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Date of meeting	**Wednesday, 12th June, 2013**
Time	**7.00 pm**
Venue	**Committee Room 1, Civic Offices, Merrial Street, Newcastle-under-Lyme, Staffordshire, ST5 2AG**
Contact	Peter Whalan

Health Scrutiny Committee

AGENDA

PART 1 – OPEN AGENDA

1 Apologies

2 Declarations of Interest

3 MINUTES OF A PREVIOUS MEETING

Minutes of the meeting held on 17 April to follow

4 Briefing Note on Public Health/Health and Wellbeing (Pages 1 - 32)

5 SUPPORTING DOCUMENTS (Pages 33 - 132)

- Newcastle under Lyme District Profile 2013
- Newcastle Borough Council. Enhanced Joint Strategic Needs Assessment 2012
- Local Healthwatch, Health and wellbeing boards and Health Scrutiny

6 Work Plan (Pages 133 - 134)

7 URGENT BUSINESS

To consider any business which is urgent within the meaning of Section 100 B(4) of the Local Government Act 1972.

Members: Councillors D Becket, Eastwood (Chair), Mrs Hailstones, Mrs Johnson, Loades, Mrs Simpson and Taylor.J

Members of the Council: If you identify any personal training/development requirements from any of the items included in this agenda or through issues raised during the meeting, please bring them to the attention of the Democratic Services Officer at the close of the meeting.

Meeting Quorum

16+= 5 Members; 10-15=4 Members; 5-9=3 Members; 5 or less = 2 Members.

Officers will be in attendance prior to the meeting for informal discussions on agenda items.

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Health Scrutiny Committee – June 2012

Briefing Note on Public Health/Health and Well-Being

In relation to the recent set of health reforms, the view from Government is that no one organisation can 'do' Public Health alone and that – despite upper tier authorities leading on this area of work – districts have a clear role to play in delivering improvements.

Public health is based on three main areas (as reflected in our own Health and Well-Being Strategy – attached): -

- Health improvement – three main areas being smoking, alcohol and healthy eating
- Wider determinants of health – economic development, community safety
- Health protection – e.g. food safety, noise control, pest control

The 'district offer', therefore, centres on 4 aspects of district work: -

- Frontline services provided by districts which contribute to public health – specifically environment health, housing and planning
- Public assets owned by districts
- Partnership working overseen by districts
- Assessing needs – the role played by districts in understanding needs

In terms of health improvement, partnership working and assessing needs could see districts play a part in delivering this agenda.

There are also links to the wider determinants of health which involve districts – leisure provision, economic development, community safety for example.

In terms of health protection, districts directly provide most of these services.

The delivery of the Public Health Outcomes, therefore, involves considerable input from districts. This work can be translated into three main areas: -

- Strategic – linking needs set out in the Joint Strategic Needs Assessment (JSNA) to interventions and developing understanding of the impact of these interventions
- Partnership working – working with others to achieve positive outcomes
- Working with health – liaising with CCGs and H & WB Boards to develop work and create opportunities

Public Health England has argued that health is not really improving in England, and that is because of a focus on hospital care rather than prevention.

Issues to consider
There are a number of issues the Committee may want to consider.

- Are the needs of our individual service areas and the local authority clearly understood in health terms by the Health and Well Being Board ?
- Could joint service offers be made to the H & WB Board?
- How do our services fit with the H & WB Board?
- Do our services provide anything to the evidence base to support future interventions?

Some councils such as Chelmsford have developed a distinct public health role for themselves – is that something we want to do - to address our data and issues through clear liaison with the CCG and Public Health. Chelmsford has produced a PH Strategy in order to encapsulate the issues they are facing and how they propose to deal with them.

The role our services play – environmental health, planning, housing, as well as economic development, community safety – are central to this, and we need them to play a bigger part in how public health is developed in the Borough. In environmental health, for example, officers work 100% of their time on public health issues and we need to ensure that these areas contribute to the JSNA, engage with the CCG/Public Health; and influence the H & WB Board (same with Planning and Housing).

There may be an opportunity for us to debate with Public Health and the CCG about funding – there is nothing stopping us from pooling resources in key areas of work and for us potentially to take our share of savings from preventative approaches which cost less than acute care – a number of other areas have included % savings targets in their joint strategies to move from acute to preventative work – is this something we can do?

The overall message was that the changes to public health represent an opportunity for districts such as ours, but we need to seek to bring all the different elements together and ensure that they are speaking with the structures at county level.

The Newcastle under Lyme Health and Wellbeing Strategy 2013 – 2018

Overview

This Health and Wellbeing Strategy seeks to identify and prioritise the key determinants of health in Newcastle under Lyme, develop a shared approach to addressing health inequalities and ensure that our residents are well placed to benefit from current health reforms.

We recognise that many of the issues we face locally are the same as those we face as a nation, but we have prioritised our actions to areas where the information we have indicates, for us, a worse position than the national picture.

Like all areas we are facing the challenges of an ageing population, but we have the added challenge of there being stark differences in life expectancy between different wards of the Borough.

We have higher levels of obesity for both children and the adult population in the Borough than the England as a whole.

We have fewer people eating five portions of fruit or vegetables a day than the England average and a growing number of families receiving support from the food bank. This situation impacts not only in terms of obesity but also in terms of disease such as diabetes and heart disease.

Due to the ageing population and levels of deprivation (both rural and urban) in parts of the borough many are at risk of social isolation. We understand the importance of communities in tackling theses issues particularly for the elderly, the young and the financially disadvantaged who by the nature of their situation need support within their immediate neighbourhood. A further symptom within our population is a growing number of people with dementia

We have higher numbers of smokers and high levels of alcohol consumption compared to the national picture and these impact heavily in terms of lung and liver disease.

Whilst we will work in partnership with other agencies to improve housing, employment opportunities and early detection of disease as we know these have a positive effect on peoples health we also want people to take control of their own health through health lifestyle choices.

We are seeking to create a happier and healthier community, with a better quality of life for all, for people to be in better mental health and by having some resources put into prevention there will be an overall reduction in treatment costs.

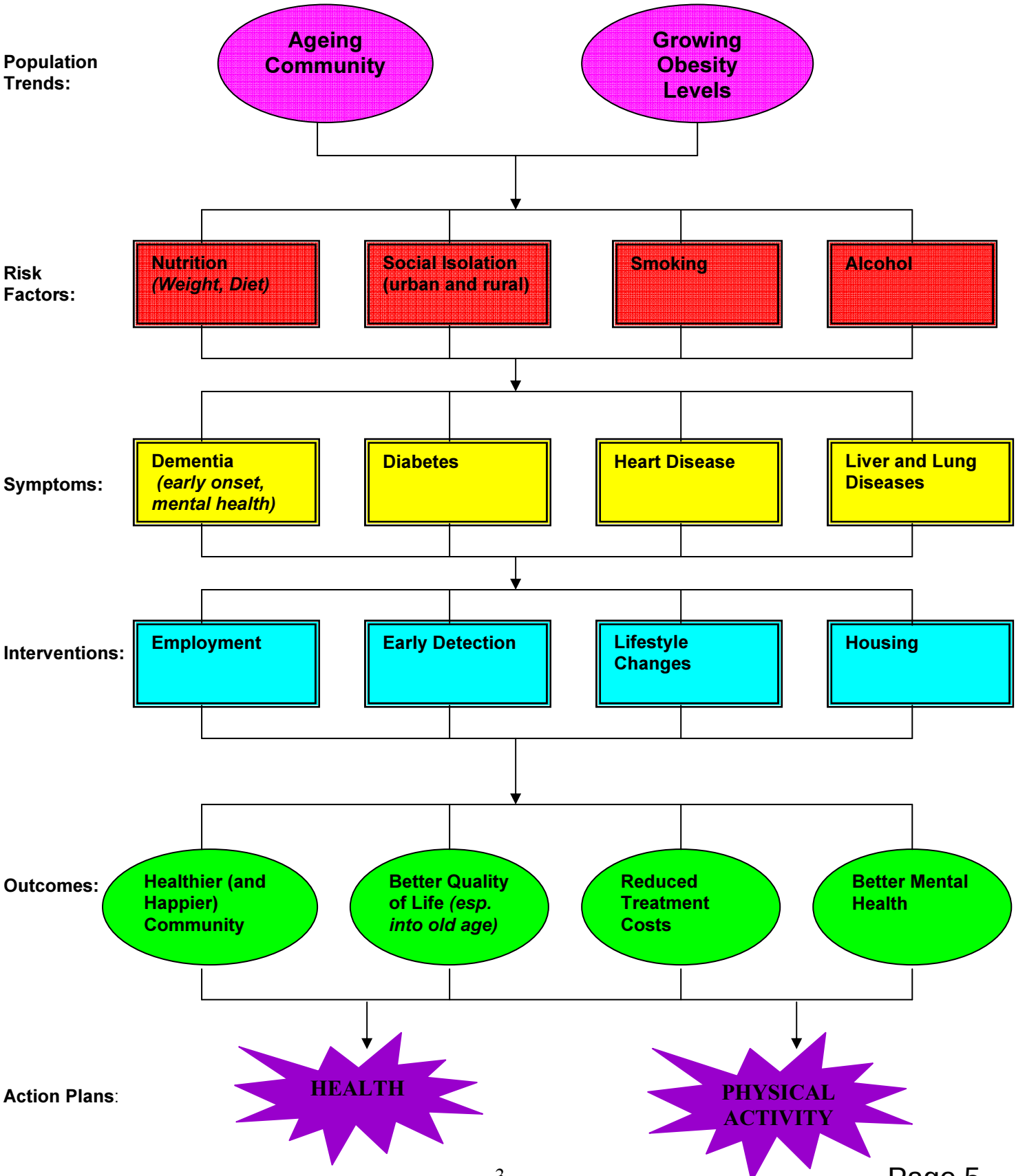
Our plans will be taken forward in two action plans: One for health and one for physical activity. We see these as ‘two sides of the same coin’, with those for health to tackle pre existing conditions from early onset and those for physical activity to encourage healthy lifestyles to prevent the on set of disease or aid recovery.

The overall Health and Wellbeing Strategy for Newcastle under Lyme is summarised in the following diagram. What follows is a fuller exploration of the issues and actions.

Councillor John Williams
Cabinet Portfolio Holder- Stronger and Active Neighbourhoods
Newcastle under Lyme Borough Council

Newcastle under Lyme

Health and Wellbeing Challenges



Background

The Marmot Review into health inequalities in England – 'Fair Society, Healthy Lives' was published on 11 February 2010 and has prompted widespread health reforms to address the social determinants of health, which can lead to health inequalities.

The detailed report contains many important findings, some of which are summarised below.

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods
- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years
- There is a social gradient of health inequalities - the lower one's social and economic status, the poorer one's health is likely to be
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status
- Health inequalities are largely preventable and there is both a strong social justice case and a pressing economic case for addressing this.
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community

Key to Marmot's approach to addressing health inequalities is to create the conditions for people to take control of their own lives. Consequently new health structures have been brought into force from April 2013, with both the NHS and local authorities having a new legal duty to improve health inequalities. Local councils, in particular, have a vital role in building the wider determinants of good health and working to support individuals, families and communities.

Nationally there is a new NHS Commissioning Board but locally the Clinical Commissioning Group (CCG) is the cornerstone of the new health system. Each of the GP practices in Newcastle under Lyme is now part of the North Staffordshire CCG, responsible for commissioning care for people in the Newcastle, Stoke and Staffordshire Moorlands areas.

The CCG will commission the majority of health services, including emergency care, elective hospital care, maternity services, and community and mental health services. In 2013/14 they will be responsible for a budget of £235 million. .

Staffordshire County Council now has responsibilities and £30million funding for Public Health and along with the district and borough councils will take a greater role in improving health and reducing health inequalities. Support for this new role comes from a new executive agency - Public Health England – along with a new public health outcomes framework to direct the resources.

The Staffordshire Health and Wellbeing Board is central the new integrated approach to health and social care and brings together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch (the new, independent consumer champion for health and social care), to plan how best to meet the needs of our local population and tackle local inequalities in health.

The Health and Social Care Act sets out Monitor's role as the sector regulator for health care with responsibility for regulating all providers of NHS-funded services in England.

In its new role, Monitor will license providers, work with the NHS Commissioning Board to set prices for NHS-funded services, prevent anti-competitive behaviour, and work with commissioners to ensure continuity of services when providers get into financial difficulty.

Under the reforms, all remaining NHS trusts are expected to become foundation trusts by April 2014 and the Act outlines a new failure regime for providers that are financially unsustainable. Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) is applying for Foundation Trust status.

Introduction

Health and Wellbeing issues cannot be tackled in isolation. The approach adopted promotes healthier behaviours and lifestyles, and recognises the wider social, environmental and economic influences on health, such as poor quality housing and employment.

Our definition of 'Health and Wellbeing'

For the purposes of this strategy we use the definition from the Constitution of the World Health Organization for health and wellbeing. This says: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

Overall Vision

The vision of this strategy is to contribute to the improved health and wellbeing of our residents by supporting them to adopt and maintain a healthy lifestyle.

Our Priorities

To deliver this vision we will:

1. Look at ways to reduce health inequalities
2. Promote healthy lifestyles and healthy communities
3. Collate local information on health and well being issues and address them
4. Work with partners to develop and implement an action plan to meet the vision

Our Aims

This strategy is aligned to and forms a local response to the Staffordshire County Council Health and Wellbeing Strategy and has been developed as a result of a joint

commitment by partners to improve health and wellbeing in the Borough. The aim of the strategy is to:

- help us understand the health and wellbeing issues faced by the people of Newcastle under Lyme;
- identify ways in which people can help themselves to achieve and maintain better health and improve their wellbeing;
- increase the influence that residents have on the services that are commissioned for them;
- set out how each of the partners contributes to improving the health and wellbeing of residents.

To deliver our aims we will work with partners to:

- Develop sustainable community based services that address health inequalities and improve the physical and mental wellbeing of people.
- Support efforts to improve the long-term health of our communities.
- Help and encourage vulnerable people to lead independent lives and enjoy continued social contact.
- Encourage people to adopt healthy behaviours enabling them to be healthy and improve their wellbeing.
- Identify and tackle the social, environmental and economic factors that can affect the health and well being of individuals.
- Empower residents to take responsibility for improving their own health and wellbeing.

Key Messages for Health and Wellbeing in Newcastle under Lyme

An analysis of the Health and Wellbeing Profile for Newcastle identifies the following key messages:

- Population projections for Newcastle from 2010 to 2035 suggest there will be a growth in population (12%).The population is projected to see significant growth in people aged 65 and over (54%) and in particular those aged 75 and over (73%).
- Mosaic Public Sector 2009 allows populations to be segmented in terms of individual's demographics, lifestyles and behaviours. This allows interventions to be targeted more effectively in an appropriate style and language suited to the different lifestyle groups. Around 65% of the Newcastle population falls within one of five Mosaic groups: Ex-Council Community (18%), Industrial Heritage (15%), Suburban Mindsets (12%), Small Town Diversity (10%) and Professional Rewards (9%).
- The Index of Multiple Deprivation 2010 (IMD 2010) is a way of identifying deprived areas. There are 12 lower super output areas (LSOAs) that fall within the most deprived national quintile in Newcastle, making up 14% of the total population. These areas fall within Cross Heath, Knutton and Silverdale, Chesterton, Butt Lane, Kidsgrove, Silverdale and Parksite, Town, Holditch amd Thistleberry.
- The child wellbeing index (CWI) 2009 provides useful information at a small area level for the wellbeing of children. In Newcastle, only five of the 81 LSOAs fall within the fifth most deprived areas in England making up 7% (about 1,500 children) of the child population (aged under 16) falling within Chesterton, Cross Heath, Kidsgrove and Knutton and Silverdale.
- In 2009, nearly one in five children in Newcastle were defined as living in poverty. This is lower than the national average although it varies significantly across the district from 3% in Keele to 36% in Knutton and Silverdale
- The number of Jobseeker's Allowance claimants in Newcastle has increased between 2008 (1,500 claimants) and 2012 (2,600 claimants). In addition there are inequalities across the borough with high proportions of claimants in Cross Heath, Silverdale and Parksite, Town and Knutton and Silverdale wards.

As our general population lives longer and puts pressure on public sector spending, the gap between the most deprived wards and those that are more affluent is likely to widen, unless we tackle identified inequalities now. Some of the specific health and wellbeing issues are highlighted below.

Specific issues have been identified around infant mortality:

- Within Newcastle there are around 1,220 live births annually and fertility rates are lower than the national average. Fertility rates in Knutton and Silverdale ward are higher than the England average.
- Rates of perinatal mortality and infant mortality in Newcastle are higher than the England average whilst stillbirth rates are similar to national levels. Stillbirth rates are showing a steady upward trend while both perinatal mortality and infant mortality in Newcastle saw a significant increase between 2004-2006 and 2006-2008, although rates do appear

to have reduced slightly (not significantly) in 2008-2010. In Newcastle during the period 2008-2010 there were in total 23 stillbirths, 46 perinatal deaths and 34 infant deaths.

- More mothers in Staffordshire continue to smoke throughout their pregnancy than the England average (15% compared to 14% during 2010/11). Various estimates suggest that 17% to 20% of pregnant women in Newcastle continued to smoke throughout pregnancy, higher than the England average. Ward data for smoking in pregnancy suggest Knutton and Silverdale, Cross Heath, Holditch and Chesterton wards have high rates of smoking at delivery.
- The proportion of babies born with a birth weight of less than 2,500 grams in Newcastle is 8%, which is higher than the national average of 7%. Butt Lane, Holditch and Audley and Bignall End wards have a particular high level of babies born with a low birthweight.
- A model by the Network of Public Health Observatories suggests that around 67% of mothers in Newcastle initiated breastfeeding in 2009/10 which is lower than the England average of 74%.
- Data from the West Midlands Perinatal Institute also suggests that initiation rates in Newcastle are low (60%) and highlights that Silverdale and Parksite, Cross Heath, Holditch and Chesterton wards have particularly low levels of breastfeeding initiation rates (all below 50%).
- Provisional data from child health information systems in Staffordshire has been used to provide some analysis at district level. This shows that Newcastle also has a particularly low breastfeeding prevalence rate at six to eight weeks.

Life expectancy is also varies widely locally:

- The gap between the ward with the lowest life expectancy and the ward with the highest life expectancy is nine years for men and 13 years for women. Men and women in Bradwell, Cross Heath, Knutton and Silverdale and Town wards all have shorter life expectancy than the England average. Men in Ravenscliffe ward and women in Holditch also have shorter life expectancy.
- Around 1,220 Newcastle residents die every year, with the most common causes of death being circulatory diseases (390 deaths, 32%), cancers (330 deaths, 27%) and respiratory disease (190 deaths, 16%).
- The rates of people dying before the age of 75 (which are considered to be preventable) continue to decline in Newcastle.. However there are inequalities within Newcastle, with Cross Heath, Holditch, Knutton and Silverdale, Town, Silverdale and Parksite and Bradwell wards having particularly high levels of premature mortality. Butt Lane ward has a high premature mortality rate for cardiovascular disease whilst Knutton and Silverdale and Holditch wards have high premature cancer mortality rates.

Mental health - key messages

- The estimated numbers of people suffering mental ill-health in the community is between 27,000 and 32,200 people. Levels of severe mental illness (defined as people with schizophrenia, bipolar disorder and other psychoses) recorded on GP disease registers in Newcastle

are significantly lower than England with approximately 800 people on a register in 2010/11.

- In Newcastle, there are approximately 10 suicides per year accounting for about 1% of deaths, with rates being similar to the England average. During 2010/11 there were also around 240 self-harm admissions in Newcastle with rates being similar to the England average.

Accidents – key messages

- Accidental deaths account for around 30 deaths per year in Newcastle with rates being similar to the England average. Common causes of accidental mortality are falls (68%) and road traffic accidents (15%). However death rates from accidental falls and accidents in people aged 65 and over are particularly high.
- During 2010/11 there were over 1,390 admissions to hospital in Newcastle due to unintentional injuries (accidents). Hospital admission rates from unintentional injuries in Newcastle are lower than the national average.
- Over 450 people aged 65 and over in Newcastle were admitted to hospital for a fall-related injury during 2010/11, with rates being similar to England.
- National research indicates that only one in three people who have a hip fracture return to their former level of independence and one in three have to leave their own home and move to long-term care (resulting in social care costs). During 2010/11, there were 140 hip fracture admissions to people aged 65 and over in Newcastle with rates being similar to the England average.

Long-term conditions – key messages:

Children with disabilities or limiting long-term conditions

- There is no dataset that provides us with a complete picture of the number of children who are disabled or who have a limiting long-term illness. Figures from a variety of sources estimate that the numbers of children with a disability in Newcastle range between 700 and 4,900.

Adults with long-term conditions

- The 2001 Census found that the proportion of people with a limiting long-term illness in Newcastle was higher than the England average. Levels in most areas (17 of 24 wards) are also higher than England.

Disease

- The numbers of patients recorded on general practice disease registers when compared with the expected numbers of people on registers with specific conditions, shows that there are potentially large numbers of undiagnosed or unrecorded cases, especially for chronic kidney disease, chronic obstructive pulmonary disease, dementia, heart failure, hypertension, learning disabilities and obesity. Higher numbers of cases on the registers than would be expected are recorded for hypothyroidism and severe mental health.
- Analysis of 2008 data from a sample of practices revealed that at least one in four people have a registered disease with one tenth of the

population having more than one condition. Of all patients with a specified registered disease, around one third are also obese, around 14% are smokers and 19% are ex-smokers.

- With an ageing population, Newcastle is also predicted to see an increase in numbers of long-term conditions. This will place an increased burden on future health and social care resources.

Excess winter deaths – key messages

- There is some evidence to suggest that some deaths that occur during the winter months are preventable. National research shows that winter deaths increase more in England compared to other European countries with colder climates. This suggests that it is more than just lower temperatures that are responsible for the excess mortality. The excess winter deaths index (EWD index) indicates whether there are higher than expected deaths in the winter compared to the rest of the year.
- There are on average 70 excess winter deaths annually in Newcastle, mainly amongst older people. During 2005-2010 the EWD index in Newcastle was similar to England.

Adult immunisation – key messages

- The proportion of people aged 65 and over who have been vaccinated against flu in 2010/11 was slightly higher than the England average of 73%. However, lower proportions of other people eligible for the vaccine actually received it, i.e. those aged under 65 at risk, carers and pregnant women. Pneumococcal vaccine coverage in Newcastle is similar to the Staffordshire average (both 66%).

Smoking – key messages

- It is estimated that there are approximately 300 children aged 11-15 who are considered regular smokers.
- The latest data from the Integrated Household Survey suggest that the smoking prevalence in Newcastle was 22% - meaning 22,600 people aged 18 and over smoke. Estimates suggest that this percentage varies across areas of Newcastle from 12% to 37% and that the percentage of the routine and manual groups that smoke is about 39%, thus contributing to increases in health inequalities.
- Smoking-attributable admissions in Newcastle were similar to the England average. However, smoking-attributable deaths in adults aged 35 and over were higher than the national average.
- In 2010/11, 1,750 people accessed stop smoking services in Newcastle and 800 people quit at four weeks. The numbers of people accessing stop smoking services in Newcastle per 1,000 smokers is lower than the England average. Quit rates at four weeks are also lower than England.

Alcohol and substance misuse – key messages

- A local Staffordshire survey found 11% of children aged 11-15 across Staffordshire reported drinking alcohol in the week prior to interview, similar to the national average of 13%. The survey also found that drinking alcohol was more prevalent with boys and older children. Over a three year period (2007/08-2009/10), there were around 35 alcohol-

related admissions in children and young people under 18 in Newcastle, with rates being similar to the England average.

- Estimates suggest approximately 20,600 (20%) adults in Newcastle consume alcohol at 'increasing risk' and a further 6,300 (6%) at 'higher risk'. Estimates also suggest that 21,600 (21%) adults are binge drinkers. Across different areas of Newcastle the proportion of combined 'increasing and higher risk' drinkers ranges from 17% to 29%.
- Alcohol-specific mortality rates for men in Newcastle are higher than the England average and similar for women. Alcohol-attributable mortality rates for men and women in Newcastle are similar to the England average. In Newcastle, there were 2,600 alcohol-related admissions in 2010/11. The rate for the last three years remains similar and is lower than the England average.
- During 2010/11, levels of alcohol-related crime in Newcastle were lower than the England average and alcohol-related violent crime was similar to the England average.
- Nationally, the prevalence of drug use amongst 11 to 15 year olds has fallen from 29% in 2001 to 18% in 2010. Applying national estimates to the Newcastle population it is estimated that approximately 410 children aged 11-15 used drugs in the last month, 780 used drugs in the last year and 1,130 had used drugs at some time.
- According to Home Office figures it is estimated that there are around 680 problem drug users, defined as opiate and/or crack cocaine users aged 15-64 in Newcastle. The percentage of these estimated to be in effective treatment (47%) is lower than the England average.

Obesity, healthy eating and physical activity – key messages

- Using national estimates, about 2,900 children aged two to 15 are obese with a further 2,600 children thought to be overweight.
- Using figures from the National Child Measurement Programme (NCMP), the proportion of obese children in Reception year in Newcastle is similar to the England average (9%). Levels of obesity are much higher (19%) for children in Year 6 and although not significantly, have risen slightly in the past year. Chesterton and Kidsgrove have high proportion of children in Reception who are either overweight or obese. The prevalence of children who are either overweight or obese in Year 6 is higher than the England average in Knutton and Silverdale ward.
- Estimates suggest that levels of adult obesity in Newcastle are 26%, which is similar to the England average of 24%. The prevalence of obesity across Newcastle varies with the percentage estimated to range between 16% and 30%.
- In Newcastle consumption of five or more portions of fruit and vegetables by adults is estimated as 26%, similar to the England average (29%). There are inequalities in consumption in Newcastle with estimates for areas ranging from 18% to 35%.
- In Newcastle, less than half of children (45%) spend at least three hours of high quality PE and school sport within and beyond the curriculum per week. This is the lowest level in Staffordshire and is significantly lower than the national average.

- Adult activity levels are significantly lower. Data from the Active People Survey (2009/10) shows that only 11% of men and women in Newcastle achieved the recommended levels of physical activity, which although similar to the national average is still too low. In addition, over half (53%) of men and women were inactive, which is higher than the national average.

Teenage pregnancy – key messages

- Between 1998 and 2010 under 18 conception rates across Newcastle have reduced by 35% compared with a 14% reduction across Staffordshire and a 24% reduction across England. The teenage pregnancy rate in Newcastle between 2008 and 2010 was higher than the England average. Knutton and Silverdale, Cross Heath, Butt Lane, Silverdale and Parksite and Holditch all have higher rates than the national average.

Sexually transmitted infections (STIs) – key messages

- The number of diagnoses of new STIs is falling in Staffordshire compared to a rise nationally. It is not known if this reflects less disease in the community or if it is due to issues with data, access to services or case finding. The overall rate for acute STIs in Newcastle is lower than England.
- Data from 2010/11 shows that 25% of young people in Newcastle were screened for chlamydia, lower than the England average and falling slightly short of the 35% target. Of the 4,580 young people living in Newcastle who were screened approximately 230 (5%) had a positive result.

Physical Activity – Key Messages

- There is little local data for levels of physical activity in children. An indicator that is often used is the proportion of children who undertake at least three hours of high quality PE and school sport within and beyond the curriculum per week. This shows that in Newcastle, only 45% of children achieve this level. This is the lowest in Staffordshire and lower than the national average
- The Active People Survey (APS) includes 250 sport and recreation activities and now includes dancing and gardening. From APS 4 (2009/10) data, only 11% of men and women in Newcastle achieved the recommended levels of physical activity which although similar to the national average is too low. In addition 53% of men and women were inactive, which is significantly higher than the England average (Table 61).
- Synthetic estimates at MSOA level suggest that the proportion of adults who undertake at 30 minutes of activity at least three times a week ranges between 16% and 26%

Health and Wellbeing Challenges for Newcastle-under-Lyme

POPULATION TRENDS

Ageing Community.

Population ageing is a phenomenon that occurs when the median age of a community rises due to rising life expectancy (and/or declining birth rates).

The economic effects of an ageing population are considerable, particularly with regard to public expenditure, where the largest demands are being placed on health care. This cost is forecast to increase as the population ages and will lead to hard choices when it comes to not only providing health care but other services also. There is also evidence to suggest that the rising costs of health care are also attributable to rising drug and doctor costs, and higher use of diagnostic testing by all age groups, and not just the ageing population. Nevertheless it is commonly accepted that there is a need to shift resources from treatment into prevention so that people spend a longer period of their life in good health.

The population projection for Newcastle under Lyme shows that there will be an increase. The most marked and noticeable increase will be in the age groups of 65-69 and above. Within this total, the number of very old people grows even faster, following the national trends:

- In the UK 10 million people are over 65 years old. The latest projections are for 5½ million more elderly people in 20 years time and the number will have nearly doubled to around 19 million by 2050.
- There are currently three million people aged more than 80 years and this is projected to almost double by 2030 and reaches eight million by 2050. While one-in-six of the UK population is currently aged 65 and over, by 2050 one in-four will be.
- The pensioner population is expected to rise despite the increase in the women's state pension age to 65 between 2010 and 2020 and the increase for both men and women from 65 to 68 between 2024 and 2046. In 2008 there were 3.2 people of working age for every person of pensionable age. This ratio is projected to fall to 2.8 by 2033.

Growing Obesity Levels

Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have an adverse effect on health, leading to reduced life expectancy and/or increased health problems. Obesity is most commonly caused by a combination of excessive food energy intake, lack of physical activity, and genetic susceptibility.

Obesity increases the likelihood of various diseases, particularly heart disease, type 2 diabetes, certain types of cancer, osteoarthritis and asthma. Obesity is a leading preventable cause of death worldwide, with increasing prevalence in adults and children, and considered one of the most serious public health problems of the 21st century.

