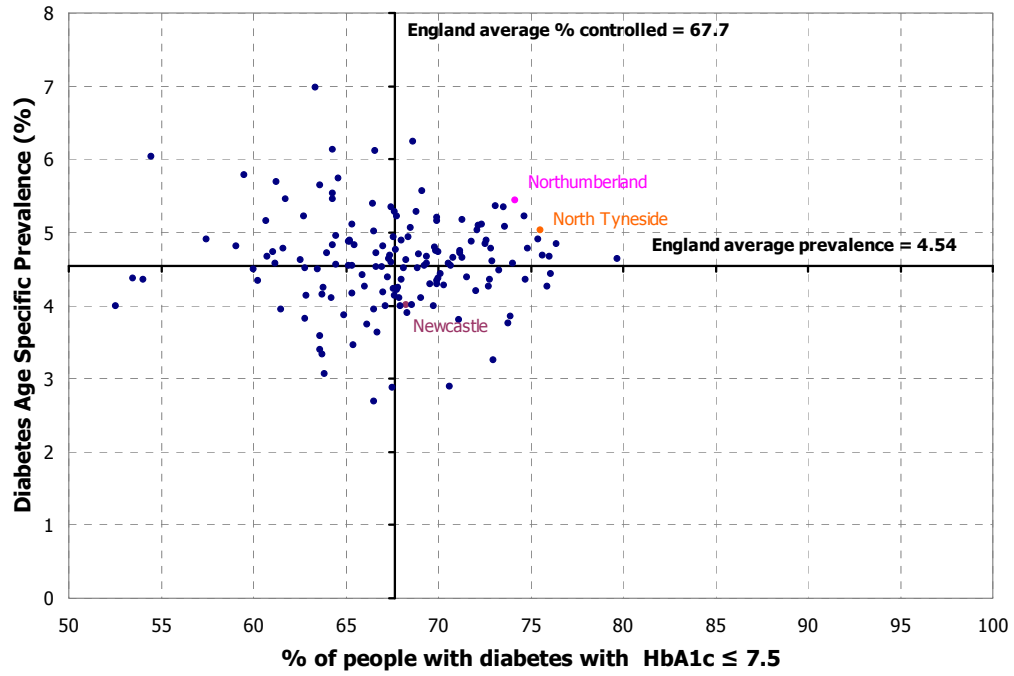
Looking at pairs of indicators together can often give a better measure of clinical quality. So if we have identified people with diabetes and added them to our practice registers and can also show that of those people on our diabetes registers, the majority have their blood sugar adequately controlled (e.g., using the measure of HbA1c ≤ 7.5) then we are in a better position to assess clinical quality.

For example (see Example 2 below) the measure of 4 week smoking quitters per 100,000 population is often used as a measure of quality of NHS Stop Smoking Services. However, this measure is related to the underlying prevalence of smoking in the population (even though there is no robust direct measure for this at present). It can been seen that there is a relationship between the number of quitters and the underlying prevalence of smoking where areas with higher smoking prevalence see generally higher quit rates; because of this, this measure should only be used for the assessment of local trends and great caution should be exercised when using this measure to make comparisons between areas.

Looking the two indicators together can provide a better measure of service quality because it allows consideration of quit rates between areas of similar estimated smoking prevalence.

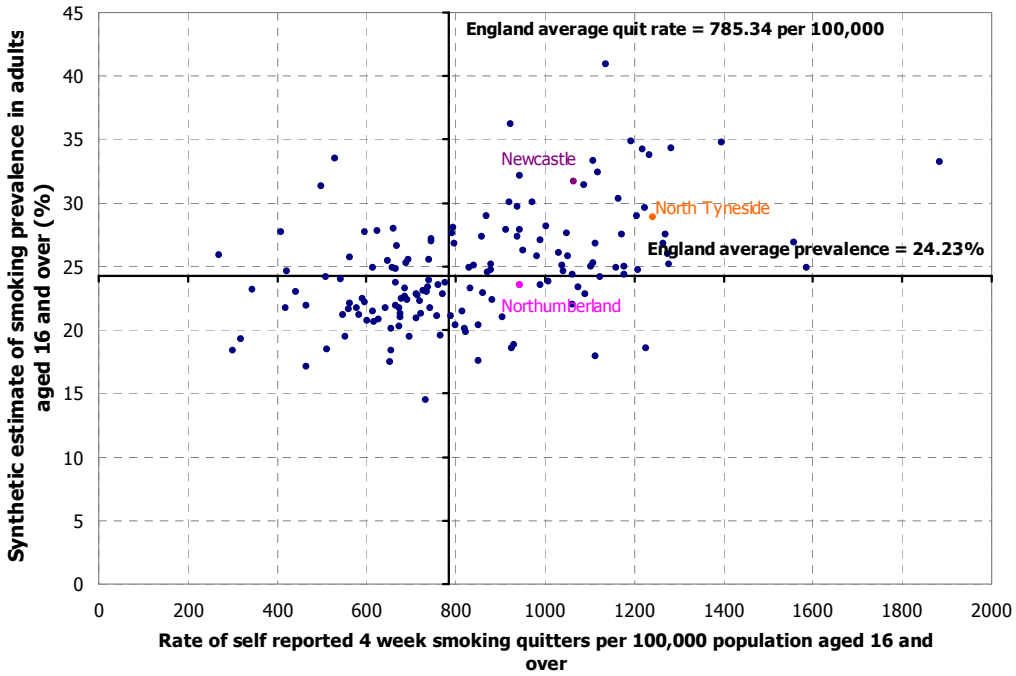
The approach to identifying and presenting appropriate pairs of indicators needs to be further developed.

Example 1: Scatter plot of age specific prevalence of diabetes in those aged 17 and over versus percentage of people with controlled blood sugar (HbA1c ≤ 7.5) – PCOs in England



SOURCE: QoF data for 2006/07, Information Centre

Example 2: Scatter plot of estimated smoking prevalence in those aged 16 and over versus 4 week smoking quitters per 100,000 persons aged 16 and over – PCOs in England



SOURCE: Synthetic estimates for 2003-2005, Neighbourhood Statistics; Smoking Quitters for 2006/07, Information Centre

QoF Exception reporting data

Exception reporting is a cause and consequence of inequalities. There may also be differences between practices in the proportion of exemptions among patients registered with conditions such as diabetes and CHD. The contract guidance for the Quality and Outcomes Framework provides practices with the rules regarding the criteria for excepting patients from Chronic Disease Registers.

Acceptable grounds for excepting a patient are:

- Informed dissent – patients declining to attend for a clinical review or have refused diagnosis/treatment. Practices are required to issue an invitation on at least three occasions in the last year to except for this reason.
- Patients for whom a clinical review would not be appropriate as a consequence of their condition (terminal illness or extreme frailty).
- Patients excepted because they have been newly diagnosed or recently registered with the practice.
- Patients with sub-optimal measures but are on maximally tolerated levels of treatment.
- Patients exhibiting a contra-indication for the treatment.
- Patients with co-morbidities which make a treatment inappropriate.
- Where an investigative service or specialist treatment service is not available.

Northumberland Care Trust shows low levels of use of exception codes when compared with other PCOs nationally.

Table 42: Percentage of eligible patients who are excepted, averaged across disease groups. QoF data 2006-07

	CHD	COPD	Diabetes	All 3 disease groups	PCT rank (out of 152)
Northumberland	7.3	7.6	4.8	5.8	4th best
ENGLAND	8.9	9.4	6.5	7.4	

SOURCE: Information Centre Quality and Outcomes Framework data 2006/07

MEDICINES MANAGEMENT

Medicines management makes a key contribution to clinical quality. Issues include the implementation of the Pharmacy White Paper[37] underpinned by:

- A review of the current enhanced services that are commissioned from pharmacies – where there is wide variation between PCOs; and
- Initiatives aimed at reducing waste e.g., prescriptions written but not dispensed, uncollected dispensed medicines, dispensed medicines not, medicines taken incorrectly.

Most Northumberland practices have some medicines management support available to them and there is obvious potential to better address key priorities, using this resource.

IMMUNISATION

Table 43: Proportion of children immunised with MMR and DPT by stated birthday, Northumberland compared to the North East and England, 2006/07

	% of children aged 2 who complete MMR	% of children aged 5 who complete both MMR doses	% of children aged 5 who complete DTP
Northumberland	93.6	87.0	92.4
NORTH EAST	88.8	80.0	85.4
ENGLAND	85.3	72.8	79.3

SOURCE: NHS Immunisation Statistics, England 2006/07, Information Centre © Crown copyright

Table 44: Percentage of the population aged 65 and over immunised with pneumococcal vaccine and influenza vaccine, Northumberland compared to the North East and England, 2006/07

	% of persons aged 65 and over immunised with pneumococcal vaccine	% of persons aged 65 and over immunised with influenza vaccine
Northumberland	72.6	76.1
NORTH EAST	70.7	76.0
ENGLAND	66.6	73.9

SOURCE: Pneumococcal Polysaccharide Vaccine Uptake Report 2006/07, Health Protection Agency; Influenza vaccine uptake, NHS Immunisation Statistics, England 2006/07, Information Centre © Crown copyright

7. SECONDARY CARE

CARDIOVASCULAR DISEASE (CVD)

Cardiovascular disease (CVD) covers a number of different problems of the heart and circulatory system, such as coronary heart disease (CHD), stroke, and peripheral vascular disease (PVD). CVD is strongly linked with other conditions, notably obesity and diabetes, and is more prevalent in lower socio-economic and ethnic minority groups. CVD is the main cause of death in the UK, with just over 208,000 deaths each year. More than one in three (36%) die from CVD each year, about half (48%) of all deaths from CVD are from CHD and more than a quarter (28%) from stroke. Looking at the mortality data for Northumberland for 2004-2006 shows that of the 3,645 CVD deaths: 1,842 (51%) were from CHD; 1,011 (28%) were from stroke; 237 (7%) were from other forms of heart disease; 171 (5%) were due to aneurysm and 100 (3%) were from heart failure; the remainder being spread across a range of causes.

Prevention

There is enormous potential to prevent premature death by targeting those at high risk for developing CVD. Proactive case finding linked with appropriate pharmaceutical management and targeted lifestyle interventions provide large benefits to individuals at most risk. Additionally, supporting people to stop smoking is the most important change to reduce their risk of developing CVD. With the emphasis moving towards preventing CVD in higher risk groups, it is important to determine those at most risk and focus efforts on reducing the prevalent risk factors. About 23% of men and 8% of women aged 40-74 years have a total 10-year cardiovascular disease (CVD) risk greater than 20%. There has already been some pilot work in cardiovascular risk assessment and discussions are taking place in Northumberland with the aim of linking to the planned national vascular screening programme.

Detection

Work to determine risk factor prevalence indicates a significant gap between predicted and actual levels. If CVD is to be prevented and managed effectively this needs to be addressed by much improved risk assessment.

Table 45: Comparison of predicted and reported hypertension prevalence, Northumberland compared to England, 2006/07

	Predicted prevalence		Recorded prevalence		Difference
	Number	%	Number	%	Number
Northumberland	84,534	26.5	49,565	15.3	-34,969
ENGLAND	12,792,138	23.8	6,705,899	12.5	-6,086,239

SOURCE: Predicted prevalence from hypertension model, Association of Public Health Observatories, 2007 © APHO; Recorded prevalence from Quality and Outcomes Framework 2006/07, Information Centre, 2007 © Crown copyright.

Comparisons of national prevalence data from the Health Survey for England and recorded prevalence from the Quality and Outcomes Framework (QoF) suggest that there is mismatch between numbers diagnosed and numbers predicted. This is probably due to under-recording of cases already known to practices, and lack of information in a proportion of cases, where patients may have been diagnosed previously by other practices or hospital consultants. There may be unexplained differences between the expected and registered prevalence of major QoF conditions, such as CHD and hypertension.

Across Northumberland CHD and stroke prevalence are higher than the average for England as a whole.

Table 46: Comparison of predicted and reported coronary hear disease prevalence, Northumberland compared to England, 2006/07

	Predicted prevalence		Recorded prevalence		Difference
	Number	%	Number	%	Number
Northumberland	16,059	5.0	16,513	5.2	454
ENGLAND	2,299,313	4.3	1,900,640	3.5	-398,673

SOURCE: Predicted prevalence from CHD model, Doncaster PCT, 2006 © Doncaster PCT; Recorded prevalence from Quality and Outcomes Framework 2006/07, Information Centre, 2007 © Crown copyright

Table 47: Stroke and TIA recorded prevalence, Northumberland compared to England, 2006/07

	Recorded prevalence	
	Number	%
Northumberland	7,640	2.4
ENGLAND	862,873	1.6

SOURCE: Recorded prevalence from Quality and Outcomes Framework 2006/07, Information Centre, 2007 © Crown copyright

CHD controlled blood pressure

Table 48: The percentage of patients with coronary heart disease, in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less

	2005/06	2006/07
Northumberland	87.2	89.5
ENGLAND	84.9	88.9

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright

In Northumberland about two thirds of practices have achieved QoF CHD rates better than the national average. However, when individual practice data are examined, there is a significant degree of variation in performance. In Northumberland, for example, examining the use of Ace

Inhibitors post-MI (CHD 11), over 50% of practices were below the average. Further data are required (preferably 2007/8 release) to understand the full picture and make inferences.

Table 49: Directly standardised mortality rate at ages under 75 years (per 100,000 population aged under 75) from cardiovascular disease (ICD-10 I00-I99), local authorities in Northumberland compared to the North East and England, 2003-2005 and 2004-2006

	Number	Rate	95%LL	95%UL
Northumberland	986	83.62	78.35	88.88
Alnwick	96	72.37	57.56	87.18
Berwick	78	67.16	51.80	82.52
Blyth Valley	262	93.97	82.58	105.37
Castle Morpeth	131	65.88	54.42	77.34
Tynedale	177	76.75	65.37	88.13
Wansbeck	242	109.32	95.45	123.19
NORTH EAST	8,757	99.78	97.67	101.89
ENGLAND	136,513	84.24	83.79	84.69

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright.

Treatment

The North of England Cardiovascular Network focuses on patient pathways for cardiac and stroke care. Across NHS North of Tyne Myocardial Infarction National Audit Project (MINAP)[38] data indicates a good thrombolysis service exists, achieved through partnership working between Acute Trusts and the North East Ambulance Service (NEAS). NEAS has rolled out a programme of paramedic thrombolysis which has had a dramatic effect on call to needle times. Changes in service delivery to Percutaneous Coronary Intervention (PCI) are being implemented across North of Tyne because of medical advances that improve patient outcomes.

For the North of England Cardiovascular Network, procedure rates for revascularisation remain below target and the national average of 1,400 per million population. On average from the two tertiary centres in the network and City Hospitals Sunderland the rate for PCI was 1,076 per million population. Even the Network's best average performance is considerably below future recommended rates for PCI; the British Cardiac Society recommendations are 2,200-3,000 per million population.

Rapid Access Chest Pain Clinics (RACPC) performance was good. In Northumberland, of 263 patients seen 190 (72%) were received within 24 hours and seen within 14 days.

The North of England Cardiovascular Network has advocated continued adherence to current angiography targets, with particular attention to clinical pathways in those areas with the greatest shortfall. As non-invasive imaging, e.g. computed tomography coronary angiography, develops there may be some reduction in demand, but the Network anticipates this being more than offset by continued growth in those areas of greatest under-provision currently.

Stroke services are considered some of the best in England and are consistently near the top of the Sentinel Audit[39] ratings. Telemedicine is used in Northumberland to enable remote reading of CT scans out of hours for stroke thrombolysis.

Cardiac Rehabilitation

The Northumberland Cardiac Rehabilitation service delivers Phase II and Phase III cardiac rehabilitation care to all patients post myocardial infarction, revascularisation and heart surgery. Around 1,000 patients per annum are referred into the service. The service aim is to promote and support patient independence and self management.

The Rehabilitation programme is managed by 2 whole time equivalent Primary Care Specialist Nurses responsible for:

- Training and maintaining the clinical governance of the service and professional standards throughout the duration of cardiac rehabilitation;
- Acting as clinical leads to all professionals providing care through the patient's pathway, including delivering initial training and ongoing clinical support;
- Auditing, monitoring and evaluating the service and adapting the programmes to meet future population requirements.

All patients follow a pathway through the four phases of rehabilitation, as follows:

- *Phase I* - initial diagnosis – the patient is introduced to the pathway by specially trained Heart Manual or Revascularisation Facilitator, usually in a secondary/tertiary setting.
- *Phase II* - initial period at home following discharge - patients are supported by specially trained community Heart Manual (MI only) or Revascularisation nurse facilitators for up to 6 weeks.
- *Phase III* - accessed at about week 6 (varies by acute event/patient recovery) - the patient attends a structured programme of 8 weeks/16 sessions of exercise, relaxation and educational information delivered by a multi disciplinary team. The education topics are designed to be interactive and patient focused, promoting understanding of their condition and to increase their ability to self manage their condition.
- *Phase IV* - patients are referred to structured Phase IV physical activities if available, and all patients are supplied with information of local activity opportunities and encouraged to continue some form of increased exercise on a regular basis.

There are 14 community based programmes in Northumberland across the four localities. All patients are assessed prior to attending and on completion of the programme. Information is passed to their GP to assist in long term structured care. A home based exercise programme was piloted during 2006/2007, with funding from the Northern Network of Cardiac Care. The programmes are delivered by a small team of specially trained nurses, with Fitness Instructors and physiotherapists who are paid on a sessional basis. The programmes maintain a staff to patient ratio of 1:5 in line with British Association of Cardiac Rehabilitation (BACR) and NSF guidelines.

The service currently offers limited support to stable Angina and Heart Failure patients and it was planned to increase the availability of phase III to these patients across all sites during

2007/08 following agreed referral protocols. Extending the range of these programmes to other long term chronic diseases (e.g., COPD patients) making better use of expertise and capacity was piloted during 2007/08.

Challenges

The National Support Team for Health Inequalities identified the need to push CVD gains even harder, capitalising on systems in place to drive quality and rigorously pursuing outliers. There is a need to drive the programmes covering CVD across primary and secondary care, using QoF as proxy for population outcomes to drive quality improvement. The NST recommended considering expanding the 'dashboard' concept for practices to include a range of measures outside QoF, facilitating practice self management, and performance development. There is a need to develop a system of 'register management' to ensure interventions are scaled appropriately and sustainable. There is a need for better information about CVD. Public health surveillance is vital in addressing challenges such as quality improvement and health inequalities.

The lack of consistent local implementation team (LIT) structure across North of Tyne and the opportunity to bridge gaps with new Local Network of Cardiac Care (LNCC) infrastructure and governance arrangements is a key challenge.

It is also necessary to ensure that appropriate capacity is available before embarking on full scale vascular risk screening.

The recent National Support Team for Health Inequalities made the following recommendations about acute management of CVD:

- Although the TIA clinics provide an excellent service, further investment is needed to achieve the timeframes required in the new stroke strategy for both TIA clinics and endarterectomy.
- It will be helpful to undertake a health equity audit (HEA) around acute management of CVD in order to understand more fully the population health needs at a local community level. Although a lot of work has already been completed to address access to specialist services for people in rural areas this remains an issue for both stroke and CHD services. There will be a need for ongoing campaigns to reinforce messages to the public about acute presentation.
- Commission the development of infrastructure support to scale up ambition on the cardiac failure pathway and management of arrhythmias. Professional capacity should accommodate training and skills development in primary care, linking to existing systems.
- Build on good quality cardiac rehabilitation with investment in an enhanced specification:
    - Move away from one-size-fits-all to segmented options for delivery, possibly menu driven.
    - Explore crossover and efficiencies with other chronic conditions.
    - Systematically track flows through the system, following up DNAs and drop-outs and setting targets for completion of each phase.
    - Audit success rates by geography, culture, GP etc. Ensure patient involvement in system design and implementation.

CANCERS

Across Northumberland cancer is a major cause of death.

Prevention

Work to prevent cancer includes tobacco control and stop smoking, alcohol, obesity, physical activity, diet, and sexual health harm reduction activities.

Detection and screening uptake

Table 50: Coverage (% of women aged 53-64 with less than 3 years since their last test) attending screening for breast cancer, Northumberland compared to the North East and England, 2005/06 to 2007/08

	2005/06	2006/07	2007/08
Northumberland	79.7	83.8	82.9
NORTH EAST	78.2	79.4	79.5
ENGLAND	75.9	76.0	76.7

SOURCE: Breast Screening Programme, National Statistics, Information Centre, 2008 © Crown copyright

At national and regional level coverage rates have improved in recent years. Northumberland has 3-year coverage rates for the 53-64 age group which well exceed the England average. According to the latest annual report produced by the Breast Screening Unit, uptake varies from 41% to 89% across Northumberland primary care practices.

The planned expansion of the programme to include women from the age of 47 outlined in the cancer reform strategy has huge implications for the programme's capacity, in particular the need for digital equipment and extra radiographers.

Table 51: Coverage (% of women aged 25-64 with less than 3.5 years since their last adequate test) attending screening for cervical cancer, Northumberland compared to the North East and England, 2005/06 to 2007/08

	2005/06	2006/07	2007/08
Northumberland	80.1	79.3	78.5
NORTH EAST	73.7	72.7	72.3
ENGLAND	69.8	69.4	69.0

SOURCE: Cervical Screening Programme, National Statistics, Information Centre, 2008 © Crown copyright

Nationally, coverage has been falling slightly over the past five years, with much of this decline being in young women. This trend is also reflected locally, with Northumberland showing downward trends in coverage.

Northumberland has 5-year coverage rates which exceed the England average; it is also one of only 3 PCOs nationally which have achieved 5 year coverage of 85% or greater.

There are concerns about the implications of 14 day turnaround, in particular for Northumberland, for GPs with regard to sending results out within 14 days of taking a sample, due to issues getting samples from north Northumberland to the laboratory at the RVI.

The implementation of HPV vaccination for cervical cancer began in autumn 2008.

