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HEALTH AND WELLBEING BOARD AGENDA

Friday, 21 July 2017 at 10.00 am in the Whickham Room - Civic Centre

From the Chief Executive, Sheena Ramsey

Item	Business
1	**Apologies for Absence**
2	**Minutes** (Pages 3 - 8) The minutes of the meeting held on 23 June 2017 are attached for approval.
2a	**Action List (Pages 9 - 14)** The Action List from the meeting held on 23 June is attached for note.
3	**Declarations of Interest** Members of the Board to declare an interest in any particular agenda item.
	Items for Discussion
4	**Contribution of the Voluntary and Community Sector to improving health and wellbeing in Gateshead** (Pages 15 - 60) Report attached to be presented by Sally Young.
5	**Gateshead Health Needs Assessment - Black and Minority Ethnic Population** (Pages 61 - 138) Report attached to be presented by Gerald Tompkins
6	**Health and Lifestyle Survey 2016 Findings** (Pages 139 - 144) Report attached to be presented by Matthew Liddle
7	**A Year of Action on Tobacco and Smoking: Five by Twenty Five** (Pages 145 - 148) Report attached to be presented by Andy Graham and Paul Gray
	Performance Management Items
8	**Better Care Fund Follow Up Report to Quarter 4 Return** (Pages 149 - 154) Report attached to be presented by Jean Kielty
9	**Updates from Board Members**

Contact: Sonia Stewart; email; soniastewart@gateshead.gov.uk, Tel: 0191 433 3045,
Date: Thursday, 13 July 2017

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GATESHEAD METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD MEETING

Friday, 23 June 2017

PRESENT	Councillor Councillor Lynne Caffrey (Gateshead Council) (Chair)	
	Councillor Paul Foy	Vice-Chair
	John Pratt	Tyne and Wear Fire Service
	Councillor Mary Foy	Gateshead Council
	Councillor Martin Gannon	Gateshead Council
	Ian Renwick	Gateshead Health NHS Foundation Trust
	Dr Bill Westwood	Federation of GP Practices
	Sheena Ramsey	Chief Executive
	Alice Wiseman	Director Of Public Health
	Kate Israel	Healthwatch Gateshead
IN ATTENDANCE:	Alison Dunn	Gateshead Citizens Advice Bureau
	Neil Bouch	The Gateshead Housing Company
	Joe Corrigan	Newcastle Gateshead CCG
	Lynn Wilson	Consultant, Public Health
	Deborah Dews	
	Jackie Cairns	
	Bernard Groen	Health Education England
	Wendy Hodgson	Healthwatch Gateshead
	Sophie Brook	UCL
	Mandy Cheetham	The Gateshead Housing Company
	John Costello	Gateshead Council
	Helen Conway	Gateshead Council
APOLOGIES:	Councillor Malcolm Graham, Councillor Ron Beadle and Councillor Michael McNestry	
	Mark Adams and Dr Mark Dornan	

HW137 MINUTES

RESOLVED - that the minutes of the meeting held on Friday 28 April be agreed as a correct record.

HW138 ACTION LIST - 28 APRIL 2017

RESOLVED - that additions and work in progress as listed on the action list be noted.

The Board received the updated one page document of the People

Communities and Care model (formerly referred to as the Neighbourhoods and Communities Model) which has incorporated the feedback received from stakeholders, including those from the Board.

The Board noted that the issue of CAMHS waiting time is also due to be considered by the Families OSC.

The Board were advised that Ian Renwick and Julie Ross came to the Care, Health and Wellbeing OSC this week to present an update on the Deciding Together, Delivering Together workstream and that Councillor Marilyn Charlton will attend the workshop on access to services that is scheduled to take place in the autumn, as vice-chair of Care Health and Wellbeing OSC.

HW139 DECLARATIONS OF INTEREST

HW140 UPDATES FROM BOARD MEMBERS

Gateshead Council

The Chair reported that a Board Development session is being organised and it would be helpful if people could feed in what they would like on the agenda. It is proposed that the session will take place in the Autumn and colleagues from the Local Government Association have offered to facilitate.

Caroline O'Neil has been appointed to the Strategic Director for Care, Wellbeing and Learning post and will start in the Autumn.

Sheena Ramsey and John Pratt reported that in the wake of the Grenfell Tower disaster Gateshead Council have been very proactive and have been working closely with the Gateshead Housing Company and the Tyne and Wear Fire and Rescue Service in getting messages out to residents and re-assuring them about their concerns.

Sheena reported that all 25 council owned blocks in Gateshead are not fitted with the cladding used at Grenfell Tower. She also pointed out that all Gateshead Tower Blocks have either a caretaker or concierge in residence on site.

Councillor Gannon also reported that he has raised the issue of the Grenfell Tower response at the LGA in London and it was felt this issue needs discussion at a national level.

Healthwatch Gateshead

Kate Israel reported that 4 people have been appointed to the Committee so far with another 3 interviews scheduled over the next couple of weeks. The priorities for Gateshead have been suggested as Carers and Support to Carers, and people's experience of accessing continuing healthcare.

HW141 GATESHEAD HEALTH & CARE WORKFORCE: CHALLENGES AND OPPORTUNITIES

The Board received presentations from Bernard Groen (Health Education North East), Jackie Cairns (CCG), John Costello (Gateshead Council) and Deborah Dews (Gateshead GP Transformation Team) on Gateshead Health & Care Workforce: Challenges and Opportunities.

During the course of the discussions on the presentations, the Board noted that:

- Issues around workforce recruitment and retention are often tied to prospects for the local area and available resources and investment in the area;
- Linked to the above, there is a need to secure local powers that will help us to shape our own destiny;
- Much work is taking place at a regional level through the Local Workforce Action Board/Group which Gateshead and Newcastle feeds into. This also links to the Sustainability and Transformation Plan (STP) and it may be helpful to have an update on this work at a future date.
- It is important to engage and work with local universities and colleges in looking to address the workforce issues identified e.g. work between the Q.E. and Gateshead college.
- We need to explore the scope for greater use of promotional videos to sell the local area (why come to the North East).
- Consideration also needs to be given to the workforce needs of services that people have been sign-posted to, including within the VCS. It was felt that this should feed into and form part of commissioning arrangements. How non-commissioned services contribute to our health and care agenda is an important consideration.
- We need to continually review how new technologies can be harnessed to support our local workforce so that it can work in new way and deliver our new models of care
- The solution to workforce shortages is not always about recruiting more of the same. The answer can often be supporting staff to work in different ways ensuring the 'prevention' is embedded in everything we do and is seen as everyone's responsibility – being proactive rather than reactive in our approach.
- 'making every contact count' is a good example of how prevention can be embedded within the roles of all staff
- There appears to be a real will to progress primary, secondary and tertiary prevention which needs to be factored in to our workforce planning and skills development
- There is a need to park 'organisational tribalism' and address workforce needs across the local health and social care system as a whole.
- An Organisational Development plan is currently being developed for the local health and care system which will have regard to the workforce challenges and opportunities identified within the presentations. This can be brought to the Board for consideration at a future date.

The Board agreed that the workforce agenda should become a regular agenda item for the Board and all partners present agreed that working together to embed the prevention agenda across our workforce would be beneficial.

RESOLVED - (i) that the information presented noted and this item to become a regular agenda item for future meetings.

(ii) that a report be brought to a future board meeting on the Organisational Development plan that is currently being developed for the local health and care system

HW142 GATESHEAD HOMELESSNESS AND MULTIPLE AND COMPLEX NEEDS: HEALTH NEEDS ASSESSMENT

Jill Harland, Speciality Registrar, Public Health presented the Board with the Executive Summary and power point presentation on the Health Needs Assessment of Gateshead Homelessness and Multiple and Complex Needs.

Sheena Ramsey wished to place on record that this piece of work is one of the most fundamental and game changing pieces of work she has ever seen and Jill Harland should be applauded for her work.

The Board recognised that there is a gap on how we identify and measure multiplicity of need and endorse the recommendation to consider this from a whole system point of view.

It was noted that the regulatory system can sometimes be a barrier to effective joint working and it was agreed that barriers need to be identified so that effective ways of addressing them can be put in place. It was also felt that local authorities should have the necessary powers to build houses to help meet local needs.

It was also noted that how we work together to meet the needs of the homeless and those with multiple and complex needs should be a barometer of how well we work together as a local system. If we can get it right for this cohort, the ripple effect for other groups can also be significant.

The Board agreed that this piece of work should be shared amongst all partner organisations and the Board also felt that lobbying should take place with our local MP's to bring the findings of this report to the attention of central government.

The Board endorsed plans to roll out the report to Strategy Group, Service Directors and all councillors over the summer and to ensure that NTW (who were not present at today's meeting) are able to contribute to actions emerging from the Health Needs Assessment findings and recommendations A workshop for the Health and Wellbeing Board and key stakeholders should be held in the Autumn to progress the findings and recommendations within the report.

The Board also suggested that the report's findings should be presented to The Gateshead Housing Company. It was also felt that Gateshead Care Partnership had a role to place in taking this work forward.

It was noted that the roll out of universal credit is imminent and this will be another factor to consider.

RESOLVED -

i) That the thanks of the Board be recorded to Jill Harland for an excellent piece of work.
ii) That the findings and recommendations arising from the health needs assessment be rolled out across the local health and care system and that a workshop be held in the Autumn to progress this work.
iii) The findings of the report to be brought to the attention of central government
iv) That an update be presented to the Board within the next six months on progress in implementing key recommendations in this document.

HW143 0 - 19 SERVICE REMODELLING AND PROCUREMENT

There was insufficient time during the meeting to cover this item and colleagues were asked to send any comments before the matter is considered by Cabinet on 18 July, to Lynn Wilson, Consultant in Public Health. Lynn will be happy to consider comments via email or face to face.

RESOLVED - that the information be noted.

HW144 BETTER CARE FUND QUARTER 4 RETURN 2016/17

There was insufficient time to consider this item during the meeting so it was agreed that this item will be covered under matters arising at the next Board meeting on 21 July 2017.

RESOLVED – that the information be noted

HW145 PHARMACY APPLICATIONS 2016/17: UPDATE

There was insufficient time to consider this item during the meeting so it was agreed that this item will be covered under matters arising at the next Board meeting on 21 July 2017.

RESOLVED – that the information be noted

HW146 ANY OTHER BUSINESS

There were no items of any other business raised

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GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 23rd June 2017			
Gateshead Health & Care Workforce: Challenges and Opportunities	A report to be brought to a future Board meeting on an Organisation Development plan currently being developed for the local health and care system. Workforce agenda to be a regular agenda item for future Board meetings. This should include contributions to regional work through the Local Workforce Action Board/Group.	Jackie Cairns All	To feed into the Board's Forward Plan
Gateshead Homelessness and Multiple and Complex Needs: Health Needs Assessment	That the findings and recommendations arising from the health needs assessment be rolled out across the local health and care system and that a workshop is held in the Autumn to progress this work. The report's findings should be presented to The Gateshead Housing Company. The findings of the report to be brought to the attention of	All	To feed into the Board's Forward Plan. Council leadership session on the report has been organised. Arrangements are being made to present the report to The Gateshead Housing Company

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
	central government. An update to be given to the Board within the next six months on progress in implementing key recommendations within the document.		
0 to 19 Service Remodelling and Procurement	Any comments to be forwarded to Lynn Wilson prior to consideration by Cabinet on 18th July.	All	**Completed**
Better Care Fund Quarter 4 return 2016/17	To be covered under matters arising at the 21st July Board meeting.	John Costello and Hilary Bellwood	A follow-up report has also been prepared for the 21st July Board meeting
Pharmacy Applications 2016/17: Update	To be covered under matters arising at the 21st July Board meeting.	Public Health	Will be covered at 21st July Board meeting
Matters Arising from HWB meeting on 28th April 2017			
Neighbourhoods & Communities Model	Comments of the Health and Wellbeing Board to be noted as part of the overall feedback received and the model altered accordingly.	Julie Ross	**Completed**
Childhood Obesity: Year 6 Data Update	That a report be received at the June Board meeting outlining a potential future model for delivery of 0 to 19 public health services.	Alice Wiseman	**Completed**
Final Gateshead	That future reports be	Joy Evans/Alice	To feed into the

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Substance Misuse Strategy & Action Plan	received by the Board so that it can scrutinise and provide challenge against progress made.	Wiseman	Board's Forward Plan
Deciding Together, Delivering Together: Update	That further updates be brought to the Board as they become available. That a report on CAMHS waiting times for Gateshead residents be brought to a future Board meeting.	Julie Ross/Ian Renwick NHS Newcastle Gateshead CCG	To feed into the Board's Forward Plan
Matters Arising from HWB meeting on 3rd March 2017			
Updates from Board Members	Consider findings of VCS study 'Doing Good in Gateshead' at a future Board meeting.	Sally Young & VCS colleagues	On the agenda of the 21st July Board meeting.
Health Protection Assurance report	Bring back a report to the Board regarding Excess Winter Deaths.	Gerald Tompkins	To feed into the Board's Forward Plan
Matters Arising from Joint HWB/CSB meeting on 17th February 2017			
Impact of Alcohol	To bring an updated Substance Misuse Strategy and Action Plan to the Board.	Joy Evans/Alice Wiseman	**Completed**

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 20th January 2017			
Updates from Board Members	A discussion to take place on workforce issues and their implications for Gateshead at a future Board meeting.	All	**Completed**
BME Needs Assessment	An analysis of primary care data to be undertaken to investigate important risk profiles for this population. An action plan to be developed to propose solutions to ensure BME communities receive important messages regarding access to appropriate services. The action plan to be implemented in appropriate ways to ensure solutions to the issues and recommendations as set out in the Health Needs Assessment.	All	**Completed** On the agenda of the 21st July Board meeting
Strategic Review of Carers Services	A further report to be brought to the Board on completion of the review.	Director of Commissioning & Quality Assurance	To feed into the Board's Forward Plan
Matters Arising from HWB meeting on 2nd December 2016			
Gateshead Sexual Health Strategy	An update on progress to be brought to the Board in a year's time.	Alice Wiseman/ Gerald Tompkins	To feed into the Board's Forward Plan

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 21st October 2016			
Action List – HWB Development	It was suggested that the LGA could be asked to help with taking forward development work with the Board.	Sheila Lock / John Costello	Ongoing
Matters Arising from HWB meeting on 9th September 2016			
Gateshead JSNA 2016 Update	An update report to be brought to the Board in September 2017.	Alice Wiseman/Iain Miller	To feed into the Board's Forward Plan
HWB Forward Plan	Partners to contact John Costello with any additional items to be included within the Forward Plan.	All	On-going
National Joint Review of Partnerships and Investment in VCS in Health & Care Sector	A further report to be brought back to the Board in three to six months' time.	Sally Young	A report on the contribution of the VCS to improving health and wellbeing in Gateshead is on the agenda of the 21st July Board meeting
Matters Arising from HWB meeting on 10th June 2016			
Drug Related Deaths in Gateshead	An update report to be brought to a future Board meeting.	Alice Wiseman	To feed into the Board's Forward Plan

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Gateshead Council

HEALTH AND WELLBEING BOARD
21st July 2017

TITLE OF REPORT: **Contribution of the Voluntary and Community Sector to improving health and wellbeing in Gateshead**

Purpose of the Report

1. To seek the views of the Health and Wellbeing Board on the contribution of the voluntary and community sector to improving health and wellbeing in Gateshead.

Background

2. In April 2016, Newcastle CVS were invited by Gateshead Council to provide support and development, networking opportunities and representation for the voluntary and community sector in Gateshead and to manage the OurGateshead website. This was initially until March 2017, until a more permanent solution could be resolved. This contract has now been extended until December 2017 and a competitive tender for the service will be issued. As part of this role, Newcastle CVS has become actively involved in the Gateshead Health and Wellbeing Board and the Chief Executive chairs the Advisory Group. The Chair of the Gateshead Health and Wellbeing Board requested a report on the state of the local voluntary and community sector and its contribution to health and wellbeing.

3. At the start of this year, Newcastle CVS carried out a survey with local voluntary and community organisations, and the findings from this study, together with information from visits and meetings provided the basis for *'Doing Good in Gateshead 2017 : Looking at the voluntary and community sector in Gateshead'.*

4. The study identified that there were:
   - 342 registered charities based in Gateshead
   - 24 mutuals
   - 42 CICs (Community Interest Companies)
   - Between 700-1000 small, local groups, activities and organisations (*using the Below the Radar methodology of 3-4 times the numbers of registered charities)*
   - 502 charities that are not based in Gateshead, but cover Gateshead in their activities eg Newcastle CVS

   The organisations survey worked with both the general and specific groups:
   - 44% work with all client groups
   - 56% work with specific groups

   These communities include asylum seekers, refugees, BAME communities, carers, children, disabled people, employed people, faith groups, families/parents, LGBT, gypsy / traveller communities, homeless people, people with learning disabilities, lone parents, and all the groups identified under the Equalities Act and having the poorest health and wellbeing.

5. The voluntary and community organisations that work in Gateshead are very varied, and the following findings come from the organisations surveyed :

   - *Staff* - More than half of those asked had no or just one member of staff, but a small number have several hundred eg Mental Health Concern. Some will employ clinically qualified staff
   - *Income* - can range from a few hundred pounds to many millions (Changing Lives). Across England, more than half of all charities have an income of less than £10,000
   - *Volunteers* - 75% of those asked have between 5-70 volunteers. However there are issues on recruitment, retention, support and training for volunteers.
   - *Governance* - trustees, management committee members, directors (not CICs) are unpaid
   - *Beneficiaries* – many tens of thousands of Gateshead residents benefit from engaging in what we do, whether directly from support, services, activities, facilities or an improved environment
   - *Regulation* – Charity Commission, Companies House, CIC register, Cooperatives and Mutuals

6. Funding and sustainability remain a key concern for many organisations and their income streams have changed significantly in the last five years, often due to the reduction in funding from local government. The position in Gateshead is reflected across the country, and the North East in particular (please see appendix)

   The key sources of funding were:
   - Grants from charitable foundations/ trusts
   - Selling goods / services (trading) eg renting rooms
   - Charitable donations from the public
   - Public sector grants – national and local government, NHS, OPCC
   - Grants from Big Lottery
   - Public sector contracts - national & local government, NHS, OPCC
   - Reserves, investment, endowment, other

7. One of the factors that had a significant impact is the amount of change that organisations have faced. The significant changes in funding, policy, regulations, commissioning practices, organisational and personnel changes in local authorities and the NHS, means this has impacted on what organisations do and how they operate.

   Of the 87 organisations that responded, last year in Gateshead :
   - 40% saw an increase in income, 37% stayed the same, 23% saw a decrease
   - 27% saw an increase in staff numbers, 59% stayed the same, 12% saw a decrease
   - 34% saw an increase in volunteer numbers, 48% stayed the same, 18% saw a decrease
   - 72% saw an increase in demand for their service, 21% stayed the same and 7% saw a decrease
   - 66% of organisations developed a new service

8. Looking at the challenges ahead, Gateshead organisations identified these as:

   - *Organisational* - Funding; recruiting and retaining volunteers; coping with increased costs; keeping up with change; keeping going / sustainability; premises issues; new trading ideas; being as efficient and effective as possible – managing the increased demands within reduced resources and higher costs; regular / constant restructures

and change to be able to cope in circumstance; responding to the communities' needs; rules around commissioning made it harder for some organisations – could Social Value be used more in contracts

- *Communities* - Impact of welfare reforms; increased poverty in communities; withdrawal of statutory services; loss of general activities; loneliness and isolation; having to pay more / pay for; (lack of) jobs / employment / sanctions

- *Organisations supporting people with disabilities (Changing Winds)* - four gone/going since 2013; changing organisations; equality agenda being downgraded; impact of welfare reforms; can't charge poor clients, carers; organisations greater use of digital; access is still an issue; communications and access; articulating need; changing needs, more complex, more intractable; safeguarding issues; poverty

9. The role of the voluntary and community sector in improving health, wellbeing and care has developed enormously in the last twenty-five years. It has multiple roles, often dependent on the size and nature of the organisation; these include:
    - As a service provider
    - As a mechanism for bringing patients, users, and carers together e.g. support groups, peer experience
    - As an advocate for individuals, groups and communities who are often excluded
    - Through the use of volunteers to enhance services and experiences
    - Engagement in the governance process
    - As a consultee
    - As a partner in decision-making
    - As an advisor on processes
    - Being involved in the production of the JSNA, and other strategies
    - As a source of information, knowledge and expertise on particular communities
    - As an improver of the physical environment
    - As a campaigner for environmental and other improvements

10. However most of these activities require capacity and resources, whether it is goodwill, time, space, volunteers, finance etc. There is a danger, identified in a number of reports, including *Doing Good in Gateshead,* that voluntary and community organisations will just somehow substitute for paid public sector staff. The shift towards social prescribing is of increasing concern as across the country a number of resources seem to be invested into sign-posters / navigators/ directories indicating where services are, but not into the services themselves. The definition of social prescribing isn't clear and seems to be bandied about without an understanding of the implications or the resources necessary to make it work properly.

    There have been some successful examples of asset transfers from the public sector to voluntary organisations, but these take time and a lot of resources. Initially public sector (mainly council) staff were able to invest time in these and provide background support and a safety net, however the more recent transfers are not as sustainable.

    Experience has demonstrated that what makes local organisations work well is the involvement and support of local people. This can take time, involve community development, be focussed on a need, and the end result has got to be what that community wants. The contractual cycle can sometimes conflict between what a commissioner wants to purchase and what an organisation believes is necessary for delivering to its community. Artificial structures parachuted in, that don't have local ownership or buy-in, are unlikely to work; an example of this across the country is National Citizen Service (NCS), a national government initiative which is often not

delivered by local organisations. In Gateshead this is delivered by Catch 22 (a national charity) and Groundwork North East (which is already active in Gateshead).

In 2010, the Government proposed the opening up of public sector contracts to the voluntary sector. These included major contracts on the Work Programme and the Criminal Justice system. In reality, the vast majority of these contracts are now delivered by private sector international companies eg Serco, A4E and G4S and the voluntary sector has had a few painful experiences as end providers. A number of medium-sized organisations do not feel able to bid for public sector contracts as these have become larger and often the requirements are onerous and disproportionate to the contract value. As public sector funding has shrunk further, a number of organisations (voluntary and private), are removing themselves from social care provision. Very recently Lifeline, a major charity (£60million) providing drug and alcohol services (albeit not in Gateshead), went into receivership.

The amount of volunteering in Gateshead is much higher than the UK, with Gateshead Council reporting that *"34% of Gateshead residents regularly taking part in an activity".* There is clearly a strong base to build upon, and councillors and council officers are involved with and aware of the sector. Newcastle CVS has built up a good rapport with a number of voluntary and community organisations in the fifteen months.

There have been major shifts in public sector organisations with more to come, and this has meant a loss of some partnerships, relationships and understanding of each other's challenges and difficulties. This could be the right time to forge a new relationship, refresh the Gateshead Compact (which is a statement of the relationships) and work together across the wider partnership to improve health and wellbeing in Gateshead.

Proposal

11. It is proposed that Board considers this report, the information contained in Doing Good in Gateshead, and the National Trends paper, the need to review the Gateshead Compact and other appropriate issues.

Recommendations

12. The Health and Wellbeing Board is asked to consider the report and how it wishes to take forwards its recommendations.

Contact: Sally Young, Newcastle CVS Tel 0191 232 7445

Newcastle Council for Voluntary Service

Doing Good in Gateshead 2017

Looking at the voluntary and community sector in Gateshead

March 2017

Acknowledgements

This report would not have been possible without the voluntary organisations and community associations staff and volunteers who kindly gave their time to fill in the online survey, come to meetings and allow Newcastle CVS staff to visit their organisations.

Contents

Executive Summary

Since 2010 there have been major changes in the voluntary and community sector (VCS). These have been driven by government policy changes, commissioning and procurement requirements, reduction in funding for local councils, the impact of welfare reforms and many other factors. Most VCS organisations have experienced external changes to their income - clearly some haven't been able to adapt to this 'New Normal', and have closed or become very different. The greater emphasis on income generation has enabled new structures such as Community Interest Companies (CICs) to develop and become established.

Voluntary and community organisations have had to rely more on unpaid volunteers, social media and different ways of delivering services and attracting funding. At the same time there's been ever-growing demand for support from local people and communities. The third element of the 'perfect storm' of reduction in funding and increase in demand is the complexity and problems of the people who are now approaching the voluntary sector for support. The reduction in statutory services means many people who would have been previously supported by local authorities and the NHS are now supported by the voluntary sector.

Yet there is a greater expectation than ever before that charity and volunteers will 'step up to the mark'. We are not yet clear what a 'Shared Society' means yet – is it resources, responsibilities or power-sharing; a combination of these or none of these? The concept of the Big Society is now firmly pushed away as it appears to have become the smokescreen for cutting back public services and a distraction. However, some key elements - the National Citizen's Service and the empasis on social finance are still important and emphasised within the current Government. But one of the Big Society platforms of social action, encouraging and enabling people to play a more active part in society, is actively encouraged by the voluntary and statutory sector.

As Gateshead Council faces major budget reductions of £70million in the next four years, inevitably one of the potential solutions is the more appropriate use of local voluntary and community organisations. Similarly as the NHS approaches its own budget problems and the complexities of the Sustainability and Transformation Plan (STP), it has discovered 'social prescribing' and the potential support from voluntary and community organisations.

This study is from the perspective of the voluntary and community sector and tries to illustrate our views. There is still an optimism and willingness to engage in addressing major challenges, but we need to be involved from the start of the process, not invited in at the end as an afterthought.

Many of the comments reflect the frustration that people are trying to do their best in difficult times, and in some instances they are being thwarted by others. Funding clearly remains the key issue as many organisations are concerned about what would happen to the people and communities they support, if they no longer existed.

There are concerns about the recruitment and retention of volunteers and that the management of volunteers has costs, which are hard to cover financially.

Although the findings are not surprising to those who know the sector in Gateshead, the figures on the breadth and the scope of sector are illuminating and illustrate the potential of what could be achieved, if the sector was properly supported and involved.

Background and Methodology

As part of its policy and research role, Newcastle CVS (Council for Voluntary Service) carried out a study of voluntary and community organisations in Gateshead. It was the first time for many years that an independent study had been carried out. In 2016 Gateshead Council staff had carried out survey about 'access to advice, guidance and representation for Gateshead's community groups and organisations'. There have been studies such as the VONNE study for North East England, but of the 100 organisations that participated, only three worked solely in Gateshead, and another eleven organisations covered Gateshead. At the time of writing, the results from the North East and Cumbria Third Sector Trends Study 2016 are being written up. Clearly there are national studies, which are referred to throughout this report; but the cohort for this study are those organisations that are based in Gateshead, but might provide services elsewhere.

The information in this report was generated from a survey carried out in December 2016 and January 2017, visits made to over 30 voluntary and community organisations in 2016, discussions at the Gateshead Voluntary Sector Leaders Group and the experiences of the CVS staff who have been working in Gateshead since April 2016. The survey was promoted through e-inform the Newcastle CVS fortnightly e-bulletin, Twitter, Facebook and direct email. The survey asked about questions about organisations' status, their achievements and challenges, and what pressures they had identified for the future.

87 responses were received by directly contacting around four hundred organisations. The breakdown of the type of the respondent group illustrates that, as usual, smaller, community organisations are under-represented in the respondents. However the profile of the respondents is very similar to that of registered charities in Gateshead.

The following response was received from an organisation, which illustrates the complexity and limitations of the study.