Obesity in the United Kingdom is a growing health concern with health officials stating that it is one of the leading causes of preventable deaths in the UK. Adult

obesity rates have almost quadrupled in the last 25 years, with 22% of Britons now obese. Obesity in the United Kingdom is usually found in lower Socio-Economic areas.

An unhealthy diet has been cited as a cause of obesity in the United Kingdom. The main reasons being the amount of pre-prepared food British people eat, the lack of fruit and vegetables in the British diet and binge drinking culture.

It is important to note that while unhealthy diets and lack of appropriate physical activity are considered leading causes of obesity; these are not the sole cause. There are a number of genetic, medical and psychological factors that play a part in some cases.

In Newcastle-under-Lyme 25.8% of adults are obese (compared with an England average of 24.2% and 19.2% of Year 6 children in Newcastle-under-Lyme are obese compared to an England average of 19.0%.

RISK FACTORS

Nutrition

Eating a balanced diet is vital for good health and wellbeing. Food provides the energy, protein, essential fats, vitamins and minerals to live, grow and function properly. A wide variety of different foods is needed to provide the right amounts of nutrients for good health. Enjoyment of a healthy diet can also be one of the great cultural pleasures of life.

An unhealthy diet increases the risk of many diet-related diseases. The major causes of death, illness and disability in which diet and nutrition play an important role include coronary heart disease, stroke, hypertension, atherosclerosis, obesity, some forms of cancer, Type 2 diabetes, osteoporosis, dental caries, gall bladder disease, dementia and nutritional anemia.

Social Isolation

Social isolation is a compelling risk factor for morbidity and mortality, and its negative consequences are most profound among the elderly, the poor, and minorities. A steadily increasing number of people are living alone and are therefore more likely to experience social isolation. The maintenance of social connections across the life span is therefore important and efforts to reduce social isolation are likely to have positive outcomes for wellbeing and mortality rates.

Smoking

Cigarette smoke contains about 4,000 different chemicals which can damage the cells and systems of the human body. These include at least 80 chemicals that can cause cancer (including tar, arsenic, benzene, cadmium and formaldehyde) nicotine (a highly addictive chemical which hooks a smoker into their habit) and hundreds of other poisons such as cyanide, carbon monoxide and ammonia.

These chemicals are drawn into the body when inhaled, where they interfere with cell function and cause problems ranging from cell death to genetic changes which lead to cancer.

Smoking contributes to coronary artery disease (hardening of the arteries) where the heart’s blood supply becomes narrowed or blocked, starving the heart muscle of vital nutrients and oxygen, resulting in a heart attack. As a result smokers have a greatly increased risk of needing complex and risky heart bypass surgery. Smoking also increases the risk of having a stroke, because of damage to the heart and arteries to the brain.

For lifetime smokers, there is a 50 per cent chance that their eventual death will be smoking-related - half of all these deaths will be in middle age.

Smoking does enormous damage to the lungs. As a result there is a huge increase in the risk of lung cancer, which kills more than 20,000 people in the UK every year.

Lung cancer is a difficult cancer to treat - long term survival rates are poor. Smoking also increases the risk of the following cancers: Oral, Uterine, Liver, Kidney, Bladder, Stomach, Cervical, and Leukaemia.

Even more common among smokers is a group of lung conditions called chronic obstructive pulmonary disease or COPD which encompasses chronic bronchitis and emphysema. These conditions cause progressive and irreversible lung damage, and make it increasingly difficult for a person to breathe.

Smoking in pregnancy greatly increases the risk of miscarriage, is associated with lower birth weight babies, and inhibits child development. Smoking by parents following the birth is linked to sudden infant death syndrome, or cot death, and higher rates of infant respiratory illness, such as bronchitis, colds, and pneumonia.

Smoking is particularly damaging in young people. Evidence shows people who start smoking in their youth - aged 11 to 15 - are three times more likely to die a premature death than someone who takes up smoking at the age of 20.

Although the health risks of smoking are cumulative, giving up can yield health benefits, regardless of the age, or the length of time someone has been smoking.

Smoking-cessation services, make a broad range of help available including medication and counselling, resulting in chances of quitting being as high as one in three (compared to just three per cent where people go it alone).

Alcohol

Harmful drinking is a major determinant for neuropsychiatric disorders, such as alcohol use disorders and epilepsy and other non-communicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. The harmful use of alcohol is also associated with several infectious diseases like HIV/AIDS, tuberculosis and sexually transmitted infections (STIs). This is because alcohol consumption weakens the immune system and has a negative effect on patients' adherence to antiretroviral treatment.

A significant proportion of the disease burden attributable to harmful drinking arises from unintentional and intentional injuries, including those due to road traffic accidents, violence, and suicides. Fatal injuries attributable to alcohol consumption tend to occur in relatively younger age groups.

The harmful use of alcohol compromises both individual and social development. It causes harm far beyond the physical and psychological health of the drinker. It harms the well-being and health of people around the drinker. An intoxicated person can harm others or put them at risk of traffic accidents or violent behaviour, or negatively affect co-workers, relatives, friends or strangers. Thus, the impact of the harmful use of alcohol reaches deep into society.

Alcohol consumption by an expectant mother may cause foetal alcohol syndrome and pre-term birth complications.

There are a number of other factors that are attributed as leading risk factors in relation to alcohol. These include: Childhood underweight, unsafe sex, poor hygiene,

high blood pressure, tobacco use, suboptimal breastfeeding, high blood glucose, indoor smoke from solid fuels, overweight and obesity, physical inactivity, high cholesterol, occupational risks, vitamin A deficiency, iron deficiency, low fruit and vegetable intake, zinc deficiency, illicit drugs, and unmet contraceptive need.

SYMPTONS

Dementia

Dementia is a term that is used to describe a collection of symptoms including memory loss, problems with reasoning and communication skills, and a reduction in a person's abilities and skills in carrying out daily activities such as washing, dressing, cooking and caring for self.

There are different types of dementia, the most common being Alzheimer's disease, a progressive form of dementia that gradually gets worse over time. Subsequently the person may lose more and more of their every day skills and abilities and may eventually be unable to perform the simplest of every day tasks without encouragement, support and supervision.

Vascular dementia is the second most commonly diagnosed dementia (after Alzheimer's disease). It is caused by the interruption of a regular supply of blood and oxygen to the brain and if the brain cells no longer function properly or die as a result a person may develop Vascular Dementia. As Vascular Dementia affects different areas of the brain each person may have different symptoms. Some may be aware of problems they are experiencing and this can lead to an increased risk of depression. Vascular Dementia progresses in obvious steps rather than a gradual reduction in skills/ abilities as with Alzheimer's disease.

Vascular dementia can be stroke-related (small vessel disease-related dementia) or people can suffer from vascular dementia and Alzheimer's disease (mixed dementia). People with conditions such as high blood pressure, heart problems, high cholesterol and diabetes are more at risk of developing vascular dementia. It is therefore recommended that these conditions are identified and treated as soon as possible.

So far there is no medical test for dementia. A diagnosis is made by excluding other conditions. The assessment process and the types of support available tend to vary depending on the services that are available in a local area.

Diabetes

Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. In the UK, approximately 2.9 million people are affected by diabetes and there are also thought to be around 850,000 people with undiagnosed diabetes.

There are two main types of diabetes, referred to as type 1 and type 2.

Type 2 diabetes is far more common than type 1 diabetes, which occurs when the body doesn't produce any insulin at all. In the UK, about 90% of all adults with diabetes have type 2 diabetes. Type 2 diabetes occurs when the body doesn't produce enough insulin to function properly, or the body’s cells don't react to insulin. This is known as insulin resistance.

It is important diabetes is diagnosed as early as possible. If left untreated, diabetes can cause many health problems. Large amounts of glucose can damage blood

vessels, nerves and organs. Even a mildly raised glucose level that doesn't cause any symptoms can have damaging effects in the long term. Diabetes cannot be cured, but treatment aims to keep the blood glucose levels as normal as possible to control symptoms and minimise health problems developing later. In some cases of type 2 diabetes, it may be possible to control symptoms through lifestyle changes, such as healthy eating. However, as type 2 diabetes is a progressive condition, eventually medication will be needed to keep blood glucose at normal levels but it helps to eat a healthy, balanced diet, stop smoking, drink alcohol in moderation and take plenty of regular exercise.

Heart Disease

Coronary heart disease (CHD) (sometimes called ischaemic heart disease) is the UK's biggest killer, causing around 82,000 deaths each year by heart attacks and heart failure. About one in five men and one in eight women die from the disease. In the UK, there are an estimated 2.7 million people living with the condition and 2 million people affected by angina (the most common symptom of coronary heart disease – chest pain). CHD generally affects more men than women, but from the age of 50 the chances of developing CHD are similar for men and women.

As well as controlling circulation the heart gets its own supply of blood from a network of blood vessels on the surface of the heart, called coronary arteries. Coronary heart disease is the term that describes what happens when the heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries. Over time, the walls of the arteries can become furred up with fatty deposits. Although coronary heart disease cannot be cured, treatment can help manage the symptoms and reduce the chances of problems such as heart attacks. Treatment can include lifestyle changes, such as doing regular exercise and stopping smoking, as well as medication and surgery.

Simple lifestyle changes can reduce the risk of getting CHD. These include:

- eating a healthy, balanced diet
- being physically active
- giving up smoking
- controlling blood cholesterol and sugar levels

A healthy heart will also have other health benefits, and help reduce the risk of stroke and dementia.

Liver and Lung Disease

The majority of liver disease can be attributed to the effects of alcohol, viral hepatitis B or C and non-alcoholic fatty liver disease, either individually or in combination. However, there are many causes of liver disease, some genetic, hereditary or congenital, and some quite rare. The liver is able to mask early stages of damage and consequently liver disease often goes undetected until the damage is considerable.

Alcoholic liver disease is where the liver is damaged by alcohol consumption. The liver filters toxins, such as alcohol, out of the blood. Alcohol is metabolised in the

liver and used to generate fat. Those who drink more than the recommended guidelines, run the risk of the liver becoming fatty. The liver cells become bloated and unable to work properly. Nearly all heavy drinkers are thought to have alcoholic fatty liver disease. Over time, a build-up of fat can harm the liver, causing inflammation that can lead to serious scarring, known as cirrhosis. In some cases, if large amounts of alcohol are consumed in a short space of time, as the liver is unable to cope damage can occur suddenly. Where scarring occurs, the liver will start to lose function. Even at this stage symptoms may not be noticed. Stopping drinking immediately and continuing to abstain will prevent any further damage. However, if damage from alcohol continues the liver will start to fail.

Hepatitis B virus is present in infected blood and other body fluids. It's incredibly infectious and is easily spread among young children or from mother to baby. It can also be passed on during sex or by sharing unsterile needles and equipment, for example during:

- Drug use
- Tattoos and body piercing
- Acupuncture
- Medical treatment
- Infection can lead to liver disease and liver cancer. A vaccination is recommended where lifestyle or work puts people at risk.

Hepatitis C virus often shows no symptoms, but long-term effects can include liver damage and cancer. The virus is passed on through infected blood in similar ways to hepatitis B. In the UK blood used for transfusion has been screened for hepatitis C since 1991. People who are most at risk are those who share needles. No vaccine exists to prevent hepatitis C infection, but treatments are available and effective in more than half of cases.

Non-alcoholic fatty liver disease (NAFLD) is a condition where the liver becomes very fatty in people who don't drink or who consume little alcohol. Although anyone can get it, those most at risk are very overweight (obese) or have diabetes.

Lung diseases are some of the most common medical conditions with smoking, infections, and genetics responsible for most lung diseases. The lungs are part of a complex system that brings in oxygen and expels carbon dioxide. Lung disease can therefore result from problems in any part of this system. Spirometry tests are an accurate way of measuring breathing efficiency and can detect symptoms of many important lung diseases early on, giving people time to make necessary lifestyle changes.

Exercise, even gentle walking for those with severe disease can help improve lung capacity, reduce the feeling of breathlessness and relieve the symptoms of early stage lung disease. In addition to exercise, there are a number of other healthy lifestyle choices that also help.

Stopping smoking will reduce irritation of the airways and help stop some of the causes coughing, shortness of breath and a range of lung diseases, such as chronic obstructive pulmonary disease (COPD) and lung cancer. Asthma is more difficult to control in people who smoke. Stopping smoking can prevent COPD getting worse, improve asthma control and reduce the risk of lung cancer.

Healthy eating will help control weight. Being overweight makes breathing more difficult, and being underweight is associated with more severe lung disease.

Influenza or other lung infections can be more dangerous for people with breathing problems. For those experiencing breathing difficulties, it is advisable to have vaccine every year particularly for those over 65.

INTERVENTIONS

Employment

Employment is one of the most important determinants of health. Having a job or an occupation is an important determinant of self-esteem. It provides a vital link between the individual and society and enables people to contribute to society and achieve personal fulfilment. The World Health Organisation identifies a number of ways in which employment benefits mental health. These include the provision of structured time, social contact and satisfaction arising from involvement in a collective effort. Therefore the loss of a job or the threat of losing a job is detrimental to health. The type of job a person has and the working conditions they are exposed to will also affect health. Historically Newcastle under Lyme has been associated with mining and heavy industry which has left a legacy of health issues. It is also important to consider the impact that employment has on other aspects of people's lives that are important for health – for example, family life, social life and caring responsibilities for family members. Here flexible working policies can help.

Unemployment can have negative effects on health and even be a cause of premature mortality. Studies show that unemployed people with no previous illness were more likely to die at a younger age than the general population.

Long-term unemployment is often associated with socio-economic deprivation. People from lower socio-economic groups are also more likely to move in and out of employment. The financial strain of unemployment can also have direct health impacts, with people in debt being more prone to depression. People in poverty die younger, have less healthy lifestyles and live in less healthy environments.

People who are unemployed are more likely to smoke and to drink to excess (although there is disagreement as to whether this behaviour or the loss of a job comes first). A spell of unemployment may have knock on effects that increase stress and affect mental health such as loss of home and relationship breakdown.

A person who is unemployed once runs a greater risk of being unemployed again. This may lead to job insecurity, a higher than normal exposure to poor quality jobs and a lack of control over working life, all of which have health implications. Many are unable to find work subsequent to recession or industrial structural change and have a tendency to drop out of the workforce. Some who do return to the workforce may do so at a lower occupational status or level of seniority and on lower wages.

Early Detection

As demographics shift and lifespan increases, a larger percentage of adults will require medical care. The rising cost of medical procedures in combination with the greater numbers of people needing assistance has started to place strain on healthcare providers. Many diseases that severely limit quality of life are difficult to manage in their later stages, but can be treated more effectively and less expensively if caught early. Early detection of health conditions is therefore increasingly of interest.

Lifestyle Changes

Of equal importance to early detection is the need for lifestyle changes and focussed prevention strategies. Improved access to health care that focuses on prevention and control of important risk factors including, physical activity, high cholesterol, healthy eating, high blood pressure, weight management, diabetes and smoking cessation is essential.

The health costs of physical inactivity per 100,000 population (Sport England commissioned data) are £2,164,876 for Newcastle under Lyme, this compares to a cost of £1,937,438 for the West Midlands and £1,817,285 for England.

Housing

The Borough has 44,042 private dwellings. The housing age profile is mixed with 17,174 (39%) dwellings constructed pre-1945 and 7,988 constructed pre -1919. The Housing Stock Condition Survey, which was completed in 2008 identified that housing condition problems remained significant within the Borough, where 18.6% of all dwellings exhibited a Category 1 Hazard.

The report, also identified significant issue with fuel poverty, where 16,960 (39.8% of all households) were in fuel poverty. A correlation was also identified between poor housing conditions and households in social and economic disadvantage, where a significant number of households living in non decent homes are elderly households (42.1%) and economically vulnerable households (32%).

An analysis of the housing register, which is maintained by Newcastle under Lyme Borough Council, shows that there are 2875 applicants who are registered, of which

- 431 households have stated that their current accommodation is overcrowded.
- 255 households are either homeless or about to be made homeless from their current accommodation.

It is well documented, that housing has a correlation with health, where decent, suitable accommodation will have a positive impact on the health of the household. Conversely, poor, unfit accommodation, which is not suitable, will have an adverse impact on both the physical and the mental health of the household.

Homes play an important role in providing occupiers with opportunities and contribute to the World Health Organization's (WHO) definition of health as 'a complete state of physical, mental and social well being'

The quality of the home has a substantial impact on health, a warm, dry and secure home is associated with better health. In addition to basic housing requirements, housing is important for many aspects of healthy living and well-being. The home is important for psychological reasons as well as its protection against the elements.

Housing Stock and Conditions

Housing conditions, housing-related support and other housing services can have an immense impact on the physical health and mental wellbeing of people. Housing stock is divided into four main housing sectors, Local Authority housing (social), Registered Provider housing (social), Owner Occupied (private) and Rented

(private). In Newcastle under Lyme there are three sectors in operation as the Council no longer has any of its own housing stock.

Fuel Poverty

Fuel Poverty is defined as "where the household has to spend more than 10% of their household income on fuel to maintain a satisfactory heating regime, as well as meeting their other fuel needs (lighting and appliances, cooking and water heating).

Cold homes and the associated problems of condensation, damp and mould can affect both the physical and mental health of occupants. These can include:

- Increased respiratory illness
- Increased blood pressure, leading to heart attacks and strokes
- Arthritis symptoms exacerbated
- Increased accidents in the home due to loss of dexterity in the hands
- Increased social exclusion – which can lead to depression and heart disease
- Impaired mental health
- Adverse effects on children's education – missing the provision of a warm quiet space to study
- Adverse effects on nutrition – homeowners choosing between spending income on warmth than nutritious food

People on low incomes who spend a lot of time at home are particularly at risk as they are faced both with being unable to adequately heat their home and with having to spend long periods in a cold dwelling.

Low income, high fuel prices and poor energy efficiency measures within the home are recognised as the key factors that cause fuel poverty especially older people, people with a disability and families with young children who are deemed most vulnerable. Fuel poverty is influenced by many factors, including income, hard to heat properties, inefficient heating systems and poor insulation. In addition to this these groups are also more likely to live in poor quality housing, which do not meet the relevant housing standards.

Hazards

Health & Safety regulations or building regulations are in place to control hazards such as Fire, Damp & Mould, Overcrowding which are all believed to have a significant and adverse effect on an individual's health. The benefits of removing these hazards are directly linked with improved mental and physical health.

Housing Services is required by the Housing Act 2004 to keep housing conditions in their area under review with a view of identifying any action that may need to be taken to address any category 1 hazards. Furthermore, the service is also required to both license and regulate HMO's (House in Multiple Occupation) meeting the definition as set out in the Act.

Energy Efficiency

Energy conservation not only benefits the environment, but also contributes to positive social, health and economic outcomes. Using energy efficiency measures can reduce the cost of heating, ventilating, and air conditioning, which account for a significant part of the overall cost of housing.

Housing Adaptations

Housing plays a central role in maintaining the independence of people with a disability, learning difficulties and as people become frailer or less mobile. Maintaining independence and being able to live life as fully as possible are all important to mental and physical health and well being. Being able to access suitable housing, or to adapt current housing can have a direct impact on delivering health and well being, as can accessing relevant support and care to remain in one's own home. Disabled Facilities Grants play a significant part in enabling people to remain independent in their own homes.

Home Improvement – Handy Person Schemes

The Home Improvement work carried out by a Handyperson Scheme can help local authorities reach vulnerable clients much faster. These schemes can also assist health service providers to reduce hospital admissions of older people having accidents. Carrying out minor repairs prevents hospital admission from falls and accidents in the home. The Council contracts the services of the Revival Home Improvement Agency to provide a range of property repairs, adaptations and well being services to vulnerable home owners and qualifying tenants in the borough.

The Wider Environment

The wider environment around the home can also impact heavily on an individual's health and well being, increasingly in these current unstable economic conditions the affordability of housing and the potential for individuals to lose their home because of debts they are unable to manage is becoming a problem for more people to manage. It should be remembered that the home is one of the major areas of financial expenditure for households. The lack of affordable housing and the threat of loosing their home because of debts they are unable to meet have become an increasing problem for homeowners, and one which often has substantial negative impacts on mental and sometimes physical health.

Homelessness

Homelessness and health are also inextricably linked. The health of homeless people is generally much worse than that of the general population. This is true for a range of health issues including diet and malnutrition, substance misuse, mental illness, sexual health problems, infectious diseases and problems related to living conditions. Being roofless also leads to a greater risk of assault and injury and is closely associated with multiple and complex health needs. Crisis (Dec 2011) report that on average homeless people die 30 years earlier than the general population.

OUTCOMES

Healthier (and Happier) Communities

The chance to deliver health and wellbeing in Newcastle under Lyme following recent health reforms gives us unprecedented opportunities to bring healthier, happier and longer lives to residents of the Borough.

This strategy will assist local government in the area in tackling health inequalities and improving health. It will also build the capacity of others working with communities, whether public, private or voluntary sectors, to tackle local health inequalities and promote wellbeing, partnership working and integration through fostering a joined-up approach to health improvement across local government, the Local Strategic Partnership, the Health and Wellbeing Board, the North Staffordshire Clinical Commissioning Group, the Joint Strategic Needs Assessments and Local Action Partnerships.

Where communities are more engaged and have more control over their health, their members are healthier and happier. We know that people with wide social networks, close families and strong links with their local voluntary/community organisations (either for support, or through volunteering) are more likely to live longer and be healthier.

Everyone is healthier and happier in communities where people are actively engaged in helping each other, whether that be more formally, through working for or volunteering with local voluntary organisations, or informally, through simply popping in to see an elderly neighbour or volunteering for a few hours a week.

We will work together to encourage and support communities to take more responsibility and control for the health and wellbeing of their members. They already provide a huge range of support to many of the people affected by the priorities in this strategy. We know that the voluntary sector in North Staffordshire already offers a diverse range of services, and therefore we believe in empowered people to take more responsibility for their own health and wellbeing; in community groups and voluntary organisations creating a support network for people if they are in need; and in statutory organisations being there when they are needed - then we can build a healthier, happier Borough.

Better Quality of Life

Quality of Life is a phrase used to refer to an individual's total wellbeing. This includes all emotional, social, and physical aspects of the individual's life. However, when the phrase is used in reference to medicine and healthcare as Health Related Quality of Life, it refers to how the individual's wellbeing may be impacted over time by a disease, a disability, or a disorder.

The understanding of Quality of Life is recognised as important in health and wellbeing as careful consideration needs to be given to the relationship between cost and value, particularly where there is a potential impact on human life. The challenge at the moment is weighing the often expensive cost of treatment (some of which may

prolong life by only a short amount of time and/or provide a minimal increase to quality of life) against the cost of prevention.

Reduced Treatment Costs

There are several web-based analysis tools and resources available to help commissioners and clinicians to analyse variations in health spend and outcome, to identify opportunities for increasing productivity, and to support decision-making about health investment for populations. Links to all of these tools and supporting guides can be found on the Health Investment Network website, available at: http://www.networks.nhs.uk/nhsnetworks/health-investment-network

Additional support for health investment analysis and interpretation of variance is available from the Director of Public Health, and the Health Observatory.

Better Mental Health

Significant NHS reform outlined in the Health and Social Care Bill 2011, along with changed priorities in public health, changes to local council responsibilities and budgets and alterations to the benefits system coincided with the new mental health strategy for England – *No health without mental health*.

A number of established and long cherished principles within mental health fit very well with the ideas:

- **Personalisation, the recovery model and wider wellbeing,** all of which require a new relationship between individuals and the services they receive.
- **Co-production,** where professionals that work on a service collaborate with those who will use that service to design it and make it work, requires new approaches to involvement and new ideas of ownership of both practice and services.
- **Peer services,** where people who have experienced a particular situation use their experience to deliver support to others experiencing similar.
- **User-led organisations,** where people with mental health difficulties lead and manage their own organisations and services.
- **Developing choice and putting those who use services in control,** where people with mental health difficulties have a real choice in the support they receive and real influence over the support available.
- **Supporting people in their communities,** where the needs of people with mental health difficulties are met by organisations and services that grow from their community and the challenges they face rather than being imposed on them.

If we are serious about improving mental health then we need to ensure that opportunities for people to take part in wider community activities are extended in the same way for people with mental health difficulties as it is to people who do not experience mental health difficulties. In this way existing stigma against them can be tackled and they can be properly included by the communities of which they are part.

ACTION PLAN

Health Actions

Dementia

De1 Identify and treat as soon as possible conditions such as high blood pressure, heart problems, high cholesterol and diabetes to reduce risk of developing vascular dementia.

De2 Ensure the assessment process and types of support available for those diagnosed with early onset dementia are amongst the best that can be offered.

Diabetes

Di1 Tackle the issues of diabetes going undiagnosed and ensure diabetes is diagnosed as early as possible.

Di2 Promote healthy eating to control symptoms through life style changes

Heart Disease

HD1 Promote healthy eating as part of a balanced diet

HD2 Promote physical activity as part of a healthy lifestyle

HD3 Prioritise and resource smoking cessation programmes

HD4 Resource programmes that monitor and control cholesterol and blood sugar levels

Liver and Lung Disease

LL1 Promote responsible drinking – within recommended guidelines

LL2 Promote safe sex and sexual health

LL3 Promote the message about the importance of using only sterile needles

LL4 Inoculate where people are at risk of Hepatitis B

LL5 Recommend weight management where this can reduce risk of non-alcoholic fatty liver disease

LL6 Assess risks of liver disease when dealing with diabetes in Action Di1 above

LL7 Promote smoking cessation programmes

LL8 Offer spirometry testing to detect symptoms of lung disease early on

LL9 Promote gentle exercise and health walks to improve lung capacity

LL10 Treat people who are underweight to guard against associated health problems including lung disease

LL11 Promote and resource influenza vaccination, particularly for those aged over 65 years

Physical Activity

The Borough Council will lead on the establishment of a Newcastle under Lyme Physical Activity Partnership to develop a comprehensive Sport and Physical Activity Strategy for Newcastle under Lyme. The priority areas will be:

- Physical activity promotion
- Children and young people
- Older people
- Active communities in areas of deprivation
- Active healthcare system
- Active workplaces

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Staffordshire County Council

Newcastle-under-Lyme District Profile

April 2013

Document Details

Title	Newcastle-under-Lyme District Profile
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Geographical coverage	Newcastle Borough
Copyright and disclaimer	

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CONTENTS

INTRODUCTION AND CONTEXT

The purpose of the district profiles is to provide decision makers and commissioners with a summary of the key issues affecting the people of the districts.

The reports incorporate weblinks to data hosted on the Staffordshire Observatory website. This will ensure that the profiles remain current and provide access to the most up-to-date data and reports.

For consistency, the reports are structured in a similar way to the Staffordshire and Stoke-on-Trent Story report, reflecting the priority outcomes identified by the Staffordshire Strategic Partnership:

1. Staffordshire will have a thriving economy
2. Staffordshire will be a safe, healthy and aspirational place to live

The profile draws on in-depth research and analysis undertaken throughout the year by the Insight team and colleagues across the partnership.

WHO LIVES IN NEWCASTLE BOROUGH?

Population (Read more)

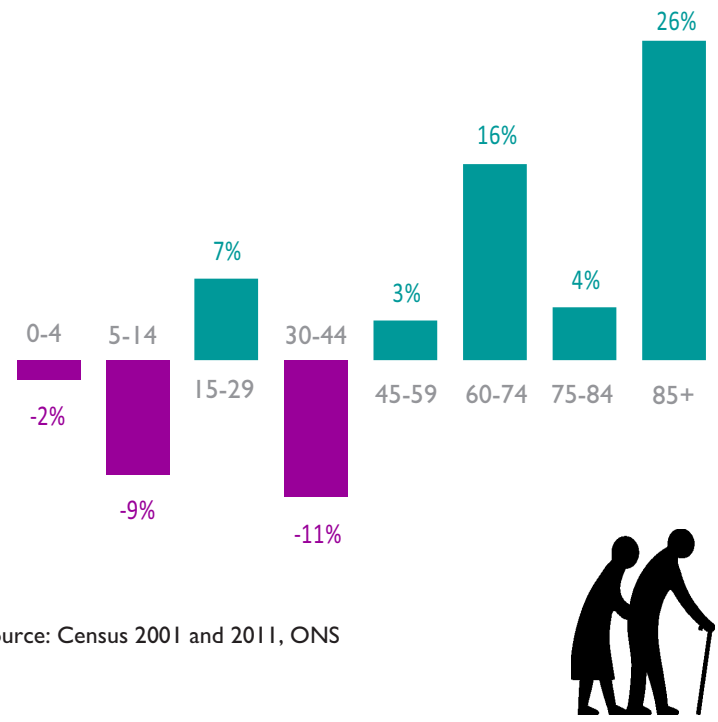
Based on the 2011 Census, the population of Newcastle Borough was around 123,900. Since 2001 the population increased by 1.5% (around 1,870 people), compared to national and county increases of 7.1% and 5.2% respectively.

The population is expected to continue to increase. By 2035 there are expected to be an additional 14,900 people living in Newcastle Borough.

Newcastle Borough's population is ageing. Between 2001 and 2011 the number of residents above the age of 60 years old in the borough has increased by 14% (almost 3,800 additional people) and the number of residents above the age of 85 has increased by 26% (an increase of over 580).

However, in Newcastle Borough the number of children and young people is decreasing, with a 7% decrease in the 0-14 age group seen over the past ten years.