The Bowel Cancer Screening programme (BCSP) commenced in the North of Tyne area in February 2008. Men and women aged 60-69 are being invited for screening. Those aged over 70 will be screened on request.

Incidence and mortality data

Table 52: Cancer incidence (2002/04) and mortality (2004/06) for selected cancers at all ages, Northumberland compared to England

	Northumberland	England
Cancer incidence 2002-2004		
Breast cancer incidence†	107.8	120.0
Prostate cancer incidence‡	89.2	95.2
Lung cancer incidence	54.6	45.7
Colorectal cancer incidence	52.6	44.2
Cancer mortality 2004-2006		
Breast cancer mortality†	25.9	28.0
Prostate cancer mortality‡	23.8	25.7
Colorectal cancer mortality	18.3	18.2
Lung cancer mortality	45.8	38.5
Cervical cancer mortality†	1.8	2.5

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright

NOTES: † - rates are for females only
‡ - rates are for males only
All are directly age standardised rates per 100,000 population; mortality is therefore compared to the total population and not to the population identified as suffering for the particular cancer.

Treatment

In 2007-08 Northumberland achieved the existing waiting time targets.

The North of England Cancer Network (NECN) has been established to ensure consistency of standards in cancer services across North England and to address inequalities. The aim of the NECN is to improve local outcomes for cancer and commission clear pathways between primary, secondary and tertiary services. In NECN the Improving Outcomes Guidance (IOG) plans have

been implemented through service reconfiguration in gynaecological cancers, urological, haematological and upper gastrointestinal cancers. Work is progressing to meet the Department of Health milestones for head and neck cancers by December 2008. IOG Action plans for the rarer cancers (sarcoma, brain, cancers occurring commonly in children and young adults) are currently being developed.

In NECN there is a robust process in place for the approval of new cancer drugs prior to NICE decisions. North East Cancer Drugs Approval Group has won national acclaim for its process and impact. NECN has driven significant reform in the development of local chemotherapy services and nurse/pharmacy led practice.

Other work includes improving radiotherapy services across the patch, incorporating recommendations from the National Radiotherapy Advisory Group (NRAG) document and the local oncology strategy group on Teesside and addressing workforce issues which have been identified during the course of the year, particularly with regards to the development and introduction of new technologies.

Challenges

Challenges include the need to support people to change their lifestyles and health-related behaviours via effective engagement with public and patients.

Effectively engaging primary care is essential to reducing variability and tackling inequalities in access to services; and between primary care practices in screening coverage. The National Support Team for Health Inequalities thought that there would be benefit from an audit of compliance by GPs in implementing NICE guidance on chest X-rays. It was also recommended that the reduction in take up of cervical screening might be addressed by sharing the effective practice that is reversing the trend in some General Practices.

There is a need to ensure adequate capacity issue for breast and bowel cancer screening. Breast cancer screening capacity needs to be addressed in order to introduce digital mammography by 2010. It may be possible to improve breast cancer screening coverage by using GP endorsement letters, piloted by the PCT, once capacity problems are addressed.

There is a recognition that data and intelligence to inform commissioning, monitor inequalities and assess quality is currently inadequate. The NST reported that work to identify and target groups who are presenting late is being held back by a shortage of data e.g., staging data. There needs to be a clear strategy for the development of local intelligence systems – particularly, agreement on the point at which proposed national data sets are adopted.

The NST recommended that commissioners and providers need to work more closely with local authorities colleagues to address the shortfalls in end of life care.

The team also recommended that through the Network, there needs to be a review and benchmarking of the rates of surgical intervention aspiring to be curative – starting with lung and colorectal surgery as information is produced through national audit. The absence of PET scanning facility is a shortfall that needs addressing urgently. Agreement on the need for a facility has not yet led to its installation, and patients are still being sent to London.

SEASONAL DEATHS

In the winter of 2006/07, there were 22,500 excess winter deaths in England. Excess winter deaths had averaged around 24,160 over the five years finishing with 2006/07. In comparison there were 1,500 excess winter deaths in the North East in 2006/07, with a five year average of 1,300. This suggests that in 2006/07 while England experienced a decrease in excess winter mortality the North East saw an increase in excess winter deaths.

During the period 2000-2007 Northumberland recorded 1,094 excess winter deaths. The proportion of excess winter deaths is greater in older age groups but excess winter mortality affects all ages.

The National Support Team for Health Inequalities made the following recommendations in relation to reducing seasonal excess mortality:

- Use Local Resilience Forums to draw together a "list of lists" identifying vulnerable people.
- Develop a core offer of support to those on the list of lists (e.g., flu vaccination, medicines management, falls assessment, good neighbours schemes).
- Involve Fire & Rescue in the assessment of cold and damp when they do home assessments.
- Consider whether this would be a suitable topic for a review by Overview and Scrutiny Committee.
- Tackle problems in relation to private rented sector, through the partnership agenda.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

One of the main causes of COPD is smoking so prevention links to tobacco control and stop smoking activities.

Table 53: Recorded prevalence of COPD, Northumberland compared to the North East and England, 2006/07

	Recorded Prevalence	
	Number	**%**
Northumberland	7,022	2.2
NORTH EAST	59,849	2.3
ENGLAND	765,806	1.4

SOURCE: Recorded prevalence from Quality and Outcomes Framework 2006/07, Information Centre, 2007 © Crown copyright.

Though recorded COPD prevalence is around 2%, it is estimated from the data collated for the COPD PBMA exercise that actual prevalence could be around 8-10%. COPD is also a major contributor to excess deaths for males and females and contributes to the gap in life expectancy across Northumberland.

COPD guidance and pathways in Northumberland are to be revised in 2008/09 aiming to optimise the management of COPD. COPD patient pathways aim to address the disparity of COPD care across Northumberland, raise awareness of the impact of COPD on patients and health systems, address the impact of COPD on the use of emergency beds and amalgamate all the elements of COPD care across acute care, specialist care, primary care and home care. Revised guidance will include supported early discharge; integration of home oxygen assessments; enhanced spirometry in primary care; and community case management.

DIABETES

Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life. It can affect infants, children, young people and adults of all ages, and is becoming more common. Diabetes can result in premature death, ill-health and disability, yet these can often be prevented or delayed by high-quality care. Diabetes is a group of disorders with many different causes, all of which are characterised by a raised blood glucose level.

Preventing Type 2 diabetes (the most common form) requires work to tackle obesity and lifestyle choices about diet and activity.

Table 54: Recorded prevalence of diabetes, Northumberland compared to the North East and England, 2006/07

	Recorded Prevalence	
	Number	**%**
Northumberland	14,199	4.4
NORTH EAST	101,690	3.8
ENGLAND	1,961,976	3.7

SOURCE: Recorded prevalence from Quality and Outcomes Framework 2006/07, Information Centre, 2007 © Crown copyright.

When prevalence is examined by practice and PBC cluster, there is marked variation. These could be explained by age and gender differences as the rates do not take this into account. However, some practices may be under-recording diabetes.

Table 55: Diabetes care: % of patients with recorded diabetes who have been screened for retinopathy and who have controlled blood sugar (HbA1c <7.5), Northumberland compared to North East and England, 2006/07

	% screened for retinopathy	**% HbA1c <7.5**
Northumberland	90.2	74.2
NORTH EAST	91.4	69.2
ENGLAND	88.6	67.7

SOURCE: Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development, 2008 © Crown copyright.

QoF data for blood pressure control, HbA1C, cholesterol and retinal screening has been analysed. There is quite marked variation between practices within Northumberland Care Trust. Death rates from diabetes are reducing. However, there is a significant under-reporting of diabetes as a cause of death as deaths are often coded to the secondary complications associated with diabetes. It may be more useful to consider diabetes attributable deaths. Northumberland appears to have a lower death rate than England and the North East region.

KEY DATA FROM PROGRAMME BUDGET MARGINAL ANALYSIS (PBMA)

Analysis of expenditure and outcomes has been carried out across Northumberland. When cost data are combined with activity and clinical outcomes data in this way, it becomes possible to explore the relative effectiveness and cost effectiveness of commissioning programmes of care. Programmes were ranked according to high or low cost and good or poor outcomes, weighted for population need.

Priorities for service development have been identified on the basis that certain programme/service areas represent clear outliers with respect to expenditure and outcomes when compared to other PCOs. The following areas are recommended for further in depth investigation:

- Cancer and tumours;
- Mental health and dementia;
- Diabetes;
- Healthy lifestyles;
- Children's health.

This work was started during 2008 and will influence service developments from 2009 onwards. These investigations will incorporate the views of key stakeholders including patients, service users, carers and the public. The conclusions and recommendations arising from this work will continue to influence our commissioning strategy.

8. CHILDREN, YOUNG PEOPLE & FAMILIES

INTRODUCTION

This section represents work in progress; it will be updated more formally in line with the review of the Children & Young People's Plan[2] (CYPP) in June 2009.

The 2007 Joint Area Review inspection was favourable about the needs analysis undertaken within Northumberland. During 2007-08, work on identifying hotspots and the service areas where investment needs to be refocused continued, culminating in the agreement of the Annual Performance Assessment Priorities with the Government Office for the North East (GONE), and the revised Children & Young People's Plan[2].

This section provides an overview of the key needs and themes that have informed the strategic priorities in the revised Children & Young People's Plan[2], both county-wide and within specific localities. They were sourced from small area profiling, and engagement with service users and external regulators. The Children & Young People's Plan[2] was revised in 2007-08 to reflect the new Local Area Agreement[1] statutory and designated targets, priorities from the Annual Performance Assessment, and the performance indicators and commissioned actions which underpin them. The Local Area Agreement and Annual Performance Assessment priorities are based on a local analysis of need which is a pre-requisite of the Children & Young People's Plan[2].

Three strategic commissioning priorities are key to the delivery of our Children & Young People's Plan[2]; they are as follows:

- Keeping children and young people safe from harm;
- Reducing inequalities; and
- Maximising opportunity for all.

The corporate responsibility for them is articulated in the draft Narrowing the Gap[40] report.

Rather than repeat the vast amount of detail in the Children & Young People's Plan[2], below is a summary of the needs that have shaped its strategic priorities, the subsequent commissioned actions, the hard data, and community or stakeholder views they have been based on. The latest data are available from http://pscm.northumberland.gov.uk/pls/portal92/docs/26511.

The Children and Young People's Plan 2008-2011[2] highlights strategic priorities that encompass the nine Annual Performance Assessment priorities, Joint Area Review recommendations, and Local Area Agreement[1] targets. They have been drawn from a detailed analysis of surveys, data and research, and agreed in consultation with the Government Office for the North East. They recognise the need to consolidate our strengths and focus on the areas that need most improvement.

The identified priorities are divided into the five Every Child Matters[41] outcomes as follows:

- Being healthy;
- Staying safe;
- Enjoying and achieving;
- Making a positive contribution;
- Achieving economic wellbeing.

Before illustrating the details of our needs analysis, the resulting priorities and commissioned actions, it is helpful to put them in context by noting extracts from our last Annual Performance Assessment self assessment, focusing on value for money and how our commissioning has worked.

Use of resources

As providers of services to children, young people and families, the core objective of our integrated children's services is to ensure poverty in childhood does not translate into poor outcomes. This includes providing parenting and family support to all those that need it and providing more targeted support for parents with poor mental health, those who misuse alcohol or drugs, and to families and children who have experienced domestic violence. In relation to schools, this will require the council to prioritise its approach towards those areas of social disadvantage where the gap in performance is most profound. This includes continuing to differentiate levels of funding to schools in these communities.

The Annual Value for Money report is used to drive budget and commissioning strategies, e.g. benchmarking showed high expenditure on "reactive" behaviour support services and, through talking to schools, Northumberland County Council is investing an additional £400,000 per annum in more preventative work to reduce exclusions and independent sector placements.

Funding is mapped to Annual Performance Assessment priorities; Northumberland County Council pass-ported the Children's Services Grant in full, protecting frontline safeguarding services. The school funding strategy is based on consultation with schools, the schools forum, and Chairs of Governors about strategic priorities to inform the Medium Term Plan for use of the Dedicated Schools Grant. Priorities identified were:

- Special Educational Needs funding to secure greater equity - the original formula was revised because it was not identifying higher incidences;
- Investment in preventative behavioural services;
- Free entitlement for early years resulting in increased "Narrowing the Gap" funding;
- Provision for specialised diplomas resulting in increased "Not in Education, Employment or Training" (NEET) and "Access to Post-16 Training" funding, to be implemented through the three year plan.

In line with our Annual Performance Assessment priority of Narrowing the Gap (equalities and anti discrimination), changing demographics in schools showed increased demand for English as an Additional Language (EAL) support, so that service has seen growth, as has investment in new units in special schools. The Putting the Learner First programme is creating a suite of Disability Discrimination Act[42] compliant assets.

How effective is your commissioning of services?

There is clear evidence that service priorities and development are based on thorough needs analysis - e.g., Connexions provision in relation to NEET outcomes - views of children, young people and parents - e.g., the role of the Schools Forum in shaping and honing developments.

The ambitious Putting the Learner First[43] strategy is designed to address three main issues:

- Standards - especially at Key Stage 2;
- Surplus places; and
- The condition of buildings.

Tailored proposals for each partnership were based on thorough understanding of the local needs - i.e., schools, communities and circumstances, informed and tested through detailed consultation with parents, pupils and the local community. Examples include:

- The Blyth all-age academy;
- The formation of two Trust School Partnerships in Ashington & Haydon Bridge;
- Support to the Coquet partnership helping the whole partnership remain viable in moving towards a federation;
- School place planning based on sophisticated modelling, responsive to local demography.

The results of effective commissioning have already been seen in terms of the relationship with Howestead's Lodge, the challenging review of the Connexions contract - resulting in better capacity to improve outcomes for those not in employment, education or training, and those with learning difficulties or other disabilities, and commissioning of Priory School and Atkinson House to increase local capacity for those with learning difficulties or other disabilities. Contract renewals have focused on issues of identified need, e.g., Children's Fund is now focusing more on participation.

At an operational level, there is clear evidence of our commissioning working, e.g. Berwick Integrated team's close links with the family centre to increase preventative services.

What are the barriers to improvement?

We have ambitious plans, especially for Enjoying & Achieving through the Putting the Learner First programme. However, Northumberland has not been allocated "Building Schools for the Future" funding thus far. In response, the County Council has invested £110m of its own funds in schools, and has secured a further £60m through the academies programme. We are actively pursuing Building Schools for the Future funding as part of the re-phasing of the national programme.

"Narrowing the Gap" is a national programme of work aiming to reduce the attainment gap (along with other outcomes) for disadvantaged groups compared to their peers. It is a key priority in Northumberland's Annual Performance Assessment and Children & Young People's Plan[2].

How are performance indicators used to reduce geographical inequalities?

The area mapping profiles presented at Children's Services Management Group provide an umbrella framework to support engagement with FACT partners and districts on key national priorities and those arising from the Annual Performance Assessment process. They have since been developed into a series of tables that rank Super Output Areas across the measures we initially agreed to adopt – because they spanned the four tiers from universal services to those required by the most at risk of harm and because they can be benchmarked with our peers. These profiles will be used to inform the work of the Commissioning Panel in 2007-08 as well as providing the Leadership team with contextual information for the balanced scorecards operating within the Leadership Team and Children's Services Directorate.

Have new or joint approaches been successful?

New approaches have been successful. Northumberland has utilised strong partnership arrangements as a blueprint to achieve common goals for new joined up approaches.

- Education support for Looked After Children and Educational Welfare Officers has improved attendance by looked after children;
- The council and Cease 24 has increased access to Domestic Violence support;
- School place planning and Head Teachers to remove surplus places; and
- Healthy Schools and Social and Emotional Aspects of Learning have been effective in developing pupils' "positive" perception of bullying and behaviour;
- The Northumberland County Council managed evaluation of a Voluntary & Community Sector service has shown the effectiveness of role models in achieving enduring change without the need to involve statutory agencies;
- Greater emphasis has been placed on supporting vulnerable children and young people through Residence Orders and Special Guardianship Orders, rather than through Looked After Children;
- Important Community Safety initiatives are having an impact, e.g., Northumbria Fire & Rescue Service's street engagement project is reducing crime amongst children and young people.

The following pages show the analysis of need that has evolved through the FACT partnership in the last three years, through the implementation of its Children & Young People's Plan[2] and the Local Area Agreement[1]. Updating this needs analysis is an ongoing practice, and we have chosen not to include all of the data that our analysis is based on, but to concentrate on how it presents a story of the county, the needs arising from it, how they feed strategic priorities and the resulting actions that are commissioned. Reference to the data sources are made so readers know how to go into more depth if required. In the following sections, further supporting information and Local Area Agreement[1] targets follow the storyboard for each of the Every Child Matters[41] outcomes.

BEING HEALTHY

Vision

The vision is for:

> *"All children and young people to grow up healthy in body and mind."*

Progress

We have already made good progress in helping children and young people to be healthier as follows:

- Through the close working relationship between the Care Trust and the Children's Services Directorate, working in alignment with a range of other partners the Healthy Schools Programme has been successful with many schools achieving the full Healthy Schools Status.
- Effective focused leadership for Child and Adolescent Mental Health Services (CAMHS) has improved multi-agency working and communication ensuring good service provision and improved timeliness of access.
- A successful Teenage Health Demonstration Site (THDS) has been established to make health advice more accessible to young people. The THDS has provided opportunities for young people to share their views about their experience of accessing health services. Their views will be taken forward during the life of the Children and Young People's Plan to ensure effective methods of improving the quality of health services for young people aged 11-19.
- The Teenage Pregnancy team has a wide-reaching teenage conception strategy and programme which provides advice around, and access to, contraception whilst providing support to those young people who do become pregnant ensuring access to the services they need.
- Services provide good support for improving young people's sexual health; effective action is taken to screen for, and treat, Chlamydia. Two teams of mobile sexual health nurses operate across Wansbeck and Blyth Valley (identified hotspots for teenage pregnancy). These teams work into secondary schools and drop-ins are established in 11 high schools with 1 more planned. Sign-posting and referral pathways are in place with the 3 schools without a drop in.

Improving physical health

Key Characteristics:
Obesity levels significantly increase between reception and year 6; there are inequalities geographically, and between sexes. Data for 2008 show obesity amongst year 6 pupils in Northumberland is slightly above the statistical neighbour average. Reducing or halting the year on year increase in obesity is a target in the Northumberland Local Area Agreement (NI56).
The provision of 2 or more hours of PE each week for 5-16 year old pupils is a target in the Northumberland Local Area Agreement (NI57). Whilst current performance is equal to the statistical neighbour average, we know it will be a challenge for schools to provide sufficient time in the curriculum for PE, given the way schools have traditionally been organised in Northumberland through a 3 tier system, and the building works involved in some areas which will reduce open space available for PE.
Sustaining breastfeeding 6 weeks after birth is a target in Northumberland's LAA (NI53). Breastfeeding rates in Northumberland are relatively low compared to the statistical neighbour average and national average. There is a well-researched link between sustained breastfeeding and reducing the infant mortality rate; reducing preventable infections and unnecessary paediatric admissions in infancy; halting the rise in obesity in under 11s; improving children's life outcomes and general wellbeing; and breaking the cycle of deprivation.
The TellUs survey showed that more children in Northumberland worry about their body than is the case nationally.

Resulting in these needs:
To narrow the gap in physical health inequalities present both within the county, and compared to the national picture.
Linked with strategies to address child poverty, this is needed to prevent more serious health problems in adult life.

Translating into this strategic priority:
Improve the physical health of children and young people.

Translating into commissioning these actions:
Implementing the Childhood obesity strategy, the Obesity Care Pathway, and Healthy Schools intervention (LAA stretch target).
Implementing strategies to promote participation in physical activity.
Using Lottery funding to develop physical activities for looked after children.
Implementing strategies to increase breastfeeding uptake and maintenance.