"We are the X society. I am finding it very difficult to answer your questionnaire as I am not sure about the interpretation of some questions and many are not relevant to us. The Gateshead Drop-in is a satellite group of the main Newcastle Branch, which is part of the north Region and that is part of the national organisation. We have recently started three new drop-ins – but it is still very early days for those. The groups are actually run by volunteers, with staff oversight.

The Gateshead group has no independent accounts. Both income and expenditure are part of Newcastle Branch accounts. Our client group is anyone affected by X either patient or carer or any family members or friends. All are welcome to seek information and advice to cope with X. We do not have "challenges" and we do not measure change. We just publicise our services in various ways and just offer an informal drop-in situation."

Clearly this is the type of organisation that is 'doing good'; it needs some professional overview and support but it is run mainly by local volunteers, some of whom suffer from the condition and their carers. But while this type of doing good is hard to quantify and won't necessarily be covered from the survey respondents, it clearly contributes towards the overall health and wellbeing in Gateshead.

Key Findings

Funding is the most pressing issue for voluntary and community organisations in Gateshead. This is regardless of whether they are small, medium or large organisations.

More than seven out of ten organisations noted an increase in demands for their services in the last year. A number of organisations reported year on year growth in demand for several years.

The recruitment and retention of volunteers is the second largest area of challenge. This concern was shared across small community organisations, which were totally run by volunteers and larger voluntary organisations.

Despite the challenges, the majority of respondents remain optimistic about the future of their organisations. Over a third want to increase the number of beneficiaries, nearly half want to increase services, nearly two thirds anticipate more volunteers and a quarter want to increase staff in the next year.

Two thirds of organisations had developed new areas of service, projects, initiatives and events during the last year. The push to innovation was still happening, despite restructures, funding cuts and other challenges.

The key challenge for the people using the services and facilities was the impact of welfare reform. There was a noticeable growth of poverty within communities, set against a background of withdrawal of statutory services and a loss of general activities.

There are over 400 registered charities, mutuals and CICs based in Gateshead with another 500 charities, based elsewhere, providing services in Gateshead. There are another 700-1000 small, local groups and organisations.

Voluntary and community groups are beginning to use their reserves to keep going rather than use them for strategic development. This is inevitable with less funding available.

Grants from charitable foundations and trusts were the most common form of income for voluntary organisations. Income from public sector grants and contracts was not the major source of income for a number of organisations.

Two out of five organisations noted an increase in income since the previous year. Income stayed the same for just over a third of organisations and just under a quarter saw a decrease in income since last year.

Most organisations were aware of the values and challenges of partnership working. Most organisations had made decisions about partnership working which were appropriate to their capacity, resources and challenges.

The big challenge remains of greater demand, fewer resources and clients having more complex needs. The issue of the number of clients with a much higher level of needs, and more problems needing resolution is a major challenge.

How big is the voluntary and community sector in Gateshead?

As in most areas, the voluntary and community sector can be divided into three different groups. The first group is the large number of smaller and community organisations, mainly with an income of under £25,000; the second is the middle group with an income of usually £25,000 - £500,000; the third is the small number of larger registered charities, with an income of over £500,000. Clearly this is a generalization and some organisations will have characteristics pertaining to more than one group.

All charities and Charitable Incorporated Organisations (CIOs) are listed on the Charity Commission website. We explored the website in January 2017 and 342 organisations were listed with an office in Gateshead. However on searching for registered charities with an area of benefit in Gateshead, there were 844 charities listed. The majority of these organisations will be based in Tyne and Wear. There will also be national organisations that provide support to Gateshead residents, even though there is no local base e.g. through advice and information and support through helplines and provided digitally. The suite of publications about small community organisations published by the Third Sector Research Centre (TSRC) came up with the observation that for every registered charity there were three or four small local organisations, which may or may not be formally constituted and offer more informal and semi-formal activities. So it is estimated there are around 1,000 of these types of (micro) groups and activities in Gateshead.

There are also a number of Community Interest Companies (CICs) that are registered at Companies House. There are currently 42 CICs registered with a Gateshead address. There are 24 organisations based in Gateshead listed on the Mutuals Public Register. These are mainly defined as 'working-men's clubs'. Although the term 'social enterprise' can be used to describe some organisations, it has no legal definition, and so is not included in these figures.

So there are around:

- 342 registered charities based in Gateshead
- 24 mutuals
- 42 CICs
- Between 700-1000 small, local groups, activities and organisations
- 502 charities that are not based in Gateshead, but cover Gateshead in their activities

Community organisations and small voluntary organisations

There are many hundreds of these organisations in Gateshead. Some are loose associations with very little income, not properly constituted (and maybe don't need be) – and consist of local people volunteering and doing good. Our experience is these many local organisations and activities often have minimal funding and just get by; they don't employ staff but can be seen as essential to the structure and well-being of local communities. Other organisations might be a bit bigger (and need to register as a charity or Charitable Incorporated Organisation if their income is over a certain level). Being incorporated means they can get a bank account and have the power to employ staff and take on a lease and are regarded as a 'legal entity'.

In the years since 2010, there has been an assumption, across the UK in line with

David Cameron's 'Big Society' initiative that volunteers and voluntary and community organisations would take over the running of many community facilities and functions. The reality has been different to the rhetoric with mainly medium-sized and larger voluntary organisations being more able to successfully take over the risks and liabilities that come with asset transfer. However there are examples of smaller, volunteer-led organisations taking over assets. In some instances these appear to have been successfully transferred, mainly because of the amount of support offered by Gateshead Council staff. It is not clear what will happen in the future as Gateshead Council reduces these resources.

Medium-sized, mainly local organisations

The second group is of those organisations, all based in Gateshead, many of which work only in Gateshead, but some have changed their boundaries and scope in order to increase their income. Most of these organisations are charities, but some are CICs (Community Interest Communities) that generate their income through trading. Some of these organisations were initially set up and run by Gateshead Council. These organisations can be 'squeezed' as the bigger organisations (see below), often employ bid-writers, and swoop in to pick up contracts that they have otherwise delivered. Several of these organisations lost significant funding in 2010 and 2011, due to changes of Government policy and funding streams, and the loss of regeneration funding. Some organisations have lost funding from Gateshead Council. Nearly all of these organisations have experienced significant changes in their funding mix.

Large Organisations

There are a small number of large charities that are based in and work in Gateshead and other areas. There are other large organisations. These organisations get their income through contracts (local and national), through the NHS, manage and lead large Big Lottery bids, trading and fund-raising. They employ staff, provide social care, improve health and well-being and often manage complex projects and funding. Most of these organisations have grown over the last five years. Most of these organisations engage in Gateshead strategic activities. All the organisations that CVS visited or engaged with were keen to work with Gateshead Council and improve the health, wealth, well-being and environment of the communities in Gateshead. The key focus for some wasn't necessarily just Gateshead, but they have capacity and resources and want to extend their services; however they don't necessarily know who to talk to / where to go.

Discussion

There is an active voluntary and community sector in Gateshead, who can take on a number of roles, but it is not able, nor does it want, to run everything. Gateshead has had a number of volunteering initiatives going back many years, and clearly the use of volunteers in 'Friends of' and other environmentally focused groups have provided a valuable resource. There have been asset transfers of community centres and volunteer-led libraries. But across the country, volunteers are being asked to do more. People will volunteer only for those causes they feel strongly about. They need support, training and encouragement. They want to offer complementary services and there are concerns voiced – by volunteers, workers, and Trade Unions, if they step into the shoes of (previously) paid workers. The issue of recruitment and retention of volunteers was the second biggest item of concern to survey respondents.

"The current climate seems to expect full time employed people who have previously been happy to volunteer to take on responsibility for making money and growing the organisation. They don't want that, it's not why they joined and they will leave. The system that rewards national governing bodies for the degree of participation in their area yet relies on volunteers to drive that participation is broken, there is an imbalance between wealthy charitable organisations and those of us acting locally on small sums of money."

"Financial self- sufficiency in the wake of funding cuts and hardship for the people using us. Negative publicity regarding the area of work we are engaged in. Replacing volunteers who want to volunteer, not run a business. They are being forced to think commercially which was never part of the attraction."

"Maintaining volunteer numbers. Maintaining the present level of fundraising. Maintaining the present levels of community awareness to our initiatives."

"As with a lot of volunteering groups age is a big factor. In our group we have an age problem and whilst the enthusiasm is not questioned maintaining levels of hands on physical engagement is at times difficult but we try to fulfil our levels of community support."

From the discussions with voluntary sector leaders, the visits and the survey, there is still concern that the public sector in Gateshead doesn't really understand the breadth and depth of what the voluntary and community sector is, does and can offer. The impact of welfare reforms, the reductions in Gateshead Council's budget, and the retraction of the NHS (particularly for mental health support) meant that voluntary organisations were dealing with people at critical parts in their lives, they were often in crisis. There was still a perception that some people still regarded the voluntary sector as dealing with non-statutory and 'fluffy' issues. This report tries to explain the breadth of the sector and its offer from very small volunteer-led local community groups, through to major charities providing statutory services and employing highly trained professional staff.

The impact of welfare reforms and increased poverty within and between communities was raised a number of times. There are more poor people, more communities in need, fewer statutory services and longer waiting times for the services that still exist.

"Austerity effects of reduction in other services including pressure on statutory services, longer waiting times, reduced eligibility for mental health services."

"Older people: health / frailty; managing with reduced abilities; Asylum seekers: learning

English; integration; Families on benefits: impact of being sanctioned; poverty."

"The problems faced by our members are extremely varied. They are generally men facing difficult times in their lives, bereavement, mental health problems, being a carer, and resulting social isolation etc. We feel that all these problems will be exacerbated by the inevitable post Brexit economic downturn, and we are glad that we can provide a vital social connection and relief from stress during the tough times ahead."

"Significant reductions in council services leading to gaps in service or increasingly disjointed services. Increasing pressure of household budgets as cost rise and people unable to cope, particularly with benefit cuts/ sanctions."

"We work with carers, so they are facing an increase in their levels of care due to social care being either not available or being so expensive that they can't afford it for their cared for and so the carer has to take on even more caring responsibility. The carer's own health and wellbeing will suffer, as will their financial situation if they have to give up work to care or take reduced hours to care."

"Coping with the welfare reforms and reduced income. Coping with tougher sanctions on their benefits. Generally avoiding homelessness as they struggle to manage their budget."

"Service provision (i.e. there is little or none). Cuts to social care and health budgets: being cast adrift in a system that does not look after this vulnerable group but which is struggling to deal with critical needs let alone substantial or moderate. This will have very detrimental effects on people with learning disabilities and their families and is a false economy as the 'prevention' costs they are saving from closing provision or making people ineligible to access provision is a short term solution. Adopting a preventative approach with services being available and accessible during life will help to reduce the longer term care needs (and therefore the costs to the State and local government) of this group. It's not rocket science. Vulnerable people such as people with learning disabilities are in danger of becoming more isolated and marginalised than they were 20 years ago under this current national programme of austerity with years of good work potentially becoming undone. This approach will cause a much heavier long-term financial burden to this country. We feel incredibly sad for the local councils and the levels of cuts they are experiencing nationwide but the austerity measures are not a long term solution and will end up costing more both morally and tangibly, in the long term. The current welfare system overhaul which is very hard indeed on people with learning disabilities and fails enormously to take their needs and position into account causes health and anxiety problems for PWLD and is leaving them feeling isolated and alone."

"More poverty, lower incomes due to benefit sanctions, benefit caps. Struggling to meet the costs of childcare. Lack of Council funded activities and provisions. (ie; social care for adults with learning disabilities)."

"Changes to benefits (Housing Benefit, Local Housing Allowance, Universal Credit etc). Changes to service provision due to cuts within the public sector which also has in impact on the third sector. Quality of life/wellbeing as a result of these challenges."

"Lack of mental health services. Benefits under attack. Disability hate crimes and prejudice."

Other commentators have described the position of local authority areas in the North East – the low Council Tax base, the inheritance of a post-industrial landscape and the general health and well-being status of local people. Gateshead has been

characterised by its approach to arts and culture, the green environment, the Metro Centre and the close working between stable public services. Residents and workers feel very proud of Gateshead, and this makes the loss of well-loved public services and facilities even more missed.

The public sector in Gateshead – the Council, the NHS, Police, Fire and Rescue Services, and criminal justice system have all experienced major cuts in their funding and have had to reorganise and reduce their services. This has inevitably meant changes in people, with the associated loss of organisational memory, partnerships and relationships. One of the features that identified Gateshead was the strong sense of place and the 'Gateshead Family', but as many public services undergo reform, there are fewer Gateshead-only service boundaries and focus. Gateshead Council is going through very senior appointments, the NHS is now focussing internally on its own budget issues and the Sustainable and Transformation Plan (STP), and other services have undergone major transformation and reforms. The Gateshead Strategic Partnership process is undergoing review and there has been an external LGA Peer review process; the results of these two reviews have not yet been shared. Voluntary organisations appreciate their involvement in partnerships and would welcome the outcome of the reviews and a refresh of the relationships.

"It is vital that all local organisations, the council and the NHS and others are involved in working within a partnership as each can bring their specialist knowledge and expertise to any project that we may wish to develop."

"Fine as long as there is an acknowledgement that funding must be viable and the partnership is not just a tick box exercise and develops into both collaboration and co- production and meaningful outcomes."

"Over the years we have had great relationships with other services, but all our time is consumed by fundraising, we don't have enough time to network."

"Our organisation has been built on strong partnerships - with the Council, local GP practices, local schools, Gateshead Learning Skills and many others. In this way we can bring the best services to our communities, work more effectively, and share skills and expertise. Particularly at a time when resources are scarce, then working effectively together must become a priority for us all, otherwise our communities will be even harder hit. We have found that the most effective partnerships are based on good relationships, shared ethos, transparency and trust."

The geography and history of Gateshead means that many community buildings and facilities are at the heart of their communities, and there are often strong relationships between community associations and local Councillors; in a number of cases Councillors are trustees. There has been a programme of asset transfer, but there are still a number of facilities that haven't been transferred. In some cases there are reservations about the capacity and capabilities of some organisations to do this. There has been strong support previously from Council staff for community buildings, and the inevitable withdrawal of some of this support has exposed that some local groups are not able to manage buildings and services. This is a similar position to many other areas; and the next step could be that instead of assuming volunteers will manage all the facilities, there could be a realistic consideration of shared services and future viability.

Organisations have been encouraged to scale up, collaborate, merge, and grow, which makes perfect sense in some instances, but not all. Experience elsewhere

has demonstrated that new procurement processes will bring in new providers, and the existing (losing) contract-holder will often have to restructure for their organisation to remain sustainable. Contracts can be won by those organisations that have better bid-writers rather than by the organisations who are the more experienced, local providers. The use of Social Value in contracts, in order to prioritise the areas important to the commissioner is one way to ensure that services reflect the commissioner's priorities.

"There will be no services, in the future. Big charities have an advantage with commissioning rather than small charities, and also commissioning is difficult for single gender work. Commissioning wants one service that delivers all (because it's easier)."

Many organisations have had to restructure and completely shift their funding model and become more efficient and effective in this process. Sometimes this internal focus can mean the diversion from providing frontline services.

Many organisations expressed frustrations at not being able to do more. Organisations clearly felt the pressure of increased demands with less capacity and resource to meet them. There were comments such as:

"Inability to meet greater local needs. Public Sector funding squeeze. Decreased capacity."

"Sustaining the organisation with a reduced budget. Dealing with higher levels of referrals and decisions about how and what to diversify into."

"Generating sustainable unrestricted income. Dealing with an increase in demand for our services. Managing ongoing change for the benefit of our service users with less resources."

The competition for funding is getting fiercer. Organisations are becoming more competitive and moving into additional geographic and thematic areas in order to bid for different tenders. At the same time organisations are encouraged to work together, whilst they are competing for funding.

Income generation can also mean that organisations are developing new services (for them) which are now in competition with other, existing services. An example raised by a local councillor was of a not for profit nursery offering similar services to the local school. Inevitably as organisations become more entrepreneurial and develop their business plans, they will compete with others for customers (and funds).

The issue of charging is always difficult, but if charges for admission, rentals, facilities and services go up too much, then the costs to the customer can become prohibitive.

Public sector grant aid is a declining source of funding; this is borne out by the NCVO Almanac 2016, which noted that the government grants (National, local and NHS) are less than half the level they were at ten years ago. The most common form of income for the Gateshead organisations that participated in the study was from charitable trusts and foundations. Forty–two organisations that responded had received public sector grants. For thirty-seven of these organisations, public sector grant aid formed less than 20% of their income.

However public sector contracts still form a useful source of income for the medium size and larger organisations. Thirty organisations that responded held public sector contracts. These contracts were with the Council, NHS / CCG, the Police and Crime Commissioner, and central government. Of these thirty organisations, six organisations got more than half their funding from that source and

seventeen organisations got less than 20% of their income from the public sector.

So there is clearly less reliance on Gateshead Council for many organisations in the form of funding; however a number of organisations indicated they wanted to participate in commissioning processes. Until Autumn 2016, there had been fewer services advertised through the tendering process (NEPO Portal), but since September 2016, there had been a noticeable increase of contracts being openly advertised. Voluntary organisations welcomed this, but noted that contract monitoring needed to be more proportionate.

There has been an amount of noise in the national press about some charities and their dubious fund-raising practices. It isn't clear yet whether this has filtered down into local communities as clearly there is a lot of trust and reliance on local organisations.

The NCVO Almanac 2016 notes that 3.22% of all charities by number receive 79.7% of the sector's total income. So there is a very uneven distribution of resources with those charities of an income of more than £1million getting nearly 80% of the overall funding. The Charity Commission register notes only ten Gateshead-based charities with an income of more than £1million.

Organisations gave several examples of how they contributed to the overall health and wellbeing of Gateshead's communities, including improving economic development.

"This sector brings much needed investment to the borough. The eyes of the country and often the international community focus on this region because of some of the important work we all do as a sector. We fight hard to provide services to help people in the borough. The money we bring in as a sector is in the £millions and it is all reinvested straight back to benefit local residents. We are not for profit but we are very valuable and complement services in the area. We should make sure this is acknowledged and our voices heard and considered at least as important, if not more important, than the commercial sector (the profit making sector) when decisions are being made."

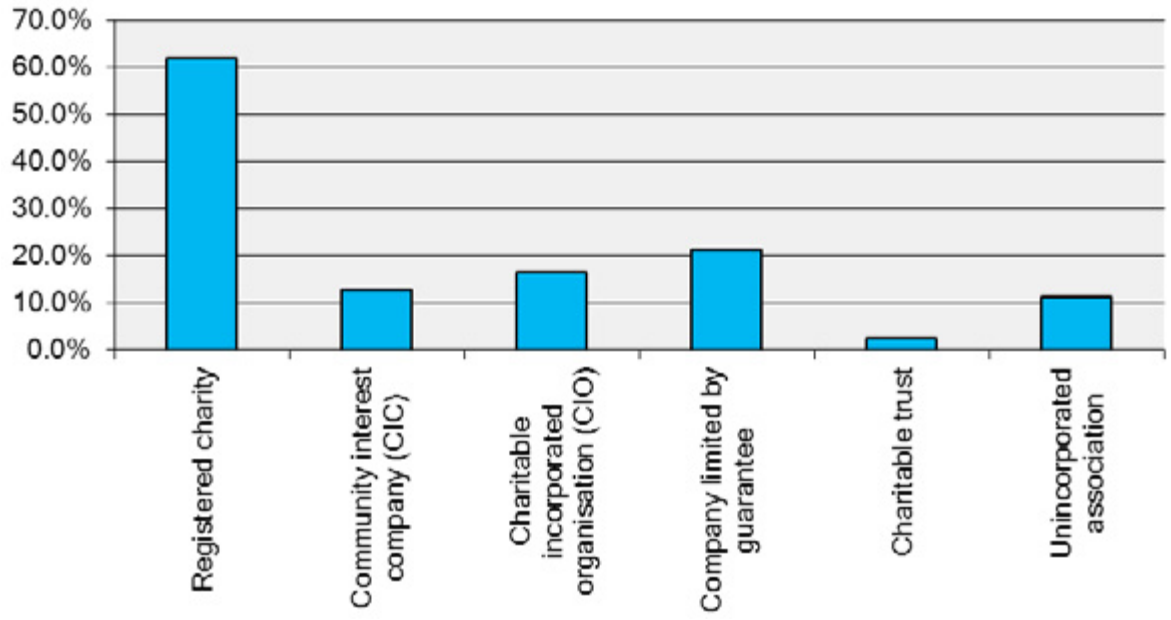
Findings

Profile of Respondents

This section describes the structure, size and activity of the organisations that responded to the survey.

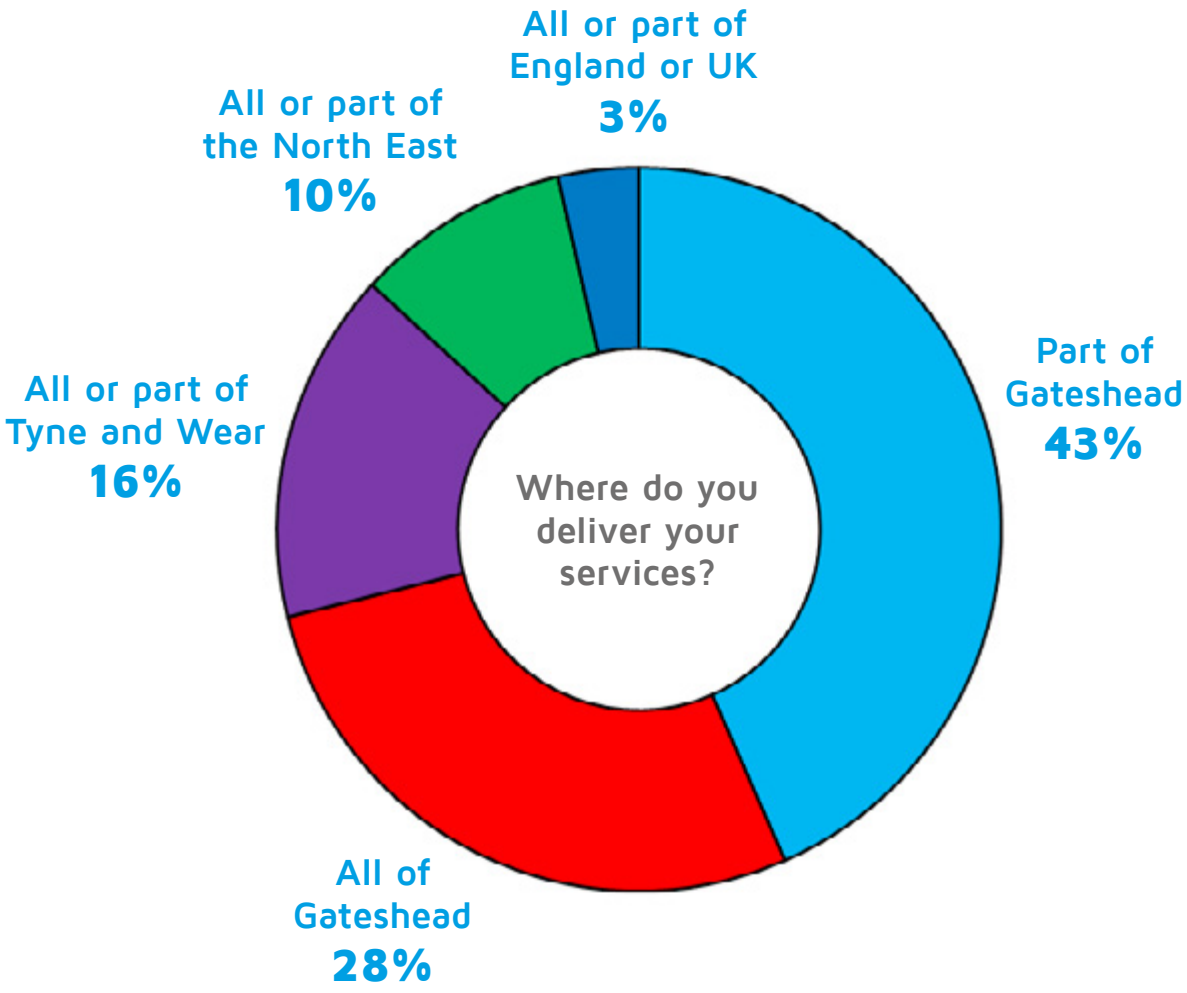
Question One : What is your organisational structure?

Registered charity	62%
Community Interest Company (CIC)	13%
Charitable Incorporated Organisation	16%
Company limited by guarantee	22%
Charitable trust	3%
Unincorporated association	11%

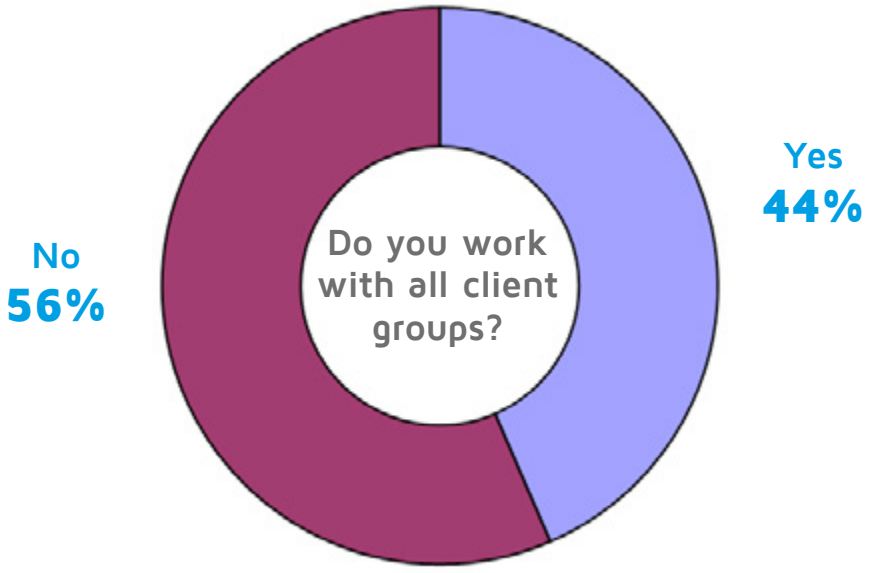


An organisation can have more than one form of structure, for instance Newcastle CVS is a registered charity and a company limited by guarantee.