Figure 1: Change in population by age group since 2001



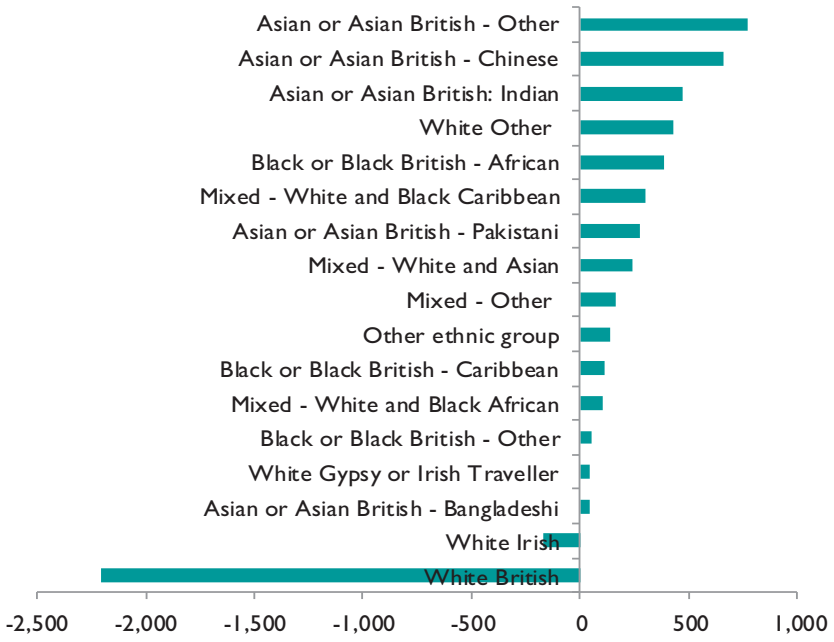
Source: Census 2001 and 2011, ONS

Ethnic diversity (Data)

Newcastle Borough is one of the most diverse districts in the county, with a BME population of around 8,400 (6.7%) in 2011, compared to 6.4% county-wide and 17.2% nationally.

Between 2001 and 2011, there was an increase in the number of people from black and minority ethnic groups of around 4,000. The Asian Other community has seen the greatest increase in population during this time period, followed by Chinese and Indian. There has been a decrease in the White British community of over 2,000 people.

Figure 2: Change in black and minority ethnic groups 2001-2011



Source: Census 2001 and 2011, Office for National Statistics

ECONOMY

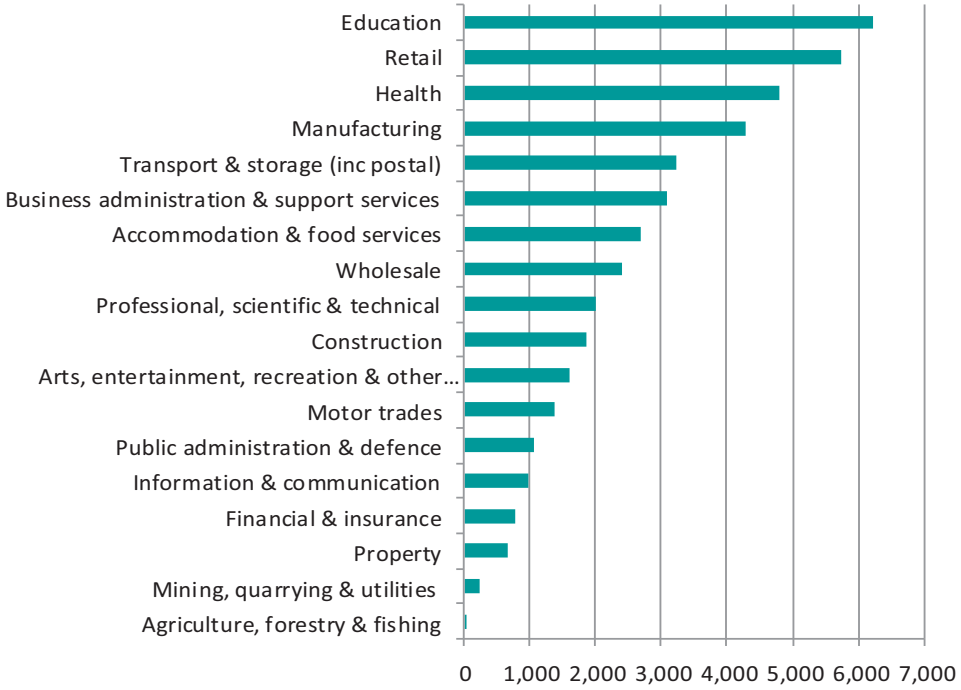
The health of the local economy is vital, as it impacts on different aspects of people's lives. A thriving economy provides a basis for improving the quality of life of the people who live in, work in and visit Newcastle.

Jobs (Data)

In total, there were around 43,000 employee jobs in Newcastle Borough in 2011. There has been an decrease of around 1,700 employee jobs in the area since 2008

Figure 3 shows the number of jobs in Newcastle Borough by 'Broad Industrial Group'. Education, retail and health are the major employment sectors in the borough, accounting for nearly 39% of all jobs. Between 2008 and 2011, there have been increases in the number of jobs in 'business administration and support services' and 'health' sectors (around 1,000 for each) and a decrease of around 1,500 jobs in the 'information and communication' sector.

Figure 3: Number of jobs in Newcastle Borough by broad industrial group, 2011

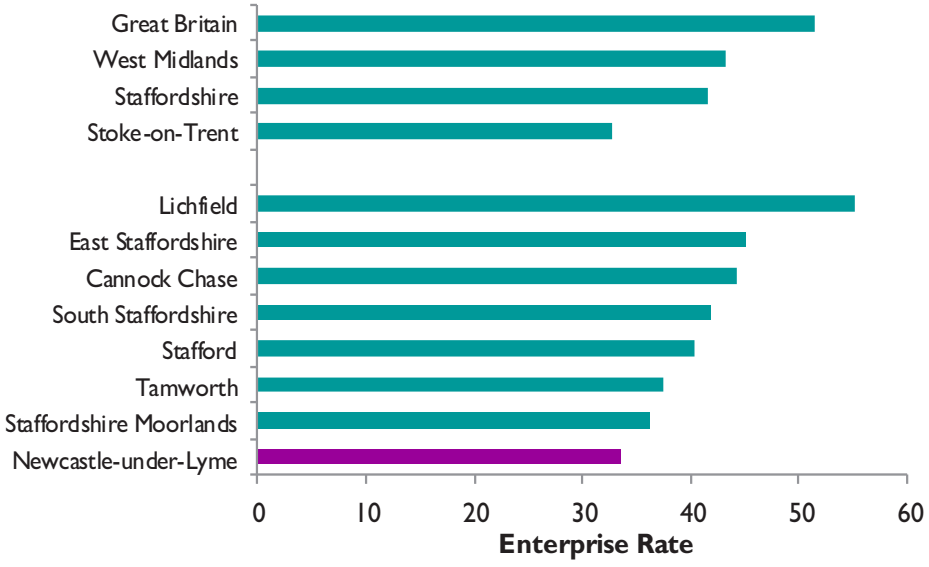


Source: Business Register and Employment Survey, NOMIS

Enterprise (Read more)

Newcastle Borough has a business start up rate of 33.6 per 10,000 resident population aged 16 and above. This is the lowest in the county, and lower than the national rate of 51.6. It has a business survival rate, at 60.8%, compared to 61.6% for the county and 58.2% nationally.

Figure 4: Business birth rate per 10,000 resident population aged 16 and above, 2011



Source: Business Demography, 2011, ONS

Workforce (Data)
'Worklessness' is the term used to describe all of those people who are economically inactive, often defined as people of working age who are not employed and are claiming a benefit, such as Jobseeker's Allowance, Employment Support Allowance and Carer's Allowance.

The proportion of residents claiming out-of-work benefits in Newcastle Borough has declined since the peak of the recession in 2009, where there were around 10,330 claimants, compared with 8,700 in 2012, equating to 10.9% of the borough's working age population[1].

Unemployment (JSA data, Youth JSA data)
In contrast to the long term nature of many people claiming out of work benefits, people who are unemployed generally tend to be a lot closer to the mainstream labour market. The claimant count is a key measure of unemployment and measures those people claiming Jobseeker's Allowance benefit (JSA).

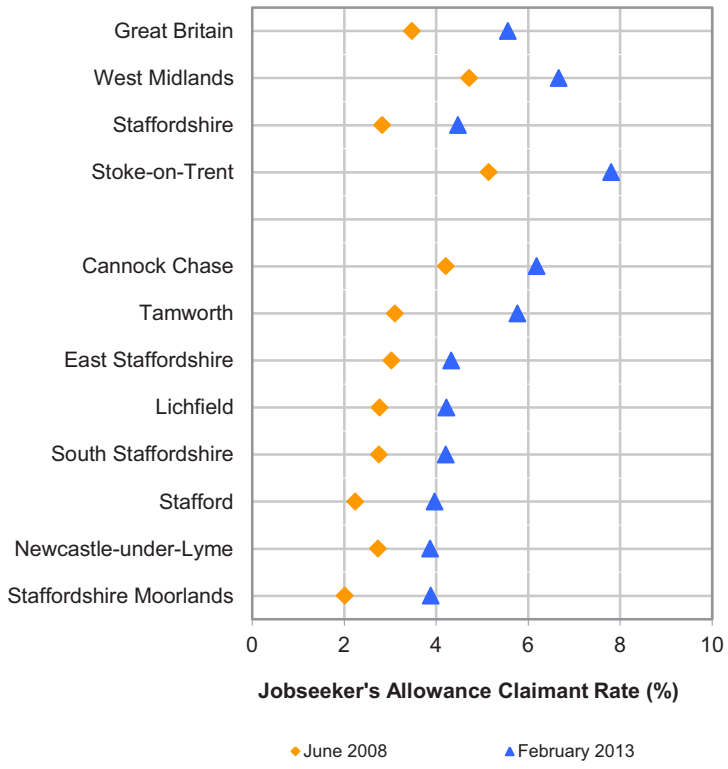
In March 2013 there were around 2,300 people claiming JSA in Newcastle Borough, 2.9% of the working age population. This was slightly higher than the county rate of 2.7%, but lower than regional (4.6%) and national (3.8%) rates. Since 2009, the overall numbers and rate have fallen and despite a slight increase in March 2012, the trend is downwards again.

Youth unemployment is a significant issue in Newcastle Borough, with the 16 to 24 age group suffering disproportionately from unemployment locally. In February 2013 there were 635 JSA claimants aged 16 to 24 in Newcastle, which represented 3.9% of the 16 to 24 population.

The rate of youth unemployment has fallen from its peak of 6.3% in April 2009, but as figure 5 illustrates rates are still higher than pre-recession levels in June 2008 (2.7%).

The welfare benefit reforms include a new integrated system of benefits and a range of changes to the welfare system which will have an impact on the local labour market. These changes have the potential to have a significant impact on some of Staffordshire's residents, providing both opportunities and challenges. The overarching aim of the reforms is to 'make work pay' and ensure that people are better off in work than on benefits, so people have

Figure 5: Youth unemployment, 2008-2013



Source: NOMIS

[1] NOMIS

the opportunity to improve their economic position. However, there will be challenges, as benefits will be reduced for some, payments will be made monthly rather than weekly, and all administration, such as applications, will be done online. There is a role to ensure that the appropriate mechanisms and employment opportunities are in place to support people back into work.

Education (Data)

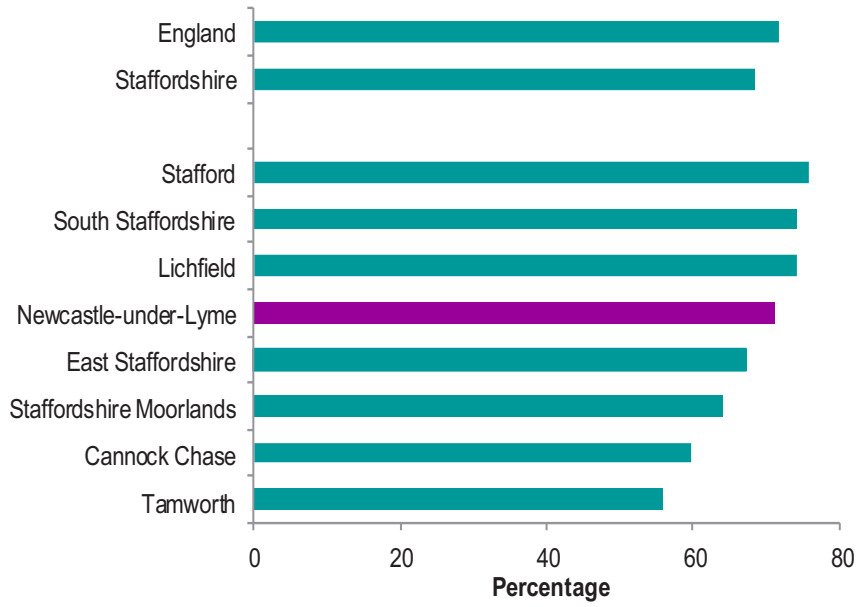
Good literacy and numeracy are key to further study and employability. Improving performance in these is important, as areas with low levels of education attainment and skills are often associated with high levels of worklessness and other socio-economic issues.

Attainment at Key Stage 4 in Newcastle Borough has continued to improve. Around 62% of pupils achieved five or more grade A* - C GCSEs including English and Maths in 2012 compared to 48% of pupils in 2008[2]. However, performance is now slightly above the regional and national averages of 59%.

Skills (Data)

Although improving the educational attainment of young people in the county may have substantial benefits over the longer term, tackling skills issues for the current working age population is equally important. This is to ensure that people have the right skills to access employment and in particular the higher value added jobs that are being targeted across the Staffordshire and Stoke-on-Trent area.

Figure 6 – Proportion of the working age population (16-64) qualified to NVQ Level 2 or above, 2011



Source: Annual Population Survey, NOMIS

Figure 6 shows that the proportion of Newcastle Borough's working age population qualified to NVQ Level 2+ was above the county and national averages in 2011, 71.2% for the borough compared to 68.5% for Staffordshire and 71.8% for England. The percentage achieving NVQ Level 4+ in Newcastle Borough is 31.0%, compared to 27.1% county wide and 34.2% nationally.

[2] Note that the results are based on the location of the school and not the home postcode of the pupil, so some pupils may live outside the district. Source: Staffordshire County Council

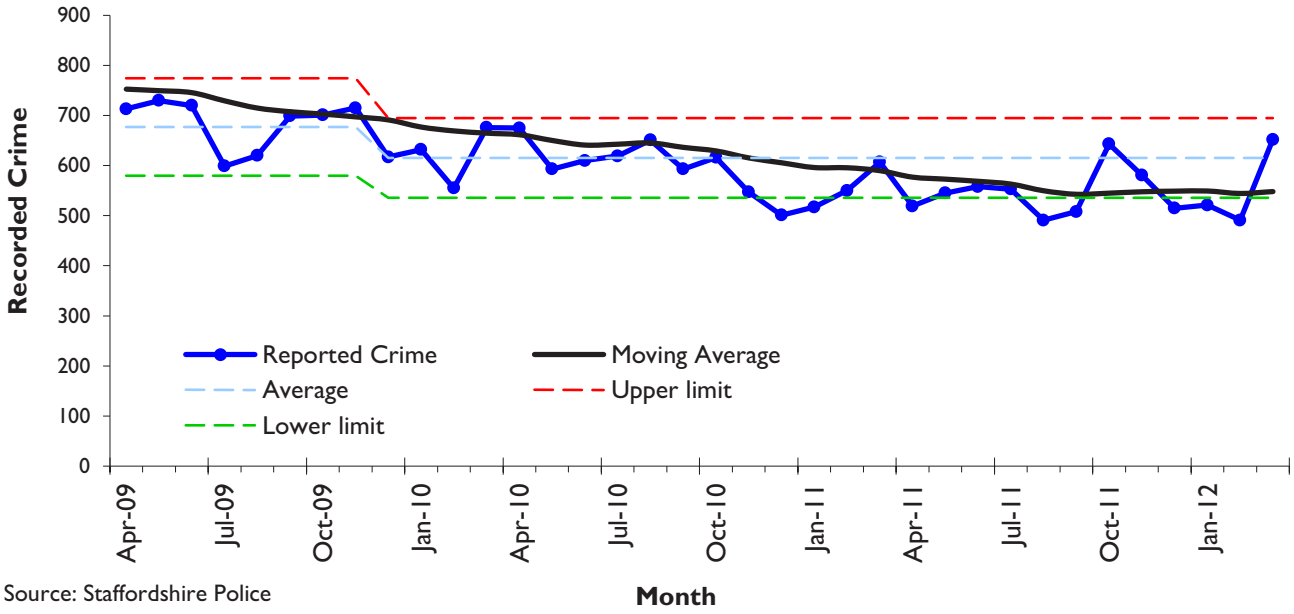
SAFETY

This section considers the safety of the district, in terms of crime and anti-social behaviour as well as the perceptions of crime.

Crime and anti-social behaviour (Read more)

Newcastle Borough is becoming safer. During 2011/12, there were 6,708 crimes recorded in the borough, equal to a rate of 54 crimes per 1,000 population. The direction of travel, as demonstrated in figure 7 below, shows a downward trend from April 2009, although this has begun to level off, with a current average of approximately 550 crimes per month.

Figure 7: Long Term Trends in Crime in Newcastle Borough, with Upper and Lower Bounds



Source: Staffordshire Police

There has also been a reduction in the number of violent crimes in 2011/12. This includes a 9% reduction in overall violence (169 fewer crimes), a 13% reduction in violence with injury (107 fewer crimes) and a 27% reduction in domestic violence (163 fewer crimes) compared with 2010/11. Despite this, there has been a 45% increase in serious violence (from 71 offences in 2010/11, to 103 offences in 2011/12).

Newcastle Borough has also experienced a modest reduction in acquisitive crime of 2% (59 crimes) during 2011/12, whilst serious acquisitive crime experienced a 16% reduction (155 crimes) through reductions in burglary of dwellings and thefts from motor vehicles. The number of personal robbery offences has also decreased.

Despite the reductions in overall crime rates, crime classified as 'other theft' has almost doubled, from 775 crimes in 2010/11 to 1,145 during 2011/12. Other theft is defined as 'theft if not classified elsewhere' and therefore is difficult to assess. The increase in Newcastle Borough is consistent with a county wide increase in this type of offence.

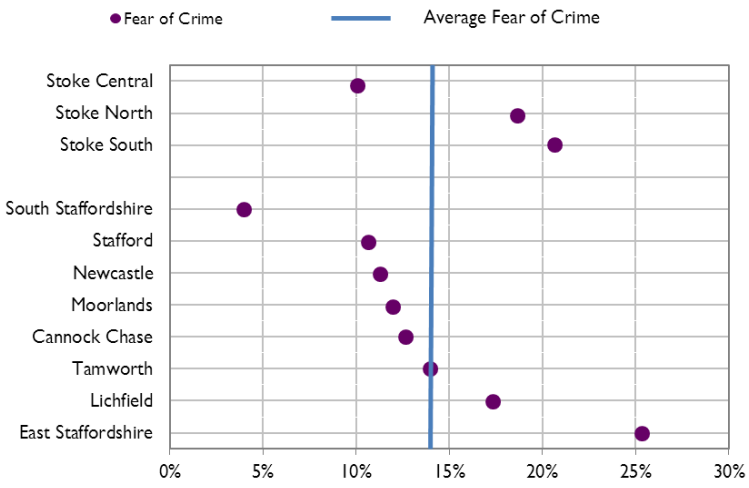
There have been considerable reductions in reported incidents of anti-social behaviour (ASB)

across Newcastle Borough. During 2011/12 there were 4,062 reported incidents, equal to a rate of 33 per 1,000 population. Whist this is 28% greater than the county rate, it represents a 18% reduction (or 882 fewer incidents) when compared with the previous year, and a 38% reduction over five years. The long term trends are clearly down.

Perceptions of crime (Read more)

Despite continuing improvements in the rate of crime, fear of crime remains an issue. According to the latest Feeling the Difference survey[3], around 11% of respondents in Newcastle Borough were fearful of being a victim of crime. This compares to 14% for Staffordshire and Stoke-on-Trent. Those people who were more fearful of being a victim of crime were also three times more likely to believe that the crime rate in their local area needed improving.

Figure 8: Percentage of residents who are fearful of crime by district



Source: Feeling the Difference, Wave 14

Alcohol misuse

There were 302 alcohol related violent offences during 2011/12, which accounted for 18% of all violence in Newcastle Borough[4]. It is thought that this is just a snapshot due to the influence of alcohol being under-recorded. Where alcohol is recorded, it is mainly a factor in violence offences in the town centre. Town ward records 28% of all alcohol related violence offences in Newcastle Borough (84 crimes). The long term trend in alcohol related violence is in line with overall violence.

Vulnerable people (Read more)

When reflecting on issues of safety and wellbeing, it is important to give consideration to the extra support and care that our vulnerable people and communities may need.
For children, the number of Looked After Children is increasing, with Staffordshire experiencing a proportionally larger increase in numbers than nationally. Numbers of children identified at risk and made subject to a Child Protection Plan have remained relatively stable over the past five years across Staffordshire, with neglect remaining the main reason for a child becoming the subject of a Plan.

The number of adult protection referrals is also increasing, partly due to proactive efforts to increase reporting as many incidents remain hidden, particularly concerns relating to neglect.

Child poverty, and therefore family poverty, is worsening, with around 18% of children in Newcastle living in poverty, compared to national figures of 21%[5]. There are hotspot areas in Chesterton, Cross Heath, Holditch, Knutton and Silverdale and Silverdale and Parksite where proportions are particularly high.

[3] Feeling the Difference involves interviewing 1200 people aged 16 and over on a 6 monthly basis about their views of the police and related issues. The latest results relate to Wave 14 undertaken in Summer 2012.
[4] Source Staffordshire Police, taken from Newcastle Borough Community Safety Strategic Assessment 2012
[5] Defined as number of children living in families in receipt of CTC whose reported income is less than 60 per cent of the median income or in receipt of IS or (Income-Based) JSA, divided by the total number of children in the area (determined by Child Benefit data) Source: HMRC

HEALTH AND WELLBEING

This section includes the health and wellbeing of Newcastle Borough, considering the overall health of the population and some of the wider determinants of health and wellbeing, all of which impact on a person's quality of life.

Life expectancy

There is a mixed picture for health across the district. The overall health of the people of Newcastle Borough has improved over the past decade, with people living longer and fewer people dying from major illnesses, such as cancer, heart and respiratory diseases.

Overall life expectancy at birth has increased both nationally and locally. Men in Newcastle Borough have similar life expectancy to the national average[6]. However women can expect to live nine months less than the England average.

Around 1,220 Newcastle Borough residents die every year, with the most common causes of death being circulatory diseases (390 deaths, 32%), cancers (330 deaths, 27%) and respiratory disease (190 deaths, 16%)[7]. The premature mortality rate from all causes for people aged under 75 is 285 per 100,000 population which is similar to the county and national averages (279 and 287 respectively). Rates have reduced by 30% between 1995-1997 and 2008-2010, compared with 30% for Staffordshire and 29% for England.

The rate of early deaths from heart disease and stroke and cancer are similar to the national rate, 70.3 and 109.5 per 100,000 population aged under 75[6].

Infant Mortality (Data)

The rate of infant mortality has improved in recent years and in Newcastle Borough it now stands at 8.7 per 1,000 live births, equating to 32 infants in 2008-10, although this is the highest in the county[8]. This compares to 4.4 per 1,000 live births for England.

Long term conditions

Long-term conditions (LTCs) are those that cannot currently be cured but can be controlled with the use of medication or other therapies. People with LTCs are more likely to see their GP, be admitted to hospital and stay in hospital longer than people without LTCs.

GP practices maintain disease registers for selected conditions. Analysis of 2008 data from a sample of practices revealed that at least one in four people have a registered disease with one tenth of the population having more than one condition.

According to these registers, there are around 5,000 people with coronary heart disease, 19,200 with hypertension and 2,800 with stroke or transient ischaemic attacks in Newcastle Borough[9]. Expected prevalence shows that significant numbers of people with LTCs may be undiagnosed or unrecorded on GP disease registers so actual numbers may be higher than this and are expected to increase in the future.

[6] Local Health Profiles, Department of Health, 2012
[7] Death Extracts, Office for National Statistics, Taken from Health and Wellbeing Profile for Newcastle Borough, Staffordshire Public Health, 2012
[8] Office for National Statistics
[8] Disease prevalence models, Public Health Observatories in England, http://www.apho.org.uk/diseaseprevalencemodels, accessed February 2012, NHS Comparators, NHS Doncaster QOF Benchmarking Tool, Quality and Outcomes Framework (QOF) for April 2010 to March 2011, Quality Management and Analysis System (QMAS) database - 2010/11 data as at end of July 2011, Copyright 2011, The Health and Social Care Information Centre, Prescribing and Primary Care Services. Taken from Health and Wellbeing Profile for Newcastle Borough Staffordshire Public Health, 2012

Mental health

Mental health is an important aspect of people's lives as it has an impact on their health, sense of overall wellbeing and their ability to take part in work and other activities.

There are estimated to be between 27,000 and 32,200 people suffering mental ill-health across Newcastle Borough[10]. Levels of severe mental illness (defined as people with schizophrenia, bipolar disorder and other psychoses) recorded on GP disease registers in Newcastle are significantly lower than England, with approximately 800 people on a register in 2010/11.

Lifestyle behaviours

Lifestyle behaviours, such as healthy eating, smoking and binge drinking present a significant challenge nationally and for Newcastle Borough, now and into the future. They have knock-on effects on other areas of people's lives and represent a significant burden on health resources.

Alcohol (Data)

Reducing the impact to the individual, community and society caused by alcohol misuse is a key priority across the county. It has far reaching consequences that impact not only on health, but also social problems, such as anti-social behaviour, crime and domestic abuse.

During recent years, hospital admissions as a result of increased consumption of alcohol have increased considerably. The rate of alcohol specific admissions, which are those that are conditions wholly related to alcohol, such as alcoholic liver disease and overdose, has increased among both males and females in Newcastle Borough equating to 375 per 100,000 male population and 224 per 100,000 female population. Similarly, alcohol-attributable admissions, which also include conditions that are caused by alcohol, such as unintentional injury and stomach cancer, have decreased in the borough from 1,981 per 100,000 population in 2006/07 to 1672 in 2010/11[11].

Obesity (Childhood data, Adult data)

Obesity is a significant public health issue, having an impact on the quality of a person's life, such as increasing the risk of other health problems and, in severe cases, restricting mobility and access to work and leisure activities.

Around 9% of reception year and 20% of Year 6 children are obese in Newcastle Borough, compared to 9% and 19% nationally. There has been an decrease in the Reception year figures since 2007/08, although the Year 6 figures have increased.

Figure 9 - Obesity rates for Year 6 children

	2007/08	2011/12	Trend
Cannock Chase	21.4%	22.9%	▲
South Staffordshire	18.6%	21.0%	▲
Newcastle Borough	19.4%	20.2%	▲
Staffordshire Moorlands	18.8%	20.1%	▼
ENGLAND	**18.3%**	**19.2%**	▲
East Staffordshire	18.7%	18.8%	↔
Stafford Borough	17.4%	18.8%	▲
Tamworth	20.8%	16.9%	▼
Lichfield Borough	17.6%	16.5%	▼

Source: National Child Measurement Programme

Over a quarter of adults in Newcastle Borough are obese, this is not significantly different than the national rate[12].

[10] Taken from Health and Wellbeing Summary for Newcastle-under-Lyme, Staffordshire Public Health, 2012
[11] Local Alcohol Profile, North West Public Health Observatory, 2012
[12] Local Health Profiles, Department of Health, 2012

Smoking

Smoking is the leading cause of preventable disease and premature mortality. It is estimated to cost the NHS up to £1.5 billion a year, causing around 80,000 premature deaths in England[13].

Data on the prevalence of smoking in children is limited. National survey data[14], when applied to the population, indicates that there are around 310 children aged 11 to 15 who are regular smokers (once a week) in Staffordshire.

In 2010/11, around 22% of adults in Newcastle Borough smoke, which compares to 21% nationally[15]. In the same year, around 1750 people accessed stop smoking services in Newcastle Borough and 800 people quite at 4 weeks, a rate of 36 per 1,000 smokers[16].

Sexual health and teenage pregnancy (Data)

Research about teenage parents and their children indicates that women from poorer backgrounds and areas with higher unemployment rates are more likely to become teenage mothers.[17] Teenage mothers suffer from poorer mental health in the three years after birth, compared to other mothers so it is important that appropriate support mechanisms are available. In addition, children of teenage mothers also suffer as young adults in terms of lower educational attainment, a higher risk of economic inactivity and of becoming a teenage mother themselves.

Figure 10 - Under 18 conception rates per 1,000 15 to 17 years old females

	2007-09	2008-10	Trend
Stoke on Trent	64.6	59	▼
Cannock Chase	56.2	55.8	▼
Tamworth	48.9	53.3	▲
Newcastle-under-Lyme	47.8	44.2	▼
East Staffordshire	42.9	39.4	▼
Staffordshire	**40.5**	**39**	▼
ENGLAND	**40.2**	**38.1**	▼
Lichfield	35.4	34.8	▼
Stafford	32.6	32.4	↔
Staffordshire Moorlands	34.3	30.3	▼
South Staffordshire	28.7	26.1	▼

Source: Office for National Statistics and Department for Education

Figure 10 illustrates that the rate of teenage conceptions has been improving in recent years. In Newcastle Borough the rate is 44.2 per 1,000 15-17 year old females, which is above the county and national rates.

Across Newcastle Borough there are hotspots of particularly high rates in parts of Knutton and Silverdale, Cross Heath, Butt Lane, Silverdale and Parksite, all have higher rates than the national average.

[13] Department of Health
[14] Smoking, drinking and drug use among young people in England, 2009, NHS Information Centre
[15] Local Health Profiles, Department of Health, Crown Copyright, 2012
[16] Source: Integrated Household Survey, Office for National Statistics (experimental statistics), Lifestyle Services data extract 2010/11 (as at 15 August 2011), NHS Healthcare Commissioning Services (HCS), NHS North Staffordshire Stop Smoking Services data extract and Smoking cessation statistics 2010/11, Lifestyle Statistics. The NHS Information Centre, Copyright. The Health and Social Care Information Centre, Lifestyles Statistics. All rights reserved, taken from Health and Wellbeing Profile for Newcastle-under-Lyme, Staffordshire Public Health, 2012
[17] Long term consequences of teenage births for parents and their children, Department of Health and Teenage Pregnancy Unit, 2004

Quality of life

There are many factors that impact an individual's quality of life, many of which have been included throughout this report. In addition, there are some of the factors that are more difficult to quantify, such as the sense of community that exists where people live and to what extent they feel that they belong and have responsibility for their local area.