Table 56: LAA targets for improving physical health

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 53: Prevalence of breast feeding at 6-8 weeks from birth	TBC (2008/09)		TBC	TBC	Care Trust
	Coverage		90.0%	95.0%	
NI 56: Obesity among primary school age children in Yr 6	16.6% obese (2005/06)	18.7%	19.1%	18.4%	Care Trust
	78.7% coverage (2005/06)	85.0%	87.5%	90.0%	
NI 57: Children and young people's participation in high quality PE and Sport	77.5%	81%	85%	89%	Northumberland Sport
Stretch target: % schools achieving healthy schools status	0% (2004/05)		90% (Dec 09)	n/a	NCC/Care Trust

Improving sexual health

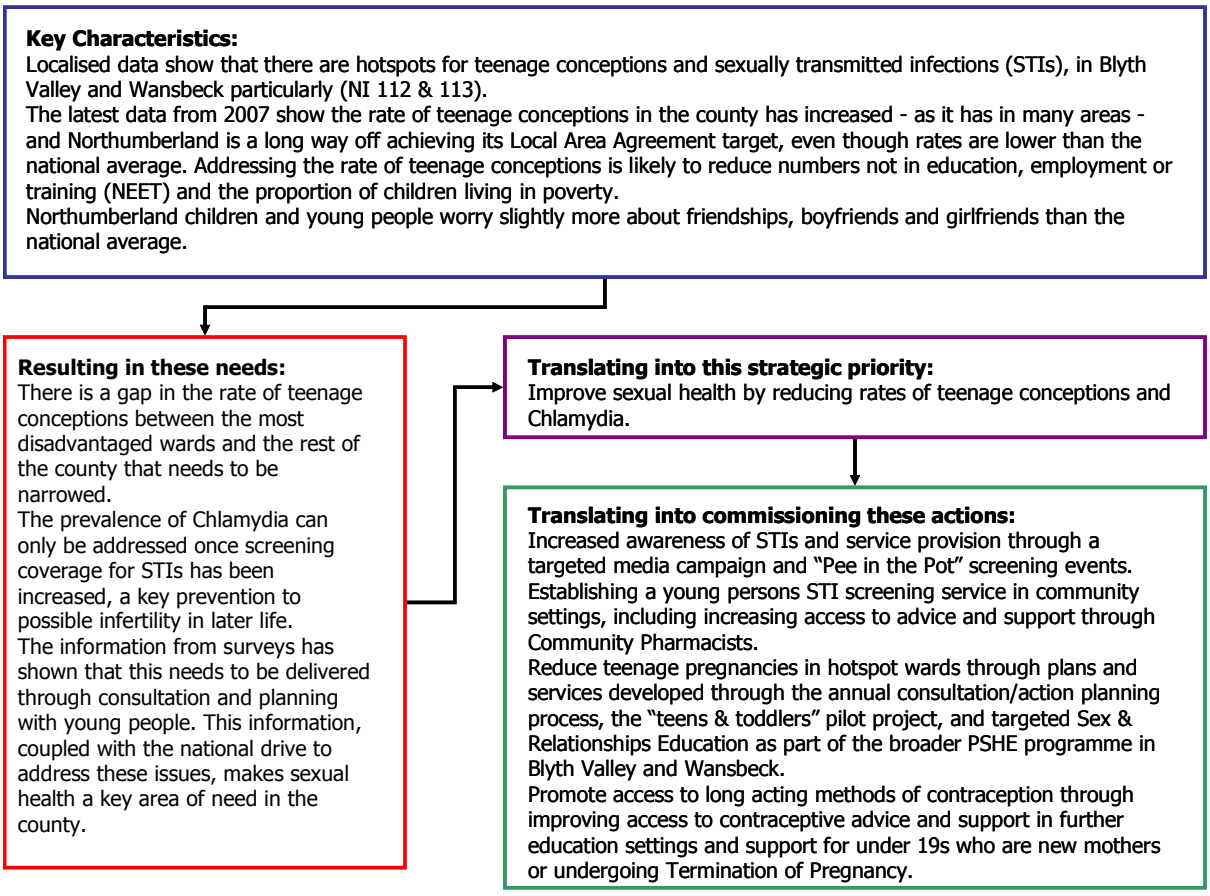


Table 57: LAA targets for improving sexual health of young people

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 112: Under 18 conception rate	38.1 per thousand (2003)	21	21	21	Care Trust
Increase the rates of Chlamydia screening for under 25's	7.7% (April to Dec 2007)	17%	25%	35%	Care Trust

Improving mental and emotional well-being

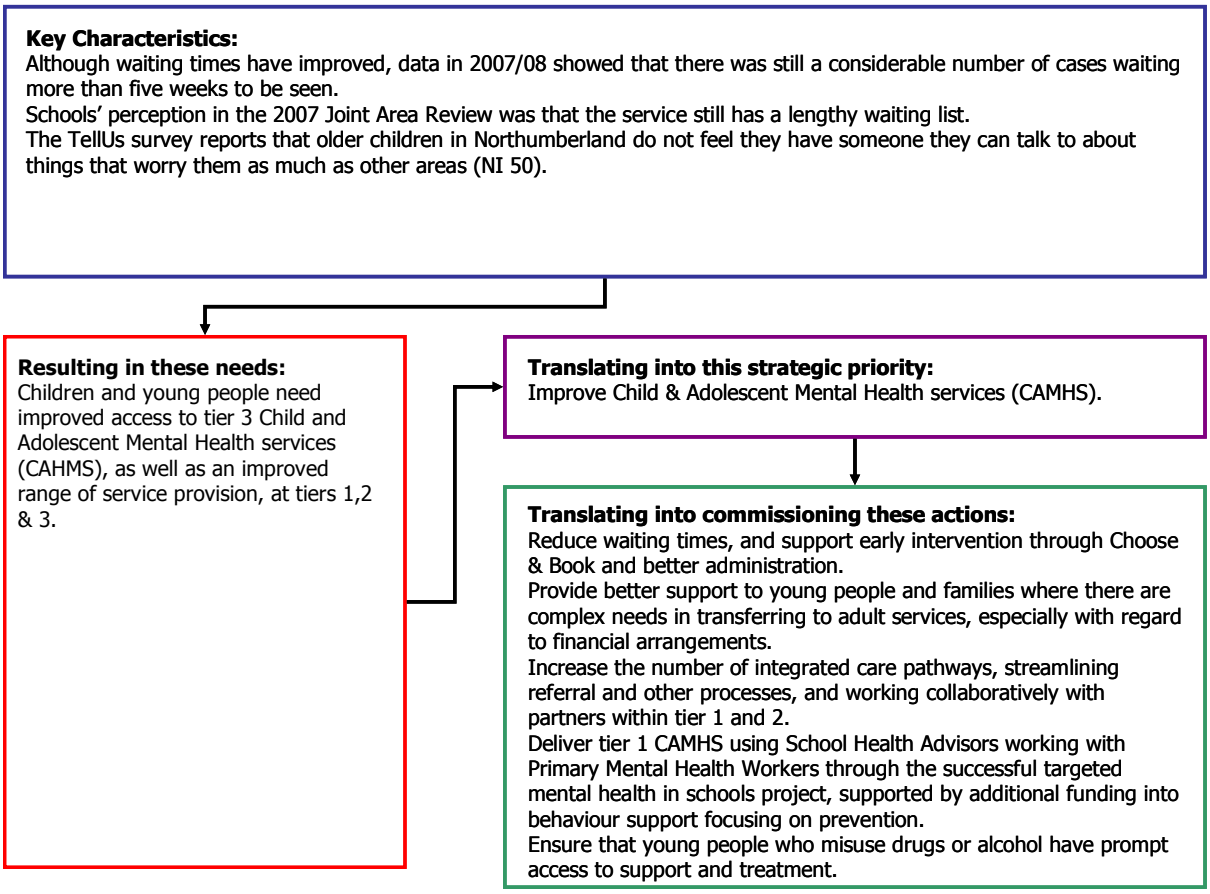


Table 58: LAA targets for ensuring the emotional well-being and mental health of children and young people

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 51: effectiveness of child and adolescent mental health services	14 out of 16 (Jan to Dec 2007)	16	16	16	Mental Health Trust
Reducing waiting times for accessing CAMH service	65% for those cases seen (01/10/2008 to 20/11/2008)	85% or more waiting 5 weeks or less	TBA	TBA	Mental Health Trust
NI 115: substance misuse by young people	13.4% stating they 'frequently' misuse substances	N/A	12.3%	10.9%	NCC

STAYING SAFE

Vision

The vision is for:

> *"All children and young people to grow up in a safe environment free from harm, fear or prejudice."*

Progress

Northumberland is consistently strong on the performance targets for child protection as follows:

- The social care systems that are in place have been found to be well-managed and effective.
- Well co-ordinated processes are in place to provide the necessary support for those families experiencing difficulties.
- Children's Services are committed to allocating qualified professionals to ensure families receive the help they need.
- The Northumberland Safeguarding Board is well established with a broad cross-section of partner agencies represented ensuring that safeguarding is everyone's business.
- Integrated teams are being developed to ensure that services work together with a joint approach amongst professionals facilitated by the appropriate sharing of information to ensure children and young people are provided with a co-ordinated approach.
- Integration is at the forefront of service delivery with integrated teams in place to ensure children and young people are provided with a powerful and comprehensive approach to improve their life chances.
- Joined-up services with a common language will continue to facilitate services being built around the child or young person; integrated processes have been established to join-up information sharing, assessment and referral to enable practitioners to work together better.
- A multi-agency thresholds document has been produced to inform frontline working practices and link in with the implementation of the Common Assessment Framework across Northumberland.
- Early intervention and preventative services will continue to be developed with a consequent reduction in the use of high cost specialist services and the provision of more low cost preventative services.

Safeguarding the most vulnerable through effective frontline practice

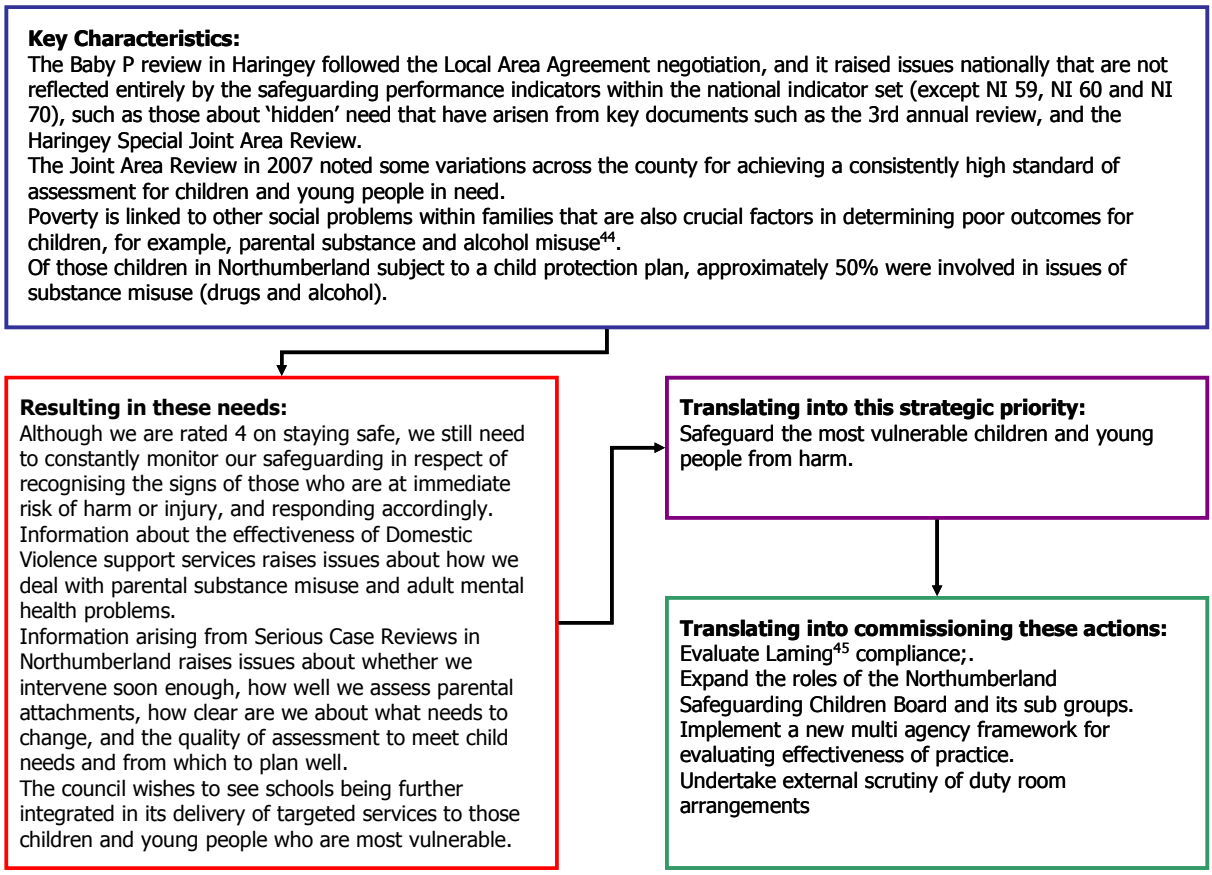


Table 59: LAA and local targets for ensuring that children and young people stay safe

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 32: repeat incidents of domestic violence	To be introduced nationally in 2009				NCC
Improving the quality of SW assessments – achieving satisfactory or above in case file audits	Baselines are in place, but the system for auditing quality of practice has been reviewed in light of national reviews (e.g. Haringey), from which new targets will be set.				NCC
Reduce the number of fatal casualties or those seriously injured through Road Traffic Accidents	14-17 (2006-07)	12-17			NCC
School children's perception of bullying	51.9% say bullied in last 4 weeks	TBA	TBA	TBA	NCC

Reducing the need for out of county placements

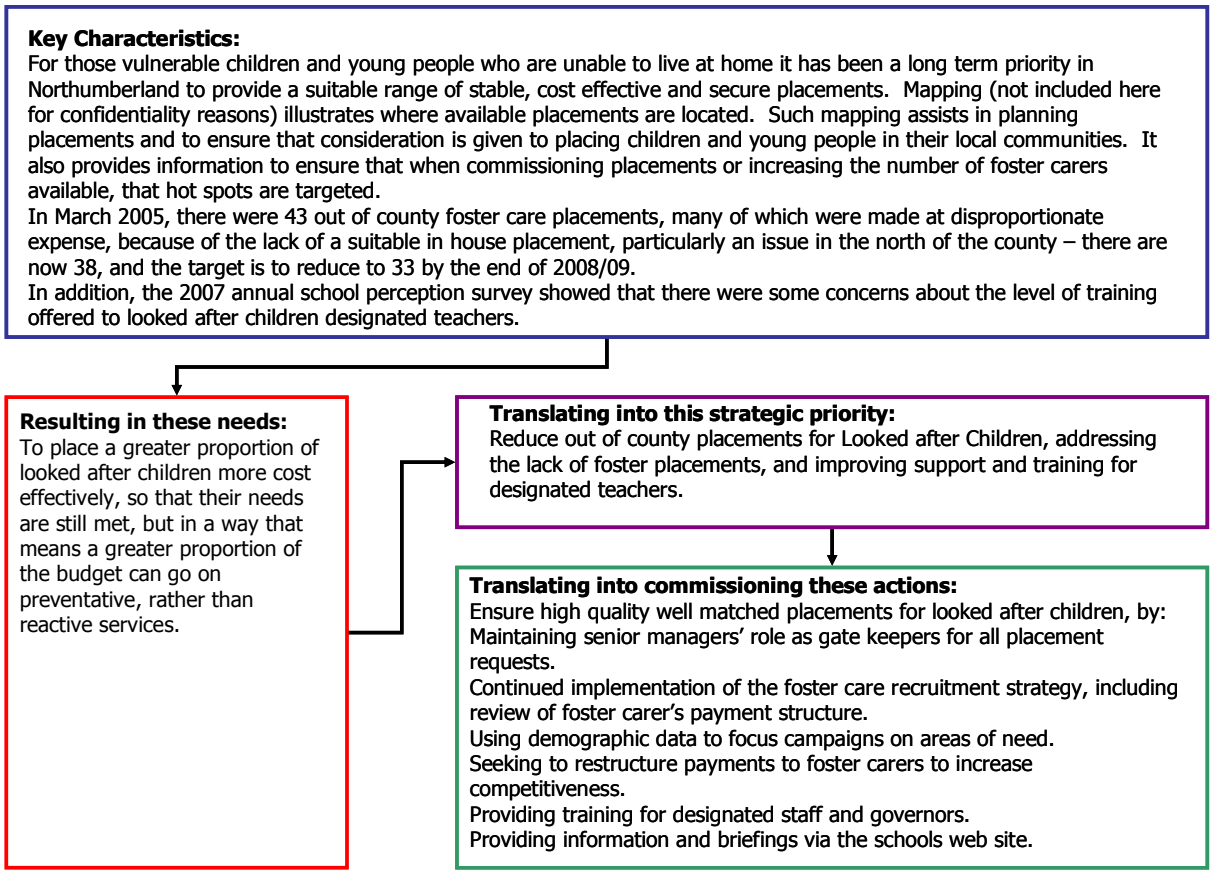


Table 60: LAA and local targets for supporting looked after children and children with learning difficulties or disabilities

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 63: stability of placements of looked after children; length of placements	66%	67%	77%	79%	NCC
Reducing the number of Independent foster agency placements and increasing the number of in house foster placements	42:144 (Sept2007)	38:148 (Sept 2008)	33:153 (March 2009)	TBC	NCC

Reducing fear and prejudice

Key Characteristics:
Around 60% of initial contacts with children's social care offices are from the police, of which around 80% relate to domestic violence. Many of these incidents occur in households where there are children present, and the Northumberland Strategic Partnership (NSP), along with the Government Office for the North East has agreed that the issue of domestic violence needs to feature in the designated LAA targets (NI 32 – reducing repeat incidents at Multi Agency Risk Assessment Conferences).
The TellUs survey shows that a higher proportion of older children in Northumberland than the statistical neighbour average say they have been bullied at least once in the last 4 weeks, and bullying has been a feature of two serious case reviews in the county.

Resulting in these needs:
Improved support services for those families where domestic violence and bullying is present, and narrowing the gap in access to services for those who are traditionally most in need, e.g. those with disabilities, those from minority ethnic backgrounds, looked after children and care leavers.

Translating into this strategic priority:
Promote a culture where children and young people are less at risk of fear and prejudice.

Translating into commissioning these actions:
Ensure those experiencing domestic violence have ready access to support, through the Domestic Violence partnership, Children's Centres, Extended schools and Voluntary Sector support services.
Work with Victim Support to ensure sustainability of services.
Support schools in the drive to combat bullying, through further implementation of the anti bullying strategy, the Emotional Health and Well Being Theme of the Healthy Schools Programme, and safe recruitment practices.
Meet the accommodation needs of care leavers, in partnership with housing providers and Supporting People.

Accident reduction

Key Characteristics:
Whilst the rate of children seriously or fatally injured in road traffic accidents has reduced in the last 10 years, the bigger picture shows that Northumberland has seen an increase in emergency hospital admissions of under 18s due to intentional or non deliberate injury.
Analysis of A&E data at a localised level shows that there are high rates in the north of the county, illustrating the unique challenges facing families with young children in particular who live in rural settings where the possibility of accidents relating to farm machinery are higher, yet modern hospital facilities less accessible.

Resulting in these needs:
Northumberland families need accessible Accident & Emergency units, and effective accident prevention strategies so that the need for hospital admission is minimised.
This is particularly important in the remoter and more disadvantaged communities where it is known that there is a link between poverty and child accidents.

Translating into this strategic priority:
Reduce road and fire-related accidents.

Translating into commissioning these actions:
Use mapping to identify road traffic accident hot spots.
Northumberland County Council road safety team work in partnership to provide road safety education cycle training and driver improvement schemes.
Fire & Rescue Service co-ordinate multi agency child safety workshops, provide Young Drivers' Awareness Training, and provide individualised education programmes for young people identified as demonstrating fire setting behaviour.
Develop and produce a range of safety education programmes for nurseries and schools across all key stages.
Continue to ensure all homes in Northumberland are fitted with a correctly operating smoke detector.

ENJOYING AND ACHIEVING

Vision

The vision is:

> *"All children and young people should have access to good quality education and be inspired to reach their potential and enjoy life through a variety of leisure pursuits and learning opportunities."*

Progress

A summary of progress is as follows:

- Education standards achieved by children in Northumberland are higher than the regional average.
- Schools receive excellent support from centrally based School Improvement Officers who support them to ensure standards are kept high and supporting schools and settings to narrow the achievement gap between children and young people who may need help.
- Where possible, those who are vulnerable or at risk are supported to achieve their potential through inclusion in mainstream education.
- High quality localised information on educational attainment is provided to schools to aid them in their drive to continually improve pupil performance.
- We are working with children and young people with special educational needs, and children and young people from black and ethnic minorities and Traveller communities to break down the barriers to service provision and support them in accessing good quality education provision is ongoing.

Re-organising the structure of schools is a key priority for the council and significant capital investment has already gone in with more planned for in the medium term capital plan to support the priority of Putting the Learner First.