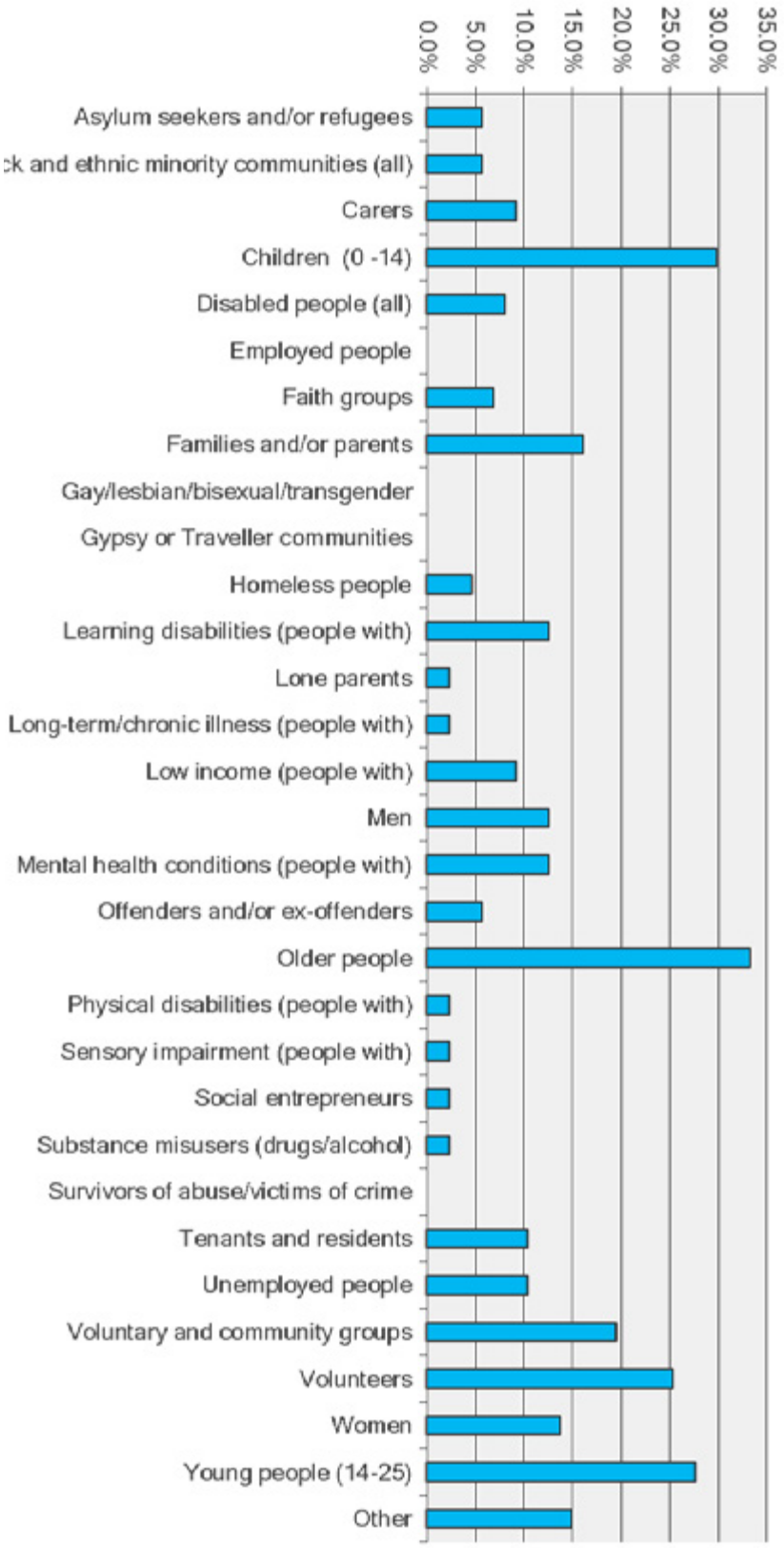
Question Two :



Question Three:



Question Four: If not, who do you work with?



Question Five: How many people are involved in your organisation?

a) Number of full time employees

0 – 1	52%
2 – 4	22%
5 – 10	8%
11 – 20	6%
21 – 50	3%
51 – 99	2%
100 or more	8%

b) Number of part time employees

0 – 1	51%
2 – 4	23%
5 – 10	16%
11 – 20	4%
21 – 50	3%
51 – 99	1%
100 or more	1%

c) Number of volunteers

0 – 1	1%
2 – 4	10%
5 – 10	22%
11 – 20	29%
21 – 50	21%
51 – 99	11%
100 or more	6%

d) Number of trustees/Management Group members

0 – 1	1%
2 – 4	23%
5 – 10	61%
11 – 20	13%
21 – 50	1%
51 – 99	0%
100 or more	0%

Recent guidance illustrates there should a minimum of four 'responsible persons' involved with any organisation. Experience has demonstrated that some trustees / management committee members are involved with more than one organisation, so adding the totals isn't helpful. However, this does illustrate several hundred people are directly involved with the management of voluntary and community organisations in Gateshead.

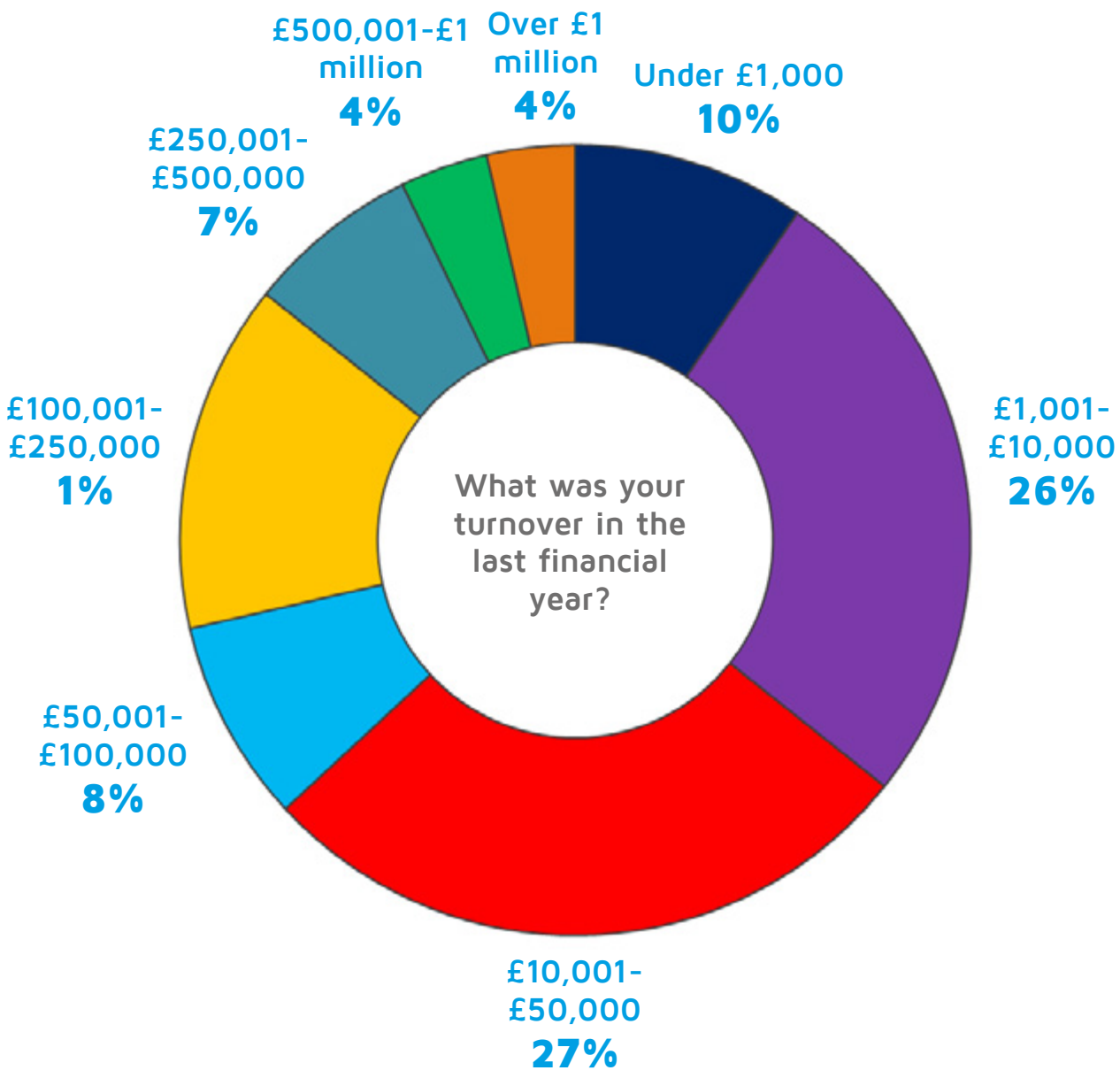
e) Approximate number of people who benefit from your organisation

0 – 1	0%
2 – 4	0%
5 – 10	3%
11 – 20	5%
21 – 50	10%
51 – 99	13%
100 or more	70%

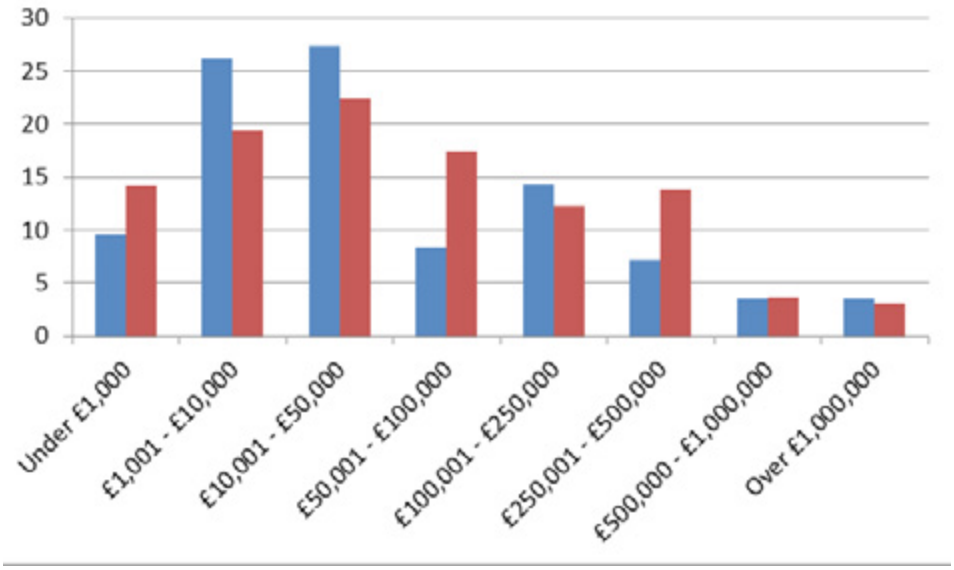
It would be wrong to conflate these figures as there will be inevitable double-counting, but clearly local voluntary and community groups in Gateshead support many thousands of local residents, as well as making the environment a better place to live and visit.

How many	Full time staff (%)	Part time staff (%)	Volunteers (%)	Trustees/ Management Group (%)	People benefitting (%)
0-1	52	51	1	1	0
2-4	22	23	10	23	0
5-10	8	16	22	61	3
11-20	6	4	29	13	5
21-50	3	3	21	1	10
51-99	2	1	11	0	13
100 or more	8	1	6	0	70

Question Six:



Turnover of respondents and charities in Gateshead



Key

Blue reflects the participants in the survey according to turnover
Red reflects registered charities with a base in Gateshead according to turnover from the Charity Commission website.

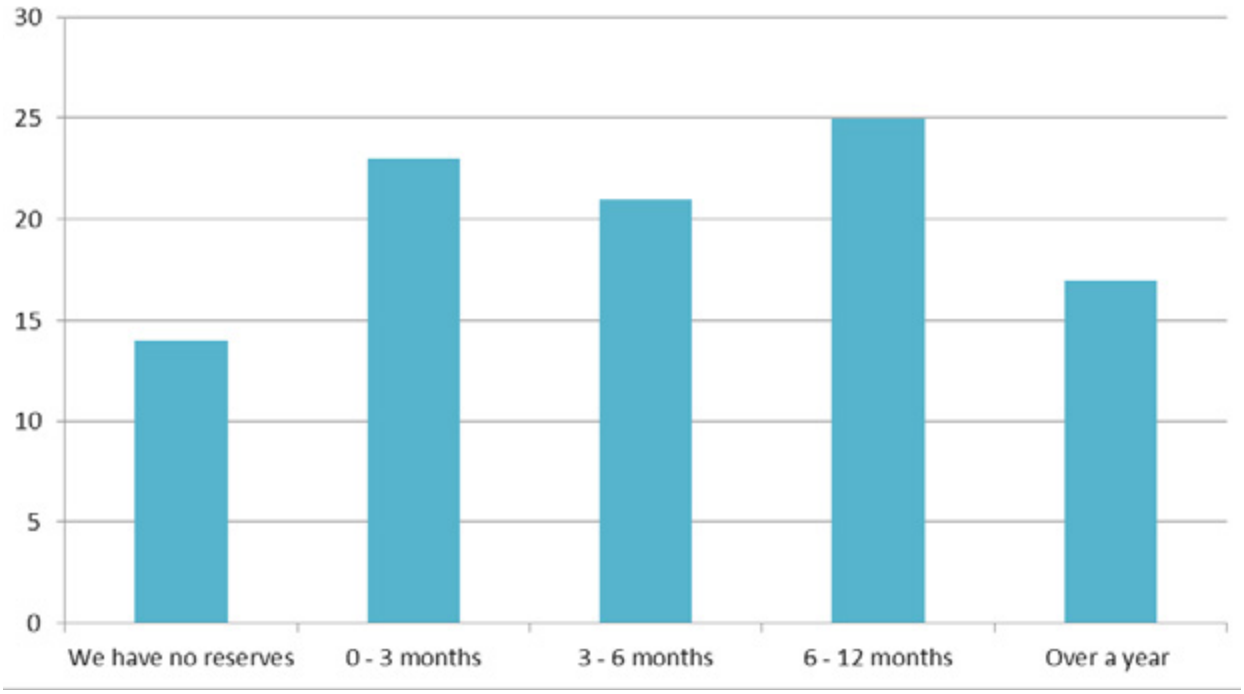
This illustrates that the survey participants are mainly reflective of charities in Gateshead. The CVS study attracted more participants from charities with a turnover of £1,000 to £50,000, and fewer in the £50,000 - £500,000 range.

Question Seven: If you had no funding or income from tomorrow, how long could your organisation keep running on its reserves?

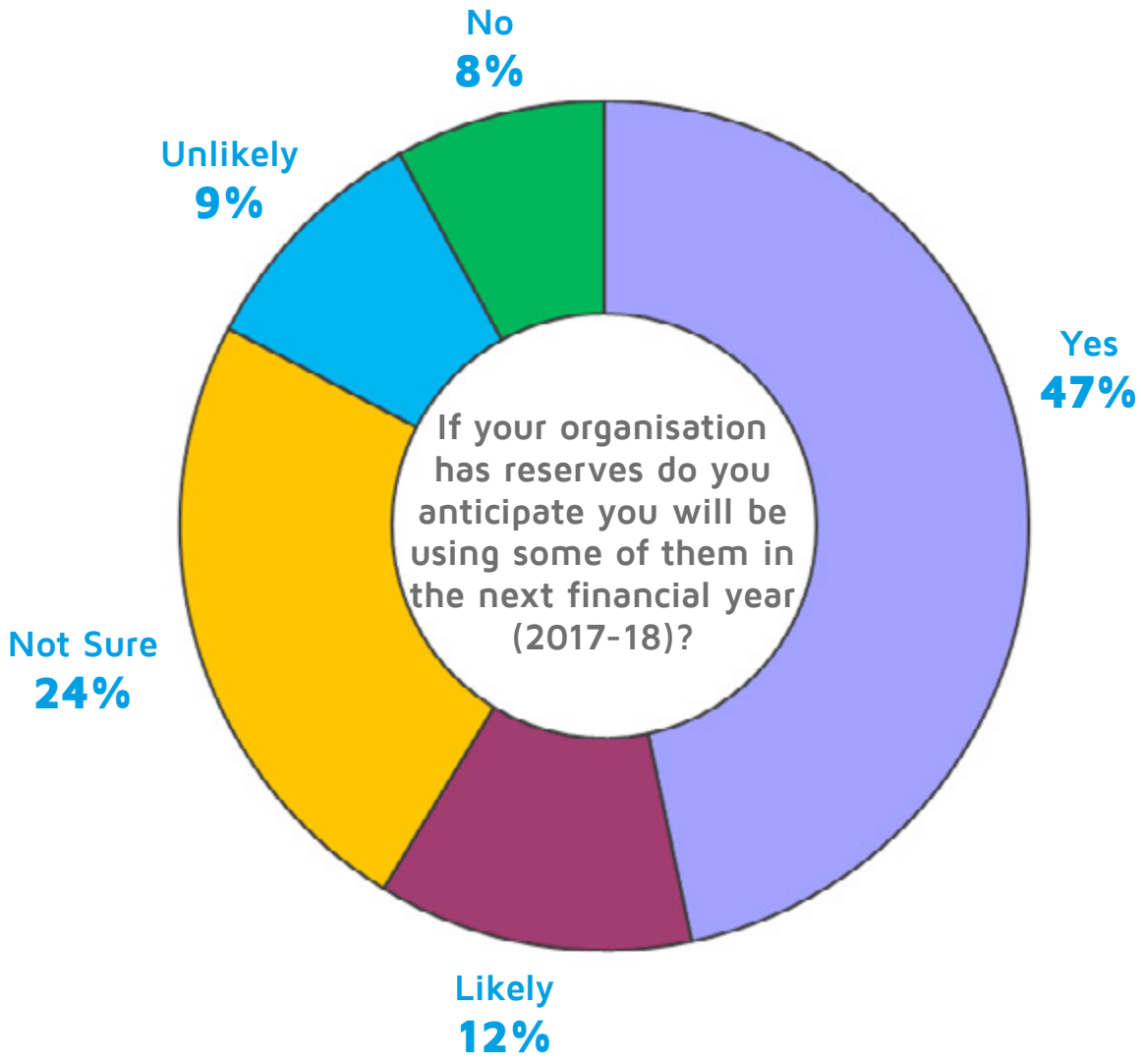
We have no reserves	14%
0 - 3 months	23%
3 - 6 months	21%
6 - 12 months	25%
Over a year	17%

This is a similar profile to information collected in other authority areas.

Reserves profile



Question Eight:



This question does not reflect liabilities and some organisations might have to keep reserves to cover loans, pension debt etc.

Question Nine : Please estimate what percentage of your annual funding (based on the last financial year for which you had figures) comes from?

This was probably the most complex question asked and organisations had to break down what percentage of their income they received from different sources. Seventy-one organisations responded (82% of the total). A number of organisations might not have understood the question, or the breakdown of sources was too difficult. There appeared to be a correlation between the size of organisations and the sources of funding; for example, larger organisations appeared more likely to get a greater percentage of their income from public sector contracts. However the numbers in the sample were too small to demonstrate statistical significance.

Thirty (of the seventy-one) organisations held public sector contracts. These contracts could be with the Council, NHS / CCG, the Police and Crime Commissioner, or central government. Of those thirty organisations that held public sector contracts, only six organisations got more than half their funding from that source. Of the thirty organisations that held public sector contracts, 17 organisations got less than 20% of their income from the public sector.

Forty–two organisations had public sector grants. For thirty-seven of these organisations, public sector grant aid formed less than 20% of their income.

Grants from charitable trusts and foundations constituted the most common form of income. For the forty-seven organisations that received income from charitable grant aid, charitable grant aid formed less than 20% of the income for 26 organisations.

Thirty-five organisations had received grants from the Big Lottery Fund. For twenty-four of these organisations, this formed less than 20% of their income; but for 5 organisations, it formed more than 50% of their funding.

Fifty-one out of seventy organisations had generated income from selling goods and services. Twenty-four of these fifty-one organisations raised more than 20% of their income this way. As ten CICs participated in this survey, this is not surprising. Generating income includes trading such as room rental, and trading services.

For fourteen organisations, charitable fund-raising and donations formed more than 20% of their income.

Only three organisations received income from endowments and investments.

Only one organisation had social investment finance; this accounted for between 6-10% of the organisation's income.

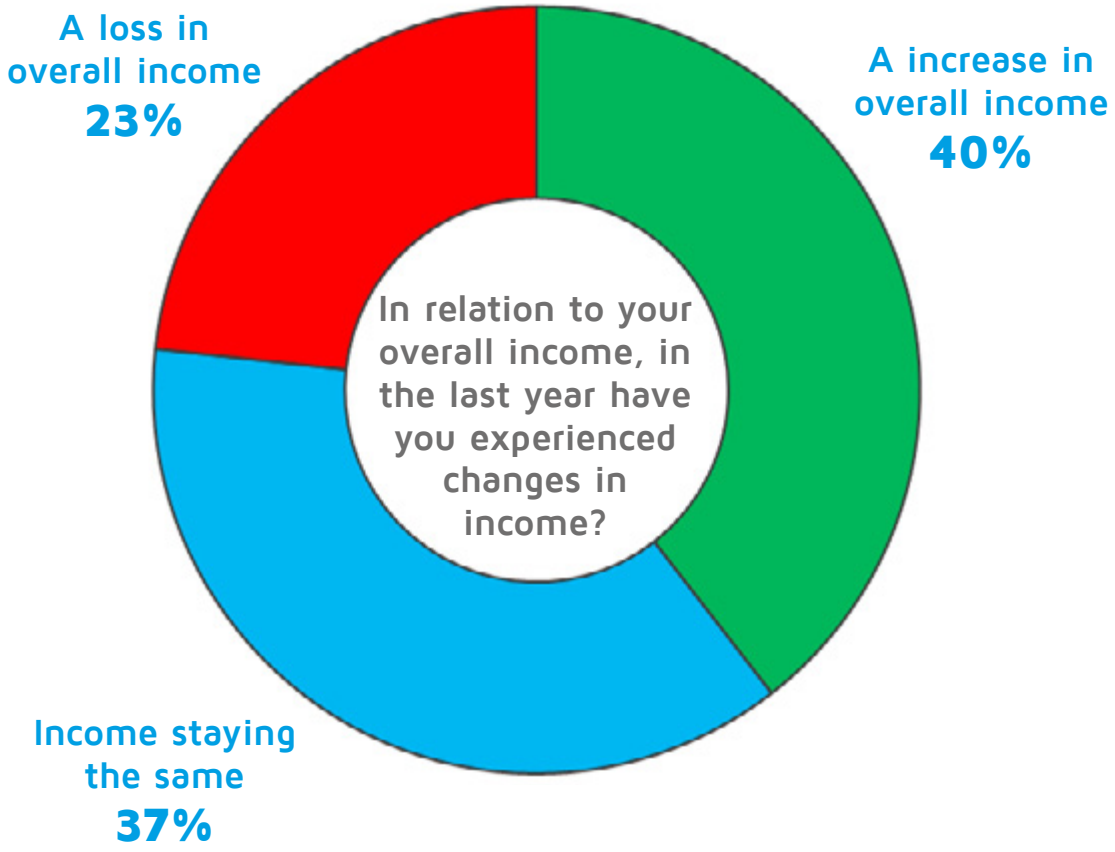
These figures generated locally were checked against recent national reports. The NCVO Almanac 2016 (which is based on information taken from charity returns for 2014) indicated that for the first time since the Almanac began, giving from individuals (£19.4billion) was greater than the giving from government (£15billion). Of the £15billion from government, over £12billion came from contracts, with less than £3billion coming from grants. The amount from government grants is less than half the amount given ten years ago. The term 'government' means national and local government, including the NHS; individual giving

refers to donations, legacies, fees for services and general fund-raising.

The other national reference point was the Small Charity Index produced by the Foundation for Social Improvement (FSI). This is a quarterly tracker and the most recent outturn indicates one in ten small charities reporting a decrease in statutory income, and 8% an increase from this source. Eighteen percent of small charities reported an increase in earned income/ trading in the last quarter. Less than 1% have used Social Impact Bonds in the last year. A small charity is defined by having an income of less than £1million by the FSI and covers nearly all the organisations based in Gateshead

This funding profile of the Gateshead participants reflected the national position, with public sector funding no longer being the primary funding source. As this was the first year of this survey, longitudinal impacts couldn't be studied, but some comments were made during the interviews which indicated public sector funding, particularly for the smaller organisations, formed a smaller source of their income, as compared to five years ago.

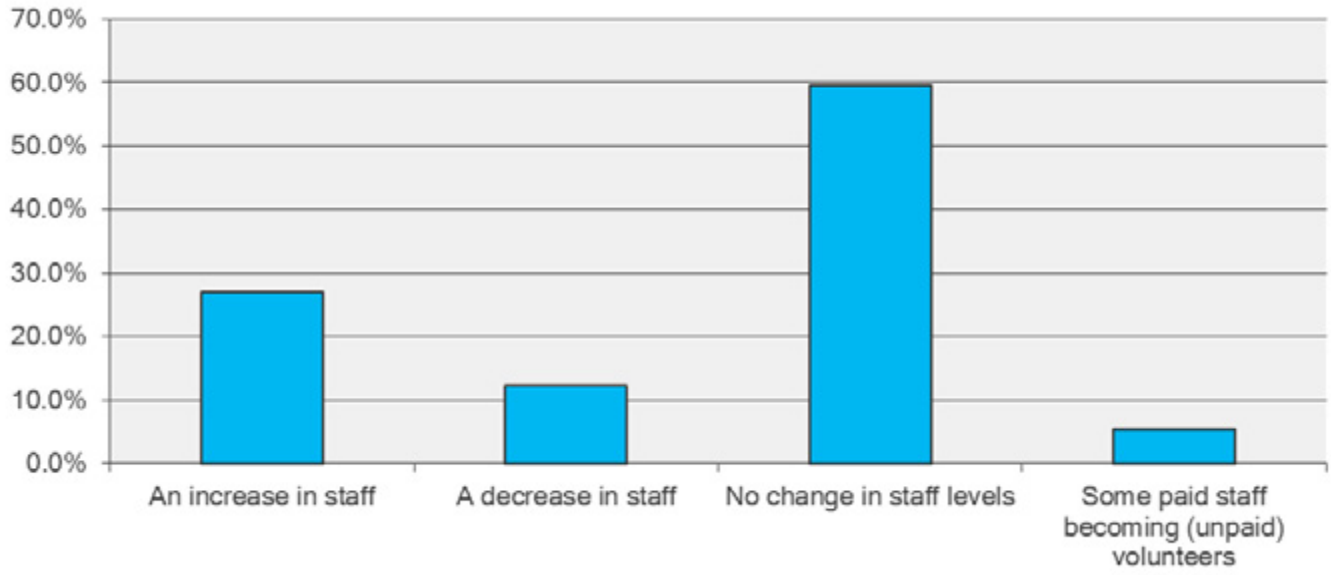
Question 10: In relation to your overall income, in the last financial year have you experienced?



This might be a surprising response given the comments on funding and the sustainability of voluntary and community organisations; but these respondents are the ones who have come through the storm, although the waters remain choppy. There have been some notable closures of organisations that have had to close for a variety of reasons. Again these responses are similar in other areas – usually around a third /a third / a third; but Gateshead respondents are slightly more positive than other areas. However before believing confidence is high and all is well, please read the comments made towards the end of this report.

Question 11: Over the past twelve months have you experienced changes in staffing numbers?

An increase in staff	27%
No change in staff levels	59%
A decrease in staff	12%
Some paid staff becoming (unpaid) volunteers	5%



Clearly staffing changes relate to income. The comments reflect some of the churn and changes within organisations. Organisations try to avoid redundancies where possible and will sometimes use reserves to keep staff. The comments from voluntary organisations indicate that in some instances whilst the number of staff overall remains the same, there are shifts in the number of hours they work; often because of short term contracts.

Question 12: Over the last year have you experienced changes in volunteer numbers?

An increase in the numbers of volunteers	34%
Volunteer levels staying the same	48%
A loss in overall volunteer numbers	18%

It is interesting to note that one in three respondents reports an increase in the numbers of volunteers, yet the second biggest challenge (after funding) was the recruitment and retention of volunteers. As organisations become more reliant on volunteers, this is clearly a crucial area of work.

Question 13 : Over the last year have you experienced changes in demands for your services?

An increase in demands for your services?	72%
No change in demands for your services?	21%
Decrease in demands for your services?	7%

Studies done elsewhere (see references at page 40) have consistently identified a 70 – 75% year on year increase in demand for services. This needs to be seen at the same time that organisations are going through their own changes and reorganisations. In the comments and in discussions, organisations frequently report that not only are they seeing more people, but the complexities and needs are changing. As statutory services are tightening their criteria for access into services, this means many people who would have received statutory services, both commissioned and / or delivered by the NHS, local authorities, probation services etc five years ago, are now excluded. So they go to the place available – the voluntary and community sector. Or they don't go anywhere at all. Organisations have had to consistently reorganise, restructure and reshape to accommodate these demands for services.

Question 14 : During the last year, has your organisation developed any new areas of service, projects, initiatives or events?