On the whole the residents of Newcastle Borough are satisfied with their local areas as a place to live, 90% compared to 91% for Staffordshire and Stoke on Trent[18]. Local consultation indicates that the three most important things in making somewhere a good place to live are crime levels (according to 52% of respondents), good schools (44%) and clean streets (43%). The top three things that they feel need improving are activities for young people (29%), roads and pavements (29%) and shopping facilities (18%).

Volunteering

Volunteering can provide a positive contribution to communities, by providing skills and experience for people to enable them to access employment, promoting health and social wellbeing for the individuals concerned and enabling the provision of services that may not otherwise be available without volunteers.

According to the latest Feeling the Difference survey, around 13% of respondents have given unpaid help to a group, club or organisation at least once a month in the previous 12 months and 34% have given informal help to individuals who are not relatives. This compares to the Staffordshire and Stoke-on-Trent figures of 13% and 27% respectively.

Household waste and fly-tipping

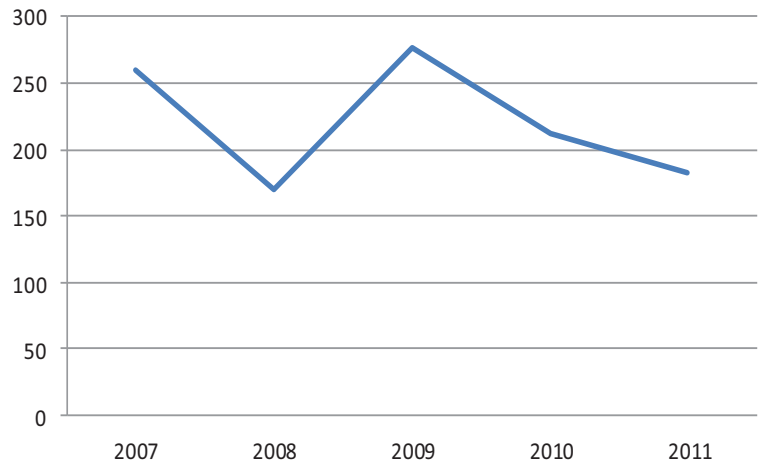
Fly-tipping is a threat to public health. The appearance of areas of fly tipping can be unsightly and have a negative impact on the wellbeing of those that live close by. Within Newcastle Borough, there were 4,305 reported cases of fly-tipping during 2011/2012, representing an increase from 3,676 in 2009/10[19].

In Newcastle Borough, 50.3% of waste was sent for reuse, recycling or composting, compared to 53.7% for Staffordshire and 43% for England. This represents an increase from 28.7% in 2009/10[19].

Housing

Housing is an important element of communities, including issues around supply, quality and affordability. The level of house building has fluctuated between 2007 and 2011, with a peak of 277 residential completions in 2009 and a low in 2008 of 170. This is a likely consequence of the recession and the fall in the housing market, but 2011 shows signs of improvement.

Figure 11: Residential housing completions, 2007-2011



Source: Staffordshire Land Availability Surveys

[18] Feeling the Difference, Wave 14, Staffordshire Police
[19] Local Authority Collected Waste Management, Department for Environment, Food and Rural Affairs, November 2011

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Newcastle Borough

Enhanced Joint Strategic Needs Assessment 2012

A Local Picture of Health and Wellbeing

Contents Page

Introduction

Newcastle Partnership provides the overarching strategic direction for the borough. The Newcastle Partnership work together to develop and implement strategies to improve outcomes and reduce inequalities in relation to a wide range of issues including health, wellbeing, crime, community safety, economy and community engagement. The partnership work together with local residents to identify local approaches and solutions to deal with agreed shared priorities.

During the last 12-months, the partnership arrangements have been considerably revised and streamlined. The Partnership processes now include a single Strategic Partnership Board for the Borough and agreement across the Partnership on two single high-level priorities: Vulnerability and Economic Growth. The Borough has also made considerable contributions to countywide collaboration on community issues, including initiating a number of cross district projects and supporting the move towards single joint commissioning arrangements for countywide domestic violence support provision, voluntary and community sector infrastructure and debt advice. In partnership we look forward to working together in future on further countywide collaboration and commissioning efforts, delivering against our shared priorities and problem factors whilst also continuing to deliver against our resident's concerns and local issues.

The Marmot Review into health inequalities in England was published on 11 February 2010. It proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. A key message from the review is that action is required across a range of cross-cutting issues and themes. The report titled "Fair Society, Healthy Lives[1]" suggests that:

"Inequalities in health arise because of inequalities in society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society."

Furthermore; the What makes us healthy? [2]report, highlights that:

"Health inequalities are driven by underlying social factors and action is required to address these causes of causes. This includes early years care, education and training, housing and place-shaping, work and employment, transport and the environment and prevention. It requires robust partnership working at a national and local level.

The new partnership structures that have been developed across the borough and that have also created links and governance arrangements with the borough's locality working structure ensures that the partnership is in the best position possible to deliver improved health outcomes for and with the residents of Newcastle-under-Lyme

[1] "Fair Society, Health Lives, a Strategic Review of Health Inequalities in England Post-2010 – Executive Summary. UCL Institute of Health Equity.
[2] What makes us healthy? The asset approach in practice: evidence, action, evaluation, Jane Foot, 2012.

What is the enhanced Joint Strategic Needs Assessment (eJSNA)?

Background

The enhanced Joint Strategic Needs Assessment (JSNA), or eJSNA is a national requirement placed on Health and Wellbeing Boards. It is expected that the eJSNA will build upon the existing JSNA document to inform the future joint Health and Wellbeing Strategy.

The approach in Staffordshire is to develop the eJSNA using more local perspectives. To achieve this all District and Borough Councils have been asked to develop their elements of an eJSNA, whilst a Staffordshire wide eJSNA working group will bring this all together to make the ejSNA as comprehensive as possible to make informed strategic decisions.

What should be included?

The JSNA will be the responsibility of the County Council and the relevant Clinical Commissioning Groups and this duty will be discharged by Health and Wellbeing Boards. The JSNA is very much open to interpretation and can cover data from many sources. However, there is an explicit requirement to involve district councils, local people, and local Healthwatch. At a local level, the task is to represent locally relevant health and wellbeing data in such a way as to ensure that it can influence local priorities. Some principles of JSNA and eJSNA are as follows:

- Strategy - They are strategic documents that are expected to take account of current and future health and social care needs of the entire population.
- Assets - They should move beyond needs to a focus on “assets”, the intention of this asset approach would be to identify synergies and opportunities for joining up services.
- Inequalities - Inequalities are a key factor and the range of factors that could be considered include: housing, worklessness or crime.
- Pooled resources - A focus on areas where things can be done together e.g. to enable greater pooling of resources
- Key issues - Prioritise the issues that require the greatest attention.

The eJSNA will inform the Health and Wellbeing Strategy, which will in turn influence and shape commissioning plans, promote joint working and encourage greater integration.

- The existing Staffordshire JSNA already provides some data at local level, this has also been enhanced by the Newcastle Health Profile, which aggregates health information at a more local level, in some cases down to ward level. The JSNA does not, yet, include a number of other potential sources of local information.

The eJSNA is, therefore, expected to reflect this wider landscape of information and will take an ‘Asset Based Approach’.

Asset Based Approach

A glass half-full: how an asset approach can improve community health and well-being[3], is a publication commissioned by the Improvement and Development Agency's (IDeA) Healthy Communities Programme. It explains that the 'Asset Approach': "values the capacity, skills, knowledge and potential in a community. It doesn't only see the problems that need fixing and the gaps that need filling. In an asset approach the glass is half-full father than half empty" – in effect it focuses on the positive and potential rather than the more familiar 'deficit approach'.

It goes on to suggest that: "A health asset is any factor or resource which enhances the ability of individuals communities and populations to maintain and sustain health and wellbeing. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses"

Assets can include:

- the resources of public, private and third sector organisations that are available to support a community
- the physical and economic resources of a place that enhance well-being.
- the networks and connections – known as 'social capital' – in a community, including friendships and neighbourliness
- the practical skills, capacity and knowledge of local residents
- the passions and interests of local residents that give them energy for change

Newcastle Borough Assets

Locality Action Partnerships are considered an asset across the borough, they provide the opportunity for the local community to engage with service providers to help identify local priorities and also to identify potential solutions to these issues. An exercise has been undertaken to map the assets across the borough. Assets have been mapped on a locality basis and borough wide assets have also been identified. The next step in this process will be to share this information with Locality Action Partnerships for the data to be enhanced. The initial scoping of assets has already identified a significant amount of resource across the borough. Details of the mapping exercise can be found in **Appendix one**.

The major physical assets across the borough include; Jubilee 2 Health and Wellbeing Centre, University Hospital North Staffordshire, Chesterton Vision, Morston House Walk-in Centre, Newcastle College, Keele University and the Community Fire Stations.

In addition there is a whole range of local services providing support and engagement opportunities for residents, many provided by public sector organisations, however, a significant number also delivered by voluntary and community sector groups.

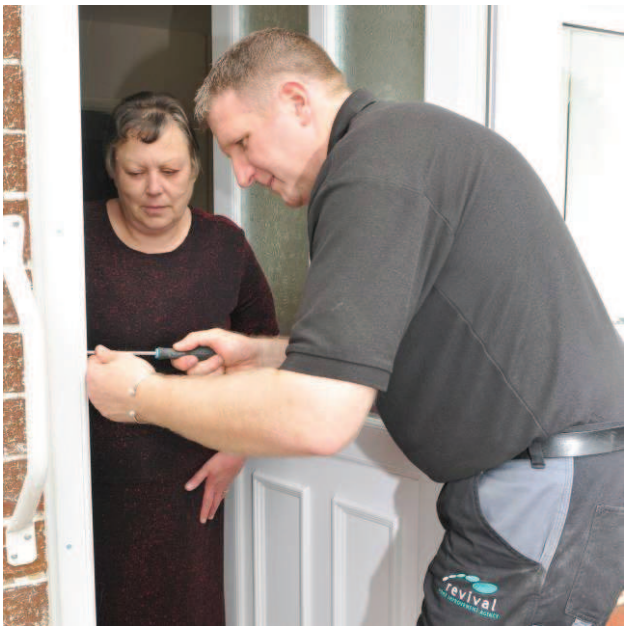
[3] A glass half-full, how and asset approach can improve community health and well-being, IDeA, Healthy Communities Programme.

Wider Determinants of Health

Social, environmental and economic factors all impact on the health of our local communities. The Dahlgren and Whitehead diagram below, highlights the number of factors and wider determinants that can have an influence on health outcomes.

The Determinants of Health (1992) Dahlgren and Whitehead [4]

"The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them; inequities in power, money and resources."[5]



The Government White Paper; Healthy Lives, Healthy People and the subsequent Health and Social Care Act 2012 adopts many of the recommendations of the Marmot Review and in recognition of the effect of the wider social determinants on health inequalities has transferred public health functions to local authorities. This transition will be challenging, however, offers the opportunity to join up planning, commissioning and services in order that the wider determinants of health can be improved and therefore reducing health inequalities and other cross cutting issues including vulnerability, crime and community safety.

[4] The Determinants of Health (1992). Dahlgren and Whitehead, Bridging the Gap, NHS, Scotland website.
[5] Marmot Review, Executive Summary, "Fair Society, Health Lives", 2010

An introduction to Newcastle-under-Lyme, Staffordshire

Newcastle-under-Lyme's name derives both from being the location of a 'new' castle, built in the 12th century and the extensive lyme forests that covered the area in the medieval period.

The borough of Newcastle-under-Lyme forms part of the conurbation of North Staffordshire, lying approximately half way between Manchester to the north and Birmingham to the south. The borough has an approximate population of 123,900[6] Newcastle's Black and Ethnic Minority (BME) population has increased since 2001 to 5%[7]. The east of the borough is dominated by urban wards, whilst the west is a predominantly rural area. There are two main towns consisting of Newcastle and Kidsgrove. The borough shares boundaries with the city of Stoke-on-Trent and has important links with the City. Newcastle-under-Lyme is a two-tier authority being one of eight of the districts that make up Staffordshire.

There are significant variations in the level of employment, health, economic wellbeing, housing and overall living standards, with the borough experiencing areas of considerable affluence, however also having three wards that have pockets of deprivation that fall into the 10 per cent most deprived in the country. Rural deprivation is also a key issue within Newcastle-under-Lyme.

Newcastle-under-Lyme has good transport links and is served by the M6 motorway to the south and west of Newcastle and by the A500 road to the north and east. The A34 road runs through Newcastle from North to South. There is a large bus station in the town centre.

The industrial base has changed significantly in the last century, with the closure of local mines and the development of the distribution and manufacturing sectors. The presence of the university at Keele, together with the development of its Science Park and Medical School demonstrate the potential and vibrancy of the area as do the developments of Newcastle College, Madeley and Millrise Extra Care Facilities, Newcastle Community Fire Station, Blue Planet and Jubilee 2 Health and Wellbeing Centre.

[6] ONS Census 2011
[7] ONS population estimates 2009

Lifestyle – Marmot Review

As previously raised, The Marmot Review, suggests health inequalities exist from the social inequalities in which people are born, grow, live, work and age. The following provides data surrounding these key themes for Newcastle-under-Lyme.

Born

Fertility rates in the Borough are lower than the national average with around 1,220 live births annually. Around 8% of babies in the Borough are born with low birthweight (below 2500 grams), this is slightly higher than England average.

Rates of perinatal mortality and infant mortality in Newcastle are higher than the England average whilst stillbirth rates are similar to national levels. Infant mortality rates in the Borough saw a significant increase between 2004-2006 and 2006-2008, although rates do appear to have reduced slightly (not significantly) in 2008-2010.

Various estimates suggest that 17% to 20% of pregnant women in Newcastle continue to smoke throughout pregnancy, higher than the England average. Also sources of information on breastfeeding suggest that there is low breastfeeding prevalence in Newcastle, both in terms of initiation at birth and at aged six to eight weeks.

Grow

The number of young people (aged under 14) has reduced since the last Census in 2001 however, projections suggest an increase in the numbers of children aged under 16 over the next 25 years (4% increase compared with 13% increase nationally).

Newcastle has 40 primary schools within its boundaries. Attainment at Key Stage 2 in the Borough is good with around 76% of children achieving Level 4 or above in English and Maths, compared to a county average of 74% (based on 2011 figures).

Of the 9 secondary schools in the Borough, 5 have specialist status covering sports, media and arts, business and language, technology and science. Results at GCSE (5 A*-C GCSEs, incl English and Maths) are better than average with around 59% of young people reaching this level of attainment compared with 56% across the rest of the county.

The Borough is also home to Newcastle under Lyme College, which is consistently in the national top 25% of further education colleges nationally for success rates in AS/A level and and advanced vocational courses and has excellent progression rates to Higher Education. The proportion of students who live in Newcastle who achieve 2 or more A level or equivalent passes in further education is in the top quartile.

In 2009, nearly one in five children in Newcastle were defined as living in poverty, lower than the national average although this varies significantly across the district from 3% in Keele to 36% in Knutton and Silverdale.

The Child Well-being Index is derived from 29 indicators that assess; material well-being, health and disability, education, crime, housing and environment from the perspective of children and young people and it also assesses the prevalence of

children in need. In Newcastle, only five of the 81 Lower Super Output Areas fall into the fifth most deprived areas in England. These areas are in the Cross Heath, Chesterton, Kidsgrove and Knutton & Silverdale wards and account for around 7% (around 1,450 children) of the under 16 population in the Borough.

Around 1 in 5 offenders suspected or accused of crime in Newcastle are male and aged between 15 and 19 years old. These offenders are most likely to be responsible for committing serious acquisitive crimes such as theft from motor vehicles and robbery of personal property.

The level of youth re-offending in Newcastle is the highest in the county, although the low number of young offenders within the cohort means that this difference is not significant. There were 26 young offenders from Newcastle Borough included within the youth re-offending cohort tracked during 2010/11, 13 of which (50%) went on to re-offend within nine months (compared with 31% across Staffordshire county).

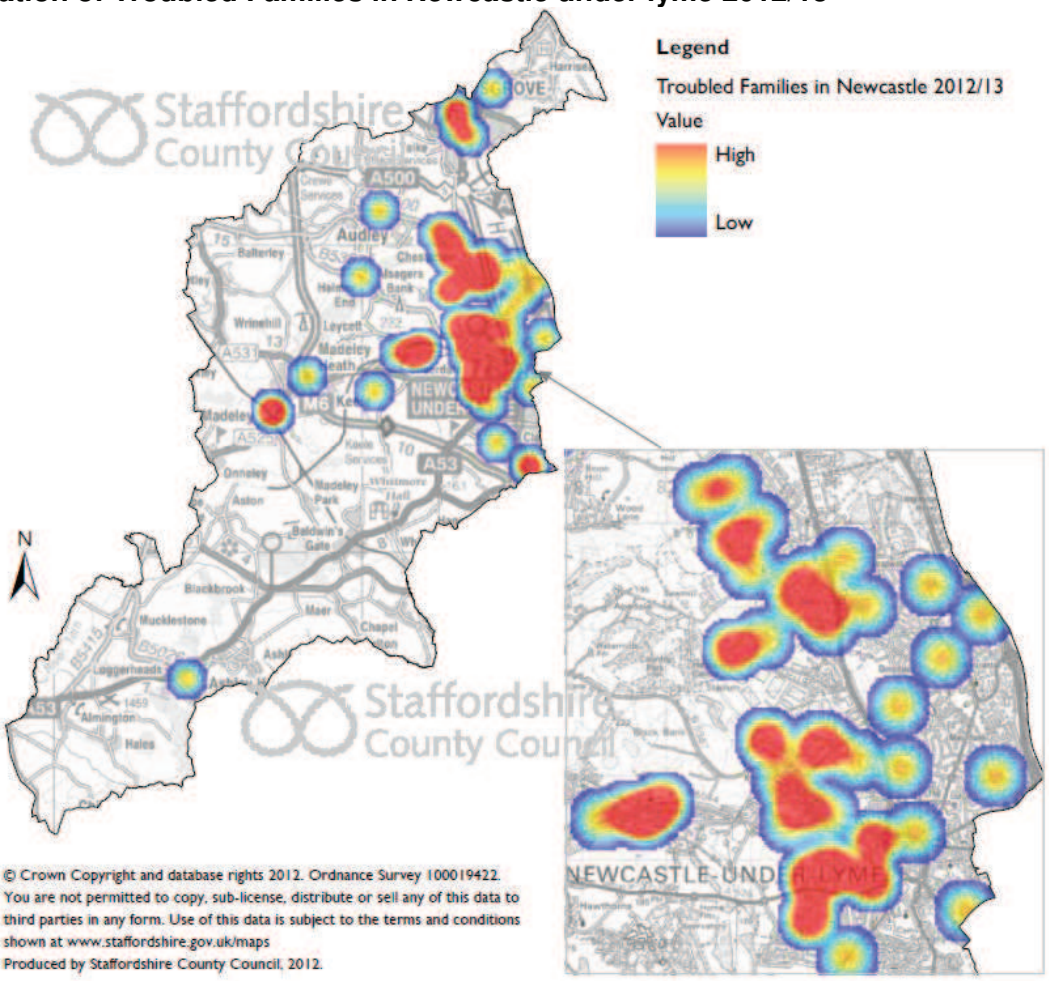
A 'Troubled Family' is defined by the Department for Communities and Local Government as a household where individuals:

- are involved in crime and anti-social behaviour,
- have children not in school,
- have an adult on out of work benefits, and
- cause high costs to the public purse.

Any family that meets all of the first three criteria should automatically be considered to be part of the troubled families project. Work has been undertaken in Staffordshire to map the actual number of troubled families with the aim of identifying, and engaging with, one third of families in 2012/13 and the remainder in 2013/14.

Across the county, 476 families have been identified that meet all three of the first criteria, or two out of three criteria plus local discretion data sets. **76** of these families (16% of the total) live in Newcastle under- Lyme Borough, equal to a rate of 1.4 families per 1,000 households. The location of these families is shown on the map over the page.

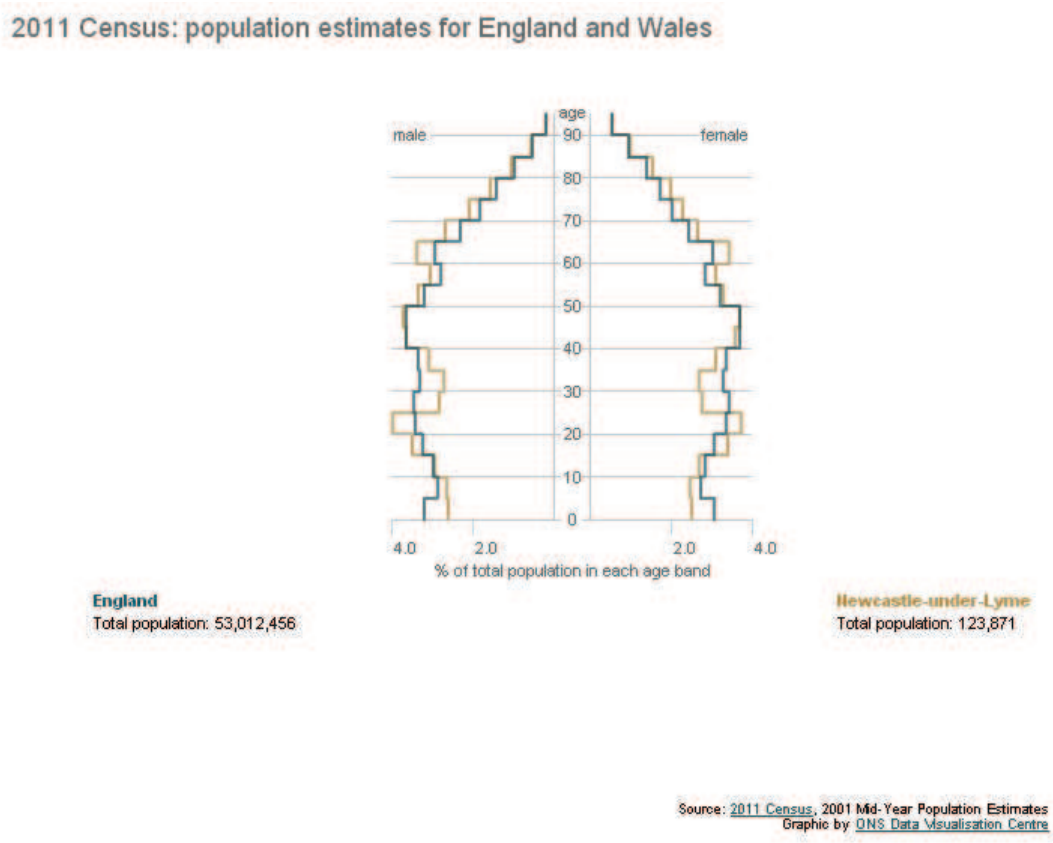
Location of Troubled Families in Newcastle under lyme 2012/13



Live

The population is generally older than England. Newcastle also has a large proportion of young adults aged 20-24 (most likely due to the student population in Keele). There are lower proportions of children under 10 and adults aged 25-39 years.

Of the 24 wards in Newcastle, 18 have high proportions of older people aged 65 and over. Chesterton, Holditch and Knutton and Silverdale wards have high proportions of children under 16 compared with England.



According to the 2011 Census there are 52,600 occupied households in Newcastle. The 2008 Private Sector House Condition Survey estimated that 44,042 homes were in private ownership, either owner-occupied or privately rented. The Survey suggested that private housing conditions in Newcastle are better than the national average with around 38.2% of these homes being categorised as 'non-decent'. 18.6% of private homes exhibited Category 1 hazards (risk of falls, excess cold, electrical and fire hazards). Homes with this type of hazard were more prevalent in the area around the town centre, in May Bank, Wolstanton and Porthill and in the north of the Borough, i.e. in and around Kidsgrove. 3.2% of private dwellings were deemed as 'unfit' at the time of the survey, these homes were more prevalent in and around the town centre area.

The Borough Council invests in the the Newcastle in Bloom campaign which is a borough wide partnership which includes residents, businesses, schools, community groups and a wide range of volunteers. The campaign aims to get more people involved to help improve their local area. More than just a floral competition, the campaign makes a contribution to promoting the local economy and increasing civic pride. It also helps improve the environment, particularly in disadvantaged areas, builds good relationships in the community and addresses important issues like sustainability and energy conservation. Newcastle has a long history of success in the national Britian in Bloom competition which reflects the investment and commitment of both the council and local residents in the local environment.

Over the last 12 months just over 18,000 (14.5%) of the Borough's residents used the council's recreational facilities, including the state of the art Jubliee 2 leisure centre that opened in early 2012. The highest proportions of users live in the Town, May Bank, Westlands, Cross Heath and Chesterton wards. Usage by residents in the Kidsgrove and Talke areas is lower than average.

In the five month period from April to August 2012 there were 143 fire incidents in Newcastle, most of which (125) were deliberate, secondary fires. Around 17% of the deliberate fires occurred in Halmerend and there were also a high proportion of incidents in Keele, Audley and Bignall End, Clayton and Wolstanton.

Work

As at September 2012, the rate of Job Seeker's Allowance claimants in Newcastle was 2.7%. This was lower than the national rate of 3.8%, however there are variations across the wards and in smaller areas of the Borough. Cross Heath had a claimant count rate of 4.9% - and in one area in this ward the rate was as high as 9.8%. The rate of JSA claimants in Loggerheads and Whitmore was 1.5%.

Young people are disproportionately suffering from unemployment across the country, and this is also true in some areas of Newcastle. In September 2012 the overall rate of youth unemployment (young people under the age of 24 claiming JSA) in the Borough was 3.8%; this is lower than the Staffordshire rate 4.7% and the rate across the country 5.8%. The following five wards have significantly higher rates of youth unemployment than is the average in the Borough:

Holditch	6.7%
Silverdale & Parksite	6.6%
Cross Heath	5.8%
Ravenscliffe	5.8%
Talke	5.7%

Job Seeker's Allowance only gives us an indication of the number of people who are available for work but who cannot find a job. Worklessness due to incapacity is also an important measure and one which also gives an insight into the health of Newcastle's residents. In February 2012 the overall rate of people claiming benefits due to their incapacity to work because of ill-health was 7.5%. As is the case with JSA, there are significant differences in the rate of claims across the Borough with rates ranging from 11.7% in Holditch, to just 0.6% in Keele. Generally between one third and a half of all claimants are receiving their benefit due to a mental health condition.

Just over 50,000 people work in the Borough of Newcastle, of which around 6,000 are self-employed - this proportion is lower than the average across the Country. A 70:30 split between full-time and part-time workers closely reflects the national pattern.

Around 30% of employment in Newcastle is in the retailing and hospitality sector, a further 25% in the local government, education and health sector. Manufacturing accounts for the lowest proportion of employment at around 9%.

The local resident workforce is slightly better qualified than the rest of the country, for example, around 32.% are qualified to degree level compared to 31.3% of the rest of Great Britain. Despite this the proportion of residents with no formal qualifications is still slightly higher than for Great Britain as a whole.

Earnings in the Borough fall behind the national average with the median annual pay for full-time workers in 2010 at £20,429, which is only 78.6% of the Great Britain figure.

Age

The population of Newcastle is generally older than England and over the next 25 years there is expected to be a growth in people aged 65 and over (54% compared with 65% nationally), with particular growth in the numbers of people aged 75 and over (73% compared to 81% nationally).

It is estimated that around 16% of older people over the age of 60 in Newcastle are living in income deprivation, this is lower than the England average. There are however, significant differences between the level of income deprivation in smaller areas in the Borough. For example in Cross Heath, 28% of older people are living in income deprivation compared to 7% in Westlands.

Residents in the Borough who are disabled, have mobility or health issues or who are becoming frail in their later years are offered assistance with their waste collection. At present around 3% of households in Newcastle, that's about 1,500 homes, receive an assisted collection.

MOSAIC

MOSAIC is a customer segmentation tool developed by Experian.

MOSAIC 'segments' the population into 69 types, each with their own set of characteristics based upon data from a wide range of sources: census, financial institutions and things like store cards, loyalty cards, and customer surveys etc. All of this data is pulled together and can, at a household level determine the likelihood of the people living there to have those characteristics. The information can also be aggregated at ward level to give an overall 'type' of resident in that ward. Obviously the higher level of the geography used, the less accurate the picture, as it is more of a generalisation.

Amongst half of the Borough's population can be categorised into one of three MOSAIC Groups:

Around 18% of residents fall into **Group K**: Residents with sufficient incomes in right-to-buy social housing. This Group is likely to contain hard working families who may not have many formal qualifications but live comfortable lifestyles and have possibly bought their homes from the local council.

16% of residents are classified as **Group J**: Owner occupiers in older-style housing in ex-industrial areas. Group J residents are likely to have below average incomes, be approaching retirement from jobs in manual roles or manufacturing.

A further 12% of residents are considered to be **Group E**: Middle income families living in moderate suburban semis. These residents are more likely to be married with children and live in comfortable, affordable homes and work in manual or white collar jobs.

Locality Matters – Our Locality Approach

As many public health functions are transferred from the NHS to local councils the What makes us healthy report considers this a "positive move, opening up opportunities for local authorities to lead local partnerships in finding local solutions which empower local people and communities by creating the conditions within which they can exercise greater control over their lives and health."

The Newcastle Partnership engages with 11 Locality Action Partnerships (LAPs) across the Borough to offer potential opportunities for residents and communities to get involved in activities, engagement and decision-making in their area. LAPs represent the Partnership's established infrastructure for the delivery of locality working and offer communities enhanced and focused access to a range of partners in order to address and deliver against local priorities.