Raising educational attainment

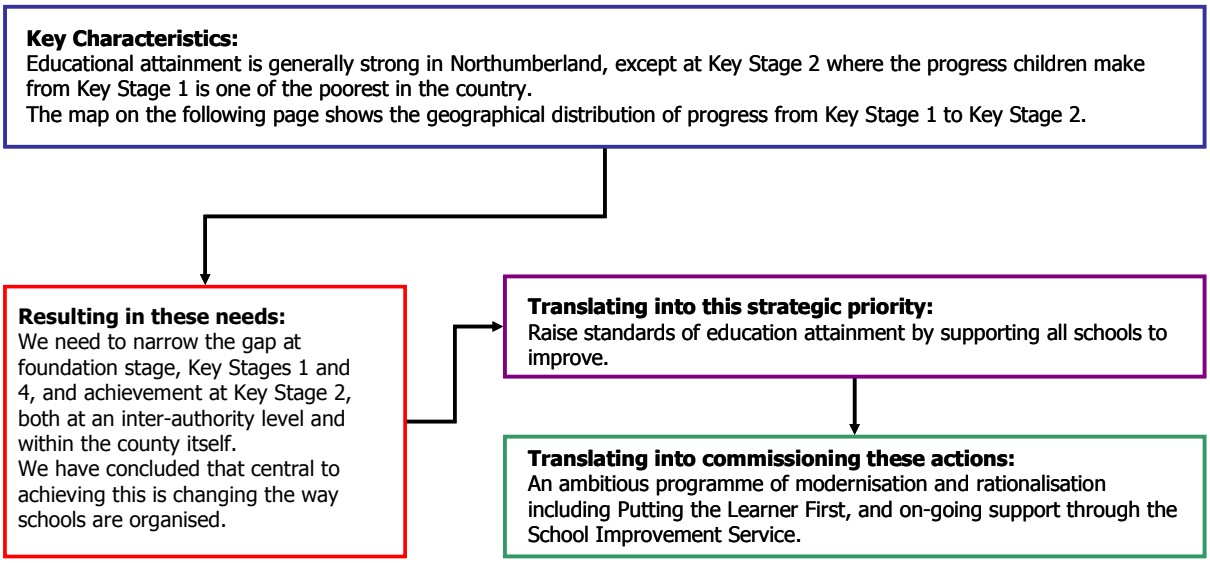
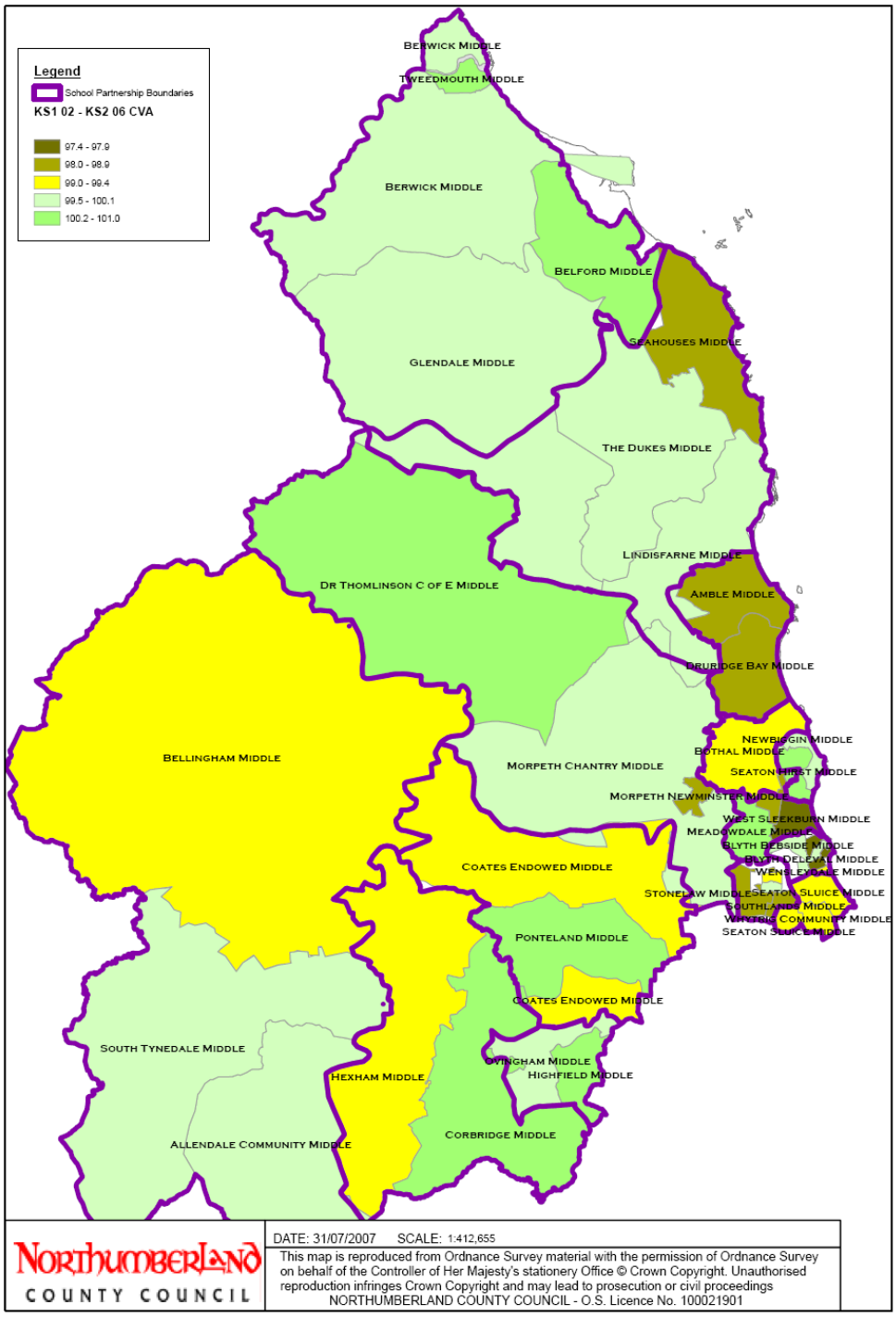


Table 61: LAA statutory education targets for improving achievement at Key Stage 2

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 73: achievement at level 4 or above in both English and Maths at Key Stage 2	70 (July 2008)	n/a	78	79	NCC
NI 93: progression by 2 levels in English between Key Stage 1 and Key Stage 2	75.5 (July 2007)	n/a	84	83	NCC
NI 94: progression by 2 levels in Maths between Key Stage 1 and Key Stage 2	66.4 (July 2007)	n/a	79	80	NCC

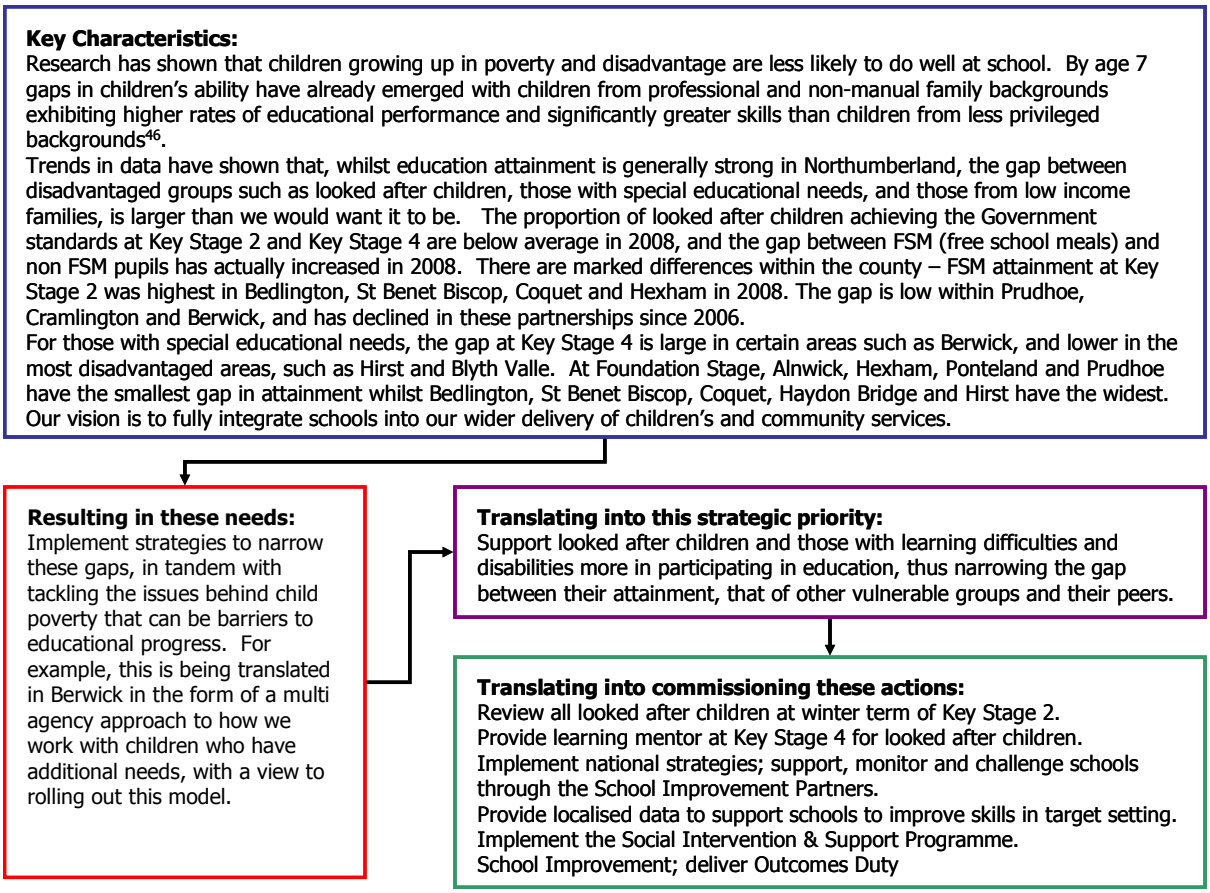
Also see page 28 for information about educational attainment at Key Stage 4.

Figure 22: Progress from Key Stage 1 to Key Stage 2 (Contextual Value Added), 2002-2006



NOTE: Value added measures have been used in the Achievement and Attainment Tables since 2002. They measure the attainment of pupils in comparison to pupils with similar prior attainment; this is fairer than using raw outcomes since schools can have very different levels of attainment on entry. For further information see:
http://www.standards.dfes.gov.uk/performance/1316367/CVAinPAT2005/

Narrowing the educational attainment gap for disadvantaged groups



We will aim to reduce the barriers to education experienced by pupils with learning difficulties or disabilities and other vulnerable groups and we will continue to implement strategies to improve the attainment and school attendance of looked after children. Action to narrow the gap for vulnerable groups includes:

- Involving looked after children and children with learning difficulties or disabilities in high level planning.
- Promoting attainment for:
    - Children and young people from black and minority ethnic groups,
    - Children and young people who require extra support in learning through special educational needs or School Action,
    - Looked after children.
- Supporting those with learning difficulties or disabilities in employment, education or training and work based learning.
- Implementing the Early Years Hard to Reach Strategy.

The Local Area Agreement target that supports this is the rate of permanent exclusions from school (NI 114). This is a 'cross-cutting' indicator that has an impact on narrowing the gap and supports strategic priorities in relation to Staying Safe and Enjoying and Achieving. Performance against this indicator is likely to impact on youth offending, young people not in education, employment or training, and Out of county placements.

It also helps to strengthen the partnership between schools, training providers and businesses underpinned by their commitment to the 14-19 Strategy outlining the links between skills, training and employment priorities.

Recent school-age population forecasting shows a likely dip of around 1,000 between 2009 and 2011; targets take account of this and reflect improvement in real numbers.

Table 62: LAA targets (including statutory education targets) for narrowing the gap for vulnerable groups

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 114: rate of permanent exclusions from school	0.12% (2006/2007)	0.12%	0.12%	0.11%	NCC
NI 92: narrowing the gap between the lowest achieving 20% in the Early Years Foundation Stage Profile and the rest	30 (July 2008)		27.9 July 09	26.9 July 10	NCC
NI 72: achievement of at least 78 points across the Early Years Foundation Stage with at least 6 in each of the scales in Personal, Social, and Emotional Development, Communication, Language and Literacy	64.5 (July 2008)	62.2	63.2	65.2	NCC
NI 99: looked after children reaching level 4 in English at Key Stage 2	28% (July 2008)		50%	TBA	NCC
NI 100: looked after children reaching level 4 in Maths at Key Stage 2	36% (July 2008)		50%	TBA	NCC
NI 101: looked after children achieving 5 or more A*-C GCSEs (or equivalent) at Key Stage 4 including English and Maths	4.5% (July 2008)		23.8%	35%	NCC
NI 87: secondary school persistent absence rate	5.3% (2007/2008)		5.5%	5.2%	NCC

Figure 23: Income Deprivation Affecting Children Index (IDACI) Score, School Partnership in Northumberland, 2006-2008

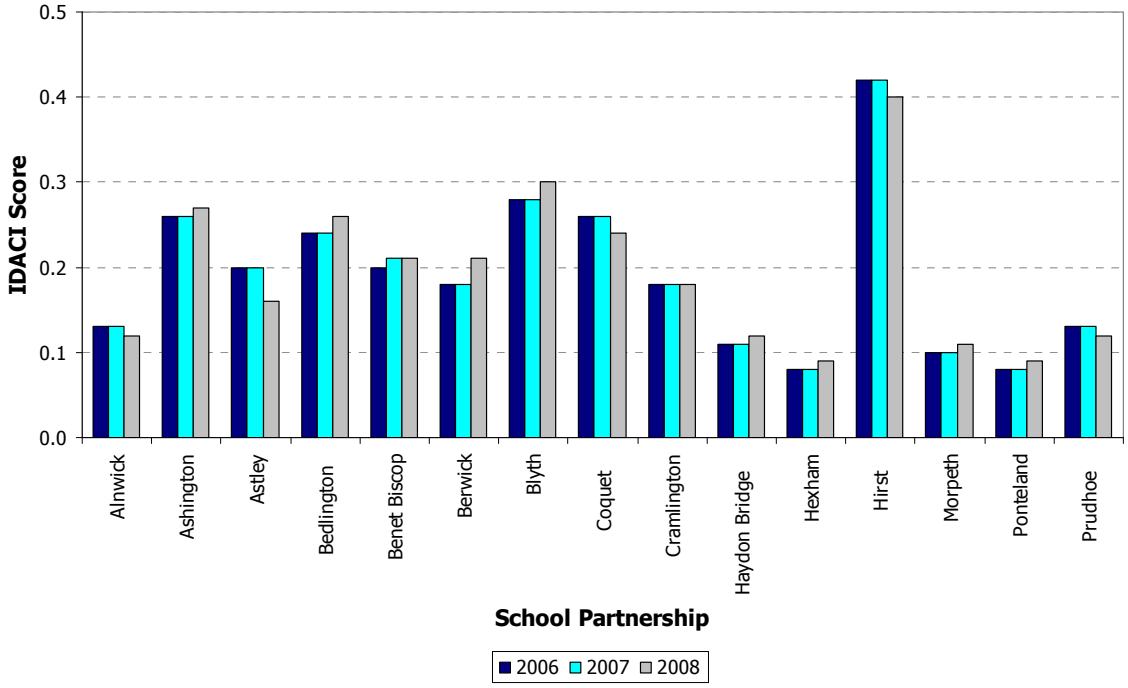


Figure 24: Gap between the bottom 20% of pupils and the rest of the cohort, School Partnership in Northumberland, 2006-2008

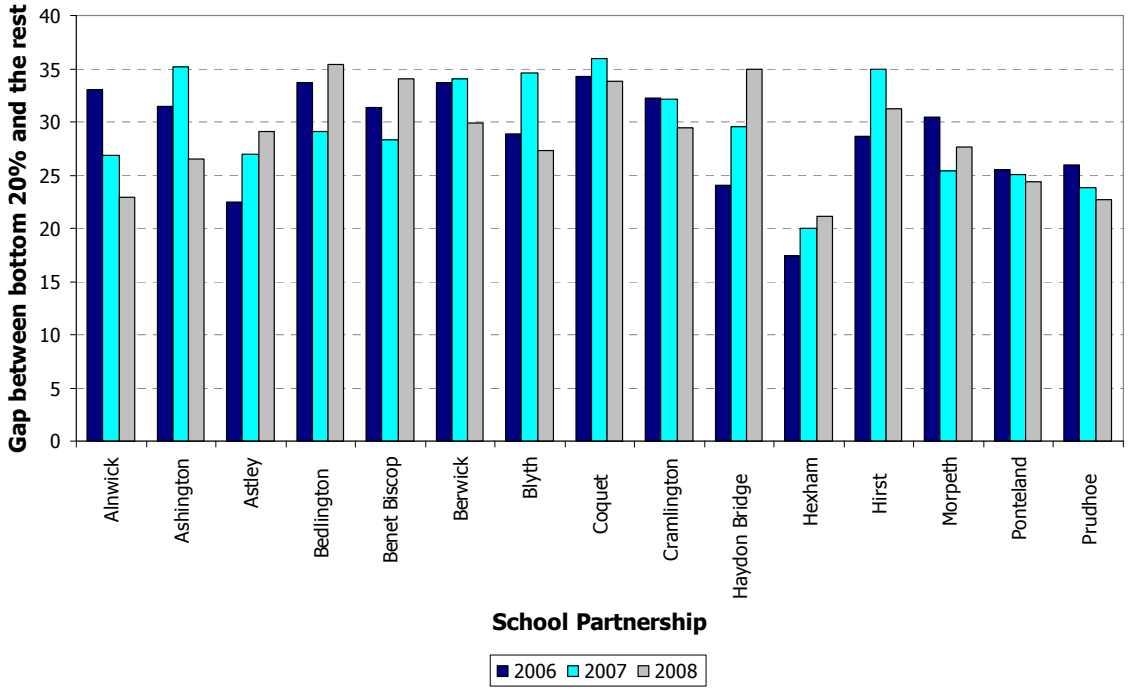


Figure 25:% Key Stage 2 Pupils achieving Level 4+ in English and Maths, School Partnership in Northumberland, 2006-2008

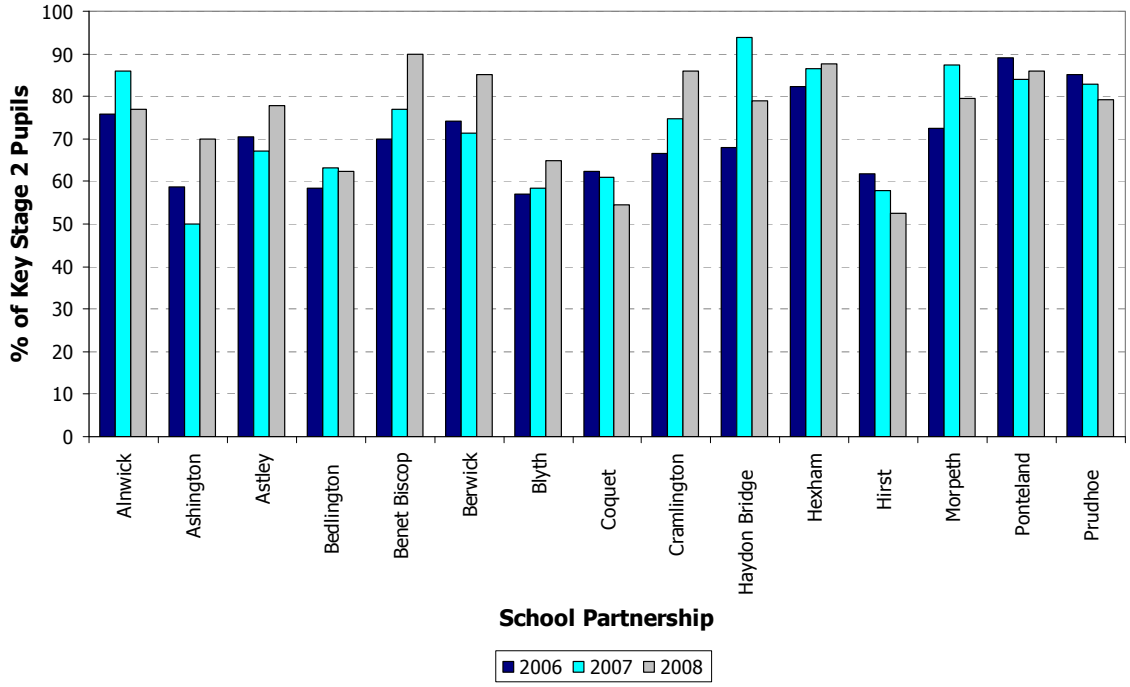


Figure 26: % Key Stage 2 Pupils gaining 2 levels in English during the Key Stage, School Partnership in Northumberland, 2006-2008

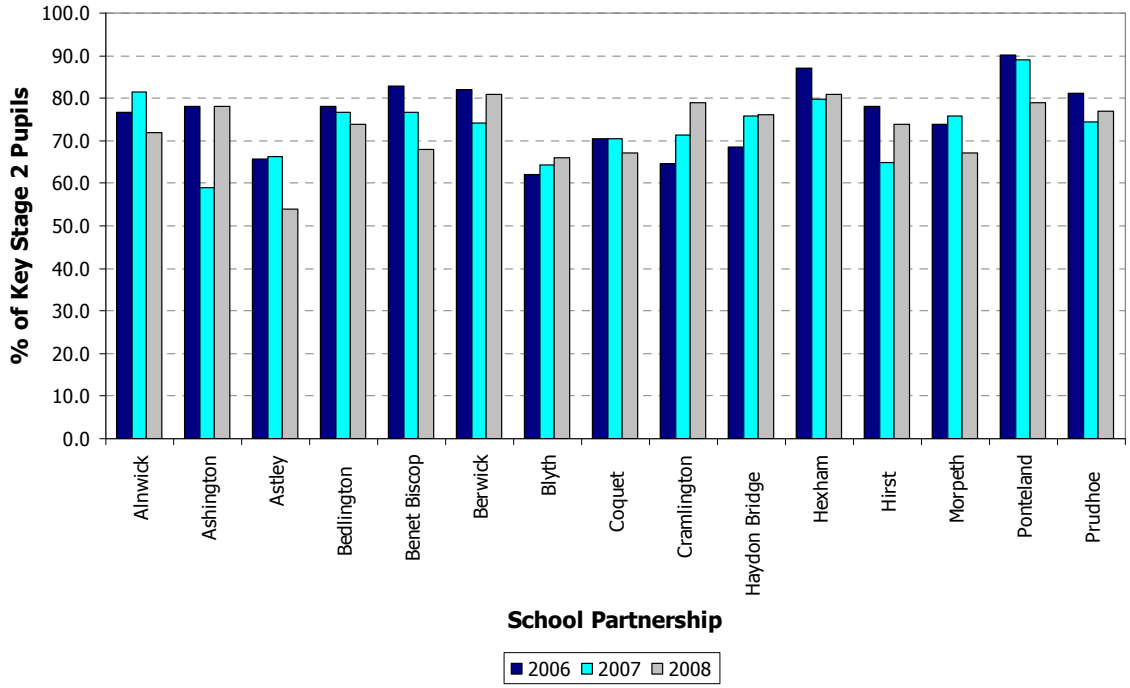


Figure 27: % Key Stage 2 Pupils gaining 2 levels in Maths during the Key Stage, School Partnership in Northumberland, 2006-2008

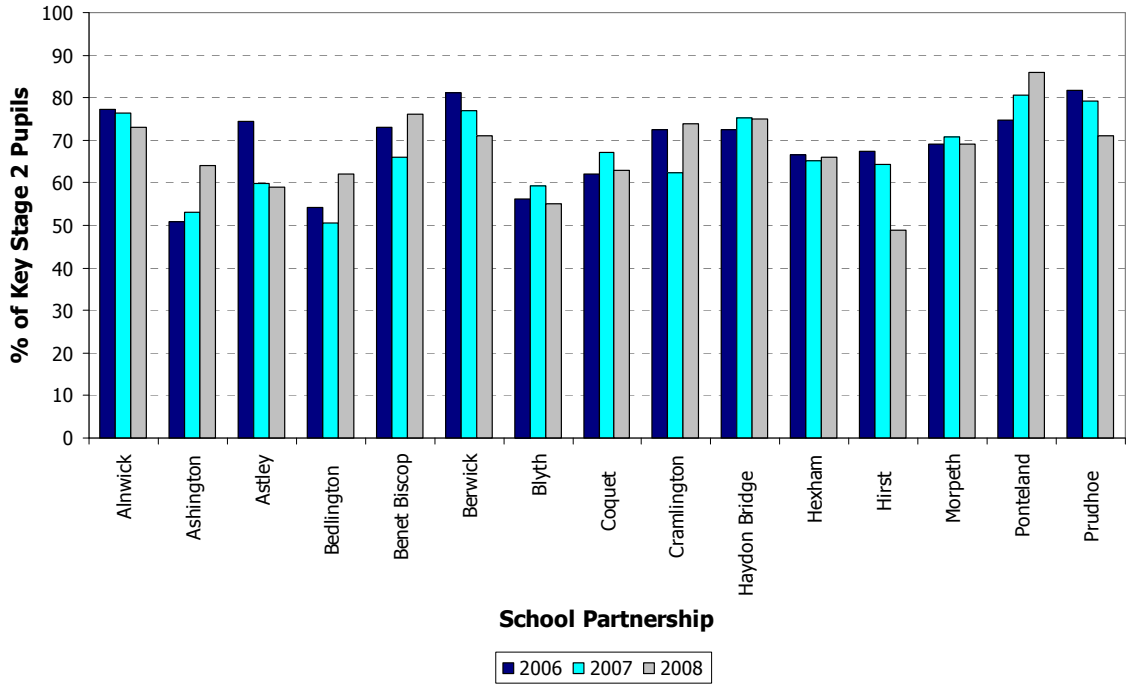


Figure 28: Gap in attainment at Key Stage 2 between the pupils with free school meals and pupils without free school meals, School Partnership in Northumberland, 2006-2008