Two thirds (66%) of the 86 respondents answered yes to this question. It is a tribute to the creativity and innovation of the voluntary and community sector, that even with all the difficulties clearly experienced, two thirds of all the respondents had developed new services. Clearly in some instances services will have been developed in order to generate income, whether additional or replacement funding.

Question 15 : In the next financial year (from April 2017) do you anticipate?

Increasing staff levels	24%
Reducing staff levels	7%
Engaging additional volunteers	61%
Reducing the number of your volunteers	1%
Expanding the number of services you provide	49%
Closing services you provide	10%
Closing the organisation	1%
Merging with another organisation	7%
Increasing the number and type of beneficiaries	37%
Reducing the number and type of beneficiaries	3%

The interesting point here is that despite clear worries and concerns, there is still positivity that the organisations will grow, engage more volunteers, offer more services and help and support more people. Again this fits in with studies from elsewhere, and those with a sample from much larger organisations (Social Landscape 2017). This expression of optimism

and enthusiasm against the background of tough of challenging times can succeed only if the right circumstances and resources are available. Some organisations have changed how they work in order to cope with reduced public sector income and direct support, in an environment of increased demands and clearly many believe they can do more. But policy makers need to consider that their decisions don't inadvertently discriminate against voluntary and community organisations.

Views of Respondents

This section describes how organisations felt about what was happening, their opinions, views, hopes and fears.

Question 16: What do you think will be the three top challenges that your organisation will face in the next two years?

Eighty organisations responded to this question, with (unsurprisingly) more than half noting funding. This is in line with other surveys, both locally and nationally, but was clearly problematic, regardless of the size of the organisation.

As well as the general funding comments, there were a number related to changing the source of funding – from grants to contracts, and a much greater emphasis on trading and being more business minded. These comments came from organisations of all sizes as even smaller, community organisations, which once had a number of their costs picked up by Gateshead Council had come to the realisation that this was no longer the case and they would have to pay for goods and services that were previously 'free' to them.

The second most common issue was volunteering; the problems of recruiting and retaining volunteers. GVOC, the former local development agency, had previously provided support around volunteering; this service is now based in Gateshead Council. There was a document on the Council website listing organisations with volunteering opportunities, but this was from September 2016. A number of the interviewees had commented that the previous system offered more individual support, particularly to people from disadvantaged groups who wanted to volunteer as often they needed additional support, and it wasn't clear if this was available and where from. Other comments included that as Gateshead Council had its own system of volunteering to complement those services that they previously provided e.g. libraries, environment and leisure (similar to many other councils), there was now a "competition for volunteers". It wasn't clear where or how smaller organisations got their support around volunteering.

The issue of increased cost pressures – rents, utilities, cost of the workforce when people were employed is common to all organisations – private, public and voluntary. Yet there is still a perception in the minds of many outside the sector that these are free goods, VAT isn't paid and there are zero business rates. Indeed the Gateshead Council budget changes in March 2017 make it more likely that a number of charities will lose the 20% discretionary rate relief they currently have, and local charities will be subject to the national changes in business rates similar to other organisations.

A number of comments noted the need to maintain or increase membership. This is separate to attracting and retaining volunteers, but volunteers would usually come from members. In some cases these would be paying members, which is linked to funding. This comment is typical "Decline in membership due to ageing of members and reluctance of younger people to join community groups." The issue of an older generation and a different set of priorities and interests for younger people emerged through several comments. There could also be the factor of smaller communities in some areas, and it isn't clear what work has been done about community engagement with newly established residential communities.

There was a sense of realism from the respondents; these are organisations that

have had to make substantial changes to how they operate. All organisations have to operate in a very different environment, and there are different drivers in implementing change. Volunteer trustees and management committee members have different motivations to paid staff, and dealing with radical restructures, redundancies and new obligations, are hard for most people. A number of volunteers get involved to set something up, respond to a need, put something right and don't want to be involved in high level organisational development and making difficult decisions.

Clearly people felt very strongly about their work and wanted to keep going, so the responses also included sustainability over a longer term, and how that could be managed. Clearly trading and new and different business is one way forward for some organisations, but they need to be clear about the product, customers, market and competition – not necessarily the language of small community groups.

The responses also included the problems of trying to manage increasing demands, whilst dealing with increased costs, and the pressures that this can create. This applied to all sizes of organisation, and for those that are volunteer-led; this can create even greater pressures for volunteers.

A selection of these comments are quoted below, but it is significant that the majority noted funding, with nearly a third raising volunteering:

"Maintaining volunteer energy and support. Finding the right expertise to develop our social enterprise model."

"Getting enough volunteers; keeping Politics (please notice the capital "P") out of the organisation. "

"An ageing membership. Shortage of volunteers for administrative and organisational duties. Possible increase to hall hire fees."

"Inability to meet greater local needs. Public Sector funding squeeze. Decreased capacity."

"Rent increase, funding, volunteers."

"Maintaining volunteer levels, maintaining users of service, expanding services and activities."

"Local Authority charges for use of leisure facilities. Club dynamics. Replacing ageing equipment."

"Community engagement and sustained income against inflationary measures. Retention of players. Need to continue capital investments to keep the club attractive."

"Increasing membership. Affording the cost of the hall for our meetings if the charge is increased. Publicising the Group. We advertise the group on Facebook, posters in local libraries, and on the OurGateshead web site."

"Maintaining our path to sustainability, already achieving set goals - two more years to full sustainability. Recruitment of volunteers. Finding external funding for major repairs to the roof and heating plant."

"Obtaining sufficient funds to keep the Library open. Retaining and recruiting volunteers. Providing events to increase usage of the Library."

"Finance and funding. Local authority cooperation. Cuts to other services pushing up demand dramatically."

"Negotiating a long term lease. Financial stability. Developing service expertise to expand our programmes."

"Reaching break-even point. Recruiting volunteers."

"Sustainability. Succession funding following BLF

including attracting contract. Worker retention."

"Recruiting, training, maintaining and managing volunteers. Finding someone to take on that responsibility. Need to expand size of kitchen - so issues with premises. Raising money to develop the lunch clubs and maintain them."

"Lack of funding for employee wages such as youth workers. We currently have a waiting list for a number of our services, this is not getting shorter and we have to limit numbers due to staff numbers."

"Top of the list will be finding the funding to improve the X Park and Town Centre. Keeping everyone on board with the project. Bringing other organisations on board to improve and expand the whole project."

"Funding, plus closure of libraries staffed by paid employees of Gateshead Council."

"Increasing number of volunteers. Help the community to be aware of the community centre's existence & availability. Improve the energy efficiency of the community centre."

"Keeping Y Library open. Increasing membership applying for grants."

"Unlike most services we have no paid staff and Z is entirely run and managed by members – people with mental health problems. So our greatest challenges are to continue running the service and get our model recognised as a good option for people with mental health problems nationally."

"Enabling and empowering our membership of Q community groups to realise their unique potential to be active agents in supporting the settlement and integration of their communities. As their role is being overshadowed by other VCS agencies and intermediary agencies who seek to use Qs merely as gateways to beneficiaries for their own services and projects and fail to see Qs as partners in collaborative work and do not share any resources with them. Finding funding for collective advocacy based work and work to support the capacity and voice of community groups themselves is increasingly difficult as most funding supports outcomes measured by movement of individual beneficiaries from A to B, and reject work they classify as infrastructure support."

"Maintaining funding. Developing new areas of work Maintaining and developing volunteer roles."

"Gateshead Council's use of K where we provide our services. Potential sale of the Centre Change of staff at the Centre."

"Increasing membership for adults and children. Finding other ways of generating income. Grants for improving our premises especially for the disabled."

"Level of income. Less support from Commissioners. Reduced opportunities for additional funding."

"Meeting demand (exceptional record breaking growth year on year for last 5 years) with 2017 projected to be another record breaking year. Outcome of the LA/CCG review of M services. The ending of key contracts and grants in 2017 representing 40% of income."

"Budget cuts, increased demand, work load increase."

"The current climate seems to expect full time employed people who have previously been happy to volunteer to take on responsibility for making money and growing the organisation. They don't want that, it's not why they joined and they will leave. The system that rewards national governing bodies for the degree of participation in their area yet relies on volunteers to drive that participation is broken, there is an imbalance between wealthy charitable organisations and those of us acting locally on small sums of money."

"Funding for our services difficulties in finding volunteers time available for us to provide swimming lessons at Gateshead Leisure Centre due to the increase in number of children who want lessons but limited time the pool is available for us to provide lessons."

"Sustaining the organisation with a reduced budget. Dealing with higher levels of referrals and decisions about how and what to diversify into."

"Moving away from being reliant upon 'grant seeking' to income generating."

"Generating sustainable unrestricted income. Dealing with an increase in demand for our services. Managing ongoing change for the benefit of our service users with less resources."

"Maintaining current contracts. Winning new contracts. Being able to retain staff and offer pay awards. This could have a knock on effect on consistency and quality of service provision. Increased competition for funding via grants and paid customers. Maintaining our membership Increased costs of existence - due to increasing success of the band requiring more highly paid conductor, increased rent of band room due to more rehearsals, and our new youth band."

"Financial stability. Attracting more volunteers. Supporting volunteers."

"Financial self- sufficiency in the wake of funding cuts and hardship for the people using us. Negative publicity regarding the area of work we are engaged in. Replacing volunteers who want to volunteer, not run a business. They are being forced to think commercially which was never part of the attraction."

"To start earning from the services we provide and have the business start paying for itself as we are currently relying on grant funding. Maintain the staff levels that we have got. Get some of our volunteers converted to being paid staff."

"Securing sustainable funding, particularly for core costs and building organisational infrastructure. Developing streams of unrestricted income. Keeping pace with demand and recruiting good staff."

"Managing growth and avoiding 'cliff edge' scenarios as large funding strands come to an end. Managing national programme staff who are remotely located. Meeting demand with appropriate resources."

"Premises that are available and accessible in Gateshead. Income generation. Increased demand for services due to public cuts."

"Reaching new markets. Recruiting and supporting volunteers. Developing corporate links."

"Volunteer capacity to carry our services we would like to. Fighting to keep our level of funding year on and on, makes it difficult to plan. Strengthening our partnership working with our CCG/Health."

"The likely reduction in funding in general. The need for substantial investment in buildings. Recruitment and retention of cadets."

"Maintaining volunteer numbers. Maintaining the present level of fundraising. Maintaining the present levels of community awareness to our initiatives."

"Running our charity as a business, keeping up with the costs of gas, electric and water (currently £11,000 +). Managing staff and wages."

"Funding. Lack of staff to cope with demand. Staff stress levels will rise due to not being able to accommodate everyone with the support they need."

"To provide an environment and activities that attracts and keeps volunteers. To provide activities that the public will support."

"Attracting funding if our core funding/contracts

are withdrawn or reduced . Increasing our capacity as we diversify our income streams to increase sustainability. Maintaining the same level of service provision, at the same standards, as we move through the possible changes in challenges."

"Lack of opportunities to exhibit our work to a broader community . No support from Local council either financial or in any other respect – e.g. networking. Very difficult to source information about other art clubs from a central point."

"Paying for running costs. This is essential to keep the Library open. Continue to provide services to the public which attract customers. Motivate existing volunteers to be proactive in transforming the Library into a Community Hub - many signed up to keep the library open and not to run a business."

Question 17: What do you think will be the three top challenges that your beneficiaries / the people you work with will face in the next two years?

Seventy six organisations responded to this question about the top challenges for their beneficiaries in the next two years. Most of the responses were framed around resources – the lack of personal finance that people would have because of benefit changes and the increased poverty in local communities as a result of this; the impact of the Council's own funding cuts and the increasing difficulties in accessing public services. As a result of these and external policy changes, reference was made to the general loss of activities and the 'running down' of communities, which could lead to loneliness and isolation.

Organisations were also aware of the impact of their own charging policies and changed (reduced) access into their own services which could discourage potential and existing users. Participants responded in terms of their own client group but there were still some common themes. Certain themes – older people, refugees and asylum seekers, people living with mental health problems, people with learning disabilities and young people, came out in several responses as they had been the subject of several policy changes.

It is notable that the words 'poverty' and 'austerity' are now used openly and are acceptable terminology within non-academic circles; again this is a shift and maybe reflective of how quickly people are accepting situations which would previously have been untenable. One of the saddest responses was the bleak "Poverty. Neglect. Mental health."

Another theme that comes through is that people and communities have several challenges; it isn't just individual benefit claims, but less money means fewer people have access to services. Also poorer people are more likely to spend their money locally; so this has an impact on the local economy. The geography of Gateshead means that for some people it isn't a single bus ride to a service, even if they can afford the bus fare. Organisations were clearly well-informed about welfare reforms/ benefit changes, but concerned that their beneficiaries didn't have the same level of understanding, or just didn't want to face the next set of changes.

The impact on health and wellbeing also featured as participants clearly recognised the links between the loss of personal income, loss of services and change in thresholds to access services which resulted in exclusion. There were references to the importance of prevention work and the resultant problems if this didn't happen. This was illustrated by the stark *"Lack of service. Being alienated from the community. Benefit cut."*

There were a number of references to jobs/ employment and training opportunities. Clearly the nature of work, and its insecurity was a concern. There were several references to sanctions (from the DWP in relation to benefit payments).

"Austerity effects of reduction in other services including pressure on statutory services, longer waiting times, reduced eligibility for mental health services."

"Financial pressures. Insecurity in employment. Housing developments around our community."

"God knows; depends on the local Councillors and their overarching plan for the larger area."

"Welfare Benefits reductions. Child Cap on Tax Credits. Community safety and Security Safe Digital Inclusion."

"A reduction in income/no pay rises making it harder to make ends meet. Cuts to local services. Having to travel to access services i.e. we no longer have a post office in our village."

"Access to affordable arts programmes. Realistic career in the arts and their aspirations. Opportunities to affordable health and wellbeing opportunities."

"Older people: health / frailty; managing with reduced abilities; Asylum seekers: learning English; integration; Families on benefits: impact of being sanctioned; poverty."

"Budgeting their income and costs. Loneliness. Health issues."

"Coping with the loss of X Library if it closes. Finding alternative garden space in the middle of X. Finding central meeting space."

"The three top challenges I would say will be benefit issues, lack of mental health services and support, being stigmatised or marginalised by the majority of society."

"The implementation of the Immigration Act 2016 from spring 2017 - most crucially the withdrawal of Government support for refused asylum seekers and shifting of that role to the discretion of Local Authorities, who are already operating on low budgets. This is likely to see an increase in destitution, and could now include families rather than just adults."

"The problems faced by our members are extremely varied. They are generally men facing difficult times in their lives, bereavement, mental health problems, being a carer, and resulting social isolation etc. We feel that all these problems will be exacerbated by the inevitable post Brexit economic downturn, and we are glad that we can provide a vital social connection and relief from stress during the tough times ahead."

"Becoming older and less able to contribute. Fewer places that they can be accommodated with a reduction in services means people have less income overall and need greater support to participate."

"Austerity in the Health and Social Care sector. Reduction in services as a result of the above. Not being consulted on change."

"A potential reduction in the services we are able to offer to carers (see above) . Ongoing cuts to LA and health budgets - reduction in services for disabled people and the impact of that on carers. DWP drive to cut benefit entitlements – PIP etc."

"We work with carers, so they are facing an increase in their levels of care due to social care being either not available or being so expensive that they can't afford it for their cared for and so the carer has to take on even more caring responsibility. The carers own health and wellbeing will suffer, as will their financial situation if they have to give up work to care or take reduced hours to care."

"No funding for people from deprived areas to access the service. Difficult to access statutory services."

"Continued unemployment. Social exclusion. Poverty."

"Moving on to independent living. Finding mainstream work. Financial stability."

"Reduction in service availability/increase in threshold to access services. Benefit reductions. Local Housing Allowance."

"Falling income, cuts in social services and benefits."

"Securing sustainable employment. Maintaining good health and wellbeing. Accessing essential services."

"Coping with the welfare reforms and reduced income. Coping with tougher sanctions on their benefits. Generally avoiding homelessness as they struggle to manage their budgets."

"Significant reductions in council services leading to gaps in service or increasingly disjointed services. Increasing pressure of household budgets as cost rise and people unable to cope, particularly with benefit cuts/ sanctions."

"Loneliness. Reduced services. Incoherent or lack of joined up sign posting."

"Service provision (i.e. there is little or none). Cuts to social care and health budgets: being cast adrift in a system that does not look after this vulnerable group but which is struggling to deal with critical needs let alone substantial or moderate. This will have very detrimental effects on people with learning disabilities and their families and is a false economy as the 'prevention' costs they are saving from closing provision or making people ineligible to access provision is a short term solution. Adopting a preventative approach with services being available and accessible during life will help to reduce the longer term care needs (and therefore the costs to the State and local government) of this group. It's not rocket science. Vulnerable people such as people with learning disabilities are in danger of becoming more isolated and marginalised than they were 20 years ago under this current national programme of austerity with years of good work potentially becoming undone. This approach will cause a much heavier long-term financial burden to this country. We feel incredibly sad for the local councils and the levels of cuts they are experiencing nationwide but the austerity measures are not a long term solution and will end up costing more both morally and tangibly, in the long term. The current welfare system overhaul which is very hard indeed on people with learning disabilities and fails enormously to take their needs and position into account causes health and anxiety problems for PWLD and is leaving them feeling isolated and alone."

"Change in benefits that means hardship for our carers. School changes that means our carers who have children with SEN makes life difficult. Local Authority having funding to carry out their statutory duties i.e. respite care etc for our parents."

"Tightening of family budgets to support the young cadets. Money. Jobs."

"More poverty, lower incomes due to benefit sanctions, benefit caps. Struggling to meet the costs of childcare. Lack of Council funded activities and provisions. (ie; social care for adults with learning disabilities)."

"Changes to benefits (Housing Benefit, Local Housing Allowance, Universal Credit etc). Changes to service provision due to cuts within the public sector which also has in impact on the third sector. Quality of life/wellbeing as a result of these challenges."

"Lack of mental health services. Benefits under attack. Disability hate crimes and prejudice."

Question 18: How do you feel about partnership working? This could be with other local organisations, the Council, the NHS or others?

Seventy nine organisations responded to this question. In some instances this was interpreted by working with others – Gateshead Council, other organisations nearby or in the same building. Partnership working tends mean contributing resources to achieve a greater impact than if those organisations had been working separately.

A number of the comments reflect how focussed individuals are in getting their own organisation to succeed or even be sustainable. This approach could mean there wasn't necessarily the resources or capacity to engage in partnership working if the main focus was on core work and fundraising for the project.

Many organisations do not have sufficient internal capacity for partnership working. Some do not understand the value. In some instances it is hard to see how it could be applied to some projects. Organisations, especially those that are volunteer-led, are focussed only on that organisation, so it seems anathema and strange to engage with others when there is no immediate impact or benefit.

For some of the medium-size and larger organisations, the issue of competition can be difficult. As there is a shift towards contracting through competitive tenders, and often for larger contracts, it can be difficult to engage with those organisations who are competing for 'your business'.

The Bluestone Consortium can provide a mechanism for partnership working for some organisations, but members are expected to engage and contribute, not just be recipients of information.

Some respondents saw opportunities in sharing core and support services as a natural advantage to partnership working.

"Welcome it. Already work in partnership with others."

"More could be done to mobilise the assets of sports facilities to progress fitness and wellbeing programmes. These are available for partnership working but H+WB's need to be more active in recognising their community resources."

"The centre has always worked in partnership with other organisations including Gateshead Council, NHS, Gateshead Evolve, local schools and other community organisations in the area."

"We would welcome partnership working and have worked with the council in partnership over the last three years. The layout of the Library / lack of space and limited parking are problematic. Closer links with other agencies is an area we need to develop."

"Positive but we are very small and seem to come under the radar in many ways."

"It is vital that all local organisations, the council and the NHS and others are involved in working within a partnership as each can bring their specialist knowledge and expertise to any project that we may wish to develop."

"We are very keen on partnership working, that is one of our key areas. Y is more than a building and framework that other services use to support their users. Over half of our activities and groups are held by different organisations."

"We are strong advocates of collaborative/ partnership working that involves a genuine and resourced role for grassroots community organisations. As themselves are unique and valuable assets both in assessing needs but also in delivery of solutions. They are not

simply gateways to a hard to reach sector of the community. They are collaborators in change. Working through collaborations and partnerships is vital, both in developing and in delivering an initiative. It's an essential, even if it's a challenge. The communities themselves are the assets to address issues. But there is a vital need to support the communities' capacity to do this. Commissioners need to have a clear appreciation of the key features of effective collaborative working and build this into commissioning and tendering processes. Commissioners should probe project/service proposals to identify if these elements have been considered in the development of the proposal, and if so whether there is evidence they have been considered appropriately. This could enable commissioners to assess whether the project/service is likely to reach the diversity of the intended beneficiary community and whether it has been designed on a strong enough evidence base to deliver a service which responds to their distinctive needs. They can also assess if claims made about delivering the work 'in partnership' are genuine claims – whether there is evidence that those partners were actually involved in identifying needs as well as have a clear and resourced role in delivery of the actions."

"Fine as long as there is an acknowledgement that funding must be viable and the partnership is not just a tick box exercise and develops into both collaboration and co- production and meaningful outcomes."

"Positive approach to partnership working. The VCS has done this for years. The successful integration of health and social care needs to include the voluntary sector."

"All for it, I am sure that some core services could be shared between organisations locally."

"We believe partnership working is very useful and are always open to new opportunities."

"We are working in partnership with other organisations, and this is very helpful."

"This is very good thing as it helps communities to learn from each other, it opens up ideas and opportunities and can identify sources of support. But it can also add layers of management and expectations that become a burden to volunteers. The community centre support systems in Northumberland can teach us a lot. ACRE, West Northumberland Consortium etc."

"Depends on the local organisation. X is an odd place, and not always pleasant."

"Only when realistic approach is taken to capacity and resources. Full cost recovery should not be a luxury – and volunteers also cost money!"

"Over the years we have had great relationships with other services, but all our time is consumed by fundraising, we don't have enough time to network."

"I wholeheartedly welcome working in partnership with any organisation to enhance our beneficiaries experience of increasing their own wellbeing."

"We will work with anyone to improve the outcomes for young people, we already work in partnership with other agencies, i.e. social workers, family nurse partnership, health visitors, midwives."

"We already work in partnership on a number of contracts. It can be difficult at times as we are also in competition in other areas."

"We already work in partnerships with other local organisations in small ways and hope to develop them further."

"In principle it is fine but who does the work? None of us are paid for doing this yet we are expected to generate everything to help tick boxes for these organisations."

"Our organisation has been built on strong partnerships - with the Council, local GP practices, local schools, Gateshead Learning Skills and many others. In this way we can bring the best services to our communities, work more effectively, and share skills and expertise. Particularly at a time when resources are scarce, then working effectively together must become a priority for us all, otherwise our communities will be even harder hit. We have found that the most effective partnerships are based on good relationships, shared ethos, transparency and trust."

"We have no problem partnership working and do on a local, regional and national level with other Y Forums such as ourselves. Therefore working in partnership with the council, NHS etc is actually part of our grant within our DfE funding."

"We do work in partnership but they send us referrals because they cannot cope with demand on their services."

"We regularly work in partnership with other third sector organisations, the NHS and the Council on a variety of projects and services."

Question 19: Are there any other comments you would like to add?

Twenty-nine organisations took the opportunity to make a response. These comments illustrate the breadth and richness of the voluntary and community sector in Gateshead. A number reference Gateshead Council. They reflect hopes, fears and some thanks.

"No two community centres are the same. I would like to see a stronger system of support - by networking meetings perhaps by district West and East or Northish and Southish. I would like to have an attached adviser to offer advice and keep energy and commitment levels up during hard times. I would like more training packages on offer at weekends to catch volunteers who work."

"Thank you for conducting this survey. Percentages above were approximated due to time constraints but believe it paints a broadly accurate picture. We feel it is vital that supreme efforts be made to reduce the speed and depth of the endless public sector funding cuts if the third sector is to adjust in order to survive. Also that crucially government be made to understand that the North East is in no position to be cut loose from central government funding support by 2020. That is a guaranteed crisis in the making."

"If you can direct us to any funders that might help us to develop our community centre - please advise."

"We have received help from Gateshead Council and GVOC in the past and been most grateful for the guidance and funding provided."

"Thank you very much for CVS support."

"We find that funding is often dependent on having a new project. Operating costs and day to day expenses etc are more difficult to get funding for. Advice and information on suitable organisations that could help would be appreciated."

"Library services are in decline we recognise this is our core business but in order to survive we need to find ways of generating income. We have a business plan but rely on grants to keep the library open. Developing into a community hub is the way forward."

"After only four months everyone in our organisation is pleased with the input and the commitment from all concerned that have helped to get our project underway."

"We have been a volunteer library since 2013, necessarily less council support/funding each year. This year we have had noticeably

diminishing footfall, and have lost a few volunteers. The Council have never owned the land the library stands on, nor the surrounding two acres, and we are told the landowners now want all the land back for a social housing development. A deal has been just about done and this building in all likelihood will be demolished. Our CIO will be wound up in March."

"We work with a greater number of groups than your survey allowed."

"The value of the Voluntary sector is not appreciated by some of the Officers within Public bodies and they see us as a resource to be over controlled - whether this is through monitoring or by a tender process that excludes innovation. There is reduced confidence that the Council and CCG actually possess the organisational memory to fully understand the power of the Voluntary sector."

"Not interested in commissioning."

"Professional fund raising is now too busy and increased use of computers is making it harder. So???????????"

"The planned reduction in housing benefit will hit us hard."

"We are a residents association in X covering about 280 homes, but with only 30 members who pay £2 per household, annually."

"There will be no services, in the future. Big charities have an advantage with commissioning rather than small charities, and also commissioning is difficult for single gender work. Commissioning wants one service that delivers all (because it's easier)."

"We find that social enterprises do not have as much support from funding organisations such as Community Foundation there seem to be a preference of charities - how do we overcome that or get them to understand that our mission and vision is similar."

"Gateshead council should expand opportunities for more commissioned services open to the voluntary sector within Gateshead and offer practical help in ex-local authority services secure appropriate site. The record of asset transfers that have been undertaken seem to very closed quietly decided actions based on conversations between limited parties. Very little public information shared regarding opportunities for asset transfer or future property options."

"This sector brings much needed investment to the borough. The eyes of the country and often the international community focus on this region because of some of the important work we all do as a sector. We fight hard to provide services to help people in the borough. The money we bring in as a sector is in the £millions and it is all reinvested straight back to benefit local residents. We are not for profit but we are very valuable and complement services in the area. We should make sure this is acknowledged and our voices heard and considered at least as important, if not more important, than the commercial sector (the profit making sector) when decisions are being made"

"Our organisation has had to move three times is as many years because of being evicted due to landlord wanting to sell building and Council leases etc. The council have been very supportive in helping us with yet another move we will have to make next year, but it puts a lot of pressure on us and we feel our parents are just fed up of our moves."

"People that could fill in grant forms for us and other small groups."

"Only that in the past Gateshead Council and their representatives have been very supportive and very constructive at all times - we could not have had a better organization to help us. Even if all the funding dries up, as it may well have to do, we will remember the great work you have done. Thanks!"

"As with a lot of volunteering groups age is a big factor in our group we have an age problem and whilst the enthusiasm is not questioned maintaining levels of hands on physical engagement is at times difficult but we try to fulfil our levels of community support."

"We still have a good relationship with our local council."

"The benefit cuts have caused huge problems and the difficulty filling 40 page forms for PIP is another ongoing issue."