"Working with communities as equal partners that bring strengths and asses to the table, rather that seeing them as places of need and deficiency, helps to mobilise all the resources in an area to promote and protect sustainable health and wellbeing." and "Effective local delivery requires effective participatory decision-making at a local level. This can only happen by empowering individuals and local communities." are key messages from both the What makes us healthy? report and the Marmot Review, "Fair Society, Health Lives" 2010. The locality working structure for Newcastle-under-Lyme again gives us an exciting opportunity to work as partners with our local communities to improve outcomes across the wider social determinants.

Nationally, locality working has been developed in different ways with the key aim of transferring some aspects of control currently exercised by local authorities and other public sector organisations to local communities and thereby effectively acknowledging the concept that 'one size doesn't fit all'. In Newcastle-under-Lyme, LAPs were initiated to give local people and communities more influence over how to improve their lives and a role in decision making and policy formulation, development and implementation. In addition, LAPs can assist in community engagement and empowerment and can play a major part in the achievement of improved health improvement, stronger communities and community cohesion.

Another substantial asset of the local community is the strength of partnership working across the borough and the potential for LAPs to be empowered to directly deliver and commission services. An example of a project delivered through a LAP is Warm and Safe in Audley which has worked with a local charity to target vulnerable and isolated groups to ensure they are being charged on the correct tariff by utilities companies. This project has resulted in individual annual savings ranging from £28.16 to £243.39, five households have been provided with home safety measures and two households referred for full benefit advice. Promotion of the project has recently been distributed through flu jab clinics and is generating increased referrals. Other LAPs feel that they could also deliver projects similar to this. There are a number of other projects being delivered by LAPs that are also having an impact on improved health outcomes.

There are 11 Locality Action Partnerships across 10 areas:

1 – (Two LAPs) Kidsgrove, Butt Lane, Newchapel, Ravenscliffe and Talke

2 – Audley, Bignall End and Halmer End

3 – Balterley, Betley, Wrinehill and Madeley

4 – Chapel and Hill Chorlton, Loggerheads, Maer and Whitmore

5 – Keele, Silverdale and Parksite

6 – Chesterton and Holditch

7 – Wolstanton, May Bank, Bradwell and Porthill

8 – Knutton and Cross Heath

9 – Poolfields, Town and Thistleberry

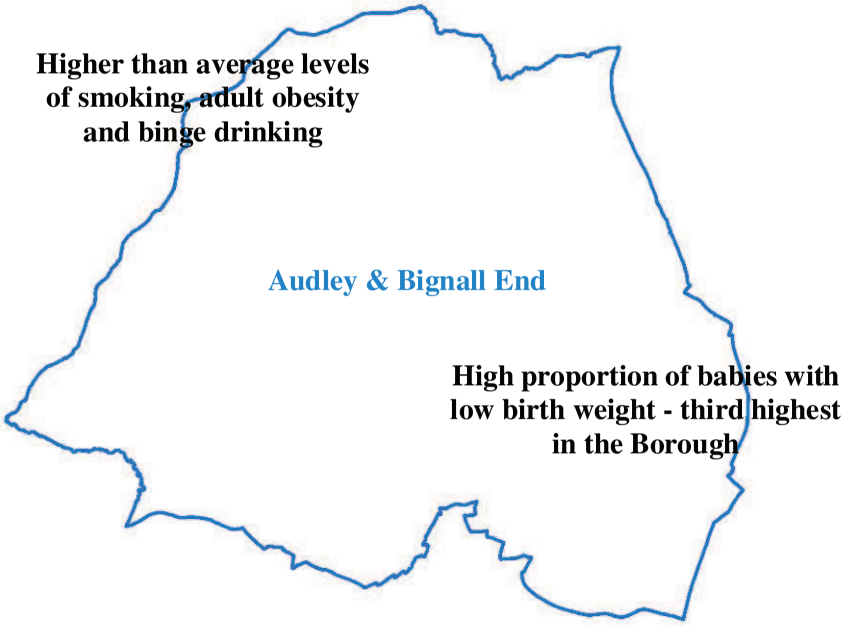
10 – Clayton, Seabridge and Westlands

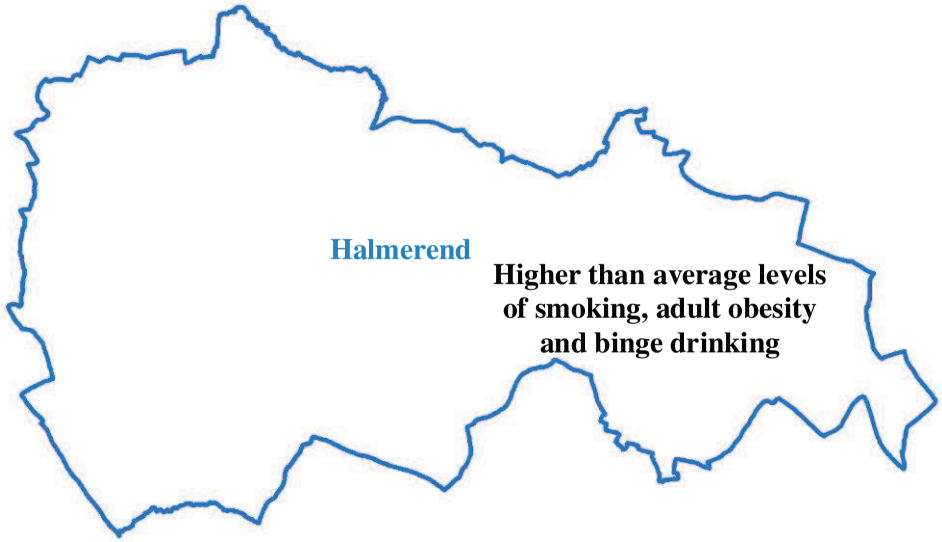
The following data sets have been collated by Locality Action Partnership area. The eJSNA has been approached in this manner as some data when collated to county or borough levels, hides pockets of deprivation; this is also true when looking at a LAP level, therefore, where possible, data has been provided at the lowest level available to help identify some of the potentially hidden issues.

In the future and as part of the development of this strategic assessment, data profiles and assessments will be provided to LAPs to help decision making and empower to get involved in local priority setting and identifying local solutions to issues identified.

LAPs will also be presented with the Asset mapping information to build on this for future reference and use.

AUDLEY LOCALITY ACTION PARTNERSHIP





NB - Only the Alsager's Bank area of the Halmerend ward falls into the Audley LAP

WIDER DETERMINANTS OF HEALTH		AUDLEY & BIGNALL END				HALMEREND	Newcastle
		Audley Road	Wood Lane	Bignall End	Audley	Alsager's Bank	
Health	Claim Incapacity Benefit[1]	6%	8%	6%	8%	7%	8%
	Have Limiting Long Term Illness[2]	19%	21%	22%	25%	24%	21%
	Smoke[3]	approx 24.0 - 32.3%					22%
	Deprivation *(decile, 1=worst)*[4]	7	7	7	4	6	-
Education	Get at least 5 GCSE's A*-C[5*]	67%				82%	59%
	Young people unemployed (aged 16-24)[6]	3.0%	3.2%	3.4%	8.4%	5.3%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	6.47%				4.23%	4.37%
	Claim Free School Meals[8]	8.3	11.6	11.4	25.4	11.7	16%
Work	Become a professional or manager[9]	27%	24%	19%	14%	19%	34%
	Are employment deprived[10]	8%	11%	10%	15%	9%	12%
	Live on benefits[11]	9%	11%	9%	17%	10%	12%
Home and family	Live in poverty as a child[12]	7%	11%	9%	25%	14%	17%
	Live in income deprived households[13]	7%	9%	6%	19%	10%	12%
	Go home to a council house[14]	10%	15%	2%	38%	12%	19%
	Are part of a lone parent family[15]	7%	7%	9%	13%	7%	9%
	Have no car or van[16]	18%	18%	18%	34%	22%	25%
Experience of crime	All crime[17]	51.4	25.8	34.7		32.7	54.3
	Anti social behaviour[18]	39.5	16.1	20.5		18.1	32.6
	Burglary[19]	1.3	3.9	1.4		1.1	2.5
And finally	Live alone as a pensioner[20]	16%	13%	16%	17%	20%	15%
	Live in poverty when they at 60+[21]	12%	13%	10%	27%	14%	16%
	Men live to the age of[22]	77.5				77.9	77.6
	Women live to the age of[23]	85.0				82.1	81.8

NB - 'x' indicates that the value for that area has been suppressed

POPULATION

The size of the population in the area has increased slightly since 2001 (an increase of around 340 residents).

The increase in population has been concentrated in residents over retirement age where there has been an increase of over 200 residents.

The overall black and minority ethnic (bme) population is generally lower than district average of 2%. The area with the highest number of bme residents is Audley Rural with around 1.22% residents. In the Bignall End area only around 0.2% of residents are from bme groups. Most non-white residents in the area are of mixed heritage.

About 75% of the area's population fall into two MOSAIC Groups:
Group K (52%); Residents with sufficient incomes in right-to-buy social housing, and
Group J (24%); Owner occupiers in older-style housing in ex-industrial areas

MATERNAL AND INFANT HEALTH

The General Fertility Rate (GFR) in both wards is lower than the national average. The proportion of babies born with a low birth weight in Audley is the third highest in the Borough at 13.7%.

MORTALITY AND ILL HEATH

Disability

Around 490 residents in the locality are in receipt of Disability Living Allowance, this is about 6% of the population, which is pretty much in line with the Borough average.

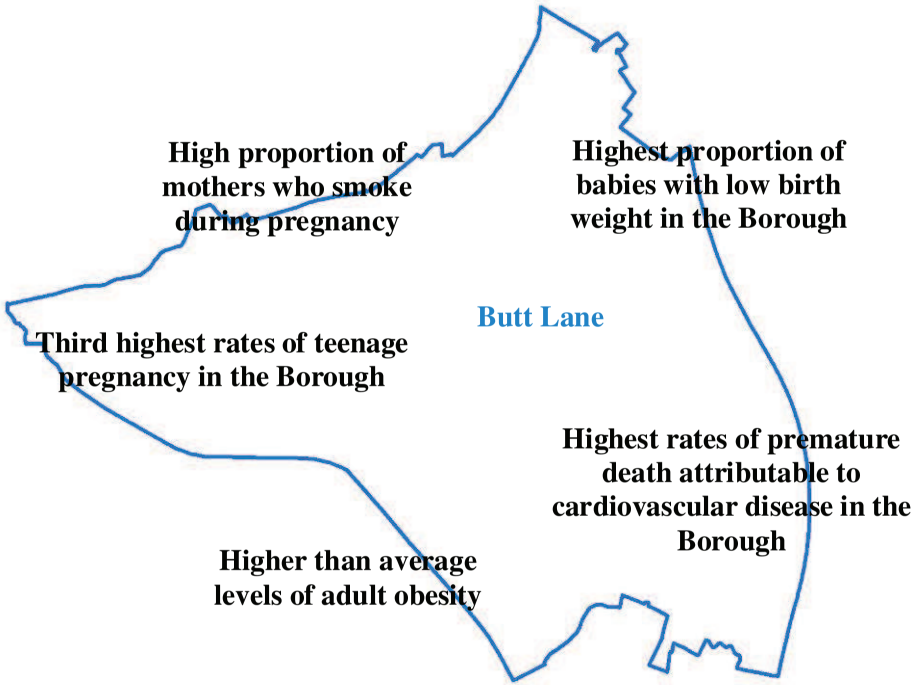
LIVING WELL

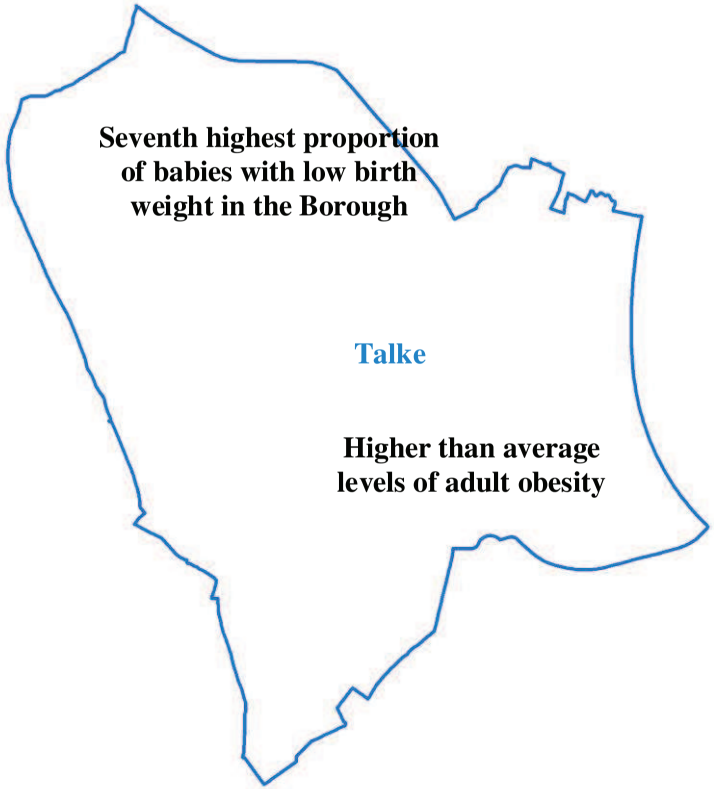
It is estimated that a slightly higher than average proportion of the adult population in the two wards smoke, are prone to binge drinking and are obese.

COMMUNITY VOICE – LAP Action Plan issues

- Provision for the elderly – Warm and Safe in Audley, Fuel Poverty, Financial Inclusion
- Youth Provision
- Environmental – Clean in Audley
- Community Engagement with LAP

Butt Lane
Locality Action Partnership





WIDER DETERMINANTS

		BUTT LANE				TALKE			Newcastle
		Clough Hall	Butt Lane	Butt Lane 2	Clough Hall Estate	Talke	Talke Roundabout	Talke Pits	
Health	Claim Incapacity Benefit[1]	8%	9%	9%	15%	9%	10%	12%	8%
	Have Limiting Long Term Illness[2]	22%	23%	21%	30%	19%	25%	24%	21%
	Smoke[3]	approx 18.5%-24%							22%
	Deprivation *(decile, 1=worst)*[4]	4	4	5	2	6	5	3	-
Education	Get at least 5 GCSE's A*-C[5]	51%				54%			59%
	Young people unemployed (aged 16-24)[6]	6.8%	9.2%	3.8%	18.3%	4.5%	3.8%	13.0%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	4.80%				5.26%			4.37%
Work	Claim Free School Meals[8]	11%	31%	24%	35%	22%	7%	22%	16%
	Become a professional or manager[9]	19%	11%	15%	12%	19%	17%	10%	34%
	Are employment deprived[10]	14%	14%	11%	21%	11%	12%	17%	12%
	Live on benefits[11]	14%	19%	14%	25%	12%	13%	20%	12%
Home and family	Live in poverty as a child[12]	16%	31%	18%	33%	9%	20%	29%	17%
	Live in income deprived households[13]	12%	21%	12%	28%	7%	9%	21%	12%
	Go home to a council house[14]	24%	35%	8%	55%	8%	7%	46%	19%
	Are part of a lone parent family[15]	6%	17%	10%	17%	6%	6%	12%	9%
	Have no car or van[16]	20%	34%	27%	40%	13%	17%	32%	25%
Experience of crime	All crime[17]	54.2		53.8		29.4	67.6		54.3
	Anti social behaviour[18]	61.4		40.7		19.1	33.0		32.6
	Burglary[19]	1.1		3.1		2.4	1.9		2.5
And finally	Live alone as a pensioner[20]	18%	17%	14%	18%	10%	15%	17%	15%
	Live in poverty when they at 60+[21]	15%	21%	16%	41%	11%	7%	25%	16%
	Men live to the age of[22]	76.4				7.69			77.6

	Women live to the age of[23]	81.6	82.7	81.8

POPULATION

The size of the population in the area has remained fairly static since 2001 (a decrease of around 200 residents).

There are around 200 fewer young people under the age of 16 in the area than in 2001. The number of residents over retirement age has increased by a similar number.

The area's residents are predominantly white British (or from other white backgrounds), and there are resident's of mixed heritage living in almost all areas in the locality. There is a small population of black and asian residents in the Talke area.

Almost 80% of the area's population fall into three MOSAIC Groups:
Group K (44%); Residents with sufficient incomes in right-to-buy social housing
Group J (21%); Owner occupiers in older-style housing in ex-industrial areas,and
Group B (14%); Residents of small and mid-sized towns with strong local roots

MATERNAL AND INFANT HEALTH

The percentage of mothers in Butt Lane who are still smoking when they deliver their baby is the fourth highest rate in the Borough but this rate is statistically similar to the regional average.

The proportion of babies born with a low birth weight in Butt Lane is the highest in the Borough at 14.2%. The rate in Talke is the seventh highest (9.7%)

MORTALITY AND ILL HEATH

Disability

Around 740 residents in the locality are in receipt of Disability Living Allowance, this is about 8% of the population, and the two wards have the fourth highest (Talke) and sixth highest (Butt Lane) claim rates in Newcastle.

Premature Mortality Rates (Cardiovascular Disease)

Premature deaths are those that occur before the age of 75. In Newcastle the premature mortality rate has fallen steadily since the mid-90's but still remains higher than the national average. The all cause premature mortality rate for both wards is similar to the national and district rates.

Between 1995-1997 and 2008-2010, premature motality rates attributable to cardiovascular disease have reduced by 58% across Newcastle as a whole.

Premature deaths attributable to cardiovascular disease are higher in Butt Lane than in any other ward in the Borough.

LIVING WELL

Obesity

It is estimated that a higher proportion than average of the adult population in the two wards are obese.

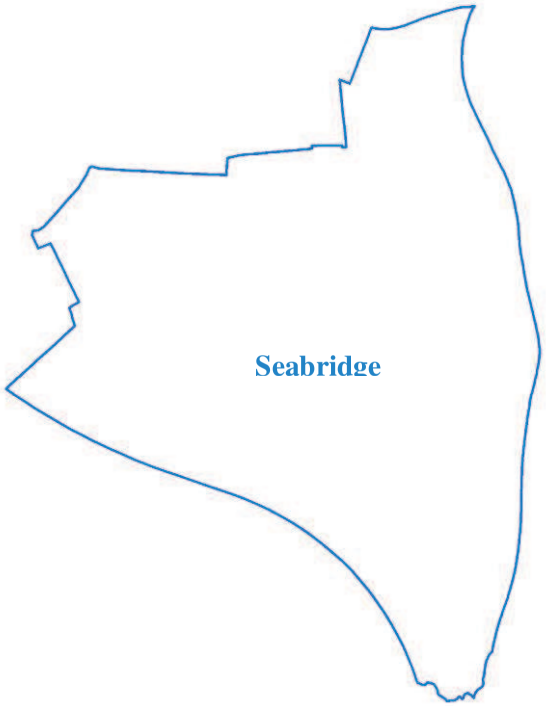
Teenage Pregnancy

During the period 2007-2009, the rate of under-18 conceptions in Butt Lane were the third highest in the Borough.

COMMUNITY VOICE – LAP Action Plan issues

- Teenage Pregnancy
- Alcohol Harm Reduction
- Provision for Elderly – Local campaigns to support elderly and awareness of services – Bogus Officials project
- Environmental – Derelict sites and Allotments project.

Amongst some of the more disadvantaged areas in the country in terms of access to services



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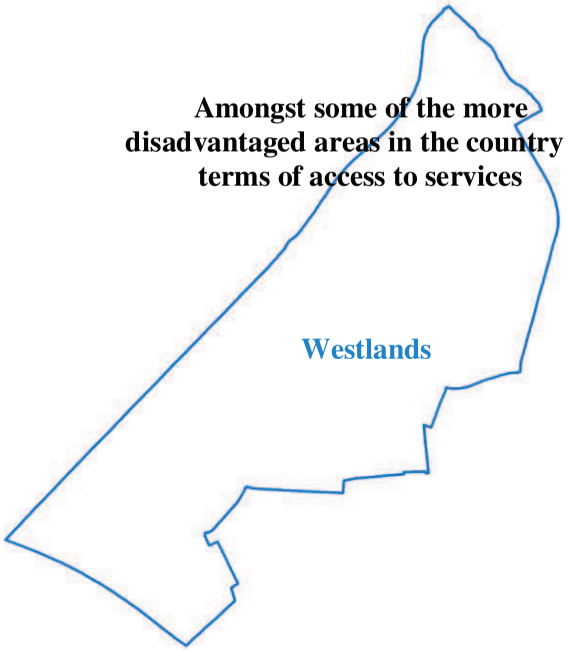


WIDER DETERMINANTS OF HEALTH		CLAYTON			SEABRIDGE				
		Clatyon	Lyme Valley	Northwood	Westbury Park North	Seabridge Lane	Gatehouse	Westbury Park South	Newcastle
Health	Claim Incapacity Benefit[1]	10%	5%	4%	3%	6%	13%	2%	8%
	Have Limiting Long Term Illness[2]	29%	22%	19%	13%	20%	27%	9%	21%
	Smoke[3]	c 18.5 - 22.9%	c 11.8 - 18.4%	c 18.5 - 22.9%		C 11.8 - 18.4%	c 18.5 - 22.9%	c 11.8 - 18.4%	22%
	Deprivation *(decile, 1=worst)*[4]	4	6	8	10	7	3	10	-
Education	Get at least 5 GCSE's A*-C (incl English and Maths[5]	44%			73%				59%
	Young people unemployed (aged 16-24)[6]	7.7%	5.2%	2.7%	-	8.1%	11.8%	4.9%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	2.05%			3.72%				4.37%
	Claim Free School Meals[8*]	25%	15%	9%	x	10%	24%	x	16%
Work	Become a professional or manager[9]	15%	25%	24%	37%	28%	13%	32%	34%
	Are employment deprived[10]	15%	8%	6%	5%	9%	18%	4%	12%
	Live on benefits[11]	17%	9%	5%	5%	8%	24%	4%	14%
Home and family	Live in poverty as a child[12]	23%	20%	10%	3%	7%	28%	3%	17%
	Live in income deprived households[13]	17%	11%	7%	3%	7%	21%	3%	12%

[*] NB - 'x' indicates that the value for that area has been suppressed

WIDER DETERMINANTS OF HEALTH		CLAYTON			SEABRIDGE				Newcastle
		Clatyon	Lyme Valley	Northwood	Westbury Park North	Seabridge Lane	Gatehouse	Westbury Park South	
	Go home to a council house[14]	36%	9%	11%	2%	13%	46%	1%	19%
	Are part of a lone parent family[15]	8%	7%	6%	6%	5%	9%	6%	9%
	Have no car or van[16]	35%	16%	16%	6%	16%	39%	6%	25%
Experience of crime	All crime[17]	29.6		15.1	33.0			19.1	54.3
	Anti social behaviour[18]	15.7		9.8	21.0			3.1	32.6
	Burglary[19]	0.7		-	1.2			3.1	2.5
And finally	Live alone as a pensioner[20]	23%	19%	16%	7%	15%	20%	4%	15%
	Live in poverty when they are 60+[21]	22%	12%	12%	7%	10%	22%	8%	16%
	Men live to the age of[22]	75.7			76.7				77.6
	Women live to the age of[23]	84.4			84.7				81.8

POPULATION

The size of the population in the area has remained fairly static since 2001 (a decrease of around 70 residents). There have been increases in the population aged 16-24 and amongst residents of retirement age, 405 and 321 residents respectively.

The overall black and minority ethnic (bme) population was is generally slightly higher than district average of 2%. The area with the highest number of bme residents is the Sutherland Drive area with around 8.2% belonging to non-white ethnic groups. In the Northwood area only around 0.9% of residents are from bme groups.

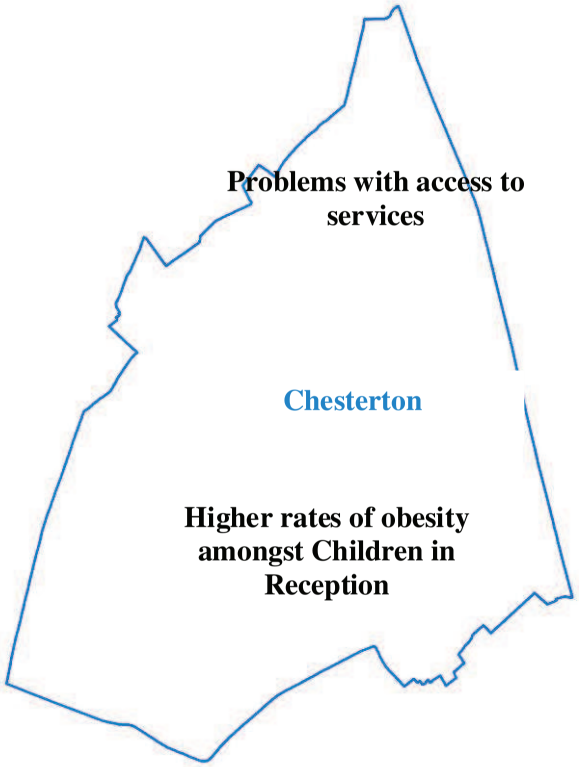
Around two thirds quarters of the area's population fall into three MOSAIC Groups:
Group D (24%) - Successful professionals living in suburban or semi-rural homes
Group E (15%) - middle income families living in moderate suburban semis
Group K (15%) - residents with sufficient incomes in right-to-buy social housing
Group B (13%) - Residents of small and mid-sized towns with strong local roots

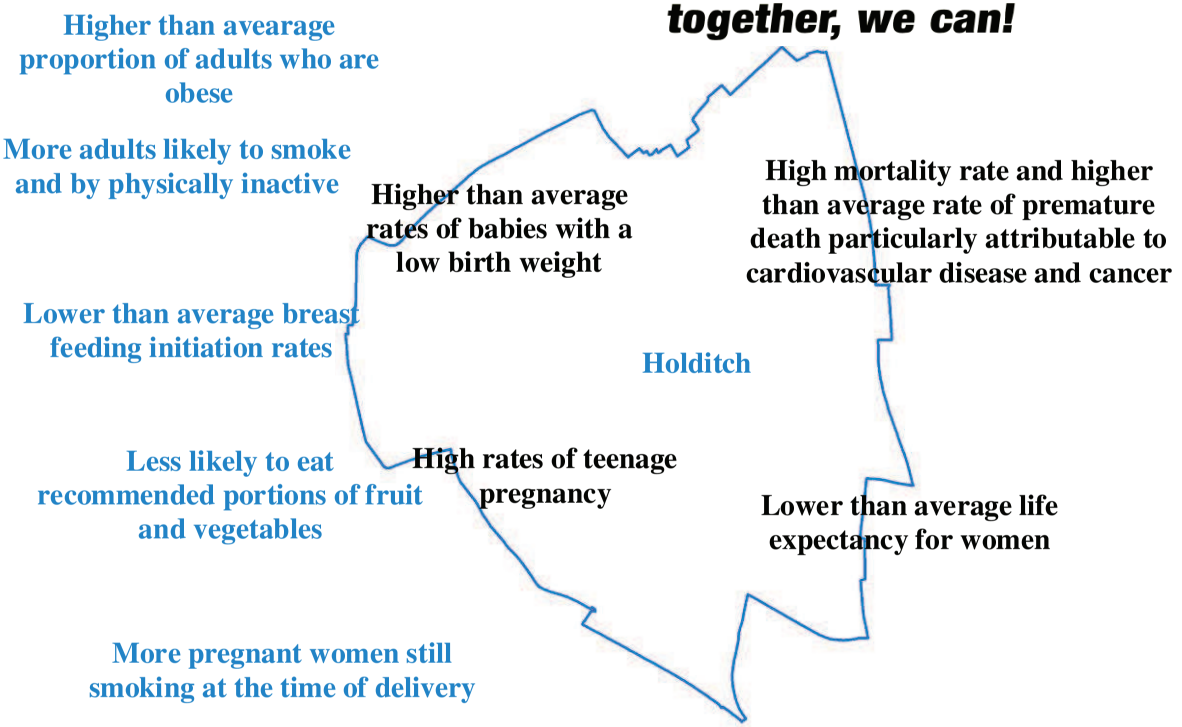
Residents in parts of the Westlands and Clayton wards are defined as living in the most disadvantaged quintile nationally for geographical access to services.

COMMUNITY VOICE – LAP Action Plan issues

- Highways – Parking and speeding
- Community Pride – Clean up events
- Youth Provision
- Anti-Social Behaviour

Greater Chesterton Locality Action PARTNERSHIP
together, we can!





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Newcastle Under Lyme Borough Council – 100019654 - 2012.

WIDER DETERMINANTS OF HEALTH		CHESTERTON					HOLDITCH			Newcastle
		Dean's Lane	Mitchell's Wood	Waterhayes	Crackley	Audley Road	Beasley	Loomer Road	Hollows Farm	
Health	Claim Incapacity Benefit[1]	5%	6%	2%	15%	16%	11%	15%	10%	8%
	Have Limiting Long Term Illness[2]	14%	18%	8%	26%	25%	25%	29%	23%	21%
	Smoke[3]	c 11.8 - 18.4%			c 32.4 - 37.2%		c 24.0 - 32.3%	c 32.4 - 37.2%		22%
	Deprivation *(decile, 1=worst)*[4]	8	6	9	2	1	2	2	4	-
Education	Get at least 5 GCSE's A*-C (incl English and Maths[5]		68%				63%			59%
	Young people unemployed (aged 16-24)[6]	4.8%	5.7%	5.6%	7.9%	13.2%	9.3%	7.5%	5.5%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]		4.76%				13.33%			4.37%
	Claim Free School Meals[8*]	4%	9%	6%	27%	42%	24%	31%	19%	16%
Work	Become a professional or manager[9]	26%	14%	27%	9%	11%	11%	10%	10%	34%
	Are employment deprived[10]	6%	9%	5%	19%	24%	17%	19%	13%	12%
	Live on benefits[11]	6%	10%	5%	23%	29%	19%	24%	16%	14%
Home and family	Live in poverty as a child[12]	5%	15%	9%	41%	50%	37%	29%	21%	17%
	~~Live in income~~	~~6%~~	~~9%~~	~~5%~~	~~27%~~	~~31%~~	~~26%~~	~~23%~~	~~14%~~	~~12%~~

[*] NB - 'x' indicates that the value for that area has been suppressed

WIDER DETERMINANTS OF HEALTH		CHESTERTON					HOLDITCH			Newcastle
		Dean's Lane	Mitchell's Wood	Waterhayes	Crackley	Audley Road	Beasley	Loomer Road	Hollows Farm	
	deprived households[13]									
	Go home to a council house[14]	9%	13%	2%	19%	45%	41%	47%	19%	19%
	Are part of a lone parent family[15]	6%	10%	8%	18%	15%	12%	15%	12%	9%
	Have no car or van[16]	10%	18%	2%	46%	48%	38%	42%	20%	25%
Experience of crime	All crime[17]	30.6			67.1		55.9		90.8	54.3
	Anti social behaviour[18]	22.1			63.8		55.0		68.1	32.6
	Burglary[19]	0.7			2.9		1.6		0.7	2.5
And finally	Live alone as a pensioner[20]	8%	7%	1%	11%	16%	17%	15%	9%	15%
	Live in poverty when they are 60+[21]	22%	12%	11%	28%	34%	26%	26%	18%	16%
	Men live to the age of[22]	77.4					75.7			77.6
	Women live to the age of[23]	81.2					79.6			81.8

POPULATION

The size of the population in the area has increased slightly since 2001 (an increase of around 470 residents).