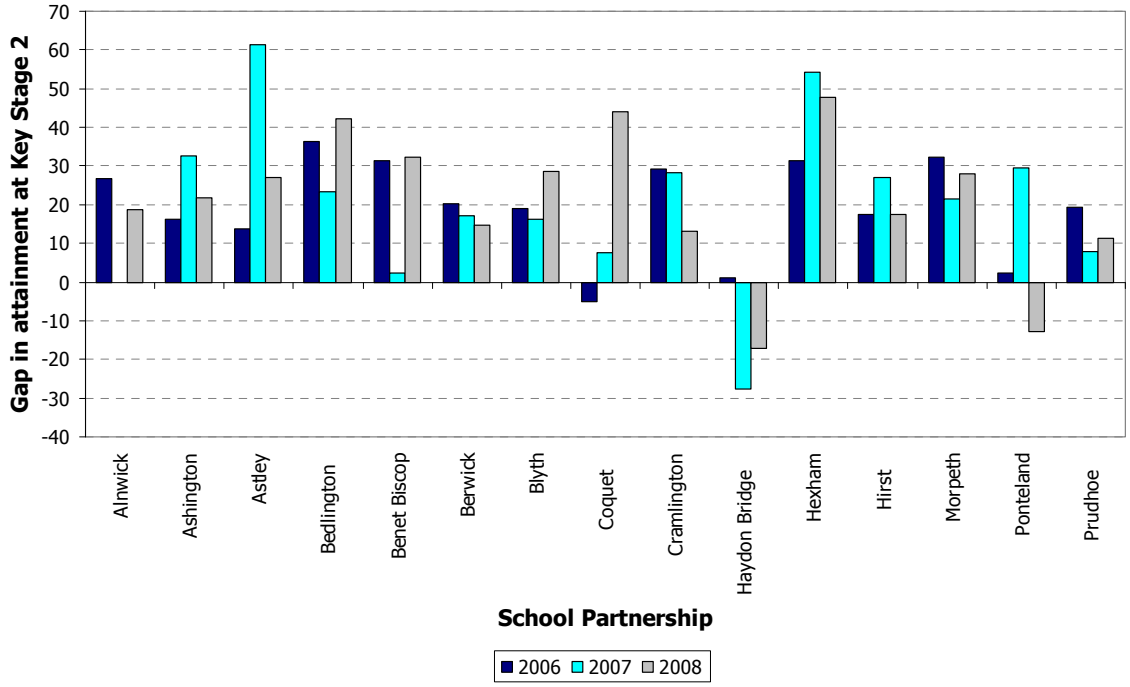


Figure 29: Gap in attainment at Key Stage 4 between the pupils with special educational needs and pupils without special education needs, School Partnership in Northumberland, 2006-2008

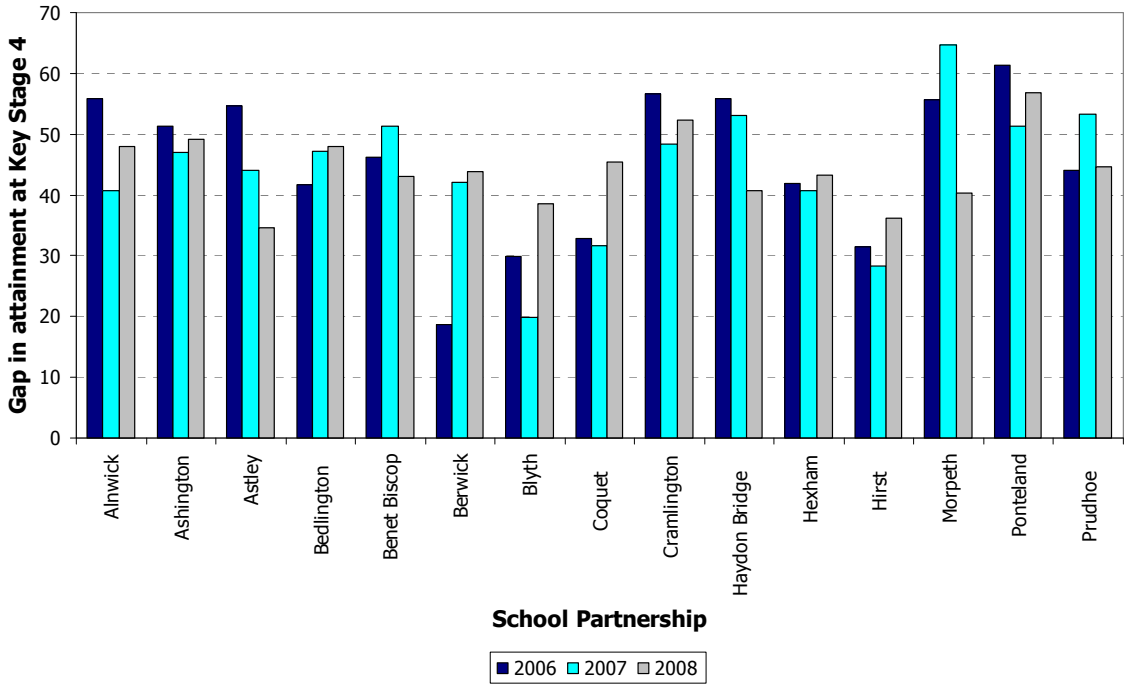


Figure 30: Persistent Absence Rates, School Partnership in Northumberland, 2007-2008

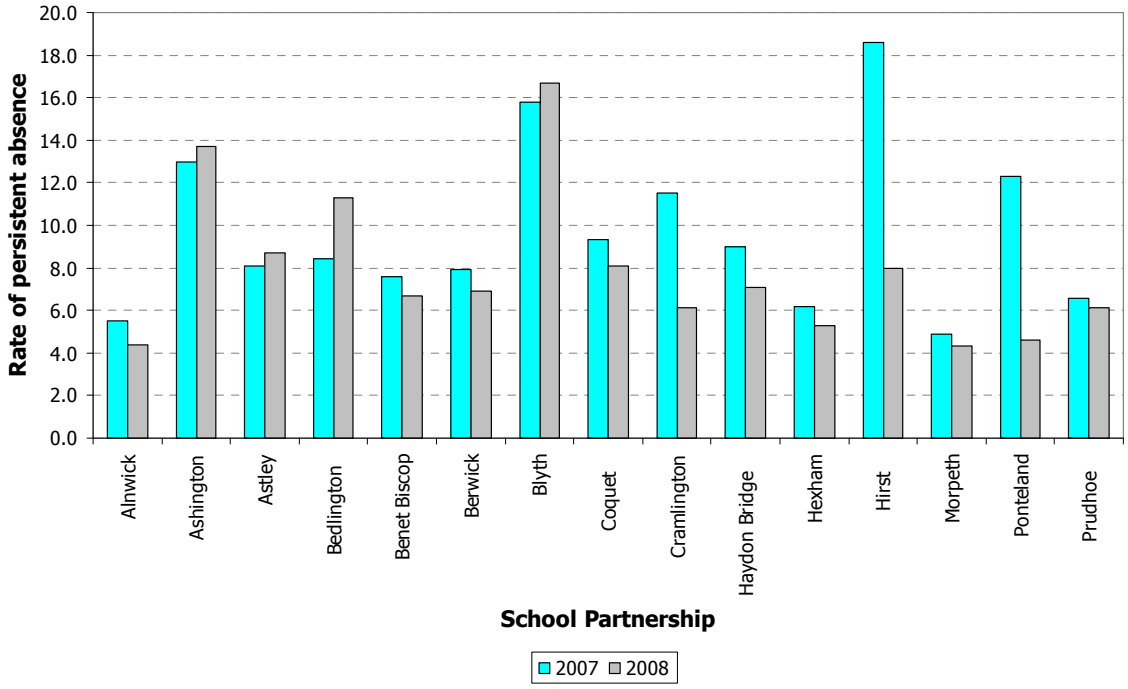


Figure 23 shows that levels of deprivation are highest in Hirst, Blyth, Ashington, Bedlington and Coquet. As discussed above, this links to lower performance. Deprivation is lowest in Hexham, Ponteland, Morpeth, Alnwick, Haydon Bridge and Prudhoe.

Figure 24 shows that in nine out of the 15 School Partnerships the gap between the bottom 20% of pupils and the rest of the cohort has narrowed since 2006, especially in Alnwick. Astley and Haydon Bridge Partnerships have seen a marked widening of the gap since 2006; however, that gap in Astley remains below that of many Partnerships. Hexham, Alnwick, Prudhoe and Ponteland have the smallest gaps; Bedlington, Haydon Bridge, St Benet Biscop, Coquet and Hirst have the widest gaps.

Based on provisional data for 2008, Figure 25 shows that the percentage of Key Stage 2 pupils achieving at least level 4 in English and Maths has improved in 11 out of 15 School Partnerships since 2006. However, this trend has not been consistent in a number of School Partnerships, where levels of attainment have fluctuated from year to year. Attainment in English and Maths has been high in Alnwick, Hexham, Ponteland and Prudhoe with good improvements being made in Astley, St Benet Biscop, Berwick and Cramlington. Attainment has been lowest in Ashington, Bedlington, Blyth, Coquet and Hirst over the last three years. It should be noted, though, that this measure does not take account of pupil context.

Based on provisional data for 2008, Figure 26 shows that progress in English (of 2 levels during Key Stage 2) has improved in three School Partnerships since 2006. Progress has been low in Astley and Blyth; St Benet Biscop, Coquet and Morpeth have seen downward trends. Progress in English has been highest in Berwick, Hexham and Ponteland (although 2008 results dropped). Cramlington has seen a good improvement in this measure.

Based on provisional data for 2008, Figure 27 shows that progress in Maths (of 2 levels during Key Stage 2) has improved in seven School Partnerships since 2006. Progress in Maths has been highest in Haydon Bridge, Ponteland and Prudhoe; progress has been lowest in Blyth and Hirst.

Based on provisional data for 2008, Figure 28 shows that the attainment gap at Key Stage 2 between FSM and non-FSM pupils was highest in Bedlington, St Benet Biscop, Coquet and Hexham in 2008; the gap in Hexham has been high across the three year period. In 2007, the gap within the Astley partnership was marked. The gap is low within Prudhoe, Cramlington and Berwick and has declined in these partnerships since 2006.

Figure 29 shows that, based data for 2008, the attainment gap at Key Stage 4 between pupils with special educational needs and pupils without special educational needs was highest in Ponteland and Cramlington and lowest in Astley, Hirst and Blyth.

Figure 30 shows that rates of persistent absence had reduced between 2007 and 2008 in 11 out of 15 School Partnerships. Rates had risen in Ashington, Astley, Bedlington and Blyth.

Reduce barriers to inclusivity & more access to leisure and education

Key Characteristics:
Research has shown that children growing up with disadvantage are more likely to have behavioural difficulties and display poor behaviour in the classroom leading to a widening of the gap in attainment as these children progress through school[47].
There is a rising need to provide placements for children with Emotional, Behavioural and Social Disorder, Autistic Spectrum Disorder, and cerebral palsy. Costs for these placements have risen rapidly over recent years largely due to demand for such places outstripping their availability. Residential special schools have needed to conform with improved care standards and referral trends have seen a greater incidence of children with challenging behaviour and this has necessitated increases in staffing levels.
Northumberland has a relatively high number of children who have a statement of special educational needs, which are costly, and resource intensive – 198 statements commenced in 2008. There are currently around 100 children placed in independent special schools.
Permanent exclusions from school reached a high of 70 in the 2007/08 academic year, and the Local Area Agreement target is to reduce this to 58 in 2008/09, 55 in 2009/10 and 50 in 2010/11 (NI 114).

Resulting in these needs:
Spending on independent special schools has been highlighted as an area of concern by the county council, as have the high number of special educational needs statements and exclusions last year.
There is a need to move to more proactive models that prevent the need for these interventions, and place children in Northumberland resources nearer home.

Translating into this strategic priority:
Reduce barriers to inclusivity so that children and young people have more access to leisure and education.

Translating into commissioning these actions:
Implement a commissioning strategy for special educational needs and pupils with learning difficulties or disabilities.
Expand Hexham Priory school and Atkinson House.
Review the funding formula for a more equitable distribution of resources.
Provide an additional £400K for behaviour support to enable schools to support children with learning difficulties or disabilities in mainstream settings.
Exercise tight control on independent special school placements, building on the multi agency approach piloted in Berwick for children with additional needs.

Table 63: Number of children with special educational needs, broken down by need category, Northumberland, 2007

Need Category	Number of Children
Speech, Language or Communication difficulty	366
Behavioural, Emotional or Social difficulty	347
Moderate Learning difficulty	334
Autistic Spectrum Disorder	238
Physical disability	173
Specific Learning difficulty	98
Severe Learning difficulty	96
Hearing impairment	54
Visual impairment	34
Other	6
TOTAL	1,746

These data are available for each school partnership, but have not been presented here at that level to conserve confidentiality.

MAKING A POSITIVE CONTRIBUTION

Vision

The vision is for:

> *"All our children and young people to be actively engaged in their learning environments and communities and to grow up making the most of their opportunities."*

Progress

A summary of progress is as follows:

- Participation is a significant strength in Northumberland where the "Having a Life" survey has been carried out annually to provide a better understanding of the views of children and young people. Over 6000 children and young people were asked for their views as part of a major consultation exercise. FACT participation standards will be promoted to all FACT partners with a view to all partners adopting them.
- Work will continue to ensure children's and young people's views inform service development including listening to the voice of children and young people who are Looked After, have learning difficulties or disabilities and care leavers.
- We will develop further and support the effective transition of young people with disabilities to Adult Services through person-centred planning, a dedicated transitions team and individual budgets.
- We will develop further and support the effective transition of Looked After children through Pathway Planning.
- The Youth Offending service has been successful in reaching the target set by the Youth Justice Board to reduce the number of first-time entrants into the criminal justice system achieving this two years ahead of schedule.

Listening to the voice of children and young people

<u>"Having a Life" Survey results for 2007</u>

The original 'Having a Life' plan was based on consultation with children and young people who chose the title and who suggested conducting an annual survey to see if things were really improving. The first 'Having a life' survey took place in the spring term of 2006 when 6,500 children and young people completed paper survey forms. The second survey took place in the spring term of 2007 and was mainly done online; 4,500 children and young people took part representing 6.8% of all under 18 year olds in Northumberland (63,360). The significant differences between the 2006 and 2007 surveys are as follows:

- A 5% increase in the number of children and young people saying they are happy;
- An increase in the number of young people over the age of 10 saying that they feel generally confident; <u>but</u>
- A decrease in the number of school age children feeling confident that they can cope with 'changes like moving or changing school';

- An improvement in the number of children under 5 feeling safe at home but this age group still feel less safe at home than older children or young people;
- An improvement on 2006, but still more than half in middle and high school age young people say bullying is a problem in school;
- Over 60% of middle and high school children and young people agree bullying is not a problem in their neighbourhood;
- 67% of children in first schools, 46% of young people in middle schools, and 40% of young people in high schools say they enjoy school - all figures are lower than for 2006.
- Only 31% of high school students find what they learn to be interesting - this is fewer than for 2006;
- 15% fewer children and young people say there are 'plenty of things to do' where they live and the TellUs Survey confirms this as a key issue for Northumberland.

Table 64: Percentage of children and young people reporting feeling valued by society through the "Having a Life Survey, 2007

I feel valued:	Age 6 to 9	10 to 12	13 and over
by adults at school	69%	54%	39%
by adults at home	82%	88%	75%
by adults in the neighbourhood	52%	55%	47%
by other young people	n/a	n/a	61%

In the 2006 survey, 60% of 5 to 12 year olds and only 50% of 12 to 18 year olds said they felt valued as part of society. In the 2007 survey, the results were as shown in Table 64 above.

There has been a 6% increase in the number of high school age young people feeling that adults listen to them. Over half of all young people now feel listened to by adults. The survey asked an 'open' question about 'three things that would make your life better', the three most popular were as reported in Table 65 below:

Table 65: The top three things that would "make life better" reported through the "Having a Life" Survey, 2007

	Age 6 to 9	10 to 12	13 and over
1	Things to do at home	Things to do	Things to do
2	Friends	School	School
3	School	Friends	Money

The data for each school that took part is available to the school; many schools have used the data for their Self Evaluation Form. School Partnership data will also be available to schools, Local Strategic Partnerships and to Children's Services. Children's services will use the data to support school partnerships, extended services, Children's Centres and FACT integrated teams.

The data have also informed this needs analysis and contributed to the evaluation of how effectively the priorities for children and young people are being delivered.

Key Characteristics:
The Joint Area Review in 2007 noted the need for us to continue developing ways in which vulnerable young people, such as looked after children and those with learning difficulties or disabilities, could participate more in the planning of services at a strategic level.
In line with this, participation is a key strand of the Integrated Youth Support service, and a programme of work is endorsed and monitored through the multi agency Participation Strategy Group, including those involved with the highly-regarded Health Demonstration site.
The TellUs survey showed that young people felt slightly more negative about how their views were listened to in school than the national average.
Although outdated, the 2001 Census showed that the number of young carers was relatively high in the more disadvantaged districts of Blyth Valley and Wansbeck, as follows: 86 in Alnwick; 81 in Berwick upon Tweed, 308 in Blyth Valley, 146 in Castle Morpeth, 181 in Tynedale, 241 in Wansbeck – a total of 1,054 for Northumberland.

Resulting in these needs:
Wider range and better quality means of supporting those who are likely to suffer disadvantage to participate in service planning.

Translating into this strategic priority:
Listen to the voice of children and young people who are looked after, have learning difficulties or disabilities, or are care leavers.

Translating into commissioning these actions:
Use a common set of identification criteria for young people requiring ongoing support into adult life; continue to implement "Person Centred Review Pilots" and the "Taking Control Pilot" activities.
Strengthen monitoring to identify themes and hot spots.
Promote access to advocacy service.
Ensure looked after children contribute effectively to their reviews.
Ensure views of young people about how to hold reviews are embedded.
Introduce "exit interviews" for young people leaving care, roll out 'Viewpoint, creating a Looked After Children Council, and ensure the contribution of looked after children to Corporate Parenting Committee meetings.
Ensure young people with learning difficulties or disabilities and looked after children are represented on the proposed Young People's Scrutiny function for the new local authority.

Integrated youth services and positive activities

Key Characteristics:
Surveys such as Having a Life and TellUs have shown that young people want more things to do, places to go, and the transport to access them.
Whilst the response in TellUs to the question about participating in positive activities (LAA target) was very encouraging (72% compared to 68% for our statistical neighbours), it needs to be seen in the context that some schools in remote areas of the county did not take part in the 2008 survey and their likely inclusion in the future may present a less positive picture due to the issues of access deprivation experienced in the west of the county in particular.

Resulting in these needs:
Broader range of extended services and youth activities, tailored to meet local requirements.

Translating into this strategic priority:
Develop integrated youth support services and promote further improvements in the quality of youth service provision.

Translating into commissioning these actions:
Ensure positive engagement of young people in good quality youth service activities, implementing recommendations from the 2007 inspection, and Targeted Youth Support.
Embed the FACT participation principles and self assessment.
Establish young people's scrutiny function.
Involve young people in 'mystery shopper' exercises to evaluate services.
Ensure Voices network becomes self sustaining.

Preventing and reducing offending

Key Characteristics:
Poor social skills in young people are strongly correlated with their engagement in a variety of risky behaviours including offending, drug abuse and non-attendance at school. Reducing offending was identified in the Northumberland Strategic Assessment as a strategic priority; it forms an important component of the public's perception of community safety.
Whilst we have done well at reducing first time entrants into the youth justice system, and have been rated well above average by the Home Office in this area, it is only very recently that Northumberland has seen an improvement in reducing the rate of re-offending amongst 10-17 year olds, and this has been an area we have agreed as a target in the local area agreement (NI 19) where we are striving to achieve a 3% reduction each year up to 2011.
Analysis has been done to look at the gender and age breakdown of young people involved with the Youth Offending Service, with peaks in the Blyth Valley and Wansbeck areas, and a higher representation of females in the latter than is generally the case.
Reducing frequent substance misuse is a priority in Northumberland's local area agreement, and whilst the baseline data from the TellUs survey need to be treated with caution (because there was a disproportionately high number of older children in our sample), the issues are still relevant as there are more under 18s in treatment in Northumberland than is the case nationally. Local area agreement targets are to reduce the percentage of children who 'misused substances' in the last 4 weeks from 13.4% to 10.9% by 2011.

Resulting in these needs:
Young people want activities that are broad based, personalised, relevant, exciting, memorable and life enriching.

Translating into this strategic priority:
Strengthen communities where children and young people feel valued, and involvement in offending is reduced

Translating into commissioning these actions:
Develop the Youth Crime Prevention Strategy in partnership with others.
Target high risk offenders and develop programmes of intervention focused on the factors linked to risk of re-offending.
Implement integrated services for young people designed to motivate young people.