"As an amateur theatre group, our volunteers are our membership and our beneficiaries are paying patrons, and so many of these latter questions don't seem particularly applicable to our situation. But I hope this all helps!"

References

Below The Radar: activities and organisations in the third sector; TSRC; 2010

Small Charity Index; FSI (Foundation for Social Improvement); 2016

Social Landscape 2017: The state of charities and social enterprises going into ACEVO and CAF; 2017

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The Road Ahead: A Review of The Voluntary Sector's Operating Environment; NCVO; 2017

The UK Civil Society Almanac; NCVO; 2016

About Newcastle CVS

Newcastle CVS gives people who struggle to be heard a voice, supports voluntary and community organisations to be resilient and sustainable and promotes a fairer society by influencing and challenging the debate.

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Voluntary Sector trends: Gateshead Health and Wellbeing Board July 2017

This paper summarises current trends within the voluntary and community sector. It draws upon several sources, most of which are reports published during the first half of 2017 that offer national, regional and local perspectives on the state of the sector.

The voluntary sector makes a significant economic impact contributing £12.2bn to the UK economy; this is similar to the GDP of Cyprus. Registered charities employ a workforce of 853,000, while civil society as a whole (other not-for-profits such as social enterprises, housing associations and mutuals) employ 2.2 million paid staff, equivalent to 7% of the UK workforce.

Across the North (North West, Yorkshire and Humber and the North East) voluntary organisations employ more people than the area's financial and insurance sector. The voluntary sector's value in the North East (measured by salaries) is £750 million. The workforce is relatively stable with 37,500 full time equivalent employees, though a 10% rise between 2010 and 2016 to 45% of staff in part-time work shows a shift in working patterns.

Volunteering also makes a significant economic and social contribution. Nationally, the economic contribution of formal volunteering is estimated at £22.6bn. In the North East 150,000 volunteers deliver 10.8m hours of work at a value of £78m to £131m. 62% of the region's voluntary organisations report that many of their volunteers are currently, or have been, service users.

The Newcastle CVS report, Doing Good in Gateshead 2017, found only 11% of organisations responding used fewer than four volunteers. Indeed 6% had 100 or more volunteers. Gateshead Council's website notes *"Volunteering is one of our greatest assets, with 34% of Gateshead residents regularly taking part in an activity"*.

Grant aid remains the most important source of income, especially for the region's small and medium sized voluntary organisations. Contracts remain a significant income stream for larger organisations (incomes above £500,000) but grants are regaining importance and creating more competition within the sector. The most recent North East Third Sector Trends study continues to find social finance and borrowing of marginal interest to the sector. Less than 3% of respondents reported borrowed money to be important and only 9% of the larger organisations was planning to borrow money in the next three years.

The national picture finds 81% of earned income from the public sector is from contracts or fees. The largest slice of this (42%) goes to major charities (incomes between £10m -£100m). It is worth noting the 61% growth between 2008 and 2015 of 'super-major charities' with incomes above £100m, whose share of public sector funding grew by 9% in 2013 - 2015. However the NCVO UK Civil Society Almanac reports individual donations as the largest source of income for the voluntary sector. These comprise donations, legacies, as well as membership fees, income from shops and trading.

In the North East, 42% of large voluntary organisations earn more 61% of their income. This compares to medium sized organisations earning 30% of their income, and small organisations 21% of income. The most recent North East Third Sector Trends study finds the voluntary sector resilient and not about to '*fall off a cliff*'. However it does find distribution of income within the sector is changing though as larger organisations begin to look to grants becoming a more significant part of their income stream.

A consistent theme across many recent reports on the state of the voluntary sector is of a squeezed middle as medium sized organisations face increasing competition for grant aid from larger and smaller organisations. The House of Lords Committee on Charities reported medium sized organisations having *'problems bidding for contracts, from increasing scale of contracts to reduced focus on quality and payment by results mechanisms that disadvantage smaller providers'*.

The Third Sector Trends Study indicates 32% of medium-sized voluntary organisations in the region have used reserves for essential costs. 83% of Gateshead respondents said that without additional income they would use all their reserves up in less than 12 months. The House of Lords (HoL) Committee describes charities as the '*eyes, ears and conscience of society'*. However it also makes clear that '*the environment in which charities are working is altering dramatically'*.

Some of the challenges facing the voluntary sector are down to its own mixed performance, for example in the take up and use of technology and digital platforms. Another area highlighted for improvement is the diversity of trustee boards. Additionally the HoL Committee states more support is needed to increase the ability of trustees to provide the leadership and direction necessary for a sustainable future.

The HoL Committee report claims that against a background of lost income (since 2009/2010) small and medium charities are struggling to adapt to changing circumstances. The Road Ahead (NCVO) and Facing Forward (Lloyds Bank Foundation) both look at the challenges for the sector and what voluntary organisations can do to adapt and respond to them.

Facing Forward is concerned specifically with small and medium voluntary organisations. It lists ten trends to watch including Brexit, a slowing economy, changing public sector and public services, digital technology, social division, public trust in charities and the Government's vision for civil society. It includes seven steps to help organisations prepare for the future include diversifying funding streams, collaboration, better use of technology and planning for the future with care. This last step means asking questions about how organisations can best meet their charitable aims with options including merger or closure.

The Road Ahead focuses on a number of structural factors some of which directly affect voluntary organisations, for example funding and charity regulation. Others have wider impact on beneficiaries and communities. These include rising prices, stagnant incomes, Brexit, political (and economic) uncertainty and the sector's relationship with Government. NCVO calls for a resetting of the voluntary sector relationship with (central) government. It notes that anti-voluntary sector rhetoric from the Government and its supporters, the Lobbying Act, anti-advocacy clauses in contracts have led to an all-time low in the relationship between the Government and the sector.

The final report from the Independence of the Voluntary Sector Panel highlights a drop in trust among the general public, largely as a result of poor fundraising practices among some very large national and international charities. The Panel also cites uncertainty about the Government's intentions towards the sector and asks whether Theresa May's ambitions to create a Shared Society and to tackle burning injustices will have more substance than David Cameron's Big Society; questions that have all been thrown into the air as a result of June's General Election.

Sources

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A Shared Society, the Independence of the Voluntary Sector in 2017, Civil Exchange, 2017

Gateshead Council

HEALTH AND WELLBEING BOARD
21st July 2017

TITLE OF REPORT: **Gateshead Health Needs Assessment: Black and Minority Ethnic Population – Follow-up Report**

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1. Purpose of the Report

The purpose of this report is to update the Health & Wellbeing Board on progress of the health needs assessment (HNA) on the black and minority ethnic (BME) population in Gateshead.

2. Background

The approval to develop this HNA was given by Health and Wellbeing Board on 9th September 2016. The draft HNA was presented to the HWB at its meeting in January 2017.

The HWB welcomed and supported its findings, and resolved:

i. That the information contained in the report be noted;

ii. that an analysis of primary care data is undertaken to investigate important risk profiles for this population;

iii. that an action plan be developed to propose solutions to ensure BME communities receive important messages regarding access to appropriate services;

iv. that the action plan be implemented in appropriate ways to ensure solutions to the issues and recommendations as set out in the Health Needs Assessment.

3. Proposal

It is proposed that the attached paper updates the HNA in the light of the primary care data provided by the CCG. It should be noted that this has led to a revision of the text in some places, and a review and refresh of the recommendations.

The recommendations are now identified to either individual organisations or to all partners in the HWB, and effectively form an action plan.

4. Recommendation

The Health and Wellbeing Board is requested to

i. receive and endorse the attached health needs assessment and

ii. receive formal update reports from each partner on progress across all relevant actions at a meeting of the Board in six months' time.

Contact: Gerald Tompkins (0191) 433 2914

Black and Minority Ethnic (BME) Groups

Health Needs Assessment

Black and Minority Ethnic (BME) Groups Health Needs Assessment

Contents

1. Executive Summary and Recommendations

Demographics

Gateshead has a comparatively small BME and White Other population compared with many areas of the country, although this is gradually increasing in size. It has risen from 1.6% (2001 census) to 3.7% (2011 census), compared with the England average of 14.6%, and schools data suggests this rise is continuing.

The ethnic minority population is on average younger than the White British population, and has a much lower proportion of older people.

The largest concentration of the BME and 'White Other' groups locally is within Gateshead town centre and surrounding areas such as Teams, Bensham and Saltwell. These areas are more deprived than the Gateshead average. Local data from the CAB suggests that for clients from BME communities, the most used advice categories are debt, benefits and tax credits.

Recording of ethnicity in primary care is low, with only 54% of patients having had their ethnicity recorded (at practice level this ranges from 11% to 87%); by comparison in secondary care recording is high (typically around the high 80% to mid-90% mark, depending on the admission type): this HNA is therefore limited in its value by the quality of the data on which it is based, particularly with regard to primary care.

Recommendation

The CCG should ensure practices record the ethnicity of all registered patients, in line with the Equality Act (2010)

Lifestyle factors and Long Term Conditions

Nationally, the prevalence of long term conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. The evidence confirms that Asian, black African and African-Caribbean and other minority ethnic groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI measurement than the white European population. NICE and other sources highlight the importance of awareness raising for BMI measurement thresholds that can be used for recognising risk and as a trigger for intervention. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

However, the local data do not reflect this expected prevalence: practice disease registers (see Appendix 3) show a prevalence of every reported condition that is at least 3 times higher in the White British population than amongst BME communities. Furthermore, the practice level data on risk factors such as smoking and BMI show lower levels of prevalence amongst BME groups than in the White British population locally. All this may reflect the relatively young age of the local BME population, but there may be other reasons: limited recording of ethnicity by many practices, lack of recognition by professionals of increased risk amongst BME communities, or possibly limited knowledge of or engagement with services or poor health literacy amongst those communities (as shown by the low uptake of health checks and smoking cessation services). The focus group participants had mixed knowledge of diabetes, health checks and e.g. high cholesterol. Some knew what diabetes was as it was common in their country of origin, others did not understand the condition.

The relatively low reported level of uptake of cancer screening amongst local BME communities should be highlighted: cancer is emerging as an important issue nationally for South Asians, so it is important that they have access to information about cancer, including methods of prevention through lifestyle, diet and how to spot symptoms early.

Recommendations

The CCG should:

- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions compared to the white population;
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions;
- Recognise the long-term strategic implications for prevention, early detection and treatment long term conditions for the BME group, as the local population will age and grow;
- Take steps to encourage practices to record BMI and smoking status of all patients along with their ethnicity;
- Assess whether local health services are making reasonable adjustments to ensure services are accessible and appropriate for local BME communities. This includes working directly with those communities, as well as the provision of education and support for self-management;
- The CCG should work with the NHS England and PHE Screening and Immunisations team to better understand the uptake of breast and cervical cancer screening amongst women from BME (including White Other) communities, and to identify how rates might be increased;
- Review its Management of IGR Guidelines to ensure they fully reflect NICE guidance PH46 in respect of BMI in black, Asian and other minority ethnic groups;
- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI;
- Seek to develop trust and relationships between organisations, communities and people.

The Director of Public Health should consider whether there are particular steps that could be taken to encourage use of smoking cessation services by local BME and White Other communities.

Mental health

Good mental health and wellbeing is fundamental to ensuring that individuals can lead fulfilling lives, contribute to society and achieve their potential. Good mental health is also interlinked with good physical health, with individuals with poor mental health reporting higher rates of long-term physical health problems.

Higher rates of some serious mental illness such as schizophrenia have been consistently reported for some black groups, and there is a higher rate of detention under the Mental Health Act for people from BME groups. Some BME communities may be less able to identify poor mental health, which, along with cultural pressures, can contribute to a lack of access to healthcare. There may also be negative perceptions of mental health services and doubts about the cultural competency of services. All of these factors can result in a delay in seeking help with the consequence that some BME communities only access services at crisis point.

Data from the CCG notes that in Gateshead recorded all-age prevalence for serious mental illness of 0.6% amongst BME communities and 1.1% amongst the White British population in Gateshead; for depression prevalence is 10.1% amongst BME (including White Other) communities and 18.9% amongst the White British population; and all-age prevalence of anxiety disorder is 8.7% amongst BME (including White Other) communities and 14.3% amongst the White British population.

Data from the Improving Access to Psychological Therapies (IAPT) service shows that recovery rates for the BME population (41.3%) are lower in NewcastleGateshead CCG area than for the White British population (48.6%).

Recommendation

- The Mental Health Partnership Board should review whether the mental health needs of people from BME communities are being identified and recorded in General Practice, and whether services are responding effectively to the needs of local BME communities

Experience of Services

Nationally people from Pakistani, Bangladeshi, Chinese and White non-UK ethnic backgrounds are less likely to say that doctors and nurses treated them with care and concern and were less likely to have confidence and trust in nurses. People from all these groups were significantly less likely to report a good overall experience of using a GP surgery compared with White British people

The focus groups suggested low levels of knowledge of services other than their GP and hospitals/A&E amongst BME communities – for example GP out of hours, walk-in centres, health checks, mental health services. There were concerns about language and interpreting: although people can speak English they may not be able to read it. This factor shows itself through unfamiliarity and limited knowledge of health and social services.

Locally, the overall standardised rates of use of hospital services – first outpatient attendances, elective in-patient admissions, non-elective in-patient admissions, and accident & emergency attendances – by BME (including White Other) communities across all ages are lower than for the White British population. However, there are some significant variations.

Only small numbers of social care clients are from BME communities, but this appears to be in line with their overall numbers in the population by age.

Recommendations

Partners in the Health and Wellbeing Board should:

- Ensure that their respective organisations and organisations who they commission with are actively aware of their requirement to collect and analyse data across workforce and delivery areas in their performance measurements and monitoring;
- Make use of equality impact assessments to understand the implications of service and policy developments for local BME communities;
- Ensure that services that they commission or provide include a focus on people from minority ethnicities, and particularly within the 25-39 age groups. Outreach services are important to encourage engagement with local services and provide information;
- Assess whether local health services are making reasonable adjustments to ensure services are accessible and appropriate for local BME communities. This includes working directly with those communities, as well as the provision of education and support for self-management;
- Consider how to raise awareness of local services for individuals within BME communities by better publicising what support is already available and how to best access it. Research recommends family based educational interventions as a means of building on existing beliefs, attitudes and behaviours, with a community-based, word of-mouth approach;
- Consult families from BME communities about their specific needs when commissioning services;
- Consult families from BME communities about information in appropriate languages and ways of promoting to BME communities;
- Consider how best to work with local BME communities and community organisations to address health lifestyle issues;
- Review whether NCMP data and QOF data in General Practice is consistently recorded and whether services are taking account of this.
- Ensure providers' information on services is readily available in appropriate languages and is promoted to BME communities;
- Commission services that are accessible for local BME communities, including in appropriate locations and at appropriate times;
- Commission peer support forums for parents and carers from local BME communities and, where appropriate, tailored support services;
- Provide advocacy, translation and interpretation services for families from BME communities who require support during health and social care pathways;
- Ensure that the BME communities chapter of the Health and Wellbeing Board's Joint Strategic Needs Assessment is 'linked to all other chapters;
- Promote accessible services to teach English as second language.

2. Purpose of Health Needs Assessment

'A community of interest is a group of people who may come from any gender, background or geographical area who have something in common. Their link can be an interest or a health issue and they may share some of the same concerns' (Gateshead, 2016). People from BME groups have been identified as a community of interest in Gateshead's Joint Strategic Needs Assessment. This document provides an overview of BME communities in Gateshead. This health needs assessment BME aims to provide quality evidence to inform Gateshead's Health and Wellbeing Board of the needs of this population group.

Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

Why undertake HNA?

- HNA is a recommended public health tool to provide evidence about a population on which to plan services and address health inequalities
- HNA provides an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation
- HNA provides an opportunity for cross-sectoral partnership working and developing creative and effective interventions

Benefits:

- Strengthened community involvement in decision making
- Improved team and partnership working
- Professional development of skills and experience
- Improved communication with other agencies and the public
- Better use of resources

Challenges:

- Working across professional boundaries that prevent power-or information-sharing
- Developing a shared language between sectors
- Obtaining commitment from 'the top'
- Accessing relevant data
- Accessing the target population
- Maintaining team impetus and commitment
- Translating findings into effective action

Health needs can be:

- Perceptions and expectations of the relevant population (felt and expressed needs)
- Perception of professionals providing services
- Perceptions of managers of commissioner/provider organisations, based on available data about the size and severity of health issues for a population, and inequalities compared with other populations (normative needs)
- Priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (corporate needs)
- HNA should involve balancing these differing needs and using the results to improve health and health services

HNA may also involve the assessment of health inequalities between or within a population. Health inequalities are defined as 'disparities in health between population groups that are systematically associated with socioeconomic and cultural factors', such as educational status, social class, ethnicity, place of residence, income.

2.1 Aims and Objectives

The aim of the health needs assessment BME is to understand the needs of BME population in Gateshead, including high-risk groups, and establish whether the content and configuration of existing services meet this demand. It aims to inform the planning and development of health and social care provision for BME population across Gateshead, by understanding the population, epidemiology, current services and future need. In addition, in understanding the needs the following questions will be answered:

- How many people in Gateshead consider themselves as BME?
- What preventative factors could reduce demand for services and reduce need for primary and secondary care interventions?
- What is the impact on physical co-morbidities for people from BME communities

Objectives for this HNA include:

- A summary of the national and local policy and strategic background;
- An estimation of current demographics in Gateshead;
- A forecast of numbers and, future population projections for Gateshead and what this may mean in terms of the needs of local people and demand for services;
- An assessment of the impact on physical co-morbidities in BME groups ;
- A summary of evidence and guidance;
- Evidence and best practice of the current response to need in Gateshead

2.2 Scope of Health Needs Assessment

The Health Needs Assessment (HNA) aims to systematically assess the needs of a population, and to assess whether local services are meeting these needs. This report will be scoping in nature and will identify areas where further work may be required. It will describe the BME population within Gateshead and will identify the health needs of BME groups. It has been produced by Gateshead Council's Public Health Team using national studies and reports, local quantitative data where available, and focus groups involving members of Gateshead's BME communities. Where there is an absence of local data, the assumption that findings from national studies will be generalizable to the Gateshead BME population has been adopted for the purpose of the HNA.

2.3 Introduction

In order to meet the challenge of designing health and social care services, it is important for commissioners and providers of healthcare to identify gaps in information about services and shortcomings in the provision of services, and to overcome these with a robust programme of work that is closely managed at board level. It is complex and challenging to meet the competencies needed to design healthcare services and deliver against the realities of a diverse society.

This HNA will:

- Describe the BME population in Gateshead with respect to the geographic distribution, age
- Describe the health needs of BME groups within Gateshead and in the UK
- Summarise the findings of a thematic analysis of the information received via HNA stakeholder focus groups undertaken with established community groups in October and November 2016
- Make recommendations to improve the health of BME communities in Gateshead

2.4 Definitions

For the purposes of this report the term ethnic minority groups encompasses all groups except the White British group. Throughout this report we use the term 'BME' as an abbreviation for 'Black and minority ethnic'. 'Black' refers to those non-White groups who have traditionally been discriminated against because of their ethnicity. 'Minority ethnic' refers to other groups who have traditionally been discriminated against because of their ethnicity or who represent a minority in society (e.g. White ethnic minorities). Information on definitions and abbreviations is shown in Appendix 1.

Minority ethnic groups are most commonly classified according to the methods used by the census, which asks people to define which ethnic group they feel they belong to. In principle, an ethnic group would be defined as a community whose heritage offers important characteristics in common between its members and which makes them distinct from other communities.

Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, skin colour, language, culture, religion and nationality, which impact on a person's identity and how they are seen by others. People identify with ethnic groups at many different levels. They may see themselves as British, Asian, Indian, Punjabi and Geordie at different times and in different circumstances. However, to allow data to be collected and analysed on a large scale, ethnicity is often treated as a fixed characteristic. BME groups are usually classified by the methods used in the UK census, which asks people to indicate to which of 16 ethnic groups they feel they belong. Census data has been used to collect quantitative data for this Health Needs Assessment.

The size of the ethnic minority populations varies substantially across regions in England, from 4 to 5% in the South West and the North East, to 40% in London. London has the largest number of people in all ethnic minority groups, except Pakistani where the largest population is in Yorkshire & the Humber and the West Midlands. These variations in the size of the population can influence the ability to analyse and interpret ethnic inequalities in health.

Within all regions in England the population of ethnic minority groups is on average younger than the White British population, although there are a couple of exceptions namely the White Irish and the White Other groups.

2.5 Summary of National Institute for Clinical Excellence (NICE) Guidance

Information documented from key NICE guidance is summarised below (for full detailed guidance see Appendix 2):

BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46) July 2013

NICE guidance aimed to determine whether lower cut-off points should be used for black, Asian and other minority ethnic groups in the UK as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke.

The evidence confirms that these groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population. It also highlights recommendations from NICE and other sources in relation to awareness raising, BMI measurement and thresholds that can be used as a trigger for intervening.to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK.

Preventing type 2 diabetes

NICE recommendations include raising awareness of the need for lifestyle interventions at a lower BMI threshold for these groups to prevent type 2 diabetes. For example, in particular, use the public health action points advocated by the World Health Organisation (WHO) as a reminder of the threshold at which lifestyle advice is likely to be beneficial for black and Asian groups to prevent type 2 diabetes.

BMI assessment, multi-component interventions and best practice standards

NICE recommendations on BMI assessment, and how to intervene, is set out in 'Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children' (NICE clinical guideline 43). Specifically, weight management programmes should include behaviour-change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake

General awareness raising

- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m2).
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions at a lower BMI than the white population.
- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI.

NICE advice: Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups (LGB13)

The prevalence of chronic conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

Action now will result in significant social care and health savings, by delaying and improving the management of complications associated with limiting long-term illnesses. It could result in particularly high savings for local authorities with a high proportion of black, Asian and other minority ethnic groups.

Lifestyle interventions targeting sedentary lifestyles and diet have reduced the incidence of diabetes by about 50% among high-risk individuals. This includes people from South Asian, Chinese, black African and African Caribbean descent with a BMI of 23 kg/m2 or more, where interventions to identify and manage pre-diabetes have been found to be cost effective.

HIV testing: increasing uptake in black Africans (PH33) March 2011

The focus of this guidance is on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission.

This guideline was previously called increasing the uptake of HIV testing among black Africans in England.

It is one of two pieces of NICE guidance published in March 2011 on how to increase the uptake of HIV testing. A second publication covers HIV testing among men who have sex with men.

Community engagement and involvement

Directors of public health and others with a remit for HIV prevention or with responsibility for the health and wellbeing of black African communities are guided to take action to, for example:

- Plan, design and coordinate activities to promote the uptake of HIV testing among local black African communities, in line with NICE guidance on community engagement. Seek to develop trust and relationships between organisations, communities and people. Communities should be involved in all aspects of the plan, which should take account of existing and past activities to address HIV and general sexual health issues among these communities.
- Recruit, train and encourage members of local black African communities to act as champions and role models to help encourage their peers to take an HIV test. This includes helping to plan awareness-raising activities or acting as a link to specific communities that are less likely to use existing services.

Planning services – assessing local need

Directors of public health, public health specialists and commissioners with a remit for sexual health and local sexual health networks should take action to:

- Assess local need.
- Developing a strategy and commission services in areas of identified need
- Ensure the strategy is planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local black African communities .
- Ensure the strategy is regularly monitored and evaluated.
- Ensure HIV testing is available in a range of healthcare and community settings (for example, GP surgeries and community centres) based on the outcomes of a needs assessment.

Smokeless tobacco: South Asian communities (PH39) September 2012

The guidance aims to help people of South Asian origin who are living in England to stop using traditional South Asian varieties of smokeless tobacco. The phrase 'of South Asian origin' refers here to people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

The term 'smokeless tobacco', as it is used in the guidance, refers to 3 broad types of products:

- Tobacco with or without flavourants, for example: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers, for example: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut, for example: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

Products, like ‘snus’ or similar oral snuff products are not included.

The guidance is for commissioners and providers of tobacco cessation services (including stop smoking services), health education and training services, health and wellbeing boards and health and social care practitioners.

It is also for all those with public health as part of their remit, in particular, the health of South Asian communities. The guidance may also be of interest to local authority elected members and members of the public.

The 6 recommendations cover:

- assessing local need
- working with local South Asian communities

- commissioning smokeless tobacco services
- providing brief advice and referral: dentists, GPs, pharmacists, and other health professionals
- specialist tobacco cessation services (including stop smoking services)
- training for practitioners.

Commissioning smokeless tobacco services in areas of identified need

Directors of public health, public health commissioners and local authority specialists responsible for local tobacco cessation services, health and wellbeing boards, clinical commissioning groups, managers of tobacco cessation services should take action:

- Provide services for South Asian users either within existing tobacco cessation services or, for example, as:
  - A stand-alone service tailored to local needs. This might cater for specific groups such as South Asian women, speakers of a specific language or people who use a certain type of smokeless tobacco product (the latter type of service could be named after the product, for example, it could be called a 'gutkha' cessation service).
  - Part of services offered within a range of healthcare and community settings (for example, GP or dental surgeries, community pharmacies and community).
- Ensure local smokeless tobacco cessation services are coordinated and integrated with other tobacco control, prevention and cessation activities, as part of a comprehensive local tobacco control strategy. The services (and activities to promote them) should also be coordinated with, or linked to, national stop smoking initiatives and other related national initiatives (for example, dental health campaigns).

Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals

Primary and secondary dental care teams (for example, dentists, dental nurses and dental hygienists), primary and secondary healthcare teams (for example, GPs and nurses working in GP practices). Health professionals working in the community, including community pharmacists, midwives and health visitors should take action to:

- Ask people if they use smokeless tobacco. In addition to delivering a brief intervention, refer people who want to quit to local specialist tobacco cessation services. This includes services specifically for South Asian groups, where they are available.
- Record the response to any attempts to encourage or help them to stop using smokeless tobacco in the patient notes (as well as recording whether they smoke).

Training for practitioners in areas of identified need

Commissioners of health and dental services, commissioners of health education and training services should take action to ensure training for health, dental health and allied professionals (for example, community pharmacists).

2.6 Gateshead Health and Wellbeing Strategy

Our Health and Wellbeing Strategy 'Active, Healthy and Well Gateshead' sets out a route map on how Gateshead Health and Wellbeing Board can work towards the ambitious vision for health and wellbeing based on evidence of local needs and evidence of what works.

The Strategy recognises the importance of the 'wider determinants' of health, both in securing the sustained health improvement of local people and addressing health inequality gaps within and between Gateshead communities. It recognises that there is a need to look at how, in Gateshead, people can build active and healthy lifestyles into their lives, how communities can make the most of peoples skills, community assets and diversity, and how the Board can help people to improve their life chances by learning new skills and securing employment to ensure a prosperous, attractive, healthy and safe Gateshead for all to enjoy.

"Local people will realise their full potential and enjoy the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead."

Gateshead Council's Vision 2030

One of the System improvement priorities is to strengthen engagement and build capacity within communities, especially those with the poorest health and make the most of community assets. This is a priority because Gateshead has a strong sense of community where local people have a clear sense of belonging to their neighbourhood and want to live in a community with a sense of pride. The strategy aims to develop communities to be sustainable and cohesive places where people share values and aspirations for the future and work together to achieve them, making the most of community assets.

This involves ensuring that local communities are engaged and empowered to be involved in decisions that affect their lives, where everyone feels valued and understood and share a sense of belonging.

The strategy identifies five key priority areas, each of which will shape the work with local communities in taking forward our joint health and wellbeing agenda:

- **Community engagement and participation** – promoting positive and effective relationships, identifying issues that concern our diverse communities and responding appropriately, and ensuring hard to reach and other groups are not disadvantaged.