The largest population increases have been evident amongst residents of middle age (between 50 and retirement age) and to a lesser degree amongst residents aged between 16 and 24. There has also been a small increase in the number of residents of retirement age.

The overall black and minority ethnic (bme) population in the locality was generally slightly lower than district average of 2%. The area with the highest proportion of bme residents is the Waterhayes area with around 3.5% belonging to non-white ethnic groups.

Almost three quarters of the area's population fall into three MOSAIC Groups:
Group K (22%) - residents with sufficient incomes in right-to-buy social housing
Group O (22%), families in low-rise social housing with high levels of benefit need
Group F (16%) - couples with young children in comfortable modern housing, and
Group I (11%) - lower income workers in urban terraces in often diverse areas

MATERNAL AND INFANT HEALTH

The proportion of pregnant women who are smoking at the time they deliver their baby is higher in both wards than is the regional average.

Babies weighing less than 2,500 grams at birth are considered to have a low birthweight. Low birthweight is one of the leading causes of infant illness, disability and death and is a good indicator of poor health experience in both early and later life. The rate of babies born with a low birth weight in Holditch is the second highest in the Borough and is also higher than the national average

The percentage of mothers who initiate breast feeding in Holditch is the third lowest rate in the Borough and in Chesterton the rate is the fifth lowest. These rates are both lower than the England average.

According to data collected in 2009, Chesterton and Holditch wards both have higher levels of childhood poverty compared to other areas in the country.

MORTALITY AND ILL HEATH

All Age, All Cause Mortality Rates

The mortality rate in Holdtich is higher than the England average and is the 5th highest rate in the Borough. Life expectancy for women in this ward is lower than average.

Premature Mortality Rates

Premature deaths are those that occur before the age of 75. In Newcastle the premature mortality rate has fallen steadily since the mid-90's but still remains higher than the national average. The all-cause premature mortality rate in Holditch is higher than the national and district rates and is the second highest in the Borough.

Between 1995-1997 and 2008-2010, premature motality rates attributable to cardiovascular disease have reduced by 58% across Newcastle as a whole. Holditch has the 2nd highest rates of premature death attributable to cardiovascular disease and also cancer.

LIVING WELL

Healthy Lifestyles

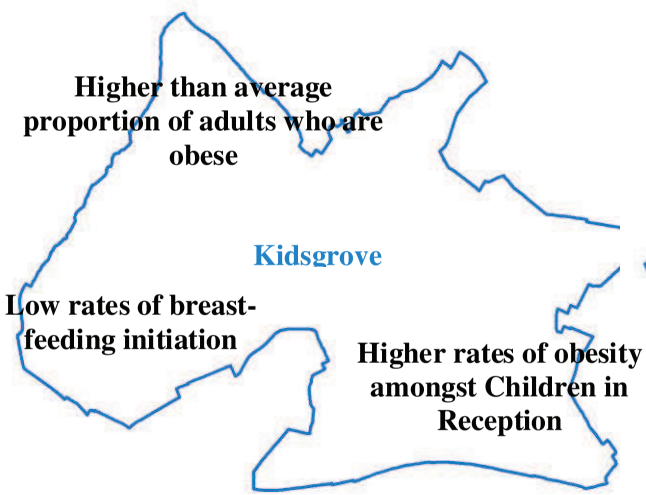
Estimates suggest that fewer adults in the two wards eat the recommended 5 portions of fruit and vegetables each day than is the average. It is also more likely that adults in Chesterton and Holditch are smokers and do not take part in regular exercise. Levels of obesity amongst adults in these areas is also likely to be higher than average. The proportion of children in Reception class in the Chesterton ward who are overweight is also higher than average.

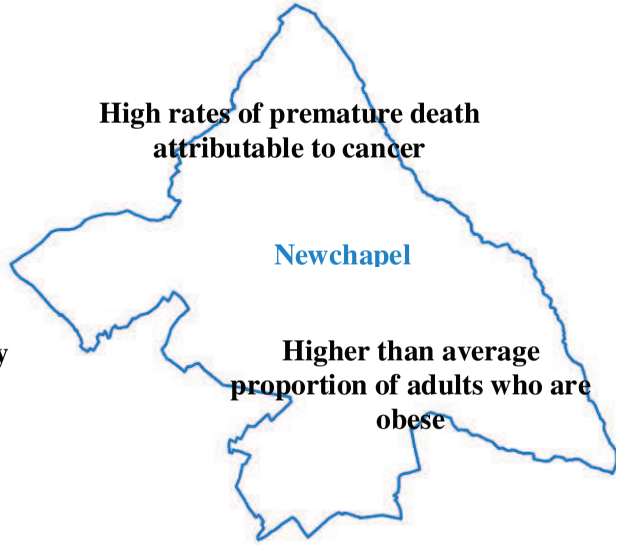
Teenage Pregnancy

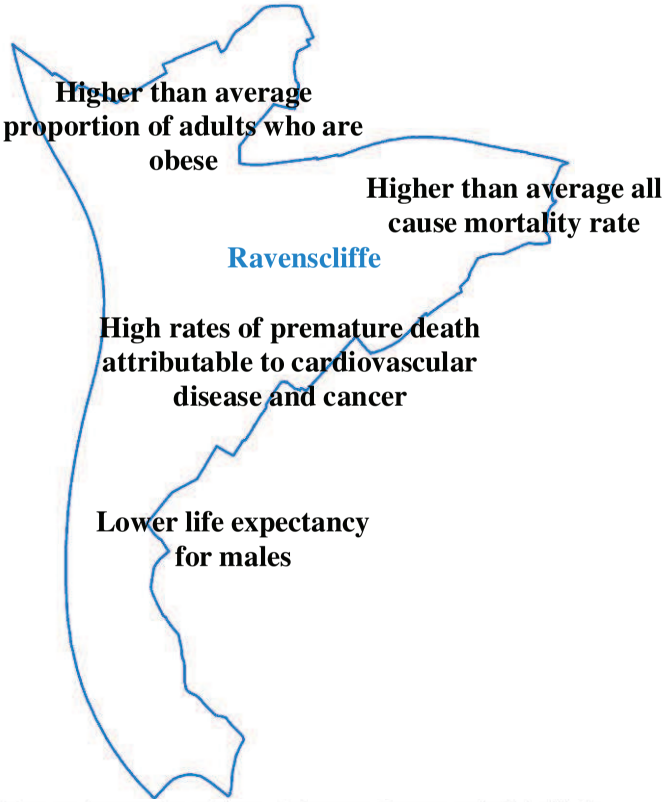
The under-18 conception rate in Newcastle is higher than the national average and in Holditch this rate is even higher. The rate in this ward is the fifth highest rate in the Borough and is almost double the national average rate.

COMMUNITY VOICE – LAP Action Plan issues

- Community engagement – Roadshows
- Community Pride – clean up events, include financial inclusion.
- Holiday youth provision
- Domestic Abuse project
- Anti-social Behaviour
- Employment and academic achievement
- Green spaces
- Health provision locally







WIDER DETERMINANTS OF HEALTH		KIDSGROVE					NEWCHAPEL		RAVENSCLIFFE			Newcastle
		Maryhill	Dove Bank	Trubshaw	Galley's Bank	Whitehill	Rookery	Mow Cop	Acres Nook	Kidsgrove Bank	Town	
Health	Claim Incapacity Benefit[1]	9%	10%	4%	8%	4%	5%	5%	6%	5%	10%	8%
	Have Limiting Long Term Illness[2]	23%	24%	13%	18%	10%	18%	19%	17%	19%	19%	21%
	Smoke[3]	c 32.4 - 37.2%		c 18.5 - 22.9%	c 32.4 - 37.2%	c 18.5 - 22.9%	c 18.5 - 22.9%		c 18.5 - 22.9%			22%
	Deprivation *(decile, 1=worst)*[4]	2	3	8	7	9	6	6	9	8	4	-
Education	Get at least 5 GCSE's A*-C (incl English and Maths[5]	41%					55%		62%			59%
	Young people unemployed (aged 16-24)[6]	8.5	7.8%	3.3%	3.6%	-	3.0%	3.0%	4.5%	3.7%	4.5%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	7.11%					4.67%		5.50%			4.37%
	Claim Free School Meals[8*]	30%	15%	x	13%	5%	10%	11%	9%	10%	22%	16%
Work	Become a professional or manager[9]	13%	8%	26%	15%	24%	18%	21%	23%	18%	15%	34%
	Are employment deprived[10]	17%	17%	7%	10%	6%	10%	8%	6%	8%	13%	12%
	Live on benefits[11]	19%	17%	7%	11%	6%	9%	8%	7%	8%	15%	14%
Home and family	Live in poverty as a child[12]	43%	24%	2%	8%	6%	11%	10%	4%	6%	14%	17%
	Live in income deprived households[13]	25%	19%	4%	7%	5%	9%	8%	3%	4%	13%	12%

[*] NB - 'x' indicates that the value for that area has been suppressed

WIDER DETERMINANTS OF HEALTH		KIDSGROVE					NEWCHAPEL		RAVENSCLIFFE			Newcastle
		Maryhill	Dove Bank	Trubshaw	Galley's Bank	Whitehill	Rookery	Mow Cop	Acres Nook	Kidsgrove Bank	Town	
Experience of crime	Go home to a council house[14]	8%	38%	6%	12%	3%	4%	8%	2%	1%	25%	19%
	Are part of a lone parent family[15]	12%	18%	6%	6%	7%	7%	6%	5%	5%	8%	9%
	Have no car or van[16]	32%	30%	10%	18%	4%	14%	15%	7%	15%	30%	25%
	All crime[17]	57.5		15.1			24.6		12.9	37.5		54.3
	Anti social behaviour[18]	31.4		16.1			7.8		7.9	30.5		32.6
	Burglary[19]	1.4		1.2			1.2		0.7	0.4		2.5
And finally	Live alone as a pensioner[20]	10%	12%	6%	14%	3%	12%	15%	7%	12%	17%	15%
	Live in poverty when they are 60+[21]	17%	21%	7%	13%	11%	14%	13%	6%	5%	25%	16%
	Men live to the age of[22]	80.0					79.1		75.9			77.6
	Women live to the age of[23]	85.1					80.8		82.6			81.8

POPULATION

The size of the population in the area has decreased slightly since 2001 (a decrease of around 200 residents).

There are around 360 fewer young people under the age of 16 in the area than in 2001. The number of residents over retirement age has increased significantly - by around 820 residents.

The area's residents are predominantly white British (or from other white backgrounds), and there are resident's of mixed heritage living in all areas in the locality.

Around 80% of the area's population fall into four MOSAIC Groups:
Group J (31%); Owner occupiers in older-style housing in ex-industrial areas
Group K (18%); Residents with sufficient incomes in right-to-buy social housing
Group B (17%); Residents of small and mid-sized towns with strong local roots, and
Group E (15%); Middle income families living in moderate suburban semis

MATERNAL AND INFANT HEALTH

The fertility rates in Kidsgrove and Newchapel are lower than the national average.

The percentage of mothers who initiate breast feeding in Kidsgrove is the fourth lowest rate in the Borough, but the rate is similar to the England average.

MORTALITY AND ILL HEATH

All Age, All Cause Mortality Rates

The mortality rate in Ravenscliffe is higher than the England average and is the 6th highest rate in the Borough. Life expectancy for men in this ward is lower than average.

Premature Mortality Rates

Premature deaths are those that occur before the age of 75. In Newcastle the premature mortality rate has fallen steadily since the mid-90's but still remains higher than the national average. The all-cause premature mortality rate for each of the three wards is similar to the national and district rates.

Between 1995-1997 and 2008-2010, premature mortality rates attributable to cardiovascular disease have reduced by 58% across Newcastle as a whole. Ravenscliffe has the 5th highest rate attributable to cardiovascular disease. The ward also has the 7th highest premature mortality rate attributable to cancer and Newchapel has the 8th highest rate.

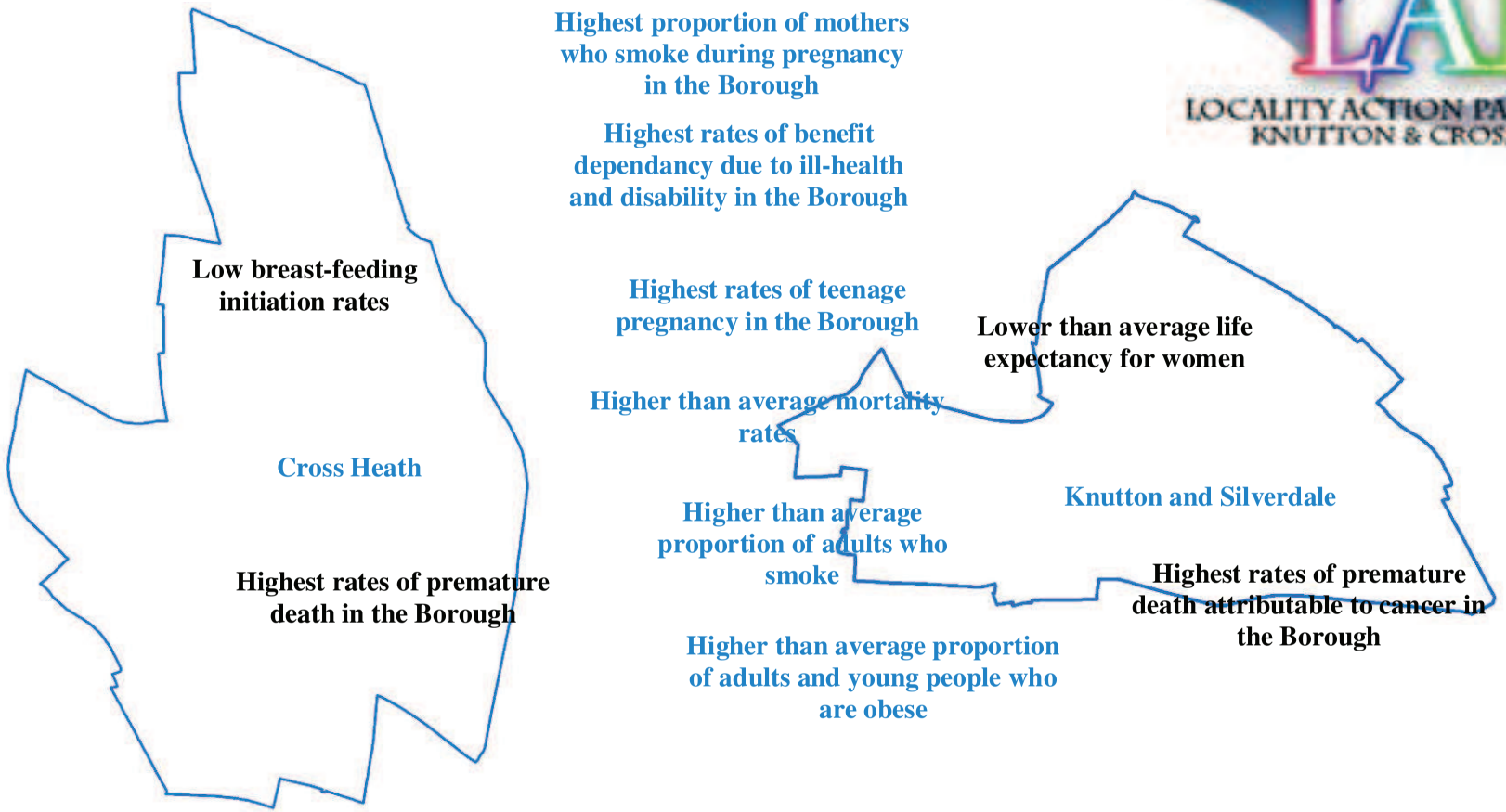
LIVING WELL

Obesity

It is estimated that a higher proportion than average of the adult population in the three wards are obese. The proportion of children in Reception class in the Kidsgrove ward who are overweight is also higher than average.

COMMUNITY VOICE – LAP Action Plan issues

- CCTV in hotpsot locations
- Alcohol Harm Reduction
- Town Centre Development including Business Crime
- Teenage Pregnancy project with Butt Lane



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Newcastle Under Lyme Borough Council – 100019654 - 2012.

WIDER DETERMINANTS OF HEALTH		CROSS HEATH				KNUTTON & SILVERDALE			Newcastle
		Upper Milehouse	Cross Heath	Lower Milehouse	Ashfields	Saints	Silverdale	Knutton Village	
Health	Claim Incapacity Benefit	8%	12%	22%	7%	14%	9%	12%	8%
	Have Limiting Long Term Illness	27%	24%	30%	22%	23%	26%	24%	21%
	Smoke	approx 35%							22%
	Deprivation *(decile, 1=worst)*	4	2	1	4	1	3	3	-
Education	Get at least 5 GCSE's A*-C	33%				37%			59%
	Young people unemployed (aged 16-24)	6.9%	9.9%	17.1%	7.5%	11.8%	7.7%	5.6%	2.7%
	Not in Employment, Education or Training (aged 16-19)	10.55%				9.70%			4.37%
	Claim Free School Meals	19%	29%	44%	22%	36%	13%	30%	16%
Work	Become a professional or manager	21%	21%	17%	28%	15%	25%	18%	34%
	Are employment deprived	13%	20%	27%	13%	22%	13%	16%	12%
	Live on benefits	15%	22%	40%	14%	29%	15%	19%	12%
Home and family	Live in poverty as a child	16%	32%	40%	25%	53%	13%	27%	17%
	Live in income deprived households	13%	24%	33%	17%	36%	14%	19%	12%
	Go home to a council house	23%	44%	63%	29%	73%	22%	23%	19%
	Are part of a lone parent family	12%	14%	14%	13%	21%	8%	9%	9%
	Have no car or van	27%	37%	56%	38%	52%	29%	34%	25%
Experience of crime	All crime	44.4		104.3		72.9	89.7		54.3
	Anti social behaviour	31.8		51.3		20.7	81.9		32.6
	Burglary	1.7		4.5		6.1	4.7		2.5
And finally	Live alone as a pensioner	16%	17%	21%	16%	11%	17	17%	15%
	Live in poverty when they at 60+	21%	26%	37%	28%	30%	26%	21%	16%
	Men live to the age of	74.9				78.2			77.6
	Women live to the age of	75.0				79.1			81.8

POPULATION

The size of the population in the area has remained fairly static since 2001 (a decrease of around 100 residents) despite a considerable amount of housing clearance in the Lower Milehouse area.

There are around 200 fewer young people under the age of 16 in the area than in 2001. There has been a slight increase in the older population (over 50).

Whilst the area's residents are predominantly white British (or from other white backgrounds), the other broad ethnic groups are all represented to varying degrees, with a particular concentration of residents of Asian heritage in the Lower Milehouse area.

70% of the area's population falls into three MOSAIC Groups:
K (30%) - Residents with sufficient incomes in right-to-buy social housing
O (20%) - Families in low-rise social housing with high levels of benefit need
J (19%) - Owner occupiers in older-style housing in ex-industrial areas

MATERNAL AND INFANT HEALTH

Fertility rates in Knutton and Silverdale are the highest in the Borough and are higher than the national average. Cross Heath rates are higher than in most other wards but are in line with the national picture.

Fewer mothers in the two areas access maternity services in the first 13 weeks of pregnancy than in the rest of the Borough.

The percentage of mothers in the two wards who are still smoking when they deliver their baby is the highest in the Borough and is higher than the regional average.

Breast feeding initiation rates in Cross Heath are the second lowest in the Borough and are lower than the regional average.

MORTALITY AND ILL HEATH

General Health

Health in the locality is worse than the average for the district with around 25% of residents reporting that they had a Limiting Long Term Illness (LLTI) at the time of the 2001 Census. In the Lower Milehouse area, the proportion is almost one third, this was the third highest proportion of any area across the Borough.

Ill Health

Knutton and Silverdale and Cross Heath have the highest percentages of working age residents who are in receipt of either Incapacity Benefit/Severe Disablement Allowance or Employment Support Allowance in the Borough. In Lower Milehouse, one fifth of working age residents are in receipt of one of these benefits.

In both wards, around half of claimants are receiving benefit support for a mental health condition.

Disability

Around 900 residents in the locality are in receipt of Disability Living Allowance, this is about 9% of the population, and the two wards have the two highest claim rates in Newcastle.

Lower Milehouse has the highest rate of claimants at just over 13%, this is the highest rate in the Borough.

Life Expectancy

Life expectancy is used as a high level indicator of the overall health of the population and is a national health inequality target.

Life expectancy is lower than the England average across the two wards.

Mortality Rates

All age all cause mortality rates are used as an alternative measure for life expectancy. The mortality rate in both wards is higher than both the England and district averages. For the period 2006-10 the mortality rate in Knutton and Silverdale was the second highest in the Borough, and the Cross Heath rate was fourth highest.

Premature Mortality Rates (All Causes)

Premature deaths are those that occur before the age of 75. In Newcastle the premature mortality rate has fallen steadily since the mid-90's but still remains higher than the national average.

The premature mortality rate for both wards is higher than the national and district rates. Cross Heath has the highest premature death rate in the Borough, Knutton and Silverdale has the third highest rate.

Premature Mortality Rates (Cancer)

The incidence (newly diagnosed cases) of cancers both locally and nationally continues to increase with the ageing population and around 640 new cases of cancer are diagnosed each year in Newcastle. The most common types of cancer in Newcastle are breast cancer, lung cancer and colorectal cancer.

Premature deaths attributable to cancer are highest in Knutton and Silverdale with a rate that is higher than another other ward in the Borough.

LIVING WELL

Smoking

It is estimated that just over a third of adults in the two wards are smokers, this proportion is higher than the average across Newcastle.

Obesity

The proportion of children in Year 6 in Knutton and Silverdale who are obese is higher than the England average.

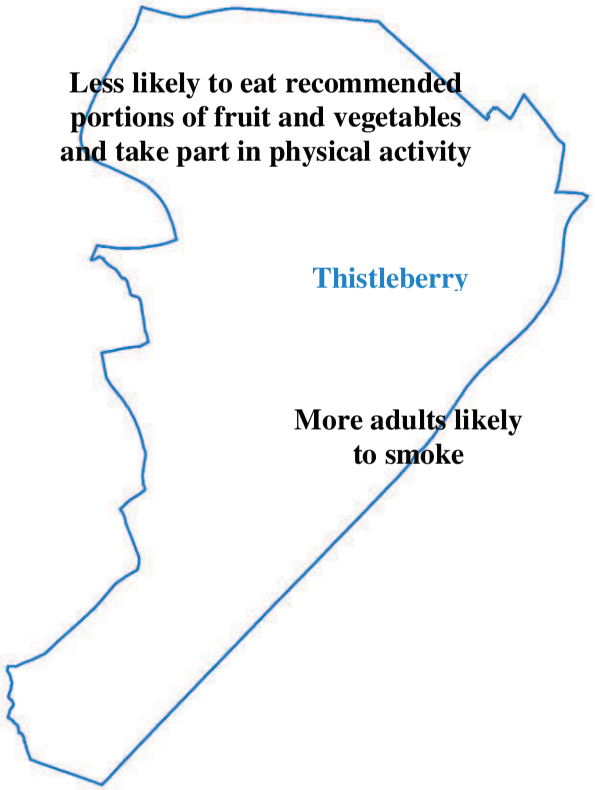
It is also estimated that a higher proportion than average of the adult population in the two wards are obese.

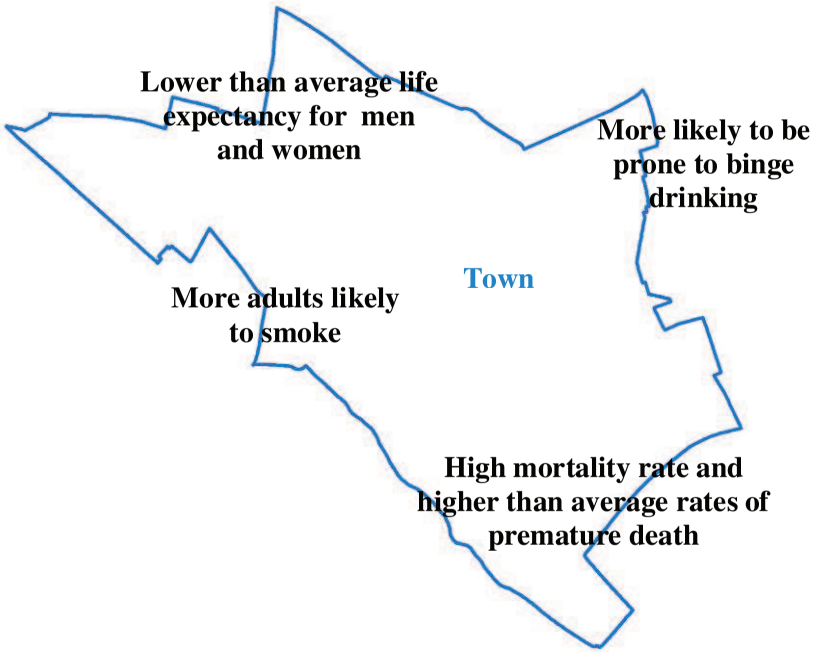
Teenage Pregnancy

During the period 2007-2009, the rate of under-18 conceptions in Knutton and Silverdale and Cross Heath were the highest and second highest in the Borough respectively

COMMUNITY VOICE – LAP Action Plan issues

- Health Promotion – through events.
- Older persons event – intergenerational activity
- Support early cancer detection project
- Dog Fouling
- Energy Saving and Fuel Poverty





WIDER DETERMINANTS OF HEALTH		THISTLEBERRY				TOWN			Newcastle
		Orme Road	Higherland	Thistleberry	Paris Avenue	London Road	Lancaster Rd	Town Centre	
Health	Claim Incapacity Benefit[1]	10%	11%	4%	4%	9%	11%	14%	8%
	Have Limiting Long Term Illness[2]	25%	28%	22%	23%	24%	21%	32%	21%
	Smoke[3]	c 32.4 - 37.2%		c 18.5 - 22.9%	c 32.4 - 37.2%	c 24.0 - 32.3%			22%
	Deprivation *(decile, 1=worst)*[4]	2	4	9	8	3	4	2	-
Education	Get at least 5 GCSE's A*-C (incl English and Maths[5]	72%				57%			59%
	Young people unemployed (aged 16-24)[6]	7.0%	3.0%	7.9%	3.7%	2.6%	7.1%	8.9%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	6.01%				6.16%			4.37%
	Claim Free School Meals[8*]	27%	25%	x	5%	15%	15%	16%	16%
Work	Become a professional or manager[9]	15%	23%	31%	42%	25%	28%	24%	34%
	Are employment deprived[10]	16%	13%	7%	7%	11%	15%	18%	12%
	Live on benefits[11]	18%	16%	8%	7%	13%	18%	23%	14%
Home and family	Live in poverty as a child[12]	37%	24%	7%	7%	25%	9%	21%	17%
	Live in income deprived households[13]	23%	20%	5%	7%	13%	12%	20%	12%
	~~Go home to a council~~	~~53%~~	~~40%~~	~~2%~~	~~15%~~	~~14%~~	~~29%~~	~~42%~~	~~19%~~

[*] NB - 'x' indicates that the value for that area has been suppressed

WIDER DETERMINANTS OF HEALTH		THISTLEBERRY				TOWN			Newcastle
		Orme Road	Higherland	Thistleberry	Paris Avenue	London Road	Lancaster Rd	Town Centre	
	house[14]								
	Are part of a lone parent family[15]	19%	9%	7%	4%	9%	6%	8%	9%
	Have no car or van[16]	45%	34%	15%	21%	37%	39%	51%	25%
Experience of crime	All crime[17]	58.5			24.8	160.9		536.2	54.3
	Anti social behaviour[18]	31.7			20.7	51.0		264.9	32.6
	Burglary[19]	3.0			5.5	7.3		5.0	2.5
	Live alone as a pensioner[20]	19%	24%	16%	24%	21%	18%	24%	15%
And finally	Live in poverty when they are 60+[21]	28%	27%	7%	7%	17%	22%	36%	16%
	Men live to the age of[22]	76.2				75.2			77.6
	Women live to the age of[23]	82.4				80.1			81.8

POPULATION

The size of the population in the area has increased since 2001 (an increase of just over 700 residents). The population increase has been evident amongst residents between the ages of 16 and 49, with the biggest rise in population amongst those aged 16-24.

The overall black and minority ethnic (bme) population was slightly higher than district average of 2%. Around 3.5% of residents in this area were from non-white backgrounds. The area with the highest number of bme residents is the Paris Avenue area with 4.8%. Most non-white residents in the area are of Asian heritage.