Table 66: LAA targets for preventing and reducing offending and increasing participation in positive activities

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 19: rate of proven re-offending by young offenders	25	3% reduction	3% reduction	3% reduction	Youth offending team
NI 110: reducing the number of first time entrants to the Youth justice system	(2006)	-5%	-5%	-5%	Youth offending team
NI 110: young people's participation in positive activities	72.3%		73.5%	75.0%	NCC

ACHIEVING ECONOMIC WELLBEING

Vision

The vision is for:

> *"Our children and young people to grow up well prepared for the future with the necessary skills in place to achieve their ambitions and confident in their own futures."*

Progress

A summary of progress is as follows:

- We have an expanding number of successful Children's Centres which, alongside extended schools, provide local centres that deliver integrated education, play, care, family support and health services.
- Learning for life, the 2020 Vision for Learning in Northumberland sets out the aspirations for learning within the county.
- Tynedale Virtual College is at the forefront of developing accessible training courses to prepare our young people for the world of work. It is an excellent example of how partners in Northumberland have come together to meet the needs of its young people.
- Partnerships between the Children's Information Service, Children's Centres and JobCentre Plus ensure that families receive the benefits they are entitled to and are supported with high quality childcare.
- The contribution of services to improving outcomes for children and young people in this area is good. Standards post-16 are rising. The percentage of young people reaching Level 3 has increased from 41.8% in 2004 to 45.8% in 2006, which is above the national average.

Maximising families' economic well-being

Key Characteristics:
There are variable rates of take up of formal childcare in Northumberland, illustrated through the working tax credit target in our local area agreement (NI 118 – striving to achieve 19% by 2011, from a baseline of 13% in 2005). Various challenges are faced such as the relatively high cost of child care compared to income and the traditional close family networks that are sometimes used rather than formal child care.
The Childcare Act, 2006[48] places new duties on local authorities to manage the childcare market and ensure sufficiency of childcare. In January 2007 Northumberland produced their childcare sufficiency assessment[49] to identify where the supply of childcare was and how this matched the actual demand for childcare.
The 2007 Joint Area Review noted the challenges in meeting the accommodation needs of vulnerable young people, such as young parents and care leavers and young offenders (NI 147 & NI 46).

Resulting in these needs:
To enable adults to access the employment market, and to tackle the root causes of poverty.

Translating into this strategic priority:
Action is taken by partners to support families in maximising their economic well-being.

Translating into commissioning these actions:
Develop the partnerships between the Children's Information Service, Children's Centres and Job Centre Plus.
Co-locate the NEET worker in the Leaving Care team.
Co-locate the Barnardos housing project with Supporting People and Teenage Pregnancy to provide a dedicated floating support service to teenage parents throughout Northumberland.
Undertake screening of all new admissions to Castington to identify young people who are the subject of care orders or eligible for a leaving care service.
Develop training for housing workers regarding the complex needs of young parents.
Use Barnabas Safe & Sound to provide and support young people with accommodation.

Tackling those who are not in education, employment or training

Table 67: Worklessness - % of dependent children who live in families reliant upon working age benefits. SOAs in Northumberland with >40%

			% of Dependent Children		
District	**Ward**	**LLSOA**	**Age 0-15**	**Age 0-4**	**Age 5-15**
Wansbeck	Seaton	E01027547	52.8	61.4	50.2
Blyth Valley	Croft	E01027416	52.3	47.4	49.3
Wansbeck	Hirst	E01027540	50.0	53.2	48.8
Wansbeck	Newbiggin East	E01027542	49.7	55.1	47.3
Blyth Valley	Newsham & New Delaval	E01027426	47.6	55.8	43.8
Blyth Valley	Cramlington West	E01027412	46.2	50.4	44.3
Castle Morpeth	Chevington	E01027443	45.8	40.5	48.0
Wansbeck	Park	E01027545	43.4	47.9	40.9
Alnwick	Amble East	E01027363	43.0	52.1	39.7
Wansbeck	Newbiggin West	E01027543	42.9	54.0	37.8
Castle Morpeth	Lynemouth	E01027451	42.6	40.2	43.6
Wansbeck	Sleekburn	E01027552	40.0	50.8	36.3

Nationally, the measure being used to indicate child poverty is the where more than 40% of an area's families have children dependent on workless benefits. Table 67 shows these figures for the Lower Layer Super Output Areas in Northumberland. It can be seen that there are disproportionately high numbers of areas in Blyth Valley and Wansbeck, compared to the other Northumberland districts. It should be noted, however, that this does not provide a complete picture of worklessness, since it misses those of working age who are not working, but who do not claim benefits.

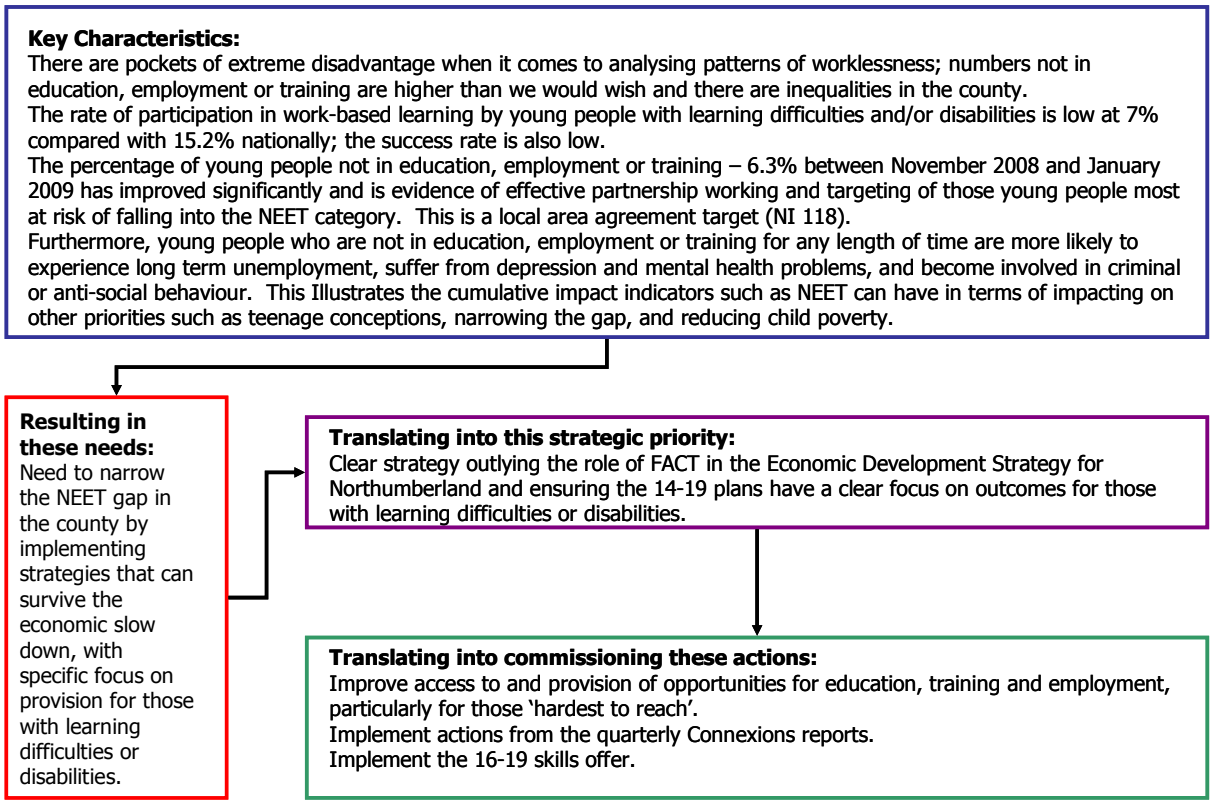


Table 68: LAA targets for reducing young people not in education, employment or training and care leavers in suitable accommodation

Indicator	Baseline	Improvement targets			Lead partner
		08/09	09/10	10/11	
NI 117: 16-18 yr olds who are not in education training or employment	8.1% (Nov 07-Jan 08)	6.3%	6.0%	5.7%	Connexions
NI 147: care leavers in suitable accommodation	83% (2006/07)	80%	85%	85%	NCC

9. ADULTS WITH LONG-TERM CARE NEEDS

OLDER PEOPLE IN NEED OF CARE

Forty percent of the population of Northumberland is over 50 years old, and by 2021 the proportion in the rural districts of the County is expected to have reached or exceeded 50%. Over the same period, the number of people aged 85 and over is expected to increase from 7,900 to almost 13,000. These dramatic changes in the balance of the population are part of an historic shift which is being experienced across the developed world; but they are happening earlier in Northumberland – especially rural Northumberland – than in most of England. Their impact on the texture of life in the county will be gradual but profound.

Alongside the changing numbers, there are equally far-reaching changes in expectations. People retiring over the next fifteen years were children or teenagers in the 1950s and 60s, when modern consumerism and teen rebellion were being invented. They are the generation of mass home-ownership and final-salary pensions, many of whom can expect a long period of healthy and economically comfortable retirement before they need the welfare services which were once the state's main responsibility towards pensioners. They are also, in the North East, the generation hit hard by the structural changes in the economy which reached their peak in the1980s, when the collapse of employment in mining and heavy industries disrupted individual and community life and led to social and political conflict. Whichever experiences people in this generation have had, when they need healthcare or social care, they will come to it with a very different cast of mind from the grateful recipients of state generosity of the past.

To ensure a co-ordinated approach across all public bodies in the County to the impact of these changes, the Northumberland Strategic Partnership has prepared the document *Older People in Northumberland: A Longer-Term View*[50], which examines the implications for all public services. That document identifies three broad groups of older people:

- **Older workers:** People who either still have jobs or are still actively seeking work (see also page 29). Once this would usually have meant men aged 50-64 and women (though not all women) aged 50-59. Now some people retire from work in their fifties and others choose to continue to work into their seventies or beyond. Some people in this group are at the pinnacle of their careers, running large organisations or earning substantial salaries because of their years of experience. But this is also the age group most likely to be hit by ageism in the workplace and the employment market, with employers still often assuming that younger workers will be more flexible and dynamic, and that over-50s will not be able to learn new skills and work in new ways. People in this group may also suffer from impairments or disabilities, perhaps associated with the nature of their work – bad backs, repetitive strain injuries and other conditions which affect their ability to work.

- **Third agers*:** People who have retired from work and can reorganise their lives around leisure, family responsibilities, non-vocational education or voluntary work. This group of older people play an important role both in child care, often looking after grandchildren

* The "third age" is a stage of life after the "first age" of childhood and the "second age" of working life, but before the "fourth age" of age-related ill-health.

while their parents work, and in caring for ill or disabled family members. They are also prominent in many areas of community life, from serving as local authority councillors to serving on the committees of small community organisations. However an important sub-group have more limited opportunities than others during their third age because of low fixed incomes, or because they depend on means-tested benefits.

- **Older people in need of care**: People whose lives are substantially affected by long-term illness or disability. Many of those in this group are people in their eighties or nineties who have age-related conditions such as osteoarthritis, visual or sensory impairment, or Alzheimer's disease. But there are also older people who are disabled by health problems much earlier in life, for instance people who suffer a severe stroke or even early-onset dementia in their early fifties.

These three groups are not wholly distinct, and people can move between them in all directions. For instance, people who have left work because of ill health in their fifties can be helped to develop the skills and confidence to move back into employment; people without stimulating social networks may develop limited expectations of life before they have health conditions which require substantial care – and in a more positive social environment, people who do require care may continue to participate in many "third ager" activities.

Public services have different goals for each of the three groups of older people:

- For **older workers**, a primary goal is to ensure that they are able to stay in work for as long as they wish to, and that people who lose their jobs for whatever reason have opportunities to return to employment. *Flexibility* of employment is also important to people in this phase of life, who may wish to choose options somewhere between full-time employment and retirement, and who may need to juggle work with caring responsibilities.

- For **third agers**, key goals are to ensure that the educational and leisure opportunities that people aspire to are available and accessible – and also that those who wish to have opportunities to contribute to wider community life. Services also need to support people in maintaining their health and fitness, so that they can continue for as long as possible in this phase of life.

- For **older people in need of care**, the key goals are to support people in remaining independent and able to participate in community life. Care services have an essential role, but need to be designed in ways that do not constrain people's lives or isolate them – and need wherever possible to emphasise rehabilitation and recovery of independence.

Within these three broad groups, there are many other differences which cut across them.

- The lives of older women are often very different from those of older men. On average, women live longer but have lower incomes and are more likely to be disabled. Because women are also often younger than their partners, more women than men live alone in their later years. Traditionally, women have also left the labour market earlier, though this is likely to change over time.

- Some older people have been disabled or have had a long-term illness for much of their lives. For instance the number of older people with a learning disability is increasing – and some conditions such as Down's Syndrome are associated with distinctive patterns of age-related ill-health.

- People from minority ethnic groups may face a distinctive experience – potentially made more difficult by the diverse and dispersed nature of the County's minority population, which may reduce the community support available. Older travellers also face distinctive issues about accommodation when they become frail.

- Other minorities, including gay and lesbian older people and people from minority faith groups, may find that services mostly targeted at older people have made assumptions based on stereotypes which assume that diversity is less likely in older age.

Key figures

The shift in the age balance of Northumberland's population is part of a broader national and international pattern, but the balance of Northumberland's population is changing much earlier than that of England as a whole, and this difference is particularly marked in rural Northumberland (see also page 18).

On the basis of 2004-based population projections:

- More than 50% of the population of the area currently covered by Berwick-upon-Tweed Borough Council will be over fifty by 2009. Alnwick District will reach the same milestone in 2016, and Tynedale in 2022. By 2121, the proportion of over-fifties in Berwick will have risen to nearly 58%, at a time when the figure for England as a whole is projected to be only 39%.
- By 2021, 5.2% of the population of Berwick, and 3.5% of the population of the County, is projected to be aged 85 and over, compared to 2.8% of the population of England. All districts in the County will have a higher proportion of over-85s than the English average, including Wansbeck (3.1%) and Blyth Valley (3.0%), which are expected to have the lowest proportions within the County.

It should be noted that the current local authority district boundaries within Northumberland will disappear in April 2009, when the new unitary council will come into being.

Research commissioned by the Wanless Review of future need for social care services[51] found no clear evidence that longer life expectancy can be expected to be accompanied by a reduction in the proportion of people in each age group who are disabled. The most reasonable planning assumption is therefore that these trends will lead to substantial increases in the number of older people in need of care.

One trend, which is expected to place particular demands on public services and on families and other community support networks, is the accelerating increase in the number of older people with dementia. If prevalence rates remain as they are now, numbers will rise by 14% between 2010 and 2015, by 17% in the following five years, and by 18% in the five years after that – rising between 2008 and 2025 from 4,038 to 6,763, a total increase of 67%[52].

Changing numbers will, however, bring some significant changes in the family support available to older people in need of care. For instance national projections suggest that the proportion of disabled older people cared for by spouses is likely to increase greatly[53], because of the increasing life expectancy of older men. Because of social expectations about gender roles, the accompanying change in the gender balance of carers will have implications which may only become clear over time.

The broad groupings of older people described above are not precisely-defined enough for exact statistics, but rough figures can be put on them. Of around 124,000 over-50s in Northumberland:

- 44,600 **older workers** were in employment at the time of the last available count[†], 39,000 of them under retirement age and 5,600 over retirement age. A further 1,500 over-50s described themselves as economically active but unemployed. An estimated 67% of people aged between 50 and retirement age were in employment.

- Around 8,500 **older people in need of care** are being supported by social services in early 2008. Of these, around 1,500 are aged between 50 and 65; 2,500 are between 65 and 80; and 4,500 are over 80.

- On a very broad definition, there are therefore up to 70,000 **third agers**. However this total includes around 8,000 people receiving incapacity benefit[‡], who might if circumstances had been different have been in work, and a large number of people who need some support which they arrange otherwise than through social services, from unpaid carers or privately. In the 2001 Census, 39% of over-50s (44,000 people) said they had a "long-term limiting illness", though not all of them will have needed care from others. This proportion rose from 22% of people aged 50-54 to 77% of people aged 90 and over.

People in their fifties are more likely than at any other age to be providing unpaid care to others (often their parents). In the 2001 Census, 22% of people in Northumberland in their fifties were carers (26% of women, and 18% of men). The reported proportion falls markedly in later years – though this may partly be because spouses providing mutual support are less likely to describe themselves as carers.

At the time of the 2001 Census, only 0.42% of over-50s in Northumberland were from a non-white ethnic group – less than half the proportion in the population as a whole. The older people were, the more likely they were to be white: 0.61% of people aged 50-54 were non-white, and this fell in every successive five-year age group to a low of 0.22% among people aged 80-84[§]. Older people in the County can therefore be expected to become progressively more diverse over time – by 2021, for instance, the people who were aged 30-34 at the time of the census will be over 50, and 1.21% of that cohort were non-white.

In 2001, 88% of Northumberland's over-50s described themselves as Christian, compared to 78% of younger adults. Only 0.5% described themselves as believers in a non-Christian

[†] Covering the year to June 2007 – figures taken from Nomis data at 2 March 2008.
[‡] 7,950 people at May 2007 were receiving incapacity benefit or severe disablement allowance.
[§] The proportions were actually rather higher for people aged 85+, though the absolute numbers were very small – only 40 over-85s in total described themselves as non-white.

religion – half the proportion for younger adults – and only 5.7% described themselves as having no religion, compared to 15.2% of younger adults[**]. As with ethnicity, the figures suggest that the County's older people will become significantly more diverse over the next fifteen years. In the shorter term, there is a generational gap in the importance of religion of any kind.

There are no census questions on sexual orientation. In 2006, the first full year of the enabling legislation, 20 male couples and 21 female couples aged over 50 formed civil partnerships in Northumberland. Northumberland was unusual in having across all ages more female partnerships than male.

MENTAL HEALTH

What we know about people's needs and how they are changing

National prevalence studies help to estimate the scale of mental health problems in Northumberland. However, national figures do vary, partly because of the changeable nature of mental health and the fact that a person's diagnosis and type of service received may change over time.

A widely quoted statistic from a 1992 survey[54] is that one in four adults has a mental health problem at any one time. This uses a wider definition of mental health problems than a more recent Office of National Statistics (ONS) survey, which puts the figure at one in six adults having 'significant mental health problems[55].

As the number of adults aged between 16 and 64 years in Northumberland is approximately 187,000, national figures[54] can be used to calculate the expected prevalence rates for Northumberland, as shown in the table below.

Table 65: National and Northumberland prevalence rates based on service use

Level of service	Prevalence as % of population at risk	Expected levels for Northumberland (no. of people)
Adults experiencing a mental health problem	30.0	56,000
Adults consulting primary care for a mental health problem	23.0	43,000
Adults diagnosed as having a mental illness	10.2	19,000
Adults receiving an assessment or care from specialist mental health services	2.4	4,500
Adults admitted to psychiatric hospitals	0.6	1,100

[**] However a higher proportion of over-50s did not answer the question about religion, so the gap may be rather less than the figures in the text suggest.

Determining how common a mental health problem by the number of people treated by health professionals, whilst useful, can exclude the number of people who experience mental distress but are not in contact with services. It is also important to remember a person's diagnosis may be changed several times in the course of their contact with psychiatric services.

An alternative approach is to undertake a community survey, such as the 2000 ONS survey, which estimated the rates of different types of mental distress experienced by adults aged 16-74 years living in private households in Great Britain. It was found that 16% of people interviewed had a neurotic disorder (as classified by DSM IV criteria), the most common being mixed anxiety and depression, with the least common being panic disorder.

Although the prevalence of anxiety and depression had increased slightly compared with a previous survey in 1993[56], the ONS concluded that there had been no change in the overall rate of neurotic disorder in the population. The prevalence of psychotic disorder had remained unchanged at 4 per 1,000 adults aged 16 to 64.

The prevalence of illicit drug dependence had approximately doubled over the seven-year period between the two surveys. In 2000, 26% of those interviewed were assessed as having a hazardous pattern of drinking during the previous year (38% of men and 15% of women). The potentially harmful relationship between substance misuse and mental health is well-documented.

An 18 month follow-up study[57] of people interviewed in the 2000 survey revealed that 8% had a disorder at both interviews; 5% who had no disorder in 2000 had experienced the onset of an episode; and 8% had a disorder in 2000 but had recovered at follow-up 18 months later.

Table 69: Summary of the main findings from the national survey

	Prevalence of Mental Health problems Percentages		
Diagnosis	**All**	**Women**	**Men**
Mixed depression and anxiety	8.8	10.8	6.8
Generalised anxiety	4.4	4.6	4.3
Depressive episode	2.6	2.8	2.3
Phobias	1.8	2.2	1.3
Obsessive compulsive disorder	1.1	1.3	0.9
Panic attacks	0.7	0.7	0.7
Psychosis (mainly schizophrenia)	0.5	0.6	0.5
Any of the above	16.4	19.4	13.5

SOURCE: Psychiatric Morbidity among Adults Living in Private Households, Office for National Statistics, 2000.

Table 70: Expected levels of different mental health problems for Northumberland

Diagnosis	National prevalence rate ONS 2000	Estimated no. in Northumberland (Pop: 16-74 c.225,000)
Mixed depression and anxiety	8.8	20,000
Generalised anxiety	4.4	10,000
Depressive episode	2.6	6,000
Phobias	1.8	4,000
Obsessive compulsive disorder	1.1	2,500
Panic attacks	0.7	1,600
Psychosis (mainly schizophrenia)	0.5	1,100
Any of the above	16.4	37,000

SOURCE: Psychiatric Morbidity among Adults Living in Private Households, Office for National Statistics, 2000.

Eating disorders

The National Institute for Health and Clinical Excellence (NICE) reports that the incidence of anorexia nervosa is around 19 per 100,000 of the population per year for women and 2 per 100,000 per year for men[58]. NICE also suggests that the prevalence for bulimia nervosa is between 0.5 and 1.0 per cent for young women. Beating Eating Disorder (beat) suggests that the prevalence rate for anorexia might be around 1–2% and prevalence rate for bulimia might be around 1-3%[59]. As many cases of eating disorder are unreported or undiagnosed, the actual figures are likely to be much higher. It has been suggested that as many as 1.5 million people in the UK might be experiencing some form of eating disorder[59].