- **Community capacity building and making the most of community assets** – supporting the development of new skills within communities and the development of new and existing voluntary and community sector groups and social enterprises to help build community assets. Also, building community resilience to withstand the current economic climate, helping communities to make the most of their assets and to harness local resources and expertise to help themselves in an emergency (in ways which complement council and emergency service responses).

- **This will also support the 'co-production' of solutions** (for example, design of services) by people who may use them alongside those who have traditionally provided or arranged them.

- **Information and communication** – ensure that local people have access to up-to-date information in **suitable formats on activities, planned developments and support available within their communities.**

- **Involving children, young people and schools** – encouraging the development of children's and youth forums that provide a platform for all young people in Gateshead; promoting community cohesion, equality and diversity and citizenship in schools, out of school activities, youth and sports clubs and uniformed organisations.

- **Supporting positive community relationships** – supporting people within communities to live, work and learn together and to respect the diversity of communities within Gateshead.

Gateshead Councils Vision 2030 sets out an ambitious and aspirational vision, that:
"Local people will realise their full potential and enjoy the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead."

The strategy aims to improve the wellbeing and equality of opportunity for everyone in Gateshead so that all residents and businesses can fulfil their potential. It aims to champion equality of opportunity in all aspects of health and social care and, in particular, the work to promote choice and to empower local people to have more control over their care and to remain independent for as long as possible.

2.7 Equality Act 2010

The Equality Act 2010 requires public bodies with strategic functions, these include government departments, local authorities and NHS bodies, when making decisions such as deciding priorities and setting objectives, to consider how their decisions might help to reduce the inequalities associated with economic disadvantage. Factors such as access to health care, education, public planning and relationships all effect the health and wellbeing of an individual (Local Government Associates 2010). Altering these environmental conditions through policy, strategy and public services may increase a person's health outcomes and overall quality of life. The Equality Act 2010 requires public bodies to determine which socio-economic inequalities they are in a position to influence.

The Equality Act 2010 supersedes the Race Relations (Amendment) Act 2000 which, in the drive for race equality, gave public authorities a new statutory duty to promote race equality. The Act also places specific duties on public (including health) authorities, together with the publication of a race equality scheme. All public authorities are also bound by the employment duty to monitor by ethnic group their existing staff, applicants for jobs, promotion and training and to publish the result annually.

The NHS Chief Executive has added to the imperative to collect and analyse high quality ethnicity-coded data.

The Ten Point Race Equality Action Plan emphasises several important activities. These include:

- meeting the service needs of people from ethnic minorities,
- ensuring a greater focus on helping people with chronic diseases and
- tackling health inequalities.

It also focuses on helping areas where ethnic minority communities are disadvantaged, and targeting recruitment and development opportunities at people from different ethnic groups, whose skills are frequently underused.

To demonstrate compliance with these duties, ethnicity monitoring data needs to be collected and analysed across the workforce and service delivery areas. Yet, experience has shown that improvements in data collection have been slow and are difficult to bring about.

The Department of Health has issued a 'Practical guide to ethnic monitoring'. This guide promotes the standard collection and use of ethnic group and related data on patients, service users and staff of the NHS and social services. It shows examples of good practice throughout the NHS which help them to meet their responsibilities.

Recommendations

It is recommended that the Health and Wellbeing Board members:

- ensure that their respective organisations and organisations who they commission with are actively aware of their requirement to collect and analyse data across workforce and delivery areas in their performance measurements and monitoring;
- make use of equality impact assessments to understand the implications of service and policy developments for local BME communities.

3. Demographic Information

The national Census provides the most comprehensive picture of the BME population available. The following section predominantly outlines Census data unless otherwise stated.

Throughout this assessment, we have used the term Black and Minority Ethnic (BME) group to refer to members of non-white ethnic groups. However, we will also consider those in White groups other than White British, which includes people from Eastern European countries as well as the Irish and Gypsy or Irish Travellers. Collectively, we have referred to these as the 'White Other' ethnic group in this assessment.

3.1 Overall

Gateshead has a comparatively small BME and White Other population compared with many areas of the country, although this is gradually increasing in size.

In the 2011 Census, the Gateshead BME population was 3.7% (or 7,472 people) compared with the England average of 14.6%. Gateshead's BME population has risen from 1.6% in 2001 and 0.8% in 1991. In 2011, Gateshead's White Other population was 2.2% (or 4,387) compared with the England average of 5.7%. Gateshead's White Other population has risen from 1.5% in 2001. In 2011 the White Other population consisted of 3,708 from groups including Eastern European countries, with an additional 592 people of Irish ethnic origin and 87 Gypsy or Irish Travellers.

The 2011 Census recorded 3,004 people whose religion was Jewish. Whilst this non-mandatory question appears to have improved enumeration of the Jewish community since the previous Census, the Jewish community themselves estimate their population size to be around 4,500, including 1,500 students. It is likely that a number of those in the White Other population will be from Gateshead's local Jewish community, but many will be included within the White British population: the Jewish community sees itself as a religious grouping rather than an ethnic minority.

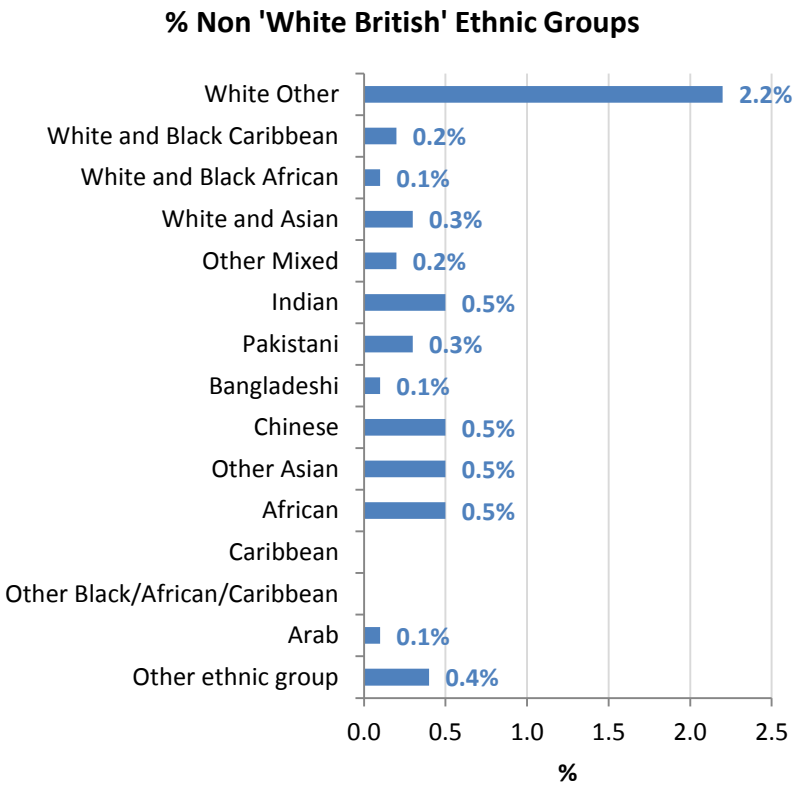
After the White Other group, the largest single minority ethnic group is Chinese with 1,054 (0.5%) people living in Gateshead. Within the south Asian group (including Indian, Pakistani, and Bangladeshi groups) there are 1,775 people (0.9%). A further 909 people (0.5%) are from other Asian groups. In total there are 3,738 people from the Asian ethnic groups.

Within the Black ethnic groups there are 1,081 people. The majority come from the Black African group with 903 people.

The Mixed ethnic groups account for 1,558 Gateshead people. Most are from the White and Asian (523) or White and Black Caribbean (412) groups.

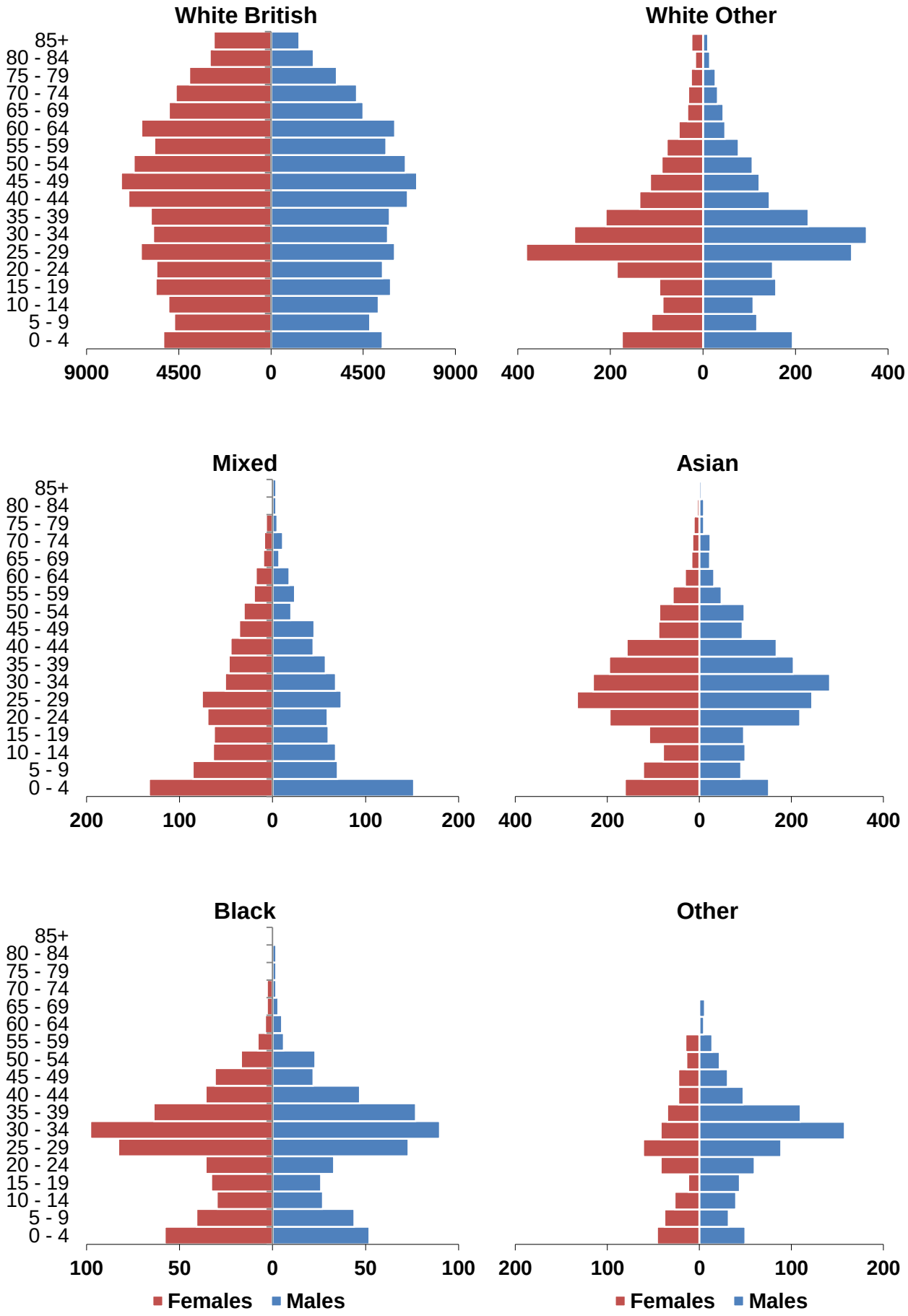
There are 1,095 people from Other ethnic groups.

2.9% of people in Gateshead do not use English as their main language.

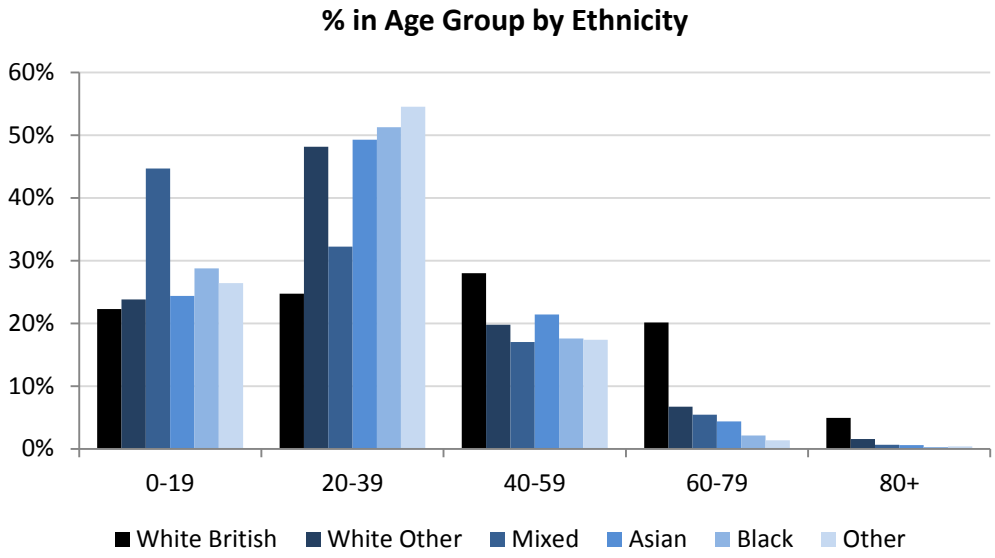


3.1.1 Age

As shown in the population pyramids below, the BME and White Other groups in Gateshead have a more youthful age structure than the White British group, which may lead to further natural increase in the future. This is particularly evident in those of younger working age and reflects population structures across the country.

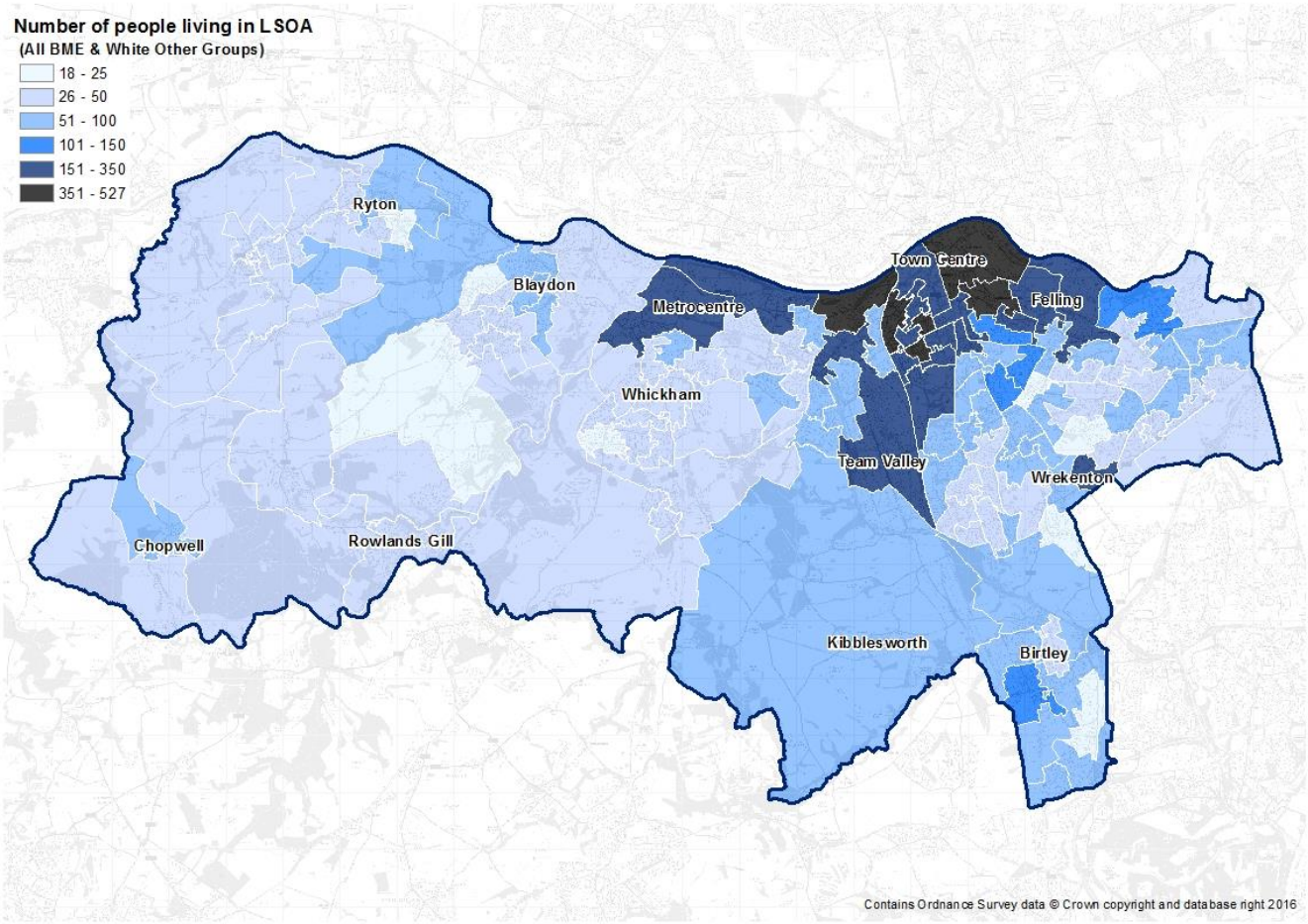


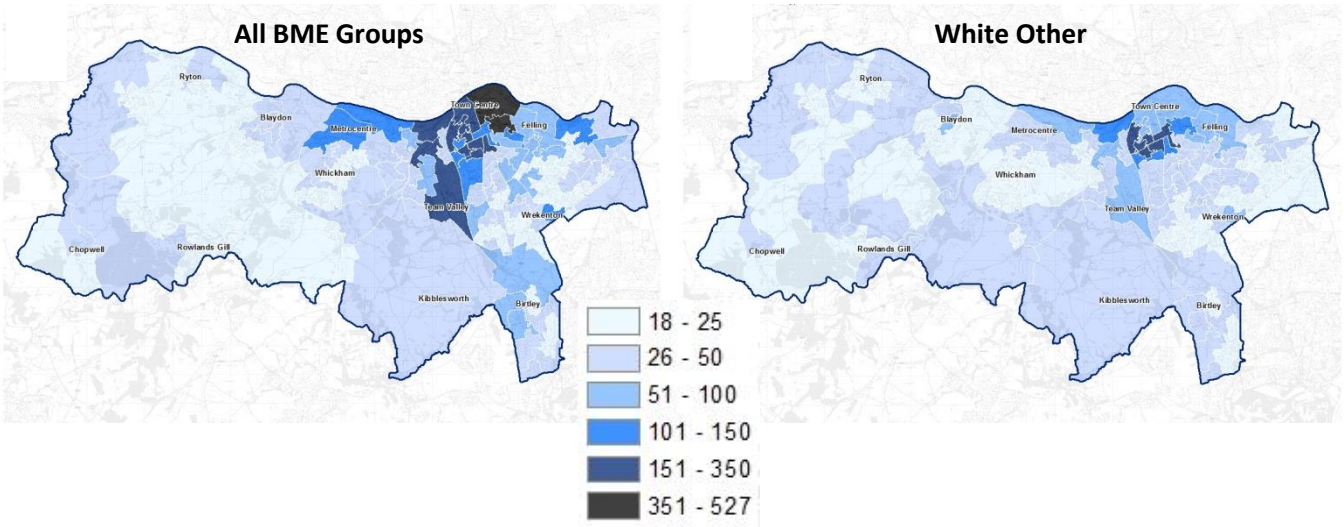
The chart on the right further demonstrates that BME and White Other groups tend to have a much lower proportion of older people when compared to the White British ethnic group. They tend to have greater proportions of young working age people. The "Mixed" ethnic group, however, has a much higher proportion of young people aged 0-19.



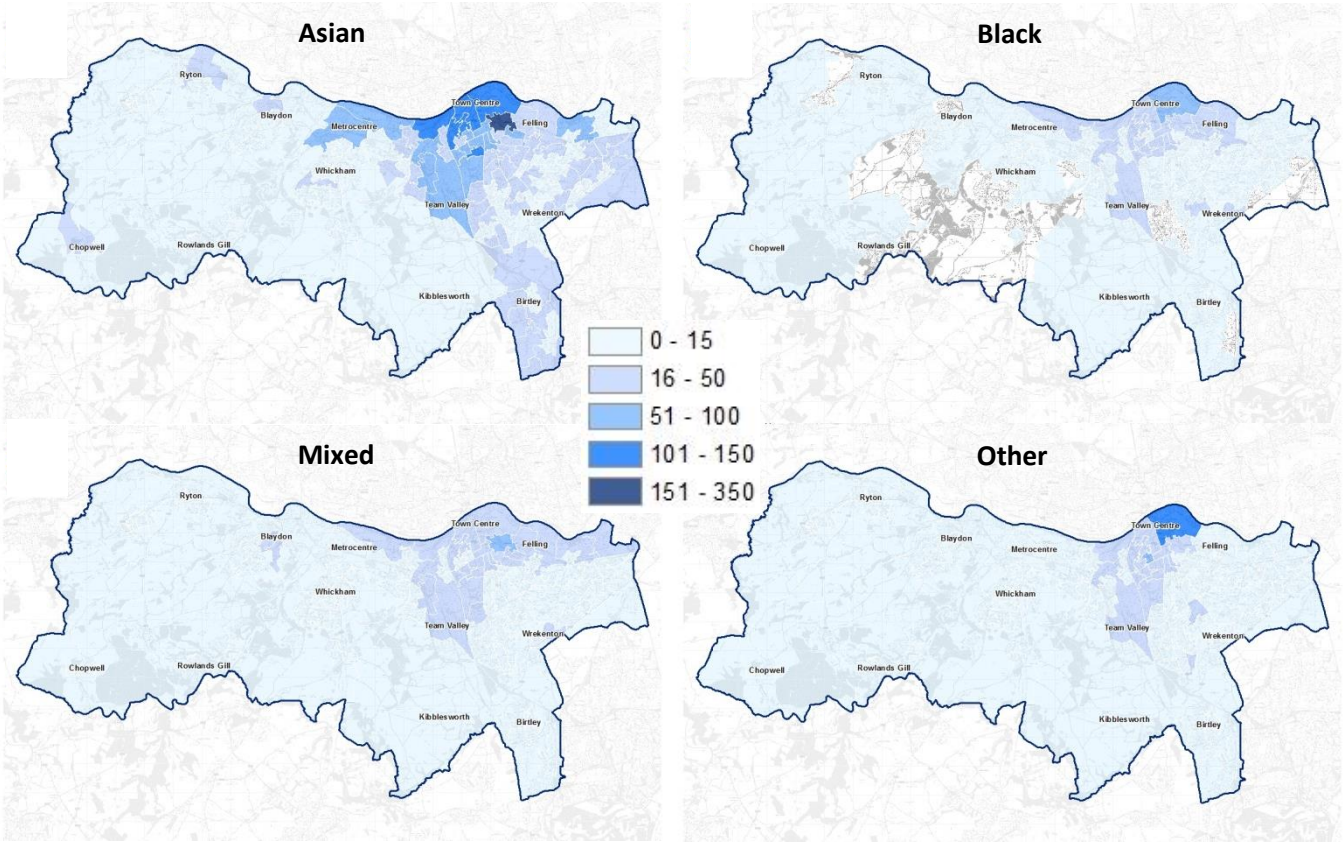
3.1.2 Geographical Distribution

The largest concentration of the BME and White Other groups is within Gateshead Town Centre and surrounding areas such as Teams, Bensham and Saltwell.

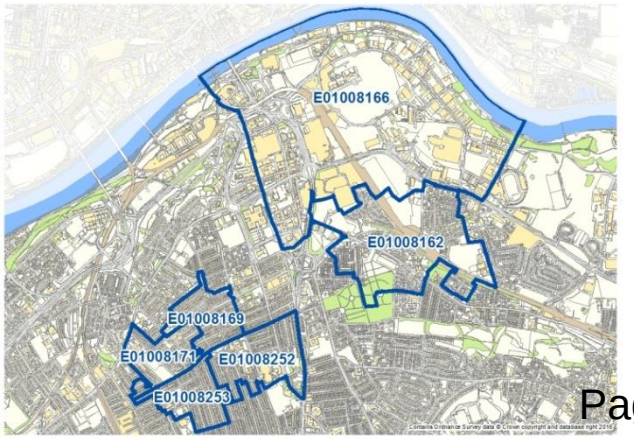




Looking at the geographical distribution for each of the broad BME groups, the pattern is similar to the 'all BME groups' map shown above, with the largest concentrations in the centre of Gateshead.



The areas with the highest concentrations of people from a BME or White Other group are shown in the map below. BME and White Other groups make up between 20% and 30% of the population in some areas as shown in the table and map below.



LSOA	Location	% BME	% White Other	% BME + White Other
E01008166	Town Centre	24	6	30
E01008169	Bensham Central	12	15	26
E01008253	Bensham South	12	11	24
E01008162	St James Village/ Sunderland Road	17	5	22
E01008171	Bensham South	8	14	22
E01008252	Bensham Central	9	10	20

3.1.3 Change Since 2001 Census

Between 2001 and 2011 the total population of Gateshead increased by 4.7% (9,063). Two thirds of this was due to increases in the BME and White Other ethnic groups. This is evident by the large increases over the same period in the White Other ethnic group, which increased by 55% (1,549), and the BME groups which, combined, increased by 145% (4,419).

		Total Population	White British	White Other	Mixed	Asian	Black	Other
Change 2001 to 2011	%	+4.7%	+1.7%	+55%	+95%	+126%	+274%	+250%
	No.	+9,063	+3,095	+1,549	+760	+2,085	+792	+782

The Asian ethnic group has seen the largest increase, with an additional 2,085 people since 2001. The fastest rate of increase was in the Black ethnic group, with an increase of 274%.

Change 2001 to 2011	Mixed				Asian					Black			Other	
	White and Black Caribbean	White and Black African	White and Asian	Other Mixed	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	African	Caribbean	Other Black	Arab	Other ethnic group
No.	+174	+175	+239	+172	+426	+126	+122	+690	+721	+695	+40	+57	+289	+493
%	+73%	+206%	+84%	+90%	+87%	+26%	+102%	+190%	+384%	+334%	+80%	+184%	n/a	+158%

The largest increases in the Asian and Black ethnic groups were the Other Asian (+721), African (+695), and Chinese (+690). There were also notable increases in the Other ethnic group (+493) and the Indian group (+426). Some of the groups, for example the White and Black African ethnic group (+206%) and the Other Black group (+184%), have increased at a fast rate but remain relatively small in number.