The Town Centre locality is one of the most diverse in the Borough with all but one of the 15 MOSAIC groups represented. Just under two thirds of the population in this are belong to one of the following five Groups:
Group I (17%) - lower income workers in urban terraces in often diverse areas
Group M (15%) - Elderly people reliant on state support
Group G (12%) - Young, well-educated city dwellers
Group B (10%) - Residents of small and mid-sized towns with strong local roots
Group K (10%) - Residents with sufficient incomes in right-to-buy social housing

MORTALITY AND ILL HEATH

All Age, All Cause Mortality Rates

The mortality rate in the Town ward is higher than the England average and is the third highest rate in the Borough. Life expectancy for both men and women in this ward is lower than the national average.

Premature Mortality Rates

Premature deaths are those that occur before the age of 75. In Newcastle the premature mortality rate has fallen steadily since the mid-90's but still remains higher than the national average. The all-cause premature mortality rate in the Town is higher than the national and district rates and is the fourth highest in the Borough.

LIVING WELL

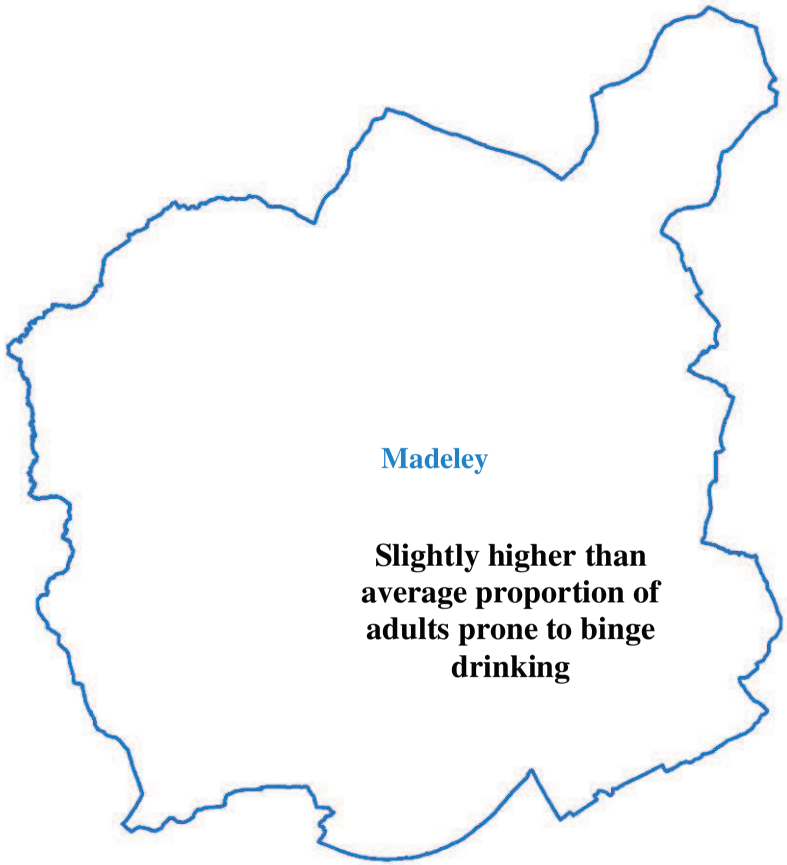
Healthy Lifestyles

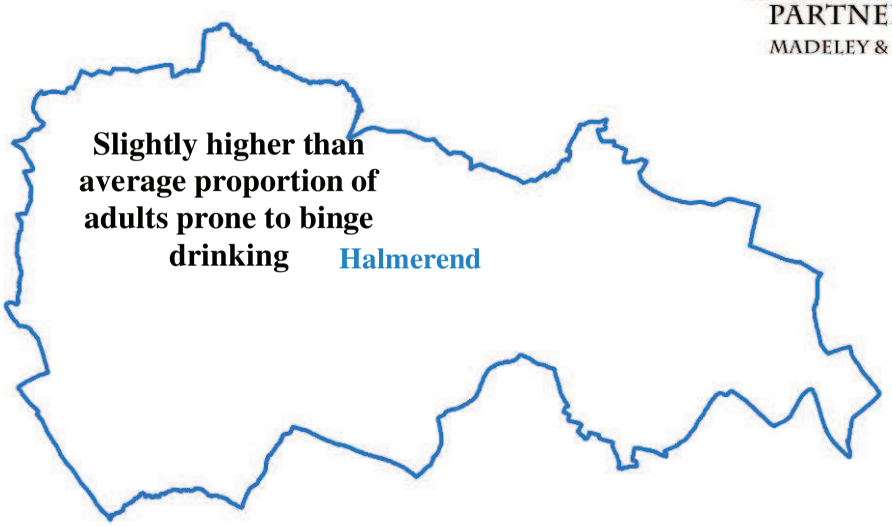
Estimates suggest that, in general, more adults in the locality are likely to smoke than is the average. Residents in the Town ward are more likely to be prone to binge drinking and people living in the Poolfields area of the Thistleberry ward are less likely to eat the recommended portions of fruit and vegetables or to take part in regular physical activity.

COMMUNITY VOICE – LAP Action Plan issues

- Community Engagement
- Parking
- Safer Nights
- Economic Development – Town Centre Partnership
- Youth provision during holidays
- Health Event – raising awareness of health promotion activities.

LOCALITY ACTION PARTNERSHIPS
MADELEY & DISTRICT





NB - Only the Betley/Balterley area of the Halmerend ward falls into the Madeley LAP

WIDER DETERMINANTS OF HEALTH		HALMEREND	MADELEY			Newcastle
		Betley/Balterley	Madeley Heath	Madeley	Madeley Rural	
Health	Claim Incapacity Benefit[1]	3%	2%	7%	5%	8%
	Have Limiting Long Term Illness[2]	18%	17%	23%	23%	21%
	Smoke[3]	approx 11.8 - 18.4%				22%
	Deprivation *(decile, 1=worst)*[4]	8	10	5	8	-
Education	Get at least 5 GCSE's A*-C[5*]	82%	60%			59%
	Young people unemployed (aged 16-24)[6]	5.7%	2.8%	6.8%	6.5%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	4.23%	3.18			4.37%
	Claim Free School Meals[8]	6%	5%	17%	14%	16%
Work	Become a professional or manager[9]	44%	37%	23%	30%	34%
	Are employment deprived[10]	5%	5%	13%	8%	12%
	Live on benefits[11]	6%	6%	14%	8%	12%
Home and family	Live in poverty as a child[12]	5%	5%	26%	15%	17%
	Live in income deprived households[13]	5%	5%	16%	9%	12%
	Go home to a council house[14]	9%	4%	37%	7%	19%
	Are part of a lone parent family[15]	6%	7%	11%	10%	9%
	Have no car or van[16]	11%	10%	27%	15%	25%
Experience of crime	All crime[17]	32.7	24.1		34.6	54.3
	Anti social behaviour[18]	18.1	28.6		21.2	32.6
	Burglary[19]	1.1	1.5		0.7	2.5
And finally	Live alone as a pensioner[20]	13%	11%	18%	15%	15%
	Live in poverty when they at 60+[21]	7%	11%	2%	11%	16%
	Men live to the age of[22]	77.9	80.4			77.6
	Women live to the age of[23]	82.1	85.1			81.8

[*] NB - 'x' indicates that the value for that area has been suppressed

POPULATION

The size of the population in the area has increased slightly since 2001 (an increase of around 190 residents).

The increase in population has been concentrated in residents over retirement age where there has been an increase of over 230 residents.

The overall black and minority ethnic (bme) population in the area was generally lower than district average of 2%. The area with the highest number of bme residents is Madeley Heath with around 1.49% residents.

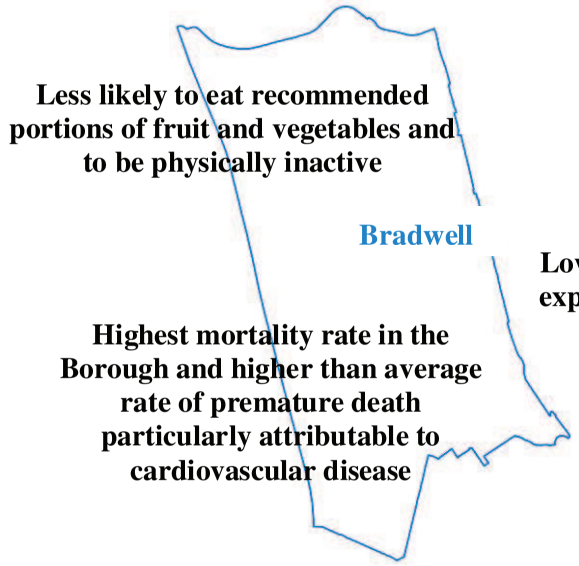
Almost two thirds of the area's population fall into three MOSAIC Groups:
Group D (27%); Successful professionals living in suburban or semi-rural homes
Group B (21%); Residents of small and mid-sized towns with strong local roots , and
Group A (15%); Residents of isolated rural communities

LIVING WELL

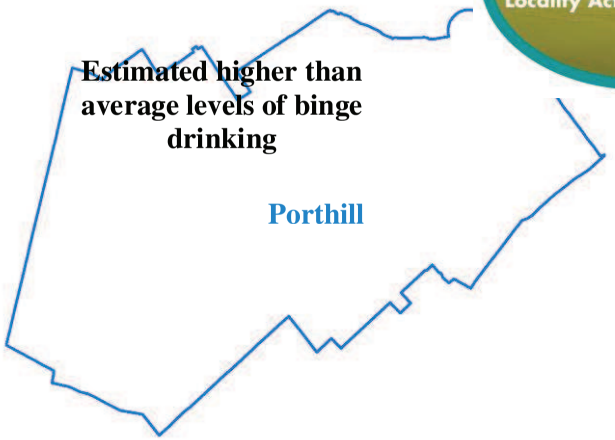
It is estimated that a slightly higher than average proportion of the adult population in the area are prone to binge drinking.

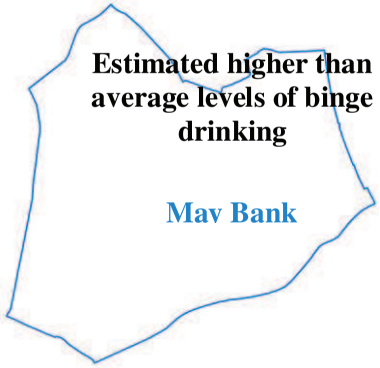
COMMUNITY VOICE – LAP Action Plan issues

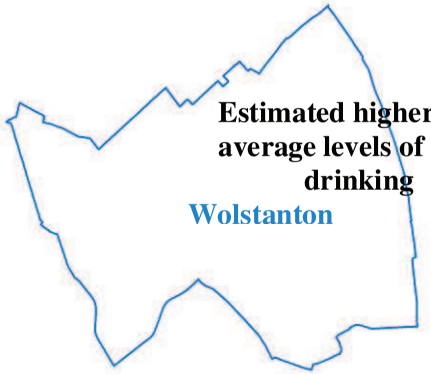
- Housing – site allocations
- Highways and speeding
- Youth Provision
- Anti-social Behaviour
- Work with Troubled Families and Families First.



East Newcastle Locality Action Partnership







WIDER DETERMINANTS OF HEALTH		WOLSTANTON				MAY BANK				Newcastle
		Ellison Street	Park Avenue	Marshlands	Retail Park	Sparch Hollow	Brampton Road	Basford Park Road	Basford Lights	
Health	Claim Incapacity Benefit[1]	7%	4%	7%	12%	5%	11%	5%	4%	8%
	Have Limiting Long Term Illness[2]	18%	17%	20%	26%	18%	28%	19%	15%	21%
	Smoke[3]	c 23.0 - 23.9%		c 18.5 - 22.9%	c 23.0 - 23.9%	c 18.5 - 22.9%	c 24.0 - 32.3%	c 18.5 - 22.9%		22%
	Deprivation *(decile, 1=worst)*[4]	6	7	8	3	8	5	8	9	-
Education	Get at least 5 GCSE's A*-C (incl English and Maths[5]	65%				65%				59%
	Young people unemployed (aged 16-24)[6]	7.9%	6.6%	4.8%	6.9%	2.6%	6.8%	3.8%	4.9%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	4.32%				2.18%				4.37%
	Claim Free School Meals[8*]	18%	7%	8%	20%	8%	8%	9%	8%	16%
Work	Become a professional or manager[9]	17%	27%	23%	15%	21%	31%	22%	28%	34%
	Are employment deprived[10]	8%	8%	8%	16%	7%	13%	6%	6%	12%
	Live on benefits[11]	12%	9%	9%	19%	8%	17%	8%	7%	14%
Home and family	Live in poverty as a child[12]	14%	5%	5%	16%	8%	22%	7%	7%	17%
	Live in income deprived households[13]	10%	7%	5%	14%	6%	13%	7%	5%	12%

[*] NB - 'x' indicates that the value for that area has been suppressed

WIDER DETERMINANTS OF HEALTH		WOLSTANTON				MAY BANK				Newcastle
		Ellison Street	Park Avenue	Marshlands	Retail Park	Sparch Hollow	Brampton Road	Basford Park Road	Basford Lights	
Experience of crime	Go home to a council house[14]	7%	2%	3%	39%	2%	31%	9%	2%	19%
	Are part of a lone parent family[15]	12%	8%	8%	11%	7%	4%	7%	8%	9%
	Have no car or van[16]	28%	19%	19%	43%	17%	32%	22%	13%	25%
	All crime[17]	57.6			60.6			32.2		54.3
	Anti social behaviour[18]	33.7			38.8			14.3		32.6
	Burglary[19]	1.5			1.7			4.0		2.5
And finally	Live alone as a pensioner[20]	14%	14%	13%	23%	14%	17%	19%	11%	15%
	Live in poverty when they are 60+[21]	21%	14%	10%	23%	9%	15%	14%	5%	16%
	Men live to the age of[22]	78.1				77.7				77.6
	Women live to the age of[23]	80.1				82.4				81.8

WIDER DETERMINANTS OF HEALTH		BRADWELL				PORTHILL			Newcastle
		High Carr	Crematorium	Bradwell Lane	Hospital	First Avenue	Boulton Street	Watlands	
Health	Claim Incapacity Benefit[1]	6%	9%	15%	7%	5%	5%	5%	8%
	Have Limiting Long Term Illness[2]	19%	22%	32%	25%	24%	19%	16%	21%
	Smoke[3]	c 11.8 - 18.4%	c 24.0 - 32.3%			c 23.0 - 23.9%			22%
	Deprivation *(decile, 1=worst)*[4]	8	4	3	6	6	7	6	-
Education	Get at least 5 GCSE's A*-C (incl English and Maths[5]	64%				57%			59%
	Young people unemployed (aged 16-24)[6]	6.7%	7.7%	5.6%	6.0%	7.2%	8.5%	2.7%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	3.95%				6.10%			4.37%
	Claim Free School Meals[8*]	4%	22%	21%	15%	9%	7%	7%	16%
Work	Become a professional or manager[9]	19%	13%	12%	19%	21%	20%	21%	34%
	Are employment deprived[10]	8%	13%	12%	19%	21%	20%	21%	12%
	Live on benefits[11]	9%	15%	21%	10%	10%	9%	9%	14%
Home and family	Live in poverty as a child[12]	4%	23%	22%	14%	13%	6%	8%	17%
	Live in income deprived households[13]	4%	15%	20%	10%	14%	7%	8%	12%
	Go home to a council house[14]	1%	23%	43%	12%	22%	7%	3%	19%

[*] NB - 'x' indicates that the value for that area has been suppressed

WIDER DETERMINANTS OF HEALTH		BRADWELL				PORTHILL			Newcastle
		High Carr	Crematorium	Bradwell Lane	Hospital	First Avenue	Boulton Street	Watlands	
Experience of crime	Are part of a lone parent family[15]	5%	9%	10%	7%	6%	8%	9%	9%
	Have no car or van[16]	13%	27%	38%	24%	28%	22%	21%	25%
	All crime[17]	44.3	53.1			39.5		36.8	54.3
	Anti social behaviour[18]	25.7	33.0			22.4		20.1	32.6
	Burglary[19]	0.6	1.8			1.5		0.7	2.5
And finally	Live alone as a pensioner[20]	12%	17%	19%	17%	21%	18%	15%	15%
	Live in poverty when they are 60+[21]	9%	18%	26%	13%	28%	15%	11%	16%
	Men live to the age of[22]	75.7				81.0			77.6
	Women live to the age of[23]	78.2				81.3			81.8

POPULATION

The size of the population in the area has increased slightly since 2001 (an increase of around 400 residents).

The population increase has been evident amongst residents of retirement age and to a slightly lesser degree amongst residents aged between 16 and 24.

The overall black and minority ethnic (bme) population was generally slightly lower than district average of 2%. The area with the highest number of bme residents is the Watlands area with just over 3.0% belonging to non-white ethnic groups. In the Marshlands area only around 0.75% of residents are from bme groups. Most non-white residents in the area are of mixed heritage, however in First Avenue the most predominant group is those with Asian heritage and in the Watlands area there is a higher proportion of residents with Chinese or other heritage.

About three quarters of the area's population fall into three MOSAIC Groups:
Group J (28%) - Owner occupiers in older-style housing in ex-industrial areas
Group E (26%) - Middle income families living in moderate suburban semis
Group K (12%) - residents with sufficient incomes in right-to-buy social housing
Group I (11%) - lower income workers in urban terraces in often diverse areas

MORTALITY AND ILL HEATH

All Age, All Cause Mortality Rates

The mortality rate in Bradwell is higher than the England average and is the highest rate in the Borough. Life expectancy for both men and women in this ward is lower than the national average.

Premature Mortality Rates

Premature deaths are those that occur before the age of 75. In Newcastle the premature mortality rate has fallen steadily since the mid-90's but still remains higher than the national average. The all-cause premature mortality rate in Bradwell is higher than the national and district rates and is the sixth highest in the Borough.

Between 1995-1997 and 2008-2010, premature mortality rates attributable to cardiovascular disease have reduced by 58% across Newcastle as a whole.
Bradwell has the 3rd highest rates of premature death attributable to cardiovascular disease in the Borough.

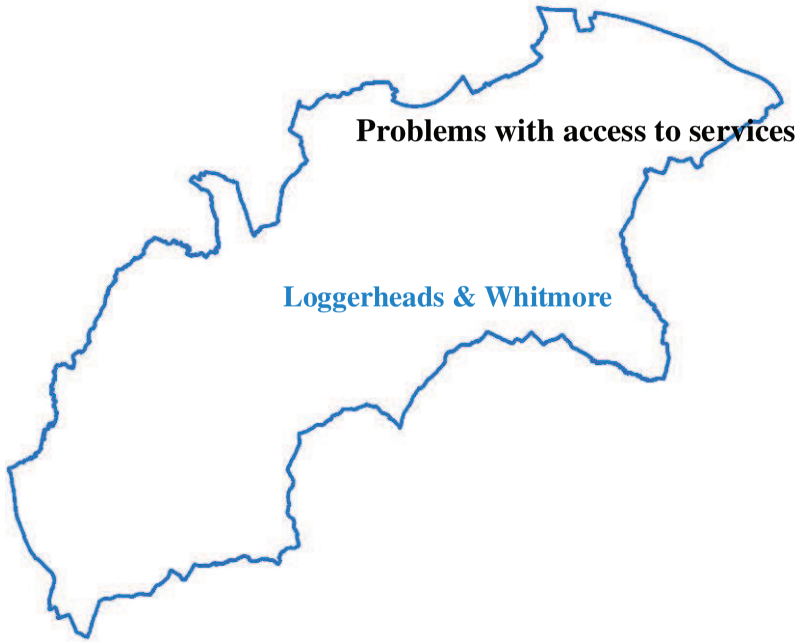
LIVING WELL

Healthy Lifestyles

Estimates suggest that fewer adults in Bradwell eat the recommended 5 portions of fruit and vegetables each day than is the average. It is also more likely that adults in this ward do not take part in regular exercise. Levels of binge drinking in Porthill, May Bank and Wolstanton are estimated to be higher than average.

COMMUNITY VOICE – LAP Action Plan issues

- Improving business and household recycling
- Youth Provision
- Health Promotion event
- Community Safety Calendar



WIDER DETERMINANTS OF HEALTH		LOGGERHEADS & WHITMORE				Newcastle
		Loggerheads	Whitmore	Ashley	Ashley Heath	
Health	Claim Incapacity Benefit[1]	9%	4%	6%	4%	8%
	Have Limiting Long Term Illness[2]	20%	16%	18%	14%	21%
	Smoke[3]	approx 11.8 - 18.4%				22%
	Deprivation *(decile, 1=worst)*[4]	5	8	7	9	-
Education	Get at least 5 GCSE's A*-C[5]	79%				59%
	Young people unemployed (aged 16-24)[6]	7.4%	5.1%	6.5%	3.5%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	1.53%				4.37%
	Claim Free School Meals[8]	10%	3%	14%	2%	16%
Work	Become a professional or manager[9]	28%	43%	44%	44%	34%
	Are employment deprived[10]	11%	5%	7%	5%	12%
	Live on benefits[11]	12%	6%	9%	5%	12%
Home and family	Live in poverty as a child[12]	12%	5%	12%	3%	17%
	Live in income deprived households[13]	10%	4%	9%	3%	12%
	Go home to a council house[14]	11%	4%	10%	2%	19%
	Are part of a lone parent family[15]	7%	6%	5%	5%	9%
	Have no car or van[16]	12%	6%	5%	5%	25%
Experience of crime	All crime[17]	43.4	28.8	19.9		54.3
	Anti social behaviour[18]	6.1	2.0	13.0		32.6
	Burglary[19]	2.0	1.2	2.0		2.5
And finally	Live alone as a pensioner[20]	12%	12%	14%	10%	15%
	Live in poverty when they at 60+[21]	13%	6%	11%	6%	16%
	Men live to the age of[22]	79.2				77.6
	Women live to the age of[23]	86.3				81.8

POPULATION

The size of the population in the area has increased slightly since 2001 (an increase of around 390 residents).

The increase in population has been concentrated in residents over retirement age where there has been an increase of over 500 residents.

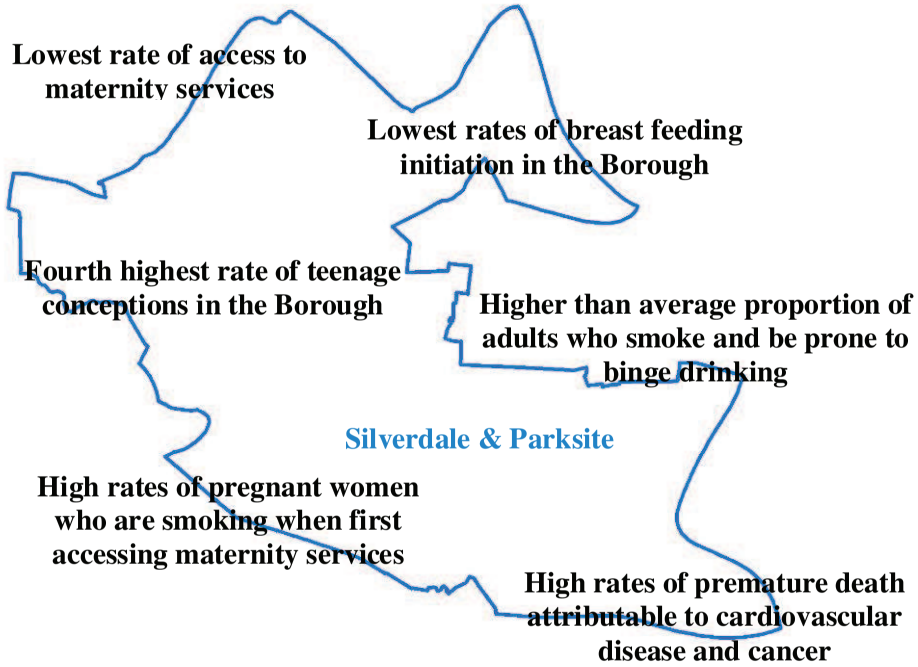
The overall black and minority ethnic (bme) population was is generally in line with the district average of 2%. The area with the highest number of bme residents is Ashley Heath with 2.3%. Most non-white residents in the area are of Asian heritage, however in the Loggerheads and Ashley Heath areas the most predominant group is those with mixed heritage.

Over 80% of the area's population falls into three MOSAIC Groups:
Group D (49%); Successful professionals living in suburban or semi-rural homes
Group A (26%); Residents of isolated rural communities, and
Group C (8%); Wealthy people living in the most sought after neighbourhoods

The Loggerheads and Whitmore area is amongst some of the most disadvantaged areas in the country in terms of access to services such as GP surgeries, schools, Post Offices, general stores and supermarkets.

COMMUNITY VOICE – LAP Action Plan issues

- Highways – speeding, road safety and winter gritting.
- Provide maps for walkers to use.
- Intergenerational activity



NB - The Silverdale, Parksite and Keele LAP includes part of one LSOA that falls into the Knutton and Silverdale ward (referred to in the table as 'Knutton'). Data for this LSOA is given where it is available, however complete data for this area is found in the Knutton Cross Heath LAP profile.

WIDER DETERMINANTS OF HEALTH		KEELE	KNUTTON & SILVERDALE	SILVERDALE & PARKSITE		Newcastle
		Keele	Knutton	Parksite	Silverdale	
Health	Claim Incapacity Benefit[1]	1%	9%	12%	10%	8%
	Have Limiting Long Term Illness[2]	8%	26%	24%	26%	21%
	Smoke[3]	c 24.0-32.3%	c 32.4-37.2%	c 24.0-32.3%		22%
	Deprivation *(decile, 1=worst)*[4]	10	4	2	5	-
Education	Get at least 5 GCSE's A*-C[5*]	X	37%	39%		59%
	Young people unemployed (aged 16-24)[6]	0.17%	7.7%	8.2%	8.8%	2.7%
	Not in Employment, Education or Training (aged 16-19)[7]	X	9.70%	13.38%		4.37%
	Claim Free School Meals[8]	X	13.4%	29.8%	17.1%	16%
Work	Become a professional or manager[9]	36%	17%	12%	15%	34%
	Are employment deprived[10]	1%	13%	20%	12%	12%
	Live on benefits[11]	1%	15%	22%	16%	12%
Home and family	Live in poverty as a child[12]	5%	13%	39%	14%	17%
	Live in income deprived households[13]	2%	14%	26%	10%	12%
	Go home to a council house[14]	16%	22%	37%	17%	19%
	Are part of a lone parent family[15]	9%	8%	14%	8%	9%
	Have no car or van[16]	16%	29%	36%	28%	25%
Experience of crime	All crime[17]	49.9	89.7	71.9		54.3
	Anti social behaviour[18]	6.5	81.9	56.2		32.6
	Burglary[19]	11.2	4.7	5.1		2.5
And finally	Live alone as a pensioner[20]	12%	17%	15%	17%	15%
	Live in poverty when they at 60+[21]	11%	26%	24%	13%	16%
	Men live to the age of[22]	79.4	75.0	76.0		77.6
	Women live to the age of[23]	91.6	79.1	81.8		81.8

[*] NB - 'x' indicates that the value for that area has been suppressed

POPULATION

The size of the population in the area has increased slightly since 2001 (an increase of around 230 residents).

The increase in population has been concentrated in residents aged between 16 and 24 and amongst residents over retirement age.

Understandably, due to the University campus, Keele has the most diverse population in the locality, and indeed the borough, with a bme population of around 10%. The rest of the locality has a fairly small bme population - either in line with or lower than the borough average.

Almost three quarters of the area's population fall into four MOSAIC Groups:
Group K (28%); Residents with sufficient incomes in right-to-buy social housing
Group J (21%); Owner occupiers in older-style housing in ex-industrial areas
Group I (13%); Lower income workers in urban terraces in often diverse areas, and
Group O (12%); Families in low-rise social housing with high levels of benefit need

MATERNAL AND INFANT HEALTH

Fertility rates in Silverdale and Parksite are the second highest in the Borough and are higher than the national average.

Fewer mothers in the Silverdale area access maternity services in the first 13 weeks of pregnancy than in the rest of the Borough, and the percentage of mothers in the ward who were smoking when they book in for maternity services is higher than the regional average.

Breast feeding initiation rates in Silverdale and Parksite are the lowest in the Borough and are lower than the regional average.

MORTALITY AND ILL HEATH

General Health

Overall health in the locality is better than the average for the district with around 17% of residents reporting that they had a Limiting Long Term Illness (LLTI) at the time of the 2001 Census. However, this lower average is due to the particularly low levels of LLTI in the Keele area. Rates in Silverdale and Parksite are higher than average at around 25%.

Ill Health

Silverdale and Parksite has the fifth highest percentage of working age residents who are in receipt of either Incapacity Benefit/Severe Disablement Allowance or Employment Support Allowance in the Borough. Just under half of claimants are receiving benefit support for a mental health condition.

Disability

Around 480 residents in the locality are in receipt of Disability Living Allowance, this is about 5% of the population. Again, the particularly low rates in the Keele ward slightly mask the higher rates in the Silverdale and Parksite ward where the overall rate is around 8%.

Premature Mortality Rates (All Causes)

Premature deaths are those that occur before the age of 75. In Newcastle the premature mortality rate has fallen steadily since the mid-90's but still remains higher than the national average.

The premature mortality rate for Silverdale and Parksite is higher than the national and district rates and is the fifth highest rate in the Borough.

Premature Mortality Rates (Cardiovascular Disease)

Between 1995-1997 and 2008-2010, premature motality rates attributable to cardiovascular disease have reduced by 58% across Newcastle as a whole.

Premature deaths attributable to cardiovascular disease are the fourth highest in Silverdale and Parksite than in any other ward in the Borough.

Premature Mortality Rates (Cancer)

The incidence (newly diagnosed cases) of cancers both locally and nationally continues to increase with the ageing population and around 640 new cases of cancer are diagnosed each year in Newcastle. The most common types of cancer in Newcastle are breast cancer, lung cancer and colorectal cancer.

Premature deaths attributable to cancer in Silverdale and Parksite are the third highest in the Borough.