Postnatal depression

Some women have a much more severe change in mood after the birth of their child and may be assessed as experiencing postnatal depression (PND). The condition is often assessed by a health visitor using the Edinburgh Postnatal Depression Scale. A number of studies indicate that 10-15% of new mothers will experience PND[60]. Puerperal psychosis is a severe and relatively rare form of postnatal depression affecting between 0.1 and 0.2 per cent of all new mothers[61].

Dementia

Five per cent of people in the UK over the age of 65, and 20 per cent of people over the age of 80 are affected by dementia[62]. There are some 650,000 people with dementia known to health authorities in the UK. Over two thirds of them are diagnosed with Alzheimer's disease[62]. The Alzheimer's Society reports that dementia currently affects around 700,000 individuals in the UK. By 2010, the number is expected to rise to around 870,000[62]. By 2021, the number is expected to increase to around 1 million. The number may be closer to 2 million by 2051[62]. This is mainly due to an increase in the UK's ageing population. However, conditions such as high cholesterol and high blood pressure can increase risk of dementia. As these conditions are

on the increase, they are also thought to contribute to an increase in the number of people suffering from dementia[63].

Phobias

The Office for National Statistics found that 1.9% of adults in Britain experience phobias[55]. In this study, it is shown that women are twice as likely as men to experience phobias. Other studies show widely differing rates: one author quotes two community surveys - one in Canada, giving a prevalence rate of 7.7%; and another very large US survey, giving a rate of 13.3 %[64].

Personality disorders

In Britain the prevalence of personality disorder ranges from 2% to 13% according to different studies. The concept of a personality disorder is controversial and use of this diagnosis is often questioned. Some diagnoses are applied more commonly to men (such as dissocial personality disorder), while others are applied more commonly to women (such as borderline personality disorder)[65]. ONS reports that the prevalence rate for personality disorder in the UK is around 5.4% for men and 3.4% for women[55].

Bipolar disorder (manic depression)

Most studies give a lifetime prevalence of between 1-2% for bipolar disorder[66]. The disorder has equal prevalence rates for men and women[67]. Although people who have a first episode of bipolar are likely to experience recurrent episodes, it is estimated that 20% of people who have a first episode of the disorder do not get another.

Obsessive compulsive disorder

Around 1.2 per cent of the population of Britain have obsessive compulsive disorder (OCD) at any one time, according to the ONS survey[55]. Other studies suggest that up to 3 per cent of the population will experience OCD at some time in their lives[68]. Several studies suggest a lifetime prevalence of 2-3%. However, NICE suggests that these figures are too high and that some studies may have over-diagnosed people participating in the studies[69]. It appears that studies are divided over whether this is more common for women: the ONS survey gives a female to male ratio of 15:9, whereas other studies have suggested no clear gender difference in diagnostic rates for OCD.

Schizophrenia

Most studies show a lifetime prevalence for schizophrenia of just under 1%. ONS suggests a per year prevalence rate of around 5 per 1,000 of the population (0.5 per cent)[55]. Based on this figure another study suggests a prevalence at any one time of about 2 per 1,000 (0.2%)[70]. While prevalence rates are the same for men and women, age and gender together is an important factor: one study shows the incidence for men aged 15-24 is twice that for women, whereas for those between 24-35, it is higher among women. This reflects a common late onset of the illness for women[71]. One estimate suggests that around 37-40 per cent of people diagnosed with psychosis will fit the diagnostic criteria for schizophrenia[70].

Other groups

To be developed:

- Service users who experience more than one disorder or disability;
- Learning disability and mental health;
- Co-existing mental health and substance misuse problems (dual diagnosis);
- Mentally disordered offenders;
- Deaf people with mental health problems.

Characteristics of adults with psychiatric disorders

Research studies have attempted to compare the characteristics of people with psychiatric disorders with those of people who are not diagnosed with mental illness, in order to discover preventative factors or those that promote recovery from mental illness. The ONS survey in 2000[55] found the following:

Compared to people with no mental health problem, those assessed as having a **common mental health problem** were more likely to be:

- Women (59% compared with 48% of those without a disorder);
- Aged between 35 and 54 (45% compared with 38%);
- Separated or divorced (14% compared with 7%);
- Living as a one person family unit (20% compared with 16%) or as a lone parent (9% compared with 4%);
- Reporting one or more physical complaints (58% with one disorder, 67% with two or more disorders compared with 38%);
- Economically inactive (39% compared to 28%) although the proportion of unemployed was similar for both groups.

Compared to people who did not have a psychotic disorder those with a **probable psychosis** were more likely to:

- Be separated or divorced (29% compared to 8% of those without disorder);
- Living in a one person family unit (43% compared with 16%);
- Have low educational qualifications (84% had qualifications no higher than GCSE level compared with 63% of those with no psychotic disorder);
- Have a semi-skilled or unskilled manual job (39% compared with 22%);
- Be economically inactive (70% compared with 30%);
- Live in accommodation rented from a local authority or housing association (49% compared to 17% of those without psychotic disorder);
- Live in an urban area (88% compared with 66%);
- Report a longstanding physical health problem (62% compared with only 42%).

Prevalence rates are the same for men and women, but age and gender together is an important factor.

Local Data

Here an attempt is made to compare some of the figures from the literature with data obtained from local patient or service user information systems. Data are more difficult to obtain locally for people with common mental health problems e.g. anxiety and depression. This is partly because people deal with these types of mental distress in a variety of ways, ranging from using their own coping strategies to using voluntary agencies, helplines, private counsellors, as well as GP, and other NHS staff.

Prevalence rates of psychotic disorders can be compared with caseload numbers from specialist community mental health services which assess the needs of people with severe and enduring mental health problems. Services currently comprise six Community Mental Health Teams, an Assertive Outreach Team and an Early Intervention in Psychosis service.

Table 71: Mental Health Care Management Caseloads at August 2008 (Working Age Adults) from SWIFT

Locality	Community Mental Health Teams	No of Service Users
South	Blyth	264
	Cramlington	236
Central	Morpeth/ Bedlington	263
	Ashington	264
West	Hexham/ Prudhoe/Ponteland	159
North	Alnwick/Berwick	305
Countywide	Assertive Outreach Team (AOT)	29
Countywide	Early Interventions In Psychosis (EIP)	51
Totals		1,571

The number of cases not only represents people living in the community, but also includes people in care homes and in psychiatric hospitals. The total number of people known to secondary specialist mental health services represents 0.51% of the population of Northumberland (307,190), which is similar to the 0.5% of the general population with psychosis estimated in the ONS 2000 survey[55]. It would be expected that more women than men would be diagnosed with a mental health problem. It is important to note that the community mental health services will undertake needs assessment and care planning for people with a range of different diagnoses, not just psychoses, for instance long term depression and anxiety, mental health problems associated with alcohol and substance misuse related problems, and personality disorders.

Other demographic data[72] suggest that the prevalence of common mental health problems usually treated within Primary Care, such as anxiety disorder and depression, is below average in Northumberland, except for higher concentrations along the east coast (Cramlington, Blyth, Newbiggin and Ashington). It has been found that unemployed people, single parent families, and those in rented accommodation are at higher risk of mental illness, which is most likely to affect people in their 30s and 40s.

Similarly, higher rates of severe mental health problems usually associated with the use of specialist mental health services are found in areas of social deprivation, which can be found mainly in South East Northumberland, and also in small areas in the North and West. However, as a whole Northumberland has a low psychiatric morbidity rate compared to the national average.

The diversity of needs

Whilst the needs of the **individual** are paramount, commissioning should be informed by an understanding of how gender, ethnicity and other aspects of inequality are related to mental health.

Ethnicity

Northumberland still has a relatively low proportion (1%) of the population who identify with an ethnic group other than white, although this is thought to be increasing. The number of people in Black and Minority Ethnic (BME) groups other than white nearly doubled from 1,547 in 1991 to 2,969 in 2001 - an increase of 91.9%[73].

Although the BME population is not as large as other areas of the country, Race Equality in Mental Health is just as an important issue in Northumberland as it is elsewhere, and Northumberland has the additional challenge of meeting the needs of people from BME communities when they are often dispersed across the rural area, with limited availability of formal networks. Research shows that people in dispersed ethnic populations are more likely to be affected by isolation, racism, and major mental health problems than those in larger ethnic communities such as inner cities[74]. Their specific cultural needs are, perhaps, less likely to be addressed by large health and social care organisations if the population is small and needs are not obvious due to the suspiciousness which many people from ethnic minorities have of mental health services, and other barriers, which are evident for this group of mental health service users throughout the country[75, 76].

In December 2005, the Department of Health published *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*[77], who was a black patient who died on a psychiatric in-patient unit.

The Department of Health established seventeen focused implementation sites (pilot sites) across the country to implement the Delivering Race Equality (DRE) action plan quickly, develop best practice and share this learning with the rest of the country. Northumberland is part of the Northumberland, Tyne & Wear DRE Focused Implementation Site. Although this is a three year programme, ending December 2008, there has been a commitment across the region to support the continued delivery of the action plan, and to expand Race Equality across all service areas.

Although there has been improved health and social care recording of ethnicity in recent years, there are still significant numbers of people for whom ethnicity is not recorded. Therefore information summarised below may be an under-representation of people from BME groups

who are using mental health services. It is more difficult at present to compile ethnicity data from primary care, so the figures below give a snapshot from secondary care:

- In 2007, **Care co-ordination** recorded 13 clients within secondary mental health care, (0.8% of the total) with none recorded in north Northumberland (Swift data).
- Out of a total of 731 admissions, 11 **in-patients** were recorded to have been admitted to a mental health hospital between April 2005 and March 2006. Of these, four people were subject to **compulsory detention**. During this time the total number of people on Mental Health Act sections was 109 (Northumberland Tyne and Wear NHS Trust data).
- Between 1st January 2006 and 30th September 2006 there were two Mental Health Act assessments undertaken by Approved Social Workers for people described as other than White British. One was recorded as admitted under section and the second was not. As of November 2006, secondary mental health services had one failed asylum seeker.
- Between July 2005 and June 2006, 675 assessments were carried out by the **Self-Harm Liaison service** of which 6 people were classified as non-white, including mixed race, mixed white/Asian, Irish, and Polish origins.
- For the period April to September 2006 there were 1483 referrals to the **Crisis Assessment and Intervention Service** (CAIS); of these 12 were service users registered as other than "White British". For 27 people ethnic status was not stated.
- As of December 2006, the **Assertive Outreach Team** (AOT) was providing support to three people from BME groups out of a total of 72.
- As of November 2006, the **Early Intervention Team** had three clients from a BME groups out of 80 service users. All three were care co-ordinated by the same clinician.
- **Community Development Workers** (BME) have reported giving information, advice and signposting to Graduate Workers for BME clients in primary care.
- Third sector providers identified three service users from BME groups in January 2007; all of them were open to care co-ordination.
- Of 1411 people on the caseloads of working age mental health teams at 13 October 2008, 13 classified themselves as having an ethnicity other than "white British", and 11 as being non-white.

Gender

Several documents[78-80] have highlighted some of the differences between men and women in terms of mental health presentation and service experience, which may in part be related to the differences in socio-economic status between the sexes:

- **Childhood and adult life experiences** - e.g., women are more likely to experience violence and abuse; young male victims of abuse have a propensity to become abusers.
- **Day-to-day social, family and economic realities** - e.g., women are more likely to live in poverty, be lone parents; men are more likely to be in full-time employment and not be primary carers.
- **Expression and experience of mental ill health -** e.g., women are more likely to self-harm, suffer from depression and anxiety; men are more likely to receive a diagnosis of anti-social personality disorder, experience an earlier onset and more disabling course of schizophrenia; women are more likely to attempt suicide and men more likely to succeed. Prevalence of eating disorders is much higher in females, many unreported. Postnatal depression is thought to be experienced by 10-15% of all new mothers.

- **Pathways into services -** e.g., women with dual diagnosis with substance misuse are more likely to be seen initially in mental health or primary care services; men are more likely to present at drug/alcohol services.
- **Treatment needs and responses** - e.g., women are more likely than men to actively seek 'talking therapies' and benefit from self-help.

Groups that are particularly vulnerable to Mental Health problems are:

- Women who are mothers and carers;
- Older women;
- Women from black and minority ethnic groups;
- Lesbian and bisexual women;
- Transsexual women;
- Women involved in prostitution;
- Women offenders;
- Women with learning disabilities;
- Women who misuse alcohol and drugs.

In some circumstances there will be a need to provide single sex services, where there is:

- Expressed preference of women to ensure choice is available;
- Specific gender, cultural or religious needs;
- Creation of a safe environment which has particular relevance to women with experience of violence and abuse, women with sexually disinhibited behaviour, older women or lesbian women.

Policy Guidance recommends single-sex acute in-patient care, residential and secure care because of reported harassment, intimidation, violence and abuse to vulnerable females by other patients, visitors, intruders or staff. For most women it may be the ability to have the **choice** of mixed or single-sex provision that is important.

Women's Mental Health: Into the Mainstream[79] outlines broad areas for the development of women's mental health care and to ensure that gender is embedded in every aspect of mental health and social care. This is followed up by Implementation Guidance[80] for mainstreaming gender and women's mental health.

Currently there are no women-only mental health day services, although counselling and support groups for women are available within the Northumberland, Tyne and Wear NHS Trust and voluntary sector.

<u>The support people require</u>

Needs are specific to the individual, who can have a unique set of worries, problems, strengths, and ways of coping with life. Needs are influenced by the context of their childhood and adolescent experiences; family, educational and socio-economic background, as well as the situation they find themselves in as an adult. That is why it is important to listen to the people who experience mental distress and their carers, taking into account their own experiences and

views in shaping the help that is offered to the individual and the service-user group as a whole.

Although not all people who experience mental distress want or require interventions outside of their own resources, the majority of people with severe and enduring mental health problems could benefit from a range of care and support on a regular basis, whether that is from family, friends, voluntary organisations and/or statutory services. Broadly-speaking, the type of help needed may include support with health and well-being, housing, finances, employment, social activities, relationships and communication.

The main areas of need for individuals experiencing severe and enduring mental health problems can be summarised as follows:

- Care and support with emotional problems;
- Help to get them through a crisis;
- Opportunities and support to learn new skills;
- To have a full life during the day;
- To get and hold down a job;
- Information about any illness they may have;
- Help with choosing between the services and treatments available;
- To get a reasonable income;
- To find somewhere suitable to live in a place of their choice;
- To make and keep friendships;
- To link with others of the same race/culture and/or gender;
- To find someone to speak on their behalf if necessary;
- Support to carers, those people providing unpaid substantial and regular support to individuals experiencing mental distress.

Some of the information on need is captured by individualised care management or care co-ordination assessments of health and social care needs, various consultation exercises at a local level, and research which influences both Central and Local Government policy for health and social care.

The Northumberland Tiered Approach[81] is a framework for the planning and provision of mental health services, grouping people together because of similarities in the types of problems they are experiencing and the level of help they need. It has helped to clarify functions and roles, and aims to get the right service to the right person at the right time.

Tier 1	Relatively common, transient or mild to moderate mental health problems characterised by distress but with a limited effect on functioning.
Tier 2	Moderate mental health problems that are not likely to improve without specialist therapy, but do not prevent most day-to-day coping.
Tier 3	Complex mental health problems, most likely long standing and recurrent, significantly impairing quality of life and functioning.
Tier 4	Severe mental health problems, with significant impairment of functioning, with social, cognitive, occupational, interpersonal and/or financial problems likely.

People with psychiatric diagnoses are one of the most socially excluded groups in society and are subject to prejudice and discrimination. Stigma is a major obstacle to people seeking or accepting help. The effects of social exclusion are frequently more disabling than the original mental health problem. Life expectancy for people with severe mental health problems is 10 years less than for the general population; they experience poor access to healthy living advice and serious physical health problems are more likely to be overlooked[82].

The impact of mental health on social inclusion is the focus of a 2004 report from the Social Exclusion Unit[83]. People with mental health problems, compared to those without, are: more likely to:

- More likely to live alone and less likely to own their own home;
- More likely to live in unsuitable accommodation and less likely to have security of tenure;
- More likely to get into debt and less likely to have access to financial services;
- More likely to be a victim of crime and less likely to have complaints of harassment taken seriously.

Less than 1 in 4 adults with mental health problems work. People more than double the risk of losing their job if they have a mental health problem. A Northumberland Needs Assessment Census in 2001 revealed that 59.4% of its sampled Mental Health service users were unemployed or on long term sick, whilst 21.9% were working part or full time and 6% were in sheltered work[84].

More than half of all people with severe mental health problems report receiving no help with finding work from health and social care services when they wanted it. Yet educational and employment opportunities are often vital for recovery; there is evidence that getting back to work is more important than any other single factor and with the right support a large proportion of people with mental health problems, including those with severe conditions, can gain and retain employment if they have the right kind of support on an ongoing basis.

The national Social Exclusion Report[83] and local responses, e.g. Northumberland's social Inclusion Action Plan[85] and Mental Health Promotion Strategy[36], recognise the need for a wide variety of agencies to work together in a number of key areas:

- **Stigma and discrimination** – to challenge negative attitudes and promote awareness of people's rights, aimed at the public, local services, schools, the media.
- **Getting the basics right** – access to decent homes, financial advice and transport.
- **The role of health and social care in tackling social exclusion** – implementing evidence-based practice in vocational services and enabling reintegration into the community, outcome-focused care planning, and the use of personal budgets and direct payment to facilitate social participation.
- **Employment** – giving people with mental health problems a real chance of sustained paid work reflecting their skills and experience, through primary care and also support for people with severe mental health problems; improving access to employment programmes and supporting and engaging employers of all sizes, supporting job retention programmes and encouraging healthy workplaces; by promoting enterprise and self employment.
- **Supporting families and community participation** – enabling people to lead fulfilling lives the way they choose; transforming day services into community resources and

pathways to employment; improving access to transport, promoting access to volunteering, education, leisure, sport, and arts opportunities; improving access to financial and legal advice removing barriers to community roles (e.g., stigma, discrimination, lack of understanding or support, low income, difficulty accessing public transport, childcare, stress on families, 'benefit trap', psychological barriers such as low confidence and self-esteem, effects of medication).

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

There may be between 21,000 and 24,000 adults aged 18-64 in Northumberland who have a moderate or severe physical disability. Not all of those people need special support – many will be able to manage their lives without help. At end of June 2008, 947 people had been assessed as needing continuing support from the Care Trust's care management service for working age adults with a physical disability or illness (YPD teams).

A comprehensive survey of the 804 people then known to this care management service was carried out in 2002. It recorded a wide variety of conditions leading to the need for support, the three commonest being arthritis, MS and disability caused by stroke.

For most of the conditions listed, the number of people receiving care arranged through care management is only a fraction of the likely prevalence in the community; for instance the number of people in Northumberland with MS is likely to be in excess of 400, based on national prevalence estimates[††].

People with sensory impairments fall into two broad groups:

- Those whose disabilities are congenital, or acquired early in life, who are the group most likely to learn sophisticated alternative skills such as sign language or the use of Braille; and
- Older people whose sight or hearing has been affected by age-related conditions.

The shift in the age balance of the County's population described earlier in this document can therefore, in the absence of significant changes in treatment, be expected top lead to substantial increases in both forms of disability.

For **hearing loss**, nationally around 2 in every 1000 children age 9-16 are deaf, of whom half became deaf before acquiring language[‡‡]. This proportion rises gradually with age throughout adulthood, increasing more rapidly over the age of 50. Fifty five percent of people over 65 are deaf or hard of hearing.

For **visual impairment**, the register maintained by the Care Trust is believed to be a fairly reliable guide to numbers. At 30 September 2008, it showed 685 adults with severe sight impairments (formerly "registered blind", and 840 with sight impairments (formerly "partially sighted"). Of the total 1,545 people registered in one or other category, 139 were aged under

[††] Based on estimated UK total of 85,000 people with MS – from www.mssociety.org.uk, 20 Oct 2008.
[‡‡] Figures in this paragraph from www.rnid.org.uk, consulted 20 October 2008.

50, 545 were aged between 50 and 79, and 841 – more than half of the total – were aged 80 or more.

Table 72: Conditions of People Receiving YPD Care Management, in order of frequency, 2002

Primary cause of disability or illness	Number	% of total	% of all with diagnosis recorded
Arthritis	129	16.0%	20.4%
Multiple sclerosis	77	9.6%	12.2%
Cerebrovascular disease	57	7.1%	9.0%
Disease of the muscles, bones or joints	36	4.5%	5.7%
Deaf or hard of hearing	34	4.2%	5.4%
Neurological diseases	33	4.1%	5.2%
Chest disease	24	3.0%	3.8%
Heart disease	22	2.7%	3.5%
Malignant disease	19	2.4%	3.0%
Back pain	16	2.0%	2.5%
Trauma to limbs	16	2.0%	2.5%
Major trauma other than traumatic paraplegia	15	1.9%	2.4%
Epilepsy	14	1.7%	2.2%
Traumatic paraplegia / tetraplegia	14	1.7%	2.2%
Diabetes mellitus	12	1.5%	1.9%
Chronic fatigue syndromes	9	1.1%	1.4%
Mental illness	9	1.1%	1.4%
Parkinson's disease	9	1.1%	1.4%
Renal disorders	9	1.1%	1.4%
Bowel and stomach disease	7	0.9%	1.1%
Spondylosis	6	0.7%	0.9%
Deaf/blind	5	0.6%	0.8%
Asthma	5	0.6%	0.8%
Blind or partially sighted	5	0.6%	0.8%
Blood disorders	3	0.4%	0.5%
Peripheral vascular disease	2	0.2%	0.3%
Skin disease	2	0.2%	0.3%
Behavioural disorder	2	0.2%	0.3%
Cystic fibrosis	1	0.1%	0.2%
Double amputee	1	0.1%	0.2%
Metabolic disease	1	0.1%	0.2%
Motor Neuron disease	1	0.1%	0.2%
Multi system disorders	1	0.1%	0.2%
Other	37	4.6%	5.8%
Not known or not recorded	171	21.3%	
Grand Total	**804**	**100.0%**	

Based on national prevalence estimates, the number of people in Northumberland who are deaf-blind would be expected to be around 120. We do not currently have reliable local information to compare this with, but we have recently appointed a social worker to specialise in work with this group.