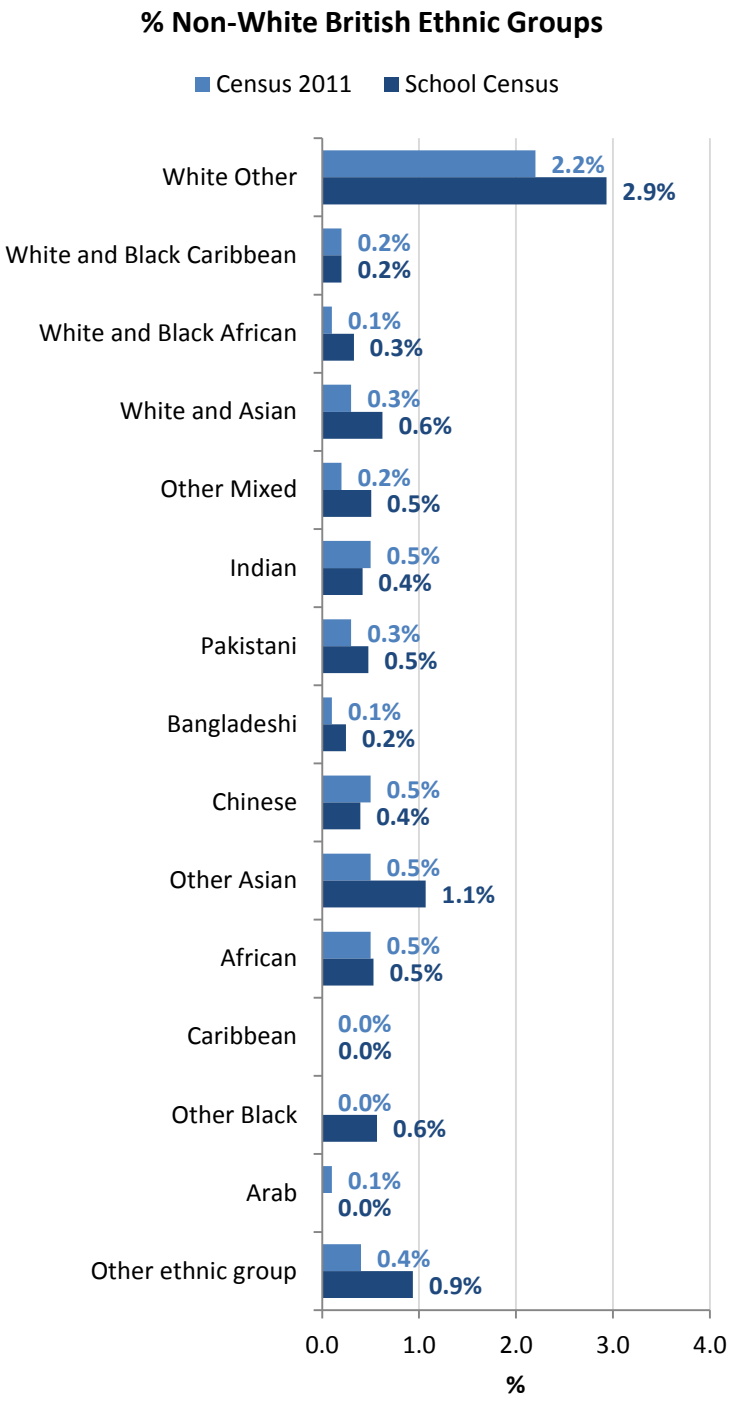
3.1.4 School Census

The school census is undertaken more regularly than the national Census data used throughout this report and therefore provides a more up-to-date estimation of the ethnic make-up of the school population.

9.2% of the school population are from BME and White Other groups. This compares with the total population figure of 5.9% from Census 2011. However, it should be noted that the school census only includes data from Gateshead Council maintained schools and Academies. This means that the Jewish schools, whose pupils some of whom may be of White Other ethnic origin, are not included in the figures shown.

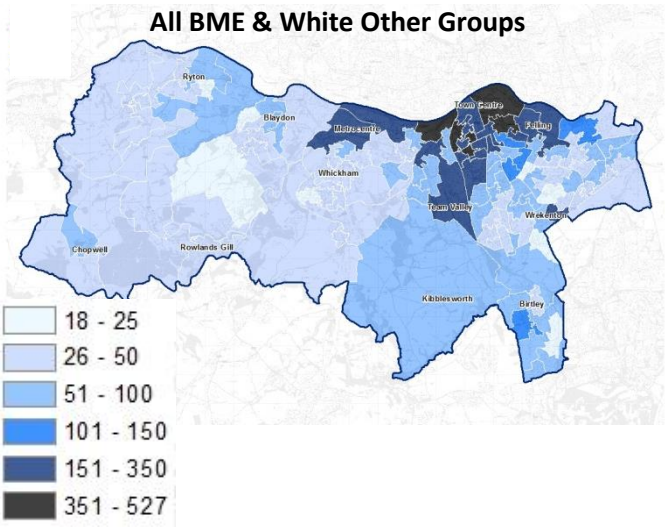
The chart on the right shows that in almost all of the BME and White Other ethnic groups there is a larger proportion of the school age population in those ethnic groups than there was in the total population. This means that the younger generation is now more ethnically diverse than the total population was in 2011 and suggests continuing growth in the BME and White Other groups.

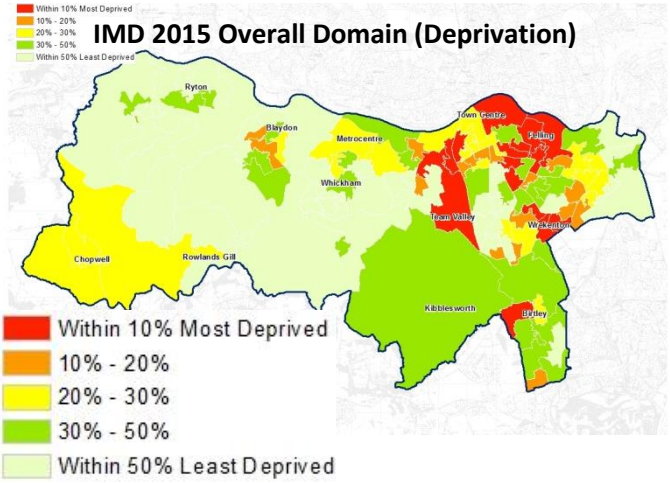
The largest differences between the total population and the school population are in the White Other group (+0.7 percentage points more in the school population), the Other Asian group (+0.6), and the Other Black group (+0.6). This reflects the changes outlined in the previous section on change since 2001 Census.



3.1.5 Deprivation

The maps below demonstrate that many Gateshead people from BME or White Other groups live in deprived areas. 38% of people from a BME or White Other group live in one of the 20% most deprived areas in England, compared with 24% for the White British group. Broadening the level of deprivation, 64% live in one of the 30% most deprived areas in England, compared with 43% for the White British group.

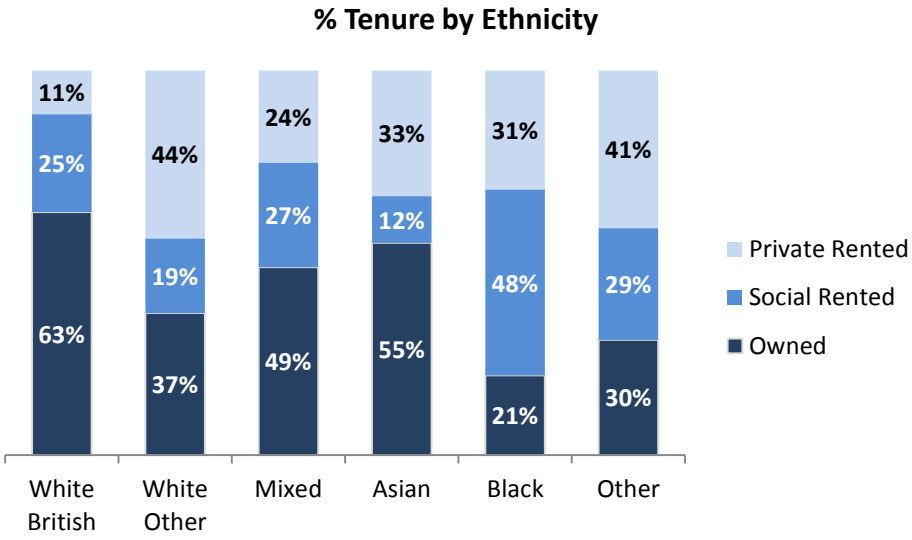




Source: DCLG, Index of Multiple Deprivation 2015

3.1.6 Tenure

People in BME and White Other ethnic groups are at least twice as likely to live in private rented accommodation than the White British population. This is shown in the chart on the right where 11% of the White British population are private renters, compared to the Mixed group at 24% and the White Other group, with the highest proportion, at 44%.



The Black group are almost twice as likely to live in social rented accommodation at 48%, than the White British population at 25%.

The White British population are most likely to own their property at 63%. The Asian group are next at 55%.

3.1.7 Migration

National Insurance Number Registrations provide an indication of the number of people from different ethnic backgrounds who move into the area to work. The data is limited in that it only identifies the inflow of migrants and only records the registration at the point it is made.

In Gateshead, in the year to June 2016, there were 835 registrations of migrants. The majority (544) were from within the European Union: 168 migrants were from the EU2 states (Bulgaria and Romania), 190 were from EU8 accession states (including Poland, Slovakia, and the Czech Republic) and 186 from the EU15 states.

Information on migrant workers is difficult to find. These groups are likely to be poorly recorded in sources such as the census and other national datasets.

World Region	Number of migrants
European Union EU15	186
European Union EU8	190
European Union EU2	168
European Union Other	18
Middle East and Central Asia	97
East Asia	30
South Asia	32
South East Asia	15
Sub-Saharan Africa	41
North Africa	26
North America	14
Central and South America	9
Oceania	14

Source: DWP, National Insurance Number Registration Jun 2016

4. Health needs of BME groups

There is a significant body of evidence that people of all ages in Black and minority ethnic communities experience health inequalities (Department of Health 2003, Equality and Human Rights Commission 2008). People working in the public sector have a responsibility to consider the needs of everyone who uses their services (Government Equalities Office 2009:30) and to engage them in discussion about developments and improvements.

In England there is a north-south divide on some health determinant indicators such as social class, with northern regions having a higher proportion in the lower social classes among most ethnic groups. The north-south pattern in educational attainment is less clear. Among health indicators, the north-south pattern in 'not good' health is very clear e.g. higher rates of 'not good' health in the northern regions among most ethnic groups

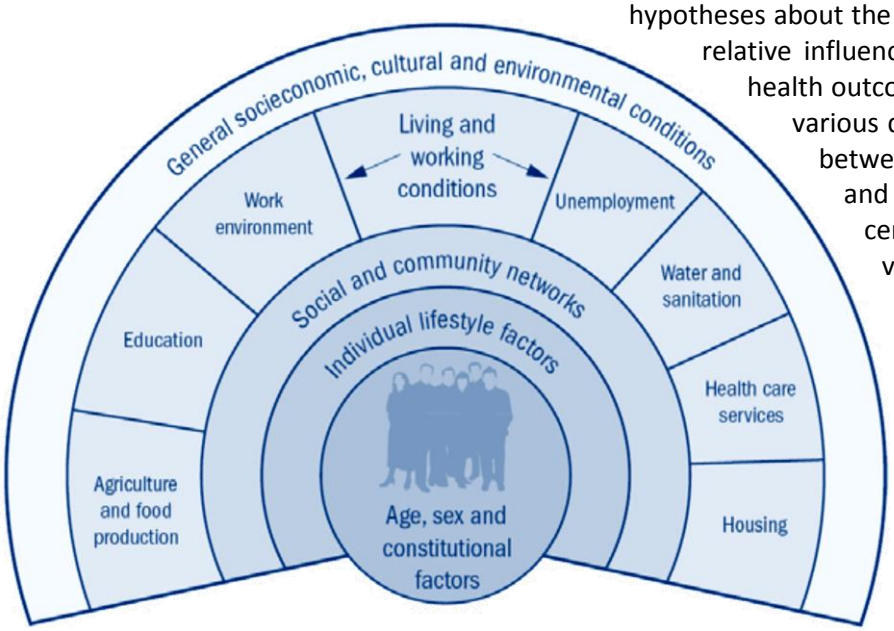
4.1 Factors impacting on health

There are a number of factors that can impact on an individual's health as demonstrated in the Dahlgren-Whitehead 'rainbow model' shown below. Certain population groups will experience worse health outcomes as a result of the effect of these factors. Determinants such as genetic differences, population structures, culture, socio-economic factors such as employment and housing quality will vary between different ethnic groups. However, differences in health outcomes are also present within ethnic groups, suggesting that more complex factors are at work than simple genetic or cultural explanations. Even factoring in the effects of socio-economic disadvantage does not fully explain differences in health outcomes seen in BME groups and therefore other factors such as racial discrimination or cultural insensitivity in the provision of healthcare services may also be having an impact.

Health inequalities in society – where your level of health is connected to your socioeconomic level – has led to a growing awareness that many health issues are related to social factors. The inverse equity hypothesis for health interventions ("Inverse Care law") was articulated by Tudor Hart (1971) with the concern that with health system initiatives, people from lower socio-economic groups benefit the least, as these groups are less able to take up any new health intervention (Victora et al 2000).

Under the Equality Act 2010, public bodies are required to eliminate unlawful discrimination, harassment and victimisation and promote equality of opportunity.

Economic, environmental and social inequalities can influence people's risk of getting ill, their ability to prevent sickness, or their access to effective treatments. This framework has helped researchers to construct a range of hypotheses about the determinants of health, to explore the relative influence of these determinants on different health outcomes and the interactions between the various determinants. It maps the relationship between the individual, their environment and health. Individuals are placed at the centre, and surrounding them are the various layers of influences on health, such as individual lifestyle factors, community influences, living and working conditions, and more general social conditions.



Dahlgren-Whitehead 'rainbow model'

The Dahlgren-Whitehead rainbow model remains one of the most effective illustrations of health determinants, and has had widespread impact in research on health inequality and influences.

Source: Dahlgren and Whitehead 1991

Recommendations to reduce health inequalities frequently emphasise improvements to socio-environmental determinants of health. Proponents of 'proportionate universalism' argue that such improvements should be allocated proportionally to population need. 'Proportionate universalism' can be applied for health inequalities to be tackled across the social gradient, as well as considering the health needs of the most vulnerable. Non-health interventions can be evaluated to better understand if, and how, health inequalities can be reduced through strategies of allocating investment in social determinants of health according to need.

Public Health and Inequalities

Factors such as income, housing, workplace, access to healthcare, education, public planning and relationships all affect the health and well-being of an individual (Local Government Association, 2010). Altering these environmental conditions through policy, strategy and public services may increase one's health outcomes and overall quality of life. Reducing health inequalities within the population is a statutory requirement under the Public Sector Equality Duty of the Equality Act 2010 for health and social care agencies to address inequalities (Equality and Human Rights Commission, 2010).

The role of socio-economic status and deprivation in explaining patterns of health by ethnic group and region is not entirely clear. For example the Pakistani and Bangladeshi groups have the highest proportions reporting that their health is 'not good' as well as the lowest proportions in the 'managerial and professional' occupations who are known to report higher rates of 'not good' health than other social groups. However, it is unlikely that this accounts for all of the variation or that socio-economic status correctly captures all of the forms of disadvantage that may be experienced by ethnic minority groups. Other factors are likely to be playing a part: e.g. environmental factors in influencing poor health outcomes for ethnic minority groups.

It is also being recognised that some health issues are particularly problematic for certain ethnic groups. For example, South Asians have a significantly higher risk of diabetes (Sproston, & Mindell 2006), and an increased risk of cardio-vascular disease (Wild et al 2007) while smoking is considerably more prevalent in some ethnic communities than others.

According to a report by NICE (2013), Professor Mike Kelly, Director of the Centre for Public Health at NICE said:

"Type 2 diabetes, heart disease and stroke are potentially life-threating conditions, which people of African, Caribbean and Asian descent and other minority ethnicities are significantly more likely to develop than the wider population. So it's vital that local authorities are supported in taking action to prevent these illnesses in people who have a high risk of developing them".

They also suffer from these conditions at a younger age (DH 2006), up to a decade or more earlier than white Europeans:

"Not only are people from these ethnic backgrounds up to 6 times more likely to be diagnosed with type 2 diabetes, they are 50% more likely to die from cardiovascular disease, and they also suffer from these conditions at a younger age".

In the UK, type 2 diabetes is more prevalent among people of South Asian, Chinese, African–Caribbean and black African descent than among the white population. They tend to progress from impaired glucose tolerance to diabetes much more quickly (more than twice the rate of white populations) (Webb et al. 2011).

A substantial proportion of Asian people at high risk of type 2 diabetes have a BMI lower than the World Health Organization (WHO) recommended cut-off point for being overweight (the same or greater than 25 kg/m2). For example, South Asians tend to have a higher percentage of body fat at a given BMI than Europeans. The WHO report suggested that 23–27.4 kg/m2 and 27.5–32.4 kg/m2 should be used to identify people within different Asian populations who may be at risk of health conditions due to their weight (WHO 2004).

This should be used as a trigger to take action in helping people from these and other minority ethnicities to avoid ill health. This is a change from the usual threshold of 25 kg/m2 signalling increased risk of chronic conditions, although 25 kg/m2 is still valid for flagging risk in white European adults.

Lifestyle interventions that targets inactive lifestyles and diet can reduce the incidence of diabetes by about 50% among high-risk individuals, including people of South Asian, Chinese, African and Caribbean descent.

As well as improving the health and wellbeing of individuals, taking effective action now also reduces future demand on health and social care services by enabling people to remain as independent as possible.

Whilst some BME groups experience worse health than others, for example, surveys show that Pakistani, Bangladeshi and Black-Caribbean people report the poorest health, with Indian, East African Asian and Black African people reporting the same health as White British, and Chinese people reporting better health. However patterns of ethnic inequalities in health vary from one health condition to the next, for example, as documented, BME groups tend to have higher rates of cardio-vascular disease than White British people, but some have lower rates of many cancers.

- Ethnic differences in health also vary across age groups, and the greatest variation by ethnicity is seen among the elderly.
- Ethnic differences in health vary between men and women, as well as between geographic areas.
- Ethnic differences in health may vary between generations. For example, in some BME groups, rates of ill-health are worse among those born in the UK than in first generation migrants.

With local authorities' wider remit for public health in communities, this highlights the importance of taking steps to address diabetes, cardiovascular disease and stroke to improve the health of local people. In our diverse population, it is essential that local authorities and their partner organisations ensure that services that they commission or provide include a focus on people from minority ethnicities, and particularly within the 25-39 age groups.

Gypsy, Roma and Travellers

For Gypsy, Roma and Traveller families, evidence suggest these groups often remain excluded from ‘mainstream services and opportunities, particularly health and education services’ (Riches, 2007). Riches (2007) argues that ‘an ‘open door’ policy for access to services is not enough’, as the individual must still know the system before accessing that system or institution.

Children of Gypsies and Travellers experience a higher burden of illness and disease, with challenges in accessing sustained healthcare, contemporary advice and information. Consequently, early identification of needs often is lacking, resulting in diagnosis and interventions not occurring until school age, which can be less effective. This can result in stress for parents trying to cope without clear support services and networks, which is why outreach services are important (Riches, 2007).

Often without a named GP, screening is extremely difficult for gypsies and travellers, with inability to access routine check-ups. Literacy difficulties are also a barrier to accessing health screening, many feeling ‘ashamed to admit that they do not understand’ (Bingham, 2010).

Gateshead’s community engagement team works with the Gypsy Roma Travelling groups to encourage engagement with local services and provide information.

Recommendations

Partners in the Health and Wellbeing Board should ensure that services that they commission or provide make reasonable adjustments to ensure they include a focus on people from minority communities, and particularly within the 25-39 age groups. Outreach services are important to encourage engagement with local services and provide information.

4.1.1 Public health issues faced by different communities

Having established that among some religious and ethnic groups there is a high level of attendance within a faith setting, it is pertinent to ask whether different groups have a tendency towards particular public health issues, whereby the faith setting might lend itself towards health-related interventions. The following table is not exhaustive, but summarises broadly at population level the particular health issues that different communities face.

(Source: November, L. 2014)

Public health issues summarised by ethnicity or religion	
Community	**Public health issues or determinants of ill-health relevant to grouping**
South Asians (predominantly Muslim, Hindu and Sikh)	**Cardiovascular disease (CVD)** The increased risk of CVD in the South Asian population is well recognised with various factors given as explanations for this disparity including language barriers and cultural taboos. **Diabetes** Type 2 diabetes is up to six times more common in people of South Asian descent than in the general population According to the Health Survey for England 2004, doctor diagnosed diabetes is almost four times as prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men, compared with men in the general population. Among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and two-and-a-half times as likely in Indian women, compared with women in the general population. During the month of Ramadan, Muslims are required to abstain from food and drink between dawn and sunset. The Koran exempts those whose health may be significantly affected, including diabetics, pregnant women and breastfeeding mothers. However in a population based study 43% of patients with type 1 diabetes and 79% of patients with type 2 diabetes report fasting in 13 Islamic countries during Ramadan . The same study showed that fasting during Ramadan significantly increased the risk of severe hypoglycaemia, with its associated health risks. **Smoking** Smoking has a lower prevalence (20%) in Indian men compared with the general population (24%), and a much higher prevalence in Bangladeshi men (40%). **Hypertension** The other notable difference is the prevalence of hypertension, with a significantly higher prevalence in Indian men (33%) than in other South Asians (20%) in Pakistanis and 16% in Bangladeshis), though comparable with the general population (32%) Prevalence for women in all South Asian populations is lower than the general population.
Some Muslim and Jewish communities	**Consanguinity** Marriage to a blood relative is common in some Muslim and Jewish communities. This more than doubles the risk of recessively inherited disorders such as congenital deafness and congenital heart disease. However, social and cultural reasons, not religious belief, are behind consanguineous marriage, and public understanding of the genetic facts behind consanguineous marriage could be increased through the participation of the media, scholars, physicians, nursing staff and society leaders including religious leaders.
Christians	Because the Christian population is so diverse, generalisations based on ethnicity are less easily made. However, of note is that White Irish men and women, who are overwhelming Catholic, are more likely than any other ethnic group to drink in excess of government recommended guidelines (58% of men and 37% of women) . The Determinants of Adolescent Social wellbeing and Health study shows the tendency towards obesity to be higher for Black Africans, especially in adolescent girls. A high

Public health issues summarised by ethnicity or religion	
Community	**Public health issues or determinants of ill-health relevant to grouping**
	proportion of Black Africans report as Christian. The majority of HIV infections in the UK is among heterosexual Black Africans, many of whom will be church (and to a lesser extent, mosque) attendees. Men born in the Caribbean are 50% more likely to die of stroke than the general population. Elevated incidence rates of schizophrenia in UK Black Caribbean's have been consistently reported.

4.1.2 Religious constraints on prescribing medication

The main dietary restrictions of religions:

Christianity
Christians have few restrictions on their diet, and none are compulsory. The historical recommendation. Practising Roman Catholics are more likely to observe fasting on holy days and specified periods of the church year, such as Lent and Seventh-day Adventists are encouraged to eat a vegetarian diet and have prohibitions on pork, alcohol, coffee and tea.

Buddhism
Buddhists have no set dietary laws and there is a great diversity. Many Buddhists refrain from meat and encourage a vegetarian diet, with moderation in all foods, and some are vegan. Other Buddhists, often from China or Vietnam, will not eat 'pungent spices' eg onion, garlic or leek.

Islam
In Islam, under sharia law, all food and drink is permitted, ie 'halal', unless explicitly prohibited, in which case it is 'haram'. Alcohol can lead to addiction, misbehaviour and has a negative impact on health, therefore it is classed as haram and prohibited. Something considered halal can become haram in preparation, for instance by using alcohol in the process. Pork and its by-products are haram for observant Muslims but according to a letter by the WHO on the findings of Islamic legal scholars, transformation of pork products into gelatin alters them sufficiently to make it permissible for observant Muslims to receive medicines containing pork gelatin, although others do not agree.

Animals not slaughtered in a specified way or that are unhealthy, diseased or a possible cause of death are all haram. Foods containing animal fats or emulsifiers from animal derivatives, blood or its by-products are haram. The acceptance of shellfish varies by community. Muslims sometimes use the term 'mushbooh' when it is unclear whether substances are halal or haram.

Practising Muslims fast from food and drink from dawn to sunset during the month of Ramadan, the ninth month of the Islamic lunar calendar.

Judaism
Judaism has a complex set of dietary laws (kashrut) that determine what food and drinks are permitted. Those that can be eaten are 'kosher' and divided into three categories: meat, dairy and pareve (permitted foods that are neither meat nor dairy). Meat and dairy products must not be eaten together; pareve products can be eaten with either meat or dairy. Shellfish and pork are strictly forbidden by Jewish dietary laws. Observant Jews will only consume kosher meat, ie from ruminant animals with split hooves (eg beef, lamb, mutton and goat) or poultry (chicken, duck, turkey and goose) that has been slaughtered according to kashrut law to be passed as kosher. Foods not complying with these specifications are non-kosher.

Prescribers need to consider and alert their patients about medications that might contain wheat starch during the festival of Passover, when wheat, barley, rye, oats and spelt are not permitted.

Hinduism
Many Hindus practise vegetarianism, but dietary practices vary between individuals. They do not usually eat eggs, but cakes or biscuits containing eggs are often considered acceptable. All other meat and fish is restricted or avoided. The cow is sacred, therefore beef cannot be eaten, but cows' produce is pure and desirable. There are numerous fasting days.

The use of bovine-based drugs or cartilage transplants derived from cattle, would have belief implications for Hindu patients, as well as for some vegans and vegetarians. Many Hindus will maintain a vegetarian diet during Diwali and Navratri, even though they might eat some meat at other times.

Sikhism
Some Sikhs are vegetarians, and may avoid all meat, fish and eggs. Others might eat meat but not that slaughtered according to the guidelines of other religions (halal or kosher), and some do not eat beef or pork. Observant Sikhs will not consume alcohol.

Many pharmaceutical products have constituents that would have implications for Jewish, Muslim, Hindu and Sikh patients e.g. those with active ingredients directly derived from animals include: Heparin, an injectable anticoagulant, Conjugated Oestrogens, used in some HRT preparations, Insulin (bovine or porcine) extracted from the pancreas of cows or pigs. However animal insulin, although still available on prescription, has largely been replaced by human insulin or insulin analogues.

Over the counter supplements with active ingredients that could be derived from animal products include: Calcium Tablets, Glucosamine, Chondroitin, Iron supplements.

How prescribers can help
Many drugs come in different forms (eg tablets or solution, as well as capsules), so a different formulation with permissible ingredients could be considered. Some manufacturers make capsule shells from a plant source, allowing Muslim and Jewish patients to consume them, as they are kosher and halal certified. There are also plant sources for stearic acid and its salts, therefore the source of magnesium stearate needs to be verified with the manufacturer before deciding on an alternative source. If the chosen treatment is not available in a different formulation, there might be a similar treatment from the same drug class that is free of nonpermitted substances. If all alternatives have been explored without success, people might wish to consult their religious leader for advice (Ogden 2016).

4.1.3 Language and Literacy
Poor linguistic competence will be a major barrier to access to health and social care for some people. As such, interpreting services are required to adequately gain consent, diagnose and treat some people. This can be a complex issue due to many languages and dialects exist in the population.

Refugees are reported to develop a survival level of competence in the use of English. There is evidence that ability to speak English is lower for women than it is for men, and is poorer for those born outside of the UK, and declines with increasing age.

Also although people can speak English they may not be able to read it. This factor shows itself through unfamiliarity and limited knowledge of health and social services

Recommendations

Gateshead Council and the Newcastle Gateshead Clinical Commissioning Group (CCG) should:

- Consult families from BME communities about their specific needs when commissioning services;
- Consult families from BME communities about information in appropriate languages and ways of promoting to BME communities;
- Ensure providers' information on services is readily available in appropriate languages and is promoted to BME communities;
- Commission services that are accessible for local BME communities, including in appropriate locations and at appropriate times e.g. highlight and promote stop smoking services to communities prior to Ramadan;
- Commission peer support forums for parents and carers from local BME communities and, where appropriate, tailored support services;
- Provide advocacy, translation and interpretation services for families from BME communities who require support during health and social care pathways;
- Ensure that the BME communities chapter of the Health and Wellbeing Board's Joint Strategic Needs Assessment is linked to all other chapters;
- Promote accessible services to teach English as second language.

4.1.4 Workforce equality

The link between staff equality and the quality of care is now well-established. Workforce equality in the NHS is gaining greater attention due to the NHS Workforce Race Equality Standard (WRES), (NHS England)

Nationally, staff from BME groups are still under-represented in management roles – they hold only 10% of NHS non-medical and 13% of adult social care management jobs.