LIVING WELL

Smoking and Binge Drinking

It is estimated that over a quarter of adults in this locality are smokers, this proportion is higher than the average across Newcastle. It is also estimated that a similar proportion of the population in the locality are prone to binge drinking. Again, this is a higher rate than the national average.

Teenage Pregnancy

During the period 2007-2009, the rate of under-18 conceptions in Silverdale and Parksite were the fourth highest in the Borough with a rate that was higher than the national average.

COMMUNITY VOICE – LAP Action Plan issues

- Community Pride – linked to circus skills, fly tipping
- Engagement with students from Keele University
- Family Employment Initiative – communicate through community – jobs event.
- Property voids and CCTV.

		Audley & Bignall End	Bradwell	Butt Lane	Chesterton	Clayton	Cross Heath	Halmerend	Holditch	Keele	Kidsgrove	Knutton & Silverdale	Loggerheads & Whitmore	Madeley	May Bank	Newchapel	Porthill	Ravenscliffe	Seabridge	Silverdale & Parksite	Talke	Thistleberry	Town	Westlands	Wolstanton	NEWCASTLE
Health	Claim Incapacity Benefit	6.9%	9.3%	10.2%	8.3%	6.4%	11.5%	5.6%	11.7%	0.6%	6.9%	11.3%	5.5%	4.7%	5.9%	4.9%	5.2%	7.1%	5.9%	11.1%	10.3%	7.6%	11.4%	5.8%	7.6%	7.5%
	Have Limiting Long Term Illness	22%	25%	24%	18%	24%	25%	22%	26%	8%	18%	24%	17%	20%	20%	19%	20%	18%	17%	25%	22%	25%	26%	18%	20%	21%
	Smoke																									22%
	Deprivation *(decile, 1=worst)*	6	5	4	5	6	3	7	3	6	10	3	8	8	8	6	6	7	7	4	5	6	3	9	6	
Education	Get at least 5 GCSE's A*-C (incl English and Maths	67%	64%	51%	68%	44%	33%	82%	63%	x	41%	37%	79%	60%	65%	55%	57%	62%	73%	39%	54%	72%	57%	84%	65%	59%
	Young people unemployed (aged 16-24)	5.4%	5.1%	5.3%	5.3%	4.2%	5.8%	4.0%	6.7%	0.2%	3.9%	4.6%	3.2%	5.2%	3.7%	3.0%	3.4%	5.8%	4.3%	6.6%	5.7%	4.2%	4.2	2.5%	2.5%	3.8%
	Not in Employment, Education or Training (aged 16-19)	6.47%	3.95%	4.80%	4.76%	2.05%	10.55%	4.23%	13.33%	0	7.11%	9.70%	1.53%	3.18%	2.18%	4.67%	6.10%	5.50%	3.72%	13.38%	5.26%	6.01%	6.16%	0.51%	4.32%	4.37%
	Claim Free School Meals	15.3%	16.3%	28.3%	18.3%	16.0%	28.4%	10.4%	25.3%	x	14.2%	27.0%	6.4%	11.2%	8.1%	10.7%	7.8%	14.9%	9.9%	25.0%	18.8%	17.1%	15.1%	5.5%	13.8%	16.0%
Work	Become a professional or manager	21%	16%	15%	19%	21%	14%	28%	10%	36%	18%	13%	40%	31%	25%	20%	21%	19%	29%	14%	16%	28%	26%	41%	21%	23%
	Are employment deprived	11%	13%	15%	12%	10%	17%	8%	16%	1%	11%	17%	7%	8%	8%	9%	9%	9%	9%	16%	14%	11%	15%	7%	10%	11%
	Live on benefits	12%	14%	18%	14%	10%	21%	9%	19%	1%	12%	20%	8%	9%	10%	8%	10%	11%	10%	19%	15%	13%	18%	8%	12%	6%
Home and family	Live in poverty as a child	13%	16%	26%	25%	16%	28%	11%	30%	5%	17%	33%	7%	15%	10%	10%	9%	9%	11%	28%	23%	21%	18%	6%	11%	17%
	Live in income deprived households	10%	13%	18%	15%	11%	21%	8%	21%	2%	12%	22%	6%	10%	8%	9%	10%	6%	8%	18%	12%	14%	15%	5%	9%	12%
	Go home to a council house	16%	20%	29%	24%	22%	40%	11%	36%	16%	14%	36%	6%	15%	12%	6%	10%	11%	16%	25%	21%	27%	29%	10%	13%	19%
	Are part of a lone parent family	9%	8%	12%	12%	7%	13%	7%	13%	9%	10%	12%	6%	9%	6%	6%	8%	6%	7%	11%	8%	10%	8%	6%	10%	9%
	Have no car or van	22%	26%	30%	27%	25%	40%	18%	34%	16%	19%	37%	8%	16%	22%	14%	24%	18%	18%	31%	21%	29%	43%	15%	28%	25%
Experience of crime	All crime	25.0	51.0	54.0	52.3	24.4	73.9	32.7	67.0	49.9	32.1	84.6	28.0	27.8	48.9	24.6	38.6	29.4	29.1	71.9	55.4	50.1	286.5	21.3	57.6	54.3
	Anti social behaviour	24.2	31.2	50.6	46.9	13.6	41.4	18.1	59.1	6.5	22.2	63.3	7.7	26.0	28.7	7.8	21.6	23.0	16.0	56.2	28.6	28.9	122.6	11.6	33.7	39.4
	Burglary	2.0	1.5	2.2	2.0	0.5	3.1	1.1	1.3	11.2	1.3	5.1	1.7	1.2	2.6	1.2	1.2	0.5	1.7	5.1	2.0	3.6	6.5	1.6	1.5	2.5
And finally	Live alone as a pensioner	16%	16%	17%	9%	20%	18%	18%	14%	12%	9%	15%	12%	14%	16%	13%	18%	12%	12%	16%	14%	21%	21%	17%	16%	15%
	Live in poverty when they are 60+	15%	17%	21%	23%	17%	28%	11%	24%	11%	15%	25%	9%	13%	11%	13%	19%	12%	12%	17%	13%	15%	25%	7%	17%	16%
	Men live to the age of	77.5	75.7	76.4	77.4	75.7	74.9	77.9	75.7	79.4	80.0	75.0	79.2	80.4	77.7	79.1	81.0	75.9	76.7	76.0	76.9	76.2	75.2	84.1	78.1	77.6
	Women live to the age of	85.0	78.2	81.6	81.2	84.4	78.2	82.1	79.6	91.6	85.1	79.1	86.3	85.1	82.4	80.8	81.3	82.6	84.7	81.8	82.7	82.4	80.1	86.0	80.1	81.9

Summary and Next Steps

This document and appendix, highlights the positive work already taking place across the borough. It confirms that the borough is in a good position to further develop their community engagement work through the Newcastle Partnership and the Locality Action Partnership structure. This eJSNA will be shared with the Staffordshire Health and Wellbeing board, in order that they can use it to help identify priorities and develop a joint strategy; it will also be used by the Newcastle Partnership to identify potential local solutions and by Newcastle Borough Council in the production of their Health and Wellbeing Strategy.

This assessment is a starting point and it will need to be developed in partnership with the local community. Additional work will take place through the Newcastle Partnership to enhance the information further, including the mapping of local community assets.

The eJSNA will be added to over the next few years and new ways will be sought to present the information. The partnership will engage further with the community in order to identify local priorities and solutions to those issues, this approach will enable us to have a true shared focus on the wider determinants of health.

The following are suggestions of how this document is intended to be developed over the next two years:

- Engagement with the LAPs and wider community to map assets that impact on health inequalities in the locality and across the borough.
- The locality data profiles will be shared with LAPs in order that they can use the local data to identify local priorities.
- The wider partnership will be engaged in this process to ensure that as much local data as possible is incorporated into the strategic assessment.
- The partnership will investigate opportunities to publish this information and ultimately to make it available on-line for regular and easy access to the data by local communities and partners.

Appendices

Appendix One - Asset Mapping; Excel Spreadsheet

References

1. The Marmot Review 2010, “Fair Society, Healthy Lives”, a strategic review of health inequalities in England post-2010, Executive Summary, www.ucl.ac.uk/marmotreview

2. What makes us healthy? The asset approach in practice: evidence, action evaluation, Jane Foot, 2012 (The follow-up to ’A glass half-full’)

3. A glass half-full: how an asset approach can improve community health and well-being, Improvement and Development Agency (IDeA), Healthy Communities Programme.

4. Wider Determinants of Health, Dahlgren and Whitehead 1992, www.bridgingthegap.scot.nhs.uk/understanding-health-inequalities/intorducing-the-wider-determinants-of-health.aspx

Data Sources:

1	Claim Incapacity Benefit	NOMIS, February 2012. ONS, Mid-year population estimates 2010
2	Have Limiting Long Term Illness	ONS, Census 2001
3	Smoke	Staffordshire Observatory/NHS North Staffordshire - Health and Wellbeing Profile for Newcastle under Lyme 2012 (APHO, Estimates of adults' health and lifestyle (2008-08))
4	Deprivation	DCLG, IMD 2010 - Multiple Index
5	Get at least 5 GCSE's A*-C	NeSS, GCSE and equivalent results based on pupil residency 2009/10
6	Young people unemployed (aged 16-24)	NOMIS, January 2012. ONS, Mid-year population estimates 2010
7	Not in Employment, Education or Training (aged 16-19)	Staffordshire County Council, Monthly NEET Report June 2012
8	Claim Free School Meals	Staffordshire Observatory, School Census 2012
9	Become a professional or manager	ONS, Census 2001
10	Are employment deprived	DCLG, IMD 2010 - Employment Domain
11	Live on benefits	NOMIS, February 2012. ONS, Mid-year population estimates 2010
12	Live in poverty as a child	DCLG, IMD 2010 - Income Deprivation Affecting Children Index (IDACI)
13	Live in income deprived households	DCLG, IMD 2010 - Employment Domain
14	Go home to a council house	ONS, Census 2001
15	Are part of a lone parent family	ONS, Census 2001
16	Have no car or van	ONS, Census 2001
17	All crime	Staffordshire Police, Crime Rates 20011/12. ONS, Mid-year population estimates 2010
18	Anti social behaviour	Staffordshire Police, Crime Rates 20011/12. ONS, Mid-year population estimates 2010
19	Burglary	Staffordshire Police, Crime Rates 20011/12. ONS, Mid-year population estimates 2010
20	Live alone as a pensioner	ONS, Census 2001
21	Live in poverty when they at 60+	DCLG, IMD 2010 Income Deprivation Affecting Older People Index (IDAOPI)
22	Men live to the age of	Staffordshire Observatory/NHS North Staffordshire - Health and Wellbeing Profile for Newcastle under Lyme 2012 (Death extracts, Office for National Statistics, Mid-year population estimates, Office for National Statistics)
23	Women live to the age of	

Local Healthwatch, health and wellbeing boards and health scrutiny

cfps Centre for Public Scrutiny
accountability, transparency, involvement

Roles, relationships and adding value

healthwatch

Local Government Association

The Centre for Public Scrutiny

The Centre for Public Scrutiny (CfPS), an independent charity, is the leading national organisation for ideas, thinking and the application and development of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

Local Government Association

The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government.

We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

The LGA covers every part of England and Wales, supporting local government as the most efficient and accountable part of the public sector.

Visit www.local.gov.uk

Acknowledgements

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Derbyshire County Council
Devon County Council
Dorset County Council
Gateshead Council
London Borough of Sutton

Introduction and what we know

Local authorities, the NHS and local community organisations have a history of working together to improve outcomes for local people. The health and care reforms introduce some new structures and processes and working out how best to bring these together with continuing existing arrangements can be complex. But what remains constant throughout the transition is a shared goal: to improve health, social care and wellbeing outcomes for communities.

This guide aims to help local leaders and others to understand the independent, but complementary, roles and responsibilities of council health scrutiny, local Healthwatch and health and wellbeing boards. This guide does not aim to cover every eventuality; it is a 'snapshot' that can be a basis for discussions about how existing and new bodies will work together and how they can build on local agreements and legislative requirements.

Council health scrutiny

Councils with social care functions can hold NHS bodies to account for the quality of their services through powers to obtain information, ask questions in public and make recommendations for improvements that have to be considered. Proposals for major changes to health services can be referred to the Secretary of State for determination if they are not considered to be in the interests of local health services. The way councils use the powers is commonly known as 'health scrutiny' and forms part of councils' overview and scrutiny arrangements. From April 2013 all commissioners and providers of publicly funded healthcare and social care will be covered by the powers, along with health and social care policies arising from the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. Health scrutiny also has a valuable pro-active role; helping to understand communities and tackle health inequalities.

Local Healthwatch

Local Healthwatch will be the local consumer champion for health and social care representing the collective voice of people who use services and the public. It will build up a local picture of community needs, aspirations and assets and the experience of people who use services. It will report any concerns about services to commissioners, providers and council health scrutiny. It will do this by engaging with local communities including networks of local voluntary organisations, people who use services and the public. Through its seat on the health and wellbeing board, local Healthwatch will present information for the Joint Strategic Needs Assessment and discuss and agree with other members on the Board a Joint Health and Wellbeing Strategy. It will also present information to Healthwatch England to help form a national picture of health and social care. Local authorities will need to ensure that their local Healthwatch operates effectively and is value for money; managing this through their local contractual arrangements.

Health and wellbeing boards

Health and wellbeing boards are committees of councils with social care responsibilities, made up of local councillors, directors of public health, adult social services and children's services; clinical commissioning groups; and local Healthwatch. They will collectively take the lead on improving health and wellbeing outcomes and reducing health inequalities for their local communities. Although set up with a minimum prescribed membership, how Boards operate will be different in response to local circumstances. Health and wellbeing boards are an executive function of the council and are responsible for identifying current and future health and social care needs

and assets in local areas through Joint Strategic Needs Assessments; and developing Joint Health and Wellbeing Strategies to set local health and social care priorities, providing a framework for the commissioning of local health and social care services. Individual Board members will be held to account in different ways (for example, clinical commissioning groups are authorised and assessed by the NHS Commissioning Board) but health and wellbeing boards can also be collectively held to account for their effectiveness through council scrutiny.

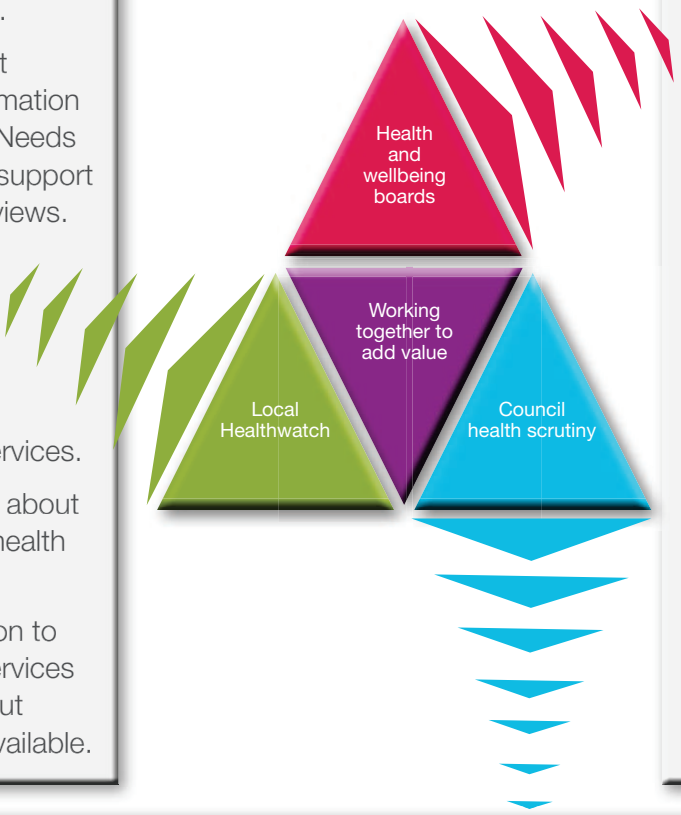
All three have a role to play in the way local services are planned and delivered. How they interact with each other will have a direct influence on improving outcomes for communities and people who use services. The 'commissioning cycle' provides a number of opportunities for each function to add value.

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

Working together for better outcomes

Local structures and ways of working will be different. With a focus on the fundamental principle of improving outcomes for local people, there are opportunities for bodies to better work together and add value to each other's work. Here are just some ways that each can bring value to the other.

- Share information from networks of voluntary and community groups.
- Gather and present evidence and information for Joint Strategic Needs Assessments and support council scrutiny reviews.
- Use good public engagement to demonstrate the 'real-time' experiences of people who use services.
- Highlight concerns about service to council health scrutiny.
- Cascade information to people who use services and the public about services that are available.



- Bring together individual and organisational knowledge, expertise and experience.
- Develop an area-wide view of health and social care needs and resources through the Joint Strategic Needs Assessment.
- Agree area-wide alignment of services to deliver improved health and wellbeing through the Joint Health and Wellbeing Strategy.
- Facilitate shared understanding of information to improve outcomes from decision making.

- Be a bridge between professionals and people who use services.
- Bring a collective memory of public engagement, policy development and local knowledge about community needs and assets.
- Be a valuable 'critical friend' throughout transition and beyond.
- Evaluate policies arising from processes and decisions and outcomes from services.
- Consider whether service changes are in the best interests of the local health service.
- Carry out pro-active qualitative reviews that can inform and enhance policy and services.

Listening and responding to communities and people who use services is fundamental to each function but each will have different reasons and ways to gather views and experiences. Sharing information and expertise is just one example of how value can be added at different points throughout the cycle of assessing need, devising strategies, commissioning and providing services.

How might this work?

The following basic scenarios are examples of how the three functions might complement rather than duplicate each other's work.

Scenario 1: Refreshed Joint Strategic Needs Assessments indicate a need for integrated health and social care teams aligned with GP practices:

Health and wellbeing board	The Board has a duty to support integrated services and, reflecting on the Joint Strategic Needs Assessment decides to include integrated teams as a priority in Joint Health and Wellbeing Strategy.
Local Healthwatch	Undertakes local research about what people who use services are looking for, identifies gaps in service provision and feeds the outcomes into the health and wellbeing board to influence the Joint Health and Wellbeing Strategy.
Council health scrutiny	Examines the process in light of councillors' knowledge of their local area and makes recommendations about how the people who use services, particularly vulnerable groups, can be informed about changes to services. Six months after implementation of the strategy, it assesses what impact the changes have had and makes recommendations for improvement.

Scenario 2: An issue related to health inequalities: a low uptake of child vaccination in particular wards:

Health and wellbeing board	The refreshed Joint Strategic Needs Assessment indicates a low uptake which has implications for health and social care in some council wards. Because the reasons are unclear, the health and wellbeing board asks health scrutiny to review the issue.
Local Healthwatch	Through their seat on the health and wellbeing board, local Healthwatch were involved in reviewing the Joint Strategic Needs Assessment, and it now uses it's local networks to gather views about why some children are not being immunised and reports this to the Board and health scrutiny.
Council health scrutiny	Health scrutiny asks local Healthwatch to gather local views. As a result of discussions with clinical commissioning groups, schools, health visitors and social workers, makes recommendations about ways to improve the uptake of immunisations. (Alternatively, in a two-tier area the District/Borough Council in which the particular wards lie could undertake the review on behalf of the county council – this is determined and co-ordinated locally to avoid duplication).

Scenario 3: A reconfiguration of maternity services across council areas:

Health and wellbeing board	Providers have proposed this as a solution to improving outcomes and make better use of available resources. The health and wellbeing board assesses whether the plans fit their Joint Health and Wellbeing Strategy and takes a strategic view on the outcomes and engagement with the clinical commissioning groups.
Local Healthwatch	Undertakes a comprehensive exercise to gather the views from people who use services and the public, checks whether consultations reflect what is known about best practice and presents views as a health and wellbeing board member and to council health scrutiny during the formal consultation process.
Council health scrutiny	Agrees that proposals are a substantial/ significant variation, and through joint arrangements with other councils, engages in early discussions with the commissioners/ providers regarding policy, plans and consultations. It also engages during the formal consultation stage to analyse the proposals in a public forum, taking evidence and coming to a conclusion about whether the proposals are in the best interests of the local health service.

Pulling out the learning

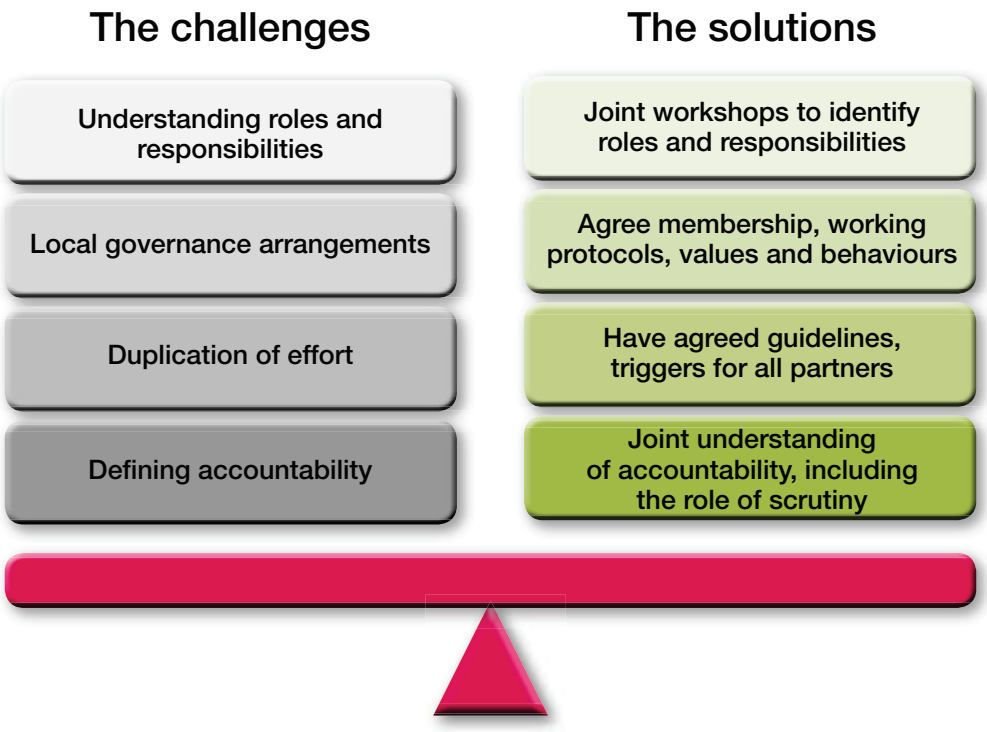
Fundamental principles

There are some fundamental principles, which have been identified by councils, these include:

- Improved health and social care are a common goal.
- Early discussions are vital to ensure no one is left out.
- Everyone has responsibility to develop relationships, not just to engage formally.
- Good relationships lead to good communication, identifying where value can be added.

The challenges, myths and solutions

Our work has identified a number of challenges for local leaders and some possible ways to achieve solutions. These challenges will be solved according to their local context and are likely to be best overcome where there is a shared willingness to work together. Whilst each function will have ways to check their progress, scrutiny can cement arrangements for transparency, inclusiveness and accountability.



Relationships – a gaze into the future…

Taking the emerging learning from our work, below is an 'appreciative' look at what roles and relationships could look like in "Healthyshire" in 2015.

Representatives from health scrutiny, local Healthwatch and the Healthyshire Health and Wellbeing Board meet together with a range of other partners to evaluate how health and care outcomes have improved over the last year. Whole system events are very popular, allowing partners to draw on their strengths and complement each other. The event creates an atmosphere of 'togetherness' where partners can contribute or challenge knowing that their views will be understood and acted on. They've got to this stage because:

Health and wellbeing board members are committed to working with others with clear lines of accountability. They encourage open and honest discussions about the challenges faced by all partners in the new landscape and have dealt with any conflicts quickly and openly. By actively seeking and sharing information, the Board has developed a comprehensive analysis of health and social care needs and assets. Balancing those needs against national and local policy it has developed a robust strategy to improve health and social care and reduce inequalities which is well understood and accepted. They work constructively with health scrutiny, welcoming their involvement. People who use services and the public are central to the Board's work, and people understand how local agencies are improving health and social care outcomes.

Local Healthwatch has built on the LINk legacy by maintaining volunteer capacity and expanding their networks to include a wide range of people and groups so that a comprehensive voice is heard at the health and wellbeing board and this is reflected in strategies and commissioning plans across health and social care. Problems are quickly brought to the attention of partners, knowing that they are listened to and acted upon. They gather and present views to support reviews carried out by health scrutiny. They have contributed to national thinking through their engagement with Healthwatch England.

Council health scrutiny has influenced health and social care in a variety of ways by encouraging transparency, involvement and accountability throughout the planning and delivery of services. Officers and councillors shared their experience and knowledge during transition so that relationships could be built. It's pro-active reviews of health and social care themes provide timely evidence and constructive recommendations to commissioners and providers. Health scrutiny is involved very early on in discussions about reconfiguration of health services and takes a view about whether changes are in the interests of local health services. It acts as a 'bridge' between politicians, professionals and communities, so that solutions are identified together.

Putting it into action

We can start by asking the right questions. Here are some that partners are already asking – you may have other questions that are relevant to your local area:

1. How do we ensure that we complement not duplicate other's work?
2. How can we best use our roles to add value so that together we improve outcomes?
3. Are we taking the right steps to build effective relationships and understanding of partners' roles and responsibilities? (Consider barriers to effective partnership working too).
4. How will we make sure we work together in transparent, inclusive and accountable ways?
5. How are we providing leadership?
6. What is working well or not so well?

For health and wellbeing boards:

1. What are we doing to demonstrate that every Board member is an equal partner?
2. How are we sharing learning and good practice with our partners and neighbours?
3. What steps are we taking to ensure that we have integrated working?
4. How are we collectively and individually demonstrating transparency, inclusiveness and accountability?
5. How are we engaging with providers to ensure delivery of outcomes?
6. How can we work alongside health scrutiny to address the wider determinants of health?

For local Healthwatch:

1. How are we balancing our dual role of 'consumer champion' and policy maker on the health and wellbeing board?
2. How have we taken the best of the LINk legacy and developed it?
3. What are we doing that demonstrates we are getting the widest range of views, particularly those of the least heard communities?
4. Can we demonstrate that we use the feedback we get to impact on our decision-making?
5. What are we doing to make it clear how we will treat any safeguarding issues we come across?
6. What steps are we taking to help health scrutiny in its role?
7. How do we plan to work with the Care Quality Commission and Healthwatch England to exchange information about the quality and safety of services?

For Council health scrutiny:

1. How can we best ensure that Joint Strategic Needs Assessments reflect needs and aspirations of local people and that Joint Health and Wellbeing Strategies reflect credible priorities that commissioners follow?
2. What steps are we taking to help people understand scrutiny and how it adds value?
3. What are we doing to pro-actively engage with clinicians but also with professionals outside health and social care?
4. How does health scrutiny work with national bodies, for example the NHS Commissioning Board, Monitor and the Care Quality Commission?
5. What can we do to be an effective 'bridge' between politicians, professionals and communities throughout the commissioning cycle?
6. Are we thinking strategically and pro-actively about how we can best use our resources to tackle inequalities and keep in touch with the experience of people who use services?

Websites

The Centre for Public Scrutiny

www.cfps.org.uk

Local Government Association

www.local.gov.uk

Care Quality Commission

www.cqc.org.uk

Healthwatch England

http://www.cqc.org.uk/public/about-us/partnerships-other-organisations/healthwatch

Publications

Health overview and scrutiny: Exploiting opportunities at a time of change

http://www.cfps.org.uk/publications?item=7008&offset=25

Smoothing the way

http://www.cfps.org.uk/publications?item=7081&offset=25

10 questions to ask if you are scrutinising arrangements for Healthwatch

http://www.cfps.org.uk/publications?item=7005&offset=25

Building successful Healthwatch organisations

http://www.local.gov.uk/c/document_library/get_file?uuid=c96a438b-dbb5-4cfa-8669-8c42a999cbdd&groupId=10171

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HEALTH SCRUTINY COMMITTEE

Title	Method of Scrutiny	Progress to Date/Actions from last Meeting	Expected Completion Date
Consultation on Mental Health Services **(AMBER)**	Full Committee	Scrutiny will continue to monitor the implementation of Stage 2. Foundation Status – still unclear whether this will be on their own or as part of amalgamation	Ongoing
Fit For the Future and move of the Accident and Emergency Centre **(AMBER)**	Full Committee	A visit to UHNS A & E took place on 4th March 2013. UHNS officers to attend Committee meeting on 17th April 2013. The identified concerns are:	
Cardiac Rehabilitation Response to County Council Health Scrutiny Report re phase IV Cardiac Rehabilitation **(GREEN)**	Full Committee	Cardiac Rehab is now being provided at Jubilee 2.	
Health and Wellbeing Strategy **(AMBER)**	Full Committee	A update was provided to the Committee from the Executive Director for Operational Services. The Council would continue to work on its on Strategy. Request from Active and Cohesive Committee that the Coordinating Committee considers the best way to scrutinise this topic - Coordinating Committee resolved the strategy should remain with Health Scrutiny, but that a working group could include Members of Active & Cohesive Scrutiny Committee Awaiting implementation of County Strategy – ongoing.	
Health and wellbeing Board **(AMBER)**	Full Committee	Cllr Frank Finlay of Stafford Borough Council appointed as additional district representative for North Staffordshire. Initial meeting held between Newcastle Borough Councillors and officers with Cllr Finlay and Stafford officer.	

Prescription Medication **(AMBER)**	Staffordshire County Council Health Scrutiny Committee	The County would look into this issue following request from this Committee. Continue to pursue at County level.	
Infant Mortality **(AMBER)**	Full Committee following a request from the County Council Health Scrutiny Committee.	Still concerns but updates received by Dr John Harvey recently appear to show numbers are reducing. Dr John Harvey to update at future meeting.	Ongoing
Francis Report	Full Committee	Request at Feb 2013 meeting that the 30 pages of the report relating to Borough and Staffordshire County Council O & S Committees be given consideration.	
Suicide Prevention	Full Committee	Request at April meeting to look into this	