LEARNING DISABILITY

What we know about peoples needs and how they are changing

It is estimated that 985,000 people in England have a learning disability (2% of the general population). This includes 828,000 adults aged 18 or more. Of these adults 177,000 are estimated users of learning disability services in England (equivalent to 0.47% of the adult population)[86].

The Department of Health estimates 145,000 adults and 65,000 children have severe and profound learning disabilities, and 1.2 million have mild or moderate learning disabilities[87]. It is predicted that the general population of England will rise 5% to 53.5 million in 2017 and 10% to 2027 to 56.0 million. These changes in the general population will be reflected in the population of people with a learning disability. In addition there are likely to be increases in the age specific prevalence rates due to increased survival rates of children with severe and complex disabilities and reduced mortality among older adults with learning disabilities. Combining the effects of these changes a growth of 11% is estimated in the decade 2001-2011 and 14% over 2001-2021 in the learning disabled population[86].

At the end of March 2008, there were 1,319 adults with a learning disability on the caseloads of Northumberland Care Management Teams. On the basis of national prevalence estimates, there would be expected to be 1,543 people in Northumberland with moderate or severe learning disability[§§] - it seems likely that the great majority of people who would meet this definition are known to the care management service.

The proportion of the population who have a learning disability falls with age, in part because some common conditions associated with learning disability also lead to a reduced life expectancy compared to the general population.

Table 73: Age breakdown of people known to learning disability care management teams

Age range	Number	Average per single year
18-29	360	30.0
30-49	517	25.9
50-64	280	18.7
65+	162	--

Despite lower life expectancy associated with some conditions, it is estimated that 50% of people with a learning disability now have the same life expectancy as the general population.

[§§] Figures from www.poppi.org.uk and www.pansi.org.uk as at 19 October 2008

One of the major issues for the next five years is likely to be the number of older people with learning disabilities who have additional needs, including physical disabilities, sensory disabilities, dementia and other age-related illnesses. For the first time, people with learning disabilities are growing older in the community, rather than being institutionalised or hospitalised. Nationally there are now more adults with a learning disability aged over 45 than under 18 years of age.

Down's syndrome

Down's syndrome is the commonest known cause of learning disability, accounting for 15-20% of the learning disabled population. Currently there are 122 people with Down's syndrome known to care management.

Amongst people with Down's syndrome life expectancy has increased dramatically, from an average of only 9 years in the early 1900s, to an average of 45 years in the 1980s and 57 years in the 1990s[***]. This trend is likely to continue.

Down's syndrome is associated with apparent premature ageing and an increased risk for developing dementia much earlier in life than the general population, often 30-40 years earlier. At least 55% of people with Downs's syndrome aged 0-69 years are affected by dementia, compared to 5% of the general population aged over 65 years. The average age of onset is 54 years and the average interval from diagnosis to death is less than 5 years.

Most people with Down's syndrome live at home with family carers, or in minimally supported living environments without the resources to cope with increased dependency. Services need to be planned based on mapping information to ensure that the appropriate range of provision is in place when it is required.

Additional needs associated with learning disability

Learning disability is often associated with other needs, summarised as follows:

- 5-50% have mental health needs (depending on definition);
- 30% have associated physical disability (a growing number with complex needs);
- 5-15% have significant challenging behaviour;
- 30% have significant sight impairment;
- 80% of people with autism are learning disabled;
- 15-30% have epilepsy;
- 40% have significant hearing problems;
- Greater risk of early onset of Alzheimer's;
- Some conditions carry greater risk of complications, such as cardiac disorder and respiratory problems;
- Risk of undetected health problems.

[***] Down's Syndrome Association. www.downs-syndrome.org.uk

Physical disability is a common complication. Cerebral Palsy is the most common cause of physical disability in childhood, a prevalence of approximately 2.5 per 1000 population, an overall increase in the last 20 years. The North of England Collaborative Cerebral Palsy Survey has shown increasing rates across the spectrum in the north of England between 1964 and 1993.

One in ten people with severe learning disabilities exhibits **challenging behaviours** that cause danger to themselves or to others. Studies indicate that children with severe learning difficulties, autism and sensory disabilities are more likely to develop behaviour which challenges as they move into adolescence and adulthood.

A Challenging Behaviour Survey carried out by psychologists in partnership with care managers in Northumberland in 2001 provided data on 829 adults with a learning disability living in the community. It identified 52 individuals who were described as presenting 'serious' challenging behaviour and these are the focus of further work. A further 108 people present challenging behaviour which is being managed, but would otherwise have been serious.

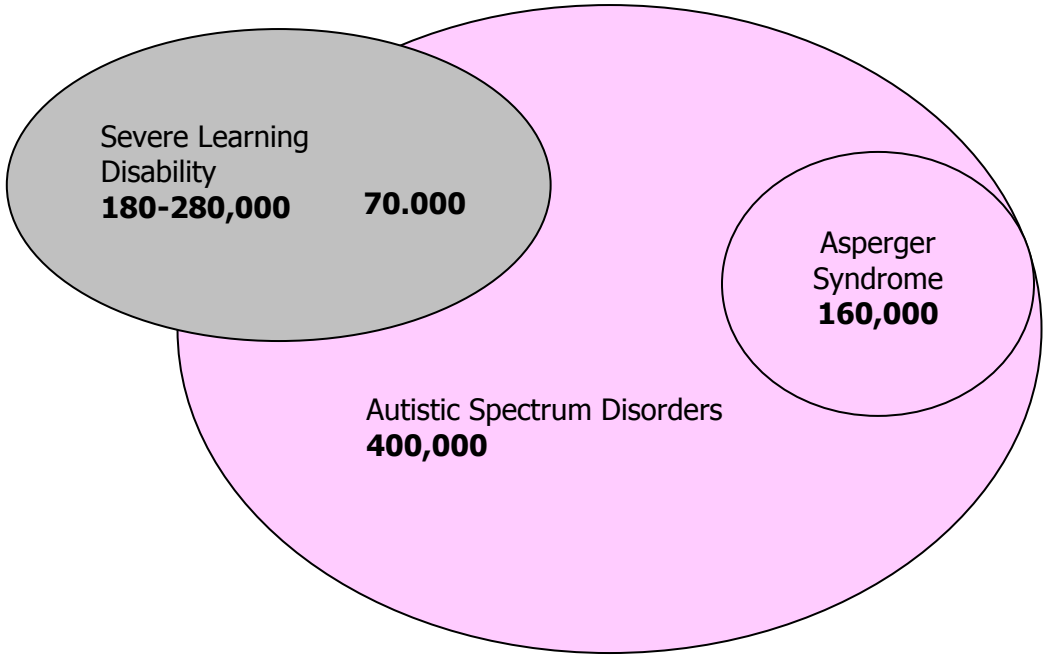
Surveys elsewhere in the UK have reported between 5% and 15% of learning disabled population with serious challenging behaviour. This would equate to 50-124 individuals in Northumberland.

Up to half of all adults with learning disabilities have **mental health** needs. Studies show this affects:

- 25% of those living in the community;
- 40% of those living in hospital.

The number of people identified as **autistic** has risen dramatically in recent years, although how much because of an actual increase or simply better diagnosis is hotly debated. There has been extensive research conducted into the prevalence of autism, producing widely varying estimates from 17 to 91 per 10,000 in the population. On some estimates, fewer than a quarter of all adults with autism spectrum disorders (ASD) have a learning disability (defined as an IQ below 70); the remainder have Asperger syndrome or other forms of ASD not associated with learning disability.

Figure 31: Number of Adults in UK with autistic spectrum disorders and severe learning disability



CARERS

This section of the JSNA outlines figures for carers living in households and does not include figures for carers in communal establishments.

At the 2001 Census, 33,500 people in Northumberland described themselves as unpaid carers – family members, partners or friends providing unpaid support to people because of illness, disability or frailty. As the table below shows, most were adults of working age, though there were also around 800 children and young people providing care, and around 1,700 carers who were themselves over the age of 75 (though in this age range some spouses supporting ill or disabled people may not see themselves as carers).

The age group most likely to describe themselves as carers was people aged 50-64, more than one in five of whom provided unpaid care. While the census did not collect information about relationships between carers and people cared for, it would be reasonable to assume that a high proportion of this group will have been providing support to their parents.

Twenty five percent of carers have cared for the same person for over 10 years. Twenty percent are caring for more than one person. Many people with special needs in relation to illness or disability also have caring responsibilities. The pressure of caring for someone can be extremely demanding, physically, emotionally and mentally.

Table 74: Ages of unpaid carers living in households, Census 2001

Age Group	Population	Carers	
		Number	%
Under 18	65564	802	1.2%
18 to 24	20324	985	4.8%
25 to 49	103445	13096	12.7%
50 to 64	61380	12916	21.0%
65-74	29090	3991	13.7%
75 and over	22130	1703	7.7%
All ages	301933	33493	11.1%

Helping to keep carers healthy is of course crucial if they are to continue to provide this essential support; it is also a matter of human rights - it is unacceptable that in addition to other disadvantage and exclusion, carers are also more likely than others to suffer from health problems themselves. In the 2001 Census, 12.3% of Northumberland carers described themselves as 'not in good health', compared with 10.1% of the general population.

Nearly a half of all carers are working either full or part-time. Over a lifetime, seven out of 10 women will be carers, and nearly six out of 10 men. Carers are assisting people of all ages, children as well as adults, but one half of all carers look after someone aged over 75.

The number of people over 85 in the UK, the age group most likely to need care, is expected to increase by over 50 per cent to 1.9 million over the next decade.

Within 35 to 40 years there could be nearly 60% increase in the demand for support from carers. By 2037, unless services are expanded or people's health improves, there could be pressure on 3.4 million more people nationally to become carers. With the rise in the older population, the number of carers could rise from 5.7 million currently to 9.1 million in 2037[88].

Northumberland is fundamentally rural in nature – nobody lives in a settlement with more than 35,000 residents. The upland communities living within the North Pennines and Cheviot Hills are among the most remote in the country. In these places, getting to even fairly basic amenities – such as a shop or GP, much less day centres or hospital – may not be easy or straightforward and carers can find it difficult to obtain advice, help and assistance. Carers' needs may be heightened by their caring role, by their isolation and, often by their inability to leave the house for very long because of the needs of the person they are caring for and this is as much an issue for carers in the urban south east of the county and county towns as in the geographically isolated areas.

Northumberland's population is also an ageing one – we have fewer children under 15 years old and more adults of pensionable age than the national average. This has implications not only for the increased number of family members taking on caring responsibilities but also on the workforce, many of whom will give up work to care.

10. SOCIAL INCLUSION

TRAVELLERS AND GYPSIES

Gypsies and Travellers have been part of the community in Northumberland for hundreds of years[89]. The definition for Gypsies and Travellers includes those recognised as a racial group under the Race Relations Act, 1976[90] and subsequent judicial decisions. These include Romany Gypsies, Irish Travellers, Scottish Travellers, New Travellers and others[89].

The traveller population

Currently Gypsies and Travellers are not recorded as a separate ethnic group within routinely collected data sources including the Census, the Labour Force Survey, the National Dwellings and Household Survey, and the General Household Survey, resulting in a lack of available demographic data for analysis[89]. Demographic information and population approximations which exist stem from the biannual Count of Gypsy and Traveller caravans[91] (Department for Communities and Local Government). This source is general accepted to represent an underestimate of population figures and has the following limitations[89]:

- A lack of consistency of approach or standard methodology across different districts;
- A count of caravans rather than people (population figures are generally taken by multiplying the number of caravans recorded by three);
- A failure to include Gypsies and Travellers who live in houses (estimated to be about 50% of the total);
- A lack of clarity about the purpose of the count, diminishing enumerator's commitments to accuracy;
- A lack of involvement of members of Gypsy and Traveller communities in the count.

However, in the absence of alternative demographic data on Gypsies and Travellers these data may be taken as an illustration of broad patterns of population movement.

Table 75: Caravan count for Northumberland July 2006 – July 2008

	Authorised sites (with planning permission)		Unauthorised sites (without planning permission)		Total caravans
	Socially rented	Private	Land owned by Gypsies	Land not owned by Gypsies	
July 2008	37	25	0	18	80
Jan 2008	53	12	0	9	74
July 2007	56	33	2	6	97
Jan 2007	53	9	2	4	68
July 2006	48	15	9	0	72

SOURCE: Department for Communities and Local Government © Crown copyright.

Current needs

Health

Owing to the omission of Travellers and Gypsies as a specific ethnic category in routine data, there is a lack of available information on the health status of Traveller and Gypsy communities within Northumberland; but a steer can be taken from research and monitoring which has been undertaken elsewhere. The health status of Gypsies and Travellers is much poorer than that of the general population, even when controlling for confounding factors such as variable socio-economic status[92]. A national study funded by the Department of Health illustrated that, compared to other UK-resident groups, Gypsies and Travellers have[93]:

- Significantly poorer health, and more self-reported symptoms of ill-health.
- An excess of miscarriages, stillbirths, neonatal deaths and premature deaths of older offspring.

Other studies note that low birth weights and morbidity in the under fives are unduly prevalent within Gypsy and Traveller communities[89,94]. Child accident rates are also thought to be higher than average for Gypsy and Traveller Children[95]. Many have speculated that this high accident rate is due to the poor condition and location of local authority sites and unauthorised stopping places. Further research is needed however to establish possible links between the condition of sites and health as evidence at present remains anecdotal[89]. Poor access to, and uptake of, health services is a major factor in Gypsy and Traveller health[92]. Evidence shows that Gypsies and Travellers use preventative health services less than their counterparts from the settled community[96]. This includes a particularly low uptake of immunisations[97].

The Local Government Association has highlighted that the lack of appropriate accommodation (long-term accommodation, transit sites etc.) means that unauthorised encampments are inevitable[89]. This leads into the 'vicious cycle' identified by the Commission for Racial Equality (CRE) - unauthorised encampments lead to heightened community tension and negative reporting, leading to pressure not to grant planning permission, leading to a shortage of authorised sites and continued unauthorised encampments.

The impact of the movement of Gypsy and Traveller communities into static housing is becoming increasingly understood[89]. Living in a house has been found to be associated with poorer health, more long-term illness and greater anxiety when compared to levels experienced in Gypsies and Travellers communities as a whole[93]. Families who have moved into housing have reported high levels of racism from neighbours, feelings of isolation and loss of identity due to distance from extended family or communities and stress and anxiety related to feeling closed in[89].

Education

In Northumberland, as nationally, it is likely that levels of attainment of Gypsy and Traveller children and young people are significantly below national averages at all key stages and that this gap will increase as children get older[89]. A similar picture will also be seen for rates of school attendance which are lower than that of any other ethnic group[89].

Current action

The Strategy for Gypsies and Travellers in Northumberland[89] includes a mapping of service provision within Northumberland for Gypsy and Traveller communities. A health needs assessment has also been conducted by a health visitor who works closely with members of these communities[98]. Together these demonstrate that specific action is being taken by a range of statutory organisations - including children and young people's services, police, fire and rescue, county and district councils and voluntary sector services such as Spurgeons - within Northumberland.

One example of local action is the Traveller Education Team. This team works with schools, families, children and other agencies to try to achieve:

- Equal access for Gypsy and Traveller children to mainstream education.
- Equal opportunities for Gypsy and Traveller children and freedom from all forms of discrimination.
- Academic achievement in line with that of all children.
- Increased awareness amongst children, staff and the wider community of Gypsy and Traveller culture, lifestyles and history.
- Support to the local authority for planning and policy development relating to or affecting local Gypsies and Travellers.

The Traveller Education Team offers a range of services including:

- Development and provision of resources for use by schools.
- Management support for senior management and school support staff to ensure appropriate placement and integration of children.
- Home/school liaison support for newly arrived families and ongoing liaison with Education Welfare Service and schools on any attendance issues.
- Family support and liaison with other services such as health and environment.
- Special school transport arrangements for highly mobile and isolated children and young people.
- Assessment of education needs of Gypsies and Travellers on unauthorised sites throughout the county if possible, arranging school places for children and young people including assistance with uniforms and emergency funds.
- Monitoring of the increasing number of children and young people whose families have opted for Elective Home Education.

Ensuring adequate healthcare access and use for Gypsy and Traveller communities is a key issue[98]. There is evidence that key workers who have access to the communities on a regular basis are able to maintain relationships with families, in particular Health Visitors through their links with mothers and babies[89,98]. For example, through positive and reassuring personal communication between a link Health Visitor, the Public Health nurse team and a local traveller community, a programme of MMR immunisation gained the approval and support of the Traveller community[98]. This community had previously greatly feared the MMR vaccination due to myths about the vaccine which had proliferated and perpetuated in part as a result of the strong oral tradition of passing health beliefs amongst the community[98].

KEY FINDINGS & RECOMMENDATIONS

SUMMARY OF FINDINGS

This document set out to provide Northumberland Care Trust and Northumberland County Council with an initial data profile and needs assessment based on existing processes of health and care service planning activity. Key findings from this baseline needs assessment are as follows:

Population changes driving demand for services

Northumberland has higher than the England average percentage of its population in middle age and older age groups. Population projections covering the next 10 years show that overall the population is expected to grow by around 3.4%. However, the most notable feature of the predicted population change is the increase in the population aged 65 years and over. As a percentage of the total population, older people (i.e., those aged 65 and over) constituted 18.6% of the population in 2006; it is predicted that they will represent 23.4% by 2016.

People with long term conditions are intensive users of health and social care services, including community services, urgent and emergency care and acute services. They use disproportionately more primary and secondary care services, and this pattern will increase over time with an ageing population.

The Northumberland Strategic Partnership has already adopted a document[99] setting out a longer-term view of the implications of the changing age balance for all public services. A co-ordinated response will be crucial to maximise older people's independence and reduce demands on high level health and social care services.

Over the next year, the Care Trust will be working towards implementing the new cardiovascular disease risk screening programme to identify those at high risk of coronary heart disease, chronic kidney disease, stroke, transient ischaemic attack or diabetes mellitus so that interventions can be delivered to prevent disease and to identify those who already have these conditions so that they can be appropriately treated and managed. Successful implementation of this programme should reduce the demand that this group of patients place upon health care services.

It will be particularly important in Northumberland to ensure that the national "transformation" of adult social care, including personal budgets for support and a greater emphasis on prevention and low level support, addresses the challenges of making these developments work for ill and disabled older people.

The recently released National Dementia Strategy[100] will mean that dementia is an area of priority for needs assessment, service review and planning over the coming year.

Another significant population change is the increasing prevalence of obesity amongst children. Being overweight or obese can have a significant impact on an individual's health; both are associated with an increasing risk of diabetes, cancer, and heart and liver disease. In

particular, the incidence of type 2 diabetes and non-alcoholic fatty liver disease, which used to be rare in children, is now increasing. These changes matter because of the pressure such illnesses put on families, the NHS and wider society.

Within Northumberland, tackling obesity has been prioritised in the health and well-being strategy, the Local Area Agreement, and as one of ten priority health outcomes to be achieved by the NHS North of Tyne through World Class Commissioning and the NHS North of Tyne Strategic Plan. This is an issue where there is recognised unmet need and considerable investment is required in prevention and treatment to address this gap.

The demographic profile of the county characterised in some parts by physical remoteness and rurality provides a particular challenge for service delivery. Many services are delivered through distributed models e.g., using primary care as a vehicle for delivering the stop smoking service or using "hub and spoke" models to deliver contraceptive and sexual health services and integrated community mental health services. This model of delivery is in contrast to the centralised model of services frequently used by neighbouring urban areas.

Focusing on inequalities

Northumberland is a diverse county with a mix of urban and rural areas. The recent approach to tackling inequalities has focused on the urban south east of the county which was designated with "spearhead" status that aimed to close the gap between the spearhead area and the England average.

There is now a need to refocus on the internal inequalities within the county, taking into account both urban and rural deprivation and focusing on differences between small areas or communities alongside the difference between Northumberland and England. This will become increasingly important as the new unitary authority is established in April 2009 and the historic district boundaries for which we have had data are lost.

Modifiable lifestyle risk factors

Of the modifiable lifestyle risk factors, smoking and alcohol consumption have been prioritised for action. Smoking has been selected because it remains the greatest contributor of premature death and disease across Northumberland. Alcohol has been selected because of the impact on a wide range of public services, because there is recognised unmet need in relation to alcohol misuse treatment services and considerable investment is required to address this gap.

Whole system approach

Using data from the Quality and Outcome Framework (QoF) to drive quality improvements in primary care and using the Commissioning for Quality and Innovation (CQUIN) payment framework[101] to drive quality through contracting arrangements with acute, community, mental health and ambulance trusts should allow a whole systems approach to health improvement issues.

During the coming year, NHS North of Tyne will be investigating the feasibility of using CQUIN to make tackling the effects of smoking on health, care and recovery the business of everyone within the NHS.

RECOMMENDATIONS

The first iteration of this process led us to decide that pulling together information into a single document was the best way to begin the process of Joint Strategic Needs Assessment. Looking ahead, we are recommending that we do not seek to reissue a profile of this type and size on a regular basis but rather develop the JSNA resource by undertaking focused topic based reviews accompanied by updating of some key data items. For instance, this may include improving our detailed understanding of some of the key conditions leading to long-term disability among working age adults, and exploring the choices that older people in Northumberland are making about where to live, and the implications of this for the planning of services. Over time these reviews will be made available to partner organisations via the web.

Partner organisations are encouraged to contribute information or needs analysis to the process and also to suggest priority topics for needs assessment.

We will be circulating this document to a wide range of stakeholders. Any comments on this baseline position profile are welcomed and should be sent to any of the following:

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