Women are under-represented in health and social care management roles – men make up 19% of NHS non-medical staff, but fill 30% of management roles. The difference is not so large in adult social care – where men are 18% of the workforce and 22% of managers.

These broad categories mask some differences between grades within roles. For example, nurses from BME groups are more likely to be in the lower grade posts (for example A4C band 5, which accounts for 66% of Asian or Asian British nurses, 57% of Black or Black British nurses, and only 46% of White nurses). They are also less likely to be in the highest grade posts (bands 8 or 9 which account for 1% of Asian or Asian British nurses, 31% of Black or Black British nurses and 5% of White nurses). Female NHS managers are more likely to be in lower grade management roles than their male management colleagues (Health and Social Care Information Centre).

National evidence suggests people from minority ethnic groups are proportionately over-represented in the medical workforce when compared to the general population in all English regions. However, white staff are more likely to be employed at the Consultant grade and staff from ethnic minority groups at the lower Associate Specialist and Staff Grade levels.

We have not gathered data on local employment of staff from minority groups.

In the North East there is an under representation in the 'routine and manual' occupations for the Indian, Asian Other and Black Caribbean ethnic minority groups. The North East also has an over representation in the 'intermediate occupations' for both the Indian and Pakistani ethnic minority groups.

Recommendations

Partners in the Health and Wellbeing Board should analyse workforce data in order to establish numbers and trends of BME workforce across health and social care.

4.1.5 Staff experience

From NHS England, analysis of the NHS 2015 staff survey results, it was found that staff from BME groups were more likely than staff from White ethnic groups to experience bullying and harassment from other staff across all types of trust. However, the picture was much more mixed around staff experiencing bullying and harassment from members of the public. This is similar to the analysis of the 2014 results carried out by NHS England.

The indicators with the largest difference between staff from BME groups and staff from White ethnic groups, across all types of Trust, were those relating to personal experience of discrimination, and belief that their employing Trust provided equality opportunities. This was also the case in 2015. For example, in 2015, 14% of staff from BME groups working in acute trusts said that they had experienced discrimination, compared with 6% of staff from White ethnic groups.

4.2 Health needs in early years (0-25 years)

4.2.1 Maternal and Infant Mortality

In 2016 the Equality and Human Rights Commission (EHRC) reported that some health inequalities are improving. There has been an improvement in infant mortality rates for White, Pakistani, Bangladeshi, African and African Caribbean children.

In the 2015 NHS maternity services survey, there were some differences in the support people received around childbirth. Asian, Asian British, Black, Black British and Arab people were more likely than people from White ethnic groups to report being given the information or explanations they needed during their care in hospital after birth.

4.2.2 Breastfeeding

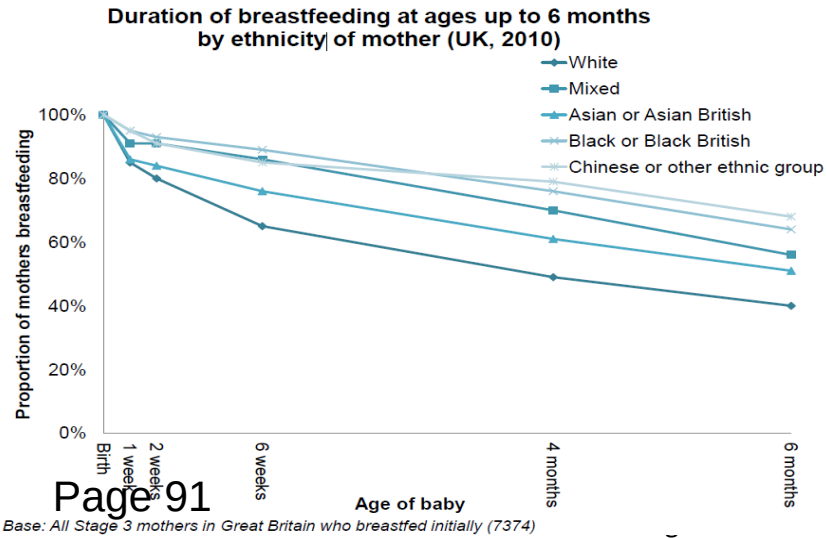
Nationally, the highest incidences of breastfeeding were found among mothers aged 30 or over (87%), those from minority ethnic groups (97% for Chinese or other ethnic group, 96% for Black and 95% for Asian ethnic group), those who left education aged over 18 (91%), those in managerial and professional occupations (90%) and those living in the least deprived areas (89%).

Prevalence of breastfeeding at all ages of baby up to nine months was highest among certain demographic groups. For example, when babies were aged six months, this was highest for mothers from managerial and professional occupations (44%), those who left education aged over 18 (46%), those aged 30 or over (45%), those living in the least deprived areas (40%) and those from minority ethnic groups (66% for Chinese or other ethnic group, 61% for Black and 49% for both Asian and Mixed ethnic groups).

Ethnicity of mother

We have not secured local data on breastfeeding by ethnicity.

Mothers from Asian, Black and Chinese or other ethnic groups were the most likely to breastfeed initially, while White mothers were the least likely (mothers of Mixed ethnic origin fell in between the two). This difference was maintained through until later ages, although to a lesser extent among Asian mothers: At six months, 66% of mothers of Chinese or other ethnic origin and 61% of Black mothers were still breastfeeding. Prevalence at six months among Asian mothers was the same as for mothers of Mixed ethnic origin (49%), but all



Base: All Stage 3 mothers in Great Britain who breastfed initially (7374)

these groups had higher prevalence than White mothers (32%).

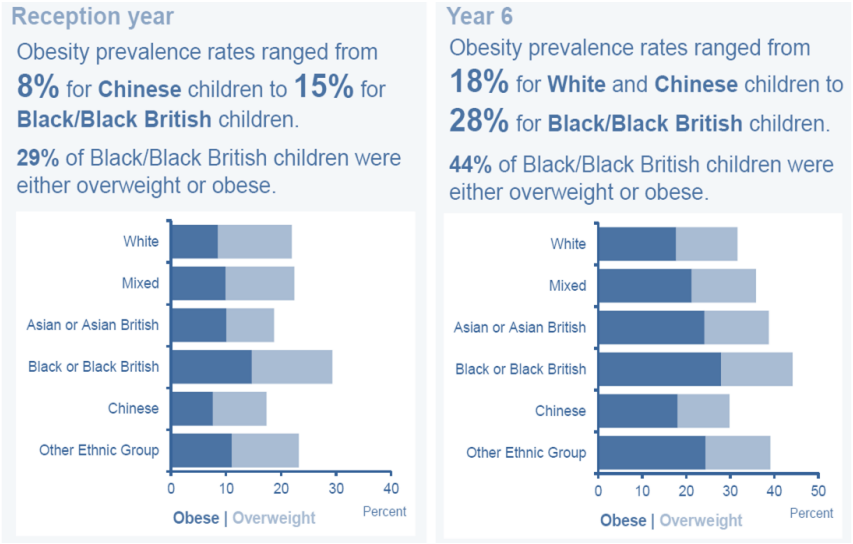
Particularly noticeable was the high level of breastfeeding among Black and Chinese or other mothers and the relatively low fall-out rate. While 95% of Black mothers breastfed initially, this had fallen to 85% at six weeks, and to 73% at four months. For mothers of Chinese or other ethnic origin, the figures were 96%, 82% and 76% respectively.

Respondents from White ethnic groups were the least likely to report being given consistent advice about feeding their baby. This is an interesting pattern, as it differed from many other health and social care surveys, which show that people in BME groups are less likely than people in White ethnic groups to say that they are given adequate information. There could be some learning from maternity services around good communication to people from a range of ethnic groups.

4.2.3 Childhood obesity

National data suggest the proportion of children who are overweight or obese varies by ethnicity and age, with rates being highest amongst those who were Black / Black British and lowest amongst Chinese at both ages. Rates increased from Reception to Year 6 across all ethnicities.

Childhood obesity by ethnicity in England



Source: National Child Measurement Programme (NCMP) 2014/15

Of the 4,344 Gateshead pupils in Reception or Year 6 who had their BMI recorded in 2015/16, 3,050 also had their ethnicity recorded (note that this data includes pupils from Jewish schools). On average 22.2% were overweight or obese at Reception and 37.5% in Year 6. However there is considerable variation across ethnic groups as follows:

Ethnicity	Reception	Year 6
	%	%
White British	23.6	37.1
White Other	25.0	49.1
Mixed	31.0	48.3
Asian	17.1	44.8
Black	37.5	37.5
Other	30.8	36.4
Ethnicity not recorded/stated	20.5	33.3
Total	22.2	37.5

(Caution should be exercised in interpreting these figures as confidence intervals do not show significant differences and therefore they should be treated as indicative only)

4.2.4 Poverty

People from most ethnic minority groups are generally more deprived in terms of socio-economic status, and poverty as indicated by eligibility for free school meals. The Pakistani and Bangladeshi groups have the lowest proportion of the population in 'managerial and professional occupations'. The highest proportions of children eligible for free school meals are among the Travellers of Irish Heritage, Gypsy/Roma, Bangladeshi and Black African groups.

4.2.5 Educational Attainment

Nationally, educational attainment is highest among the Chinese group and in every ethnic group, except the Chinese, those who are eligible for free school meals have a lower educational attainment than those who are not. The difference in education attainment between those who are eligible for free school meals and those who are not is most marked amongst the White groups.

"White families meet white professionals and seem to be on personal terms. We are made to feel like outsiders."

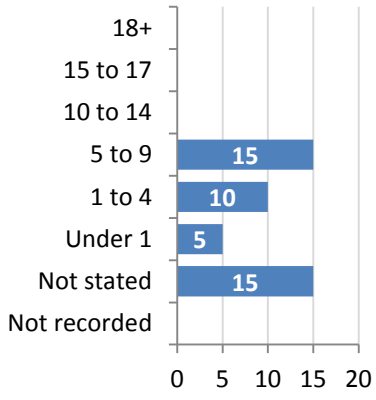
'Progress 8' is an educational attainment measure that was introduced in 2016 and looks at the progress pupils have made at key stage 4. It is one of the successors to the more familiar GCSE attainment measures. With Progress 8, a score of 1.0 means pupils make on average a grade more progress than the national average; a score of -0.5 means they make on average half a grade less progress than average. In Gateshead in 2015/16, overall the Progress 8 score was -0.15. This was particularly evident for the White ethnic group with a score of -0.19. However, BME groups performed significantly better, with scores of 0.27 for Mixed, 0.85 for Asian, and 1.24 for the Black ethnic group.

4.2.6 Female Genital Mutilation (FGM)

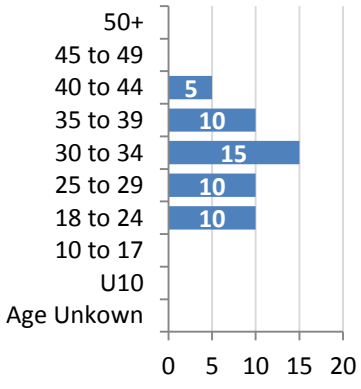
Data on Female genital mutilation is not available at local authority level. The charts below show data for the combined Newcastle Gateshead CCG area. Numbers between 0 and 4 have been supressed by the data provider (HSCIC) to avoid disclosure and figures are rounded to the nearest 5.

NB Where the definition 'Newly Recorded' is listed this stands for women and girls with FGM who have had their FGM information collected in the enhanced dataset for the first time. This will include those identified as having FGM and those having treatment for their FGM. *Please note Newly Recorded does not necessarily mean that the attendance is the woman or girl's first attendance for FGM.*

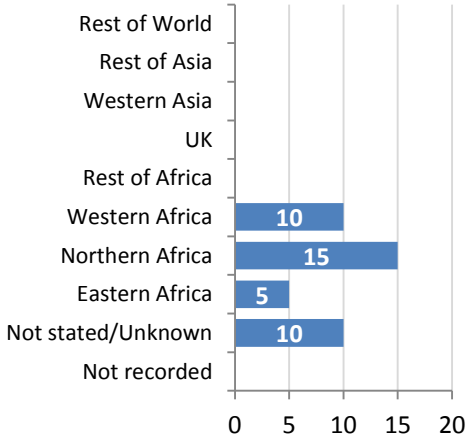
Newly recorded cases of FGM by age carried out



Newly recorded cases of FGM by age at attendance



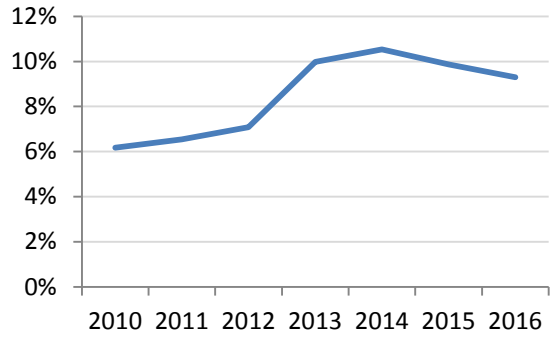
Newly Recorded cases of FGM by country carried out

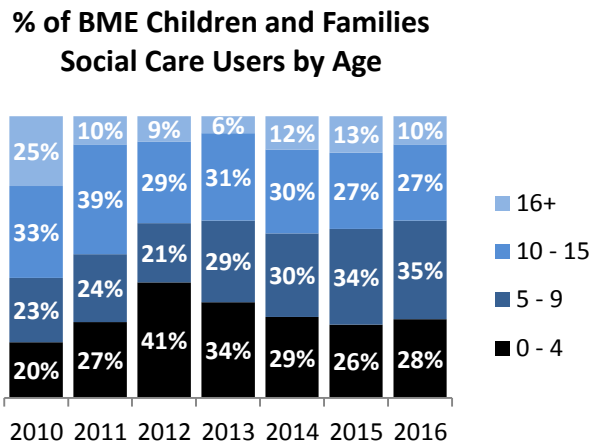


Source: HSCIC, NewcastleGateshead CCG level data rounded to nearest 5, 2015/16

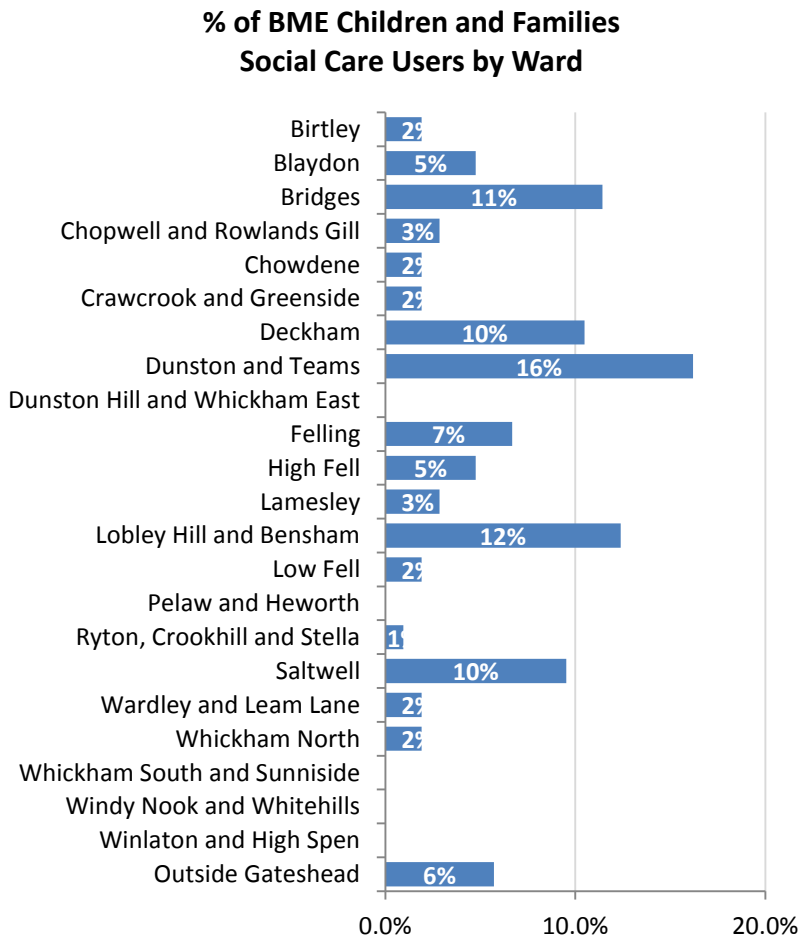
4.2.7 Children & Families Social Care BME

This information received from Gateshead Council relates to children under 18 and excludes unborn. The data combines Children in Need (CIN), Child Protection (CP) and Looked After Children (LAC). A snap shot was taken to show data for these children as at 31st August each year back to 2010.





Note that given approximately 9% of school age children are from the BME (including White Other) population, it can be seen that children from BME backgrounds are not disproportionately represented in social care.



4.2.8 Vulnerable Children (LAC, CIN, CP)

In terms of the reasons that children are looked after, or are classed as 'in need', there is little variation between children in BME groups and those in the White British group.

Looked After Children

The main reason that children are classed as being in need is 'neglect'. This was the main reason for 79% of both White British and BME children.

Children in Need

The main reason that children are classed as being in need is 'neglect'. This was the main reason for 67% of White British children and 77% of those in a BME group.

The child protection register includes the additional category 'emotional abuse'. Children on the register from BME groups are more likely to fall within this category than those from the White British group.

Child Protection Register

The main reasons that children are on the child protection register are 'neglect' and 'emotional abuse'. 'Neglect' is the main reason for 62% of White British children and 49% of children in a BME group. However, 'emotional abuse' is the main reason for a much higher proportion of BME children at 46% compared with 28% of White British children.

4.2.9 Youth Offending

Information received from the Gateshead Youth Offending Team (YOT) shows that there was a decrease of 18% of the total number of Youth Justice Disposals during 2015/16 when compared to the previous year. The number of BME and White Other cases remained low.

Ethnicity of Youth Offending Team cases 2014/15 and 2015/16

Ethnicity	2014-15		2015-16	
	No.	%	No.	%
White - British	152	95.6	124	95.4
BME and White Other	7	4.3	6	4.7

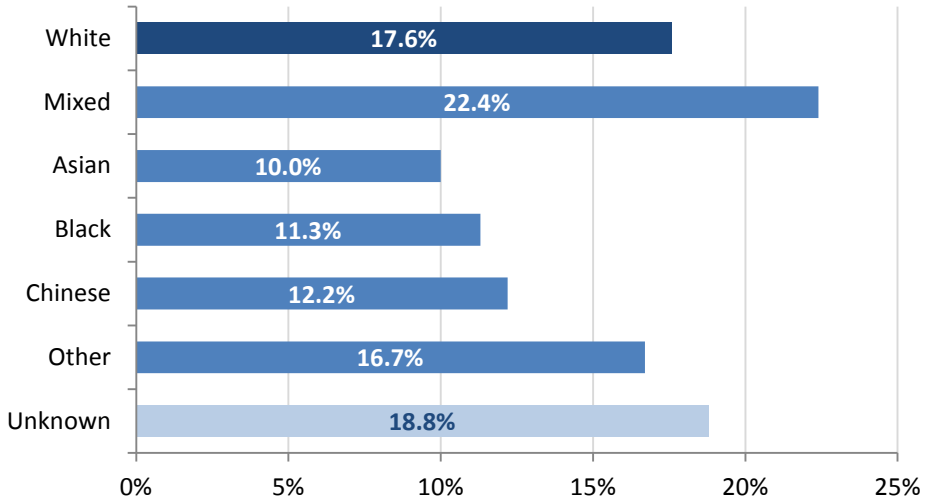
4.3 Healthy lifestyles

4.3.1 Tobacco use

All forms of tobacco use can harm health. Tobacco use amongst BME communities includes smoking of cigarettes, bidi (thin cigarettes of tobacco), or shisha (water pipe/ hookah) as well as smokeless tobacco (see guidance at Appendix 2) such as betel quid, paan or gutkha (which is a mixture of ingredients including betel nut, herbs and spices and often tobacco wrapped in betel leaf). Regarding religious themes, Bush et al (2003) found that there was some confusion about the Islamic position on smoking, with most people believing that it was mukrooh (discouraged) but not haram (forbidden), and many feeling that as long as the smoker was not addicted, smoking was acceptable. Smoking was universally felt to be taboo for women, associated with stigma and shame, and often hidden, with associated under-reporting. Among Bangladeshi men smoking was associated with socialising, sharing, and male identity.

Smoking prevalence is substantially higher amongst lower socio-economic groups, people with a mental illness and certain ethnic groups. The chart to the right shows smoking prevalence in North East England for BME populations.

Smoking Prevalence in the North East by Ethnic Group



Source: Annual Population Survey 2015

Smoking is much more common among Bangladeshi men (40%) and Pakistani men than in the general population, Indian men and South Asian women (HSCIC 2013). Cancers of the trachea, lung, and bronchus are the highest cause of death from cancer in South Asian men, with smoking being the principal risk factor. Research has shown that using smokeless tobacco raises the risk of mouth cancer and oesophageal cancer.

Data from the CCG (see Appendix 3) shows that in Gateshead 8.1% of those recorded as from the BME (including White Other) population are smokers, compared to 10.9% of those recorded 'White British'. Given the prevalence of smoking locally is understood to be 17.9% there may be under-reporting in some way. We have no local data on use of smokeless tobacco.

Smoking cessation

Monitoring of smoking cessation by ethnic group is important but hampered by a lack of reliable data on smoking prevalence. Asian, Black and Mixed minority populations have lower rates of setting a smoking quit date for both males and females. Females are more likely to set a quit date than males in every ethnic group.

The reasons for this probable under-use of stop smoking services in the main minority ethnic groupings are unknown and likely to be complex, including such barriers as the availability of materials in appropriate community languages.

Number of people setting a quit date and successfully quitting (NHS stop smoking services 2015/16)

	Setting a quit date			Successfully quit		
	Male	Female	Total	Male	Female	Total
White British	878	1226	2104	398	578	976
White Other	21	13	34	9	9	18
BME	23	11	34	7	6	13

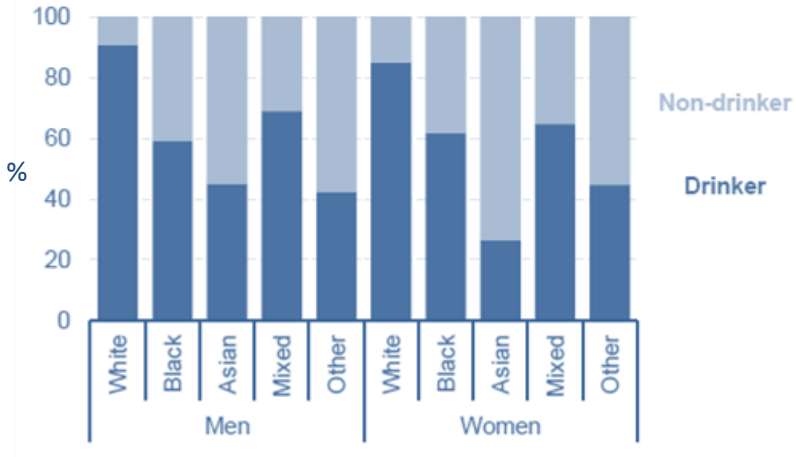
Source: Gateshead Stop Smoking Services Monitoring Return 2015/16

Recommendations

- The CCG should take steps to encourage practices to record smoking status and ethnicity of all patients
- The Director of Public Health should consider whether there are particular steps that could be taken to encourage use of smoking cessation services by local BME and White Other communities

4.3.2 Alcohol use

White Irish men and women are more likely than any other ethnic group to drink in excess of government recommended guidelines (58% of men and 37% of women). The highest treatment rates for drug misuse are in the Mixed group and lowest in the Asian group. Drinking prevalence for adults Health Survey for England, (2014) is shown below.



Drinking by ethnicity

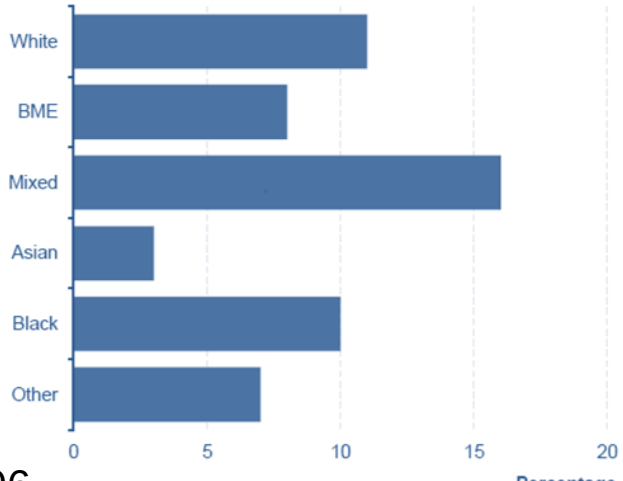
The proportion of adults who drank alcohol varied between ethnic groups. White men and women were most likely to be drinkers whilst Asian men and women were least likely to be.

4.3.3 Drug use

The prevalence of cannabis use among 15 year olds in England by ethnicity is shown in the chart below. It illustrates that while overall, BME prevalence is lower than that in the White ethnic group, the highest prevalence is in the Mixed ethnic group at 16%. The lowest prevalence was in the Asian ethnic group.

According to the National Drug Treatment Monitoring System's Adult Activity Report (Partnership), in 2016/17 92.9% of drug and alcohol treatment clients in Gateshead were White. 1.3% were White Other, 0.5% Mixed, 1.1% Asian, 0.4%

Prevalence of drug use among 15 year olds in England



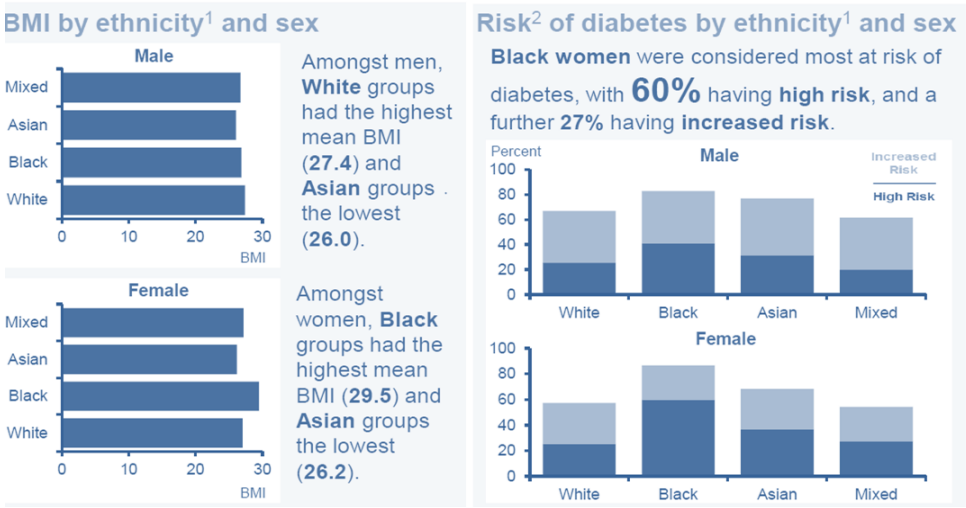
Source: What About Youth? Survey 2014

Black, 0.7% Other, and the rest had not stated their ethnicity.

4.3.4 Obesity

Amongst adults, national figures (HSE 2014) show the average BMI for both men and women was 27.2 kg/m2, which was in the overweight range (25 – 29.9 kg/m2).

Adult obesity by ethnicity in England



Health Survey for England (HSE) 2014

Figures from the CCG (appendix 2) show the recorded prevalence of obesity is 17.2% amongst the White British population but only 7.7% amongst the BME (including White Other) population. Whilst the lower levels amongst the BME population may simply reflect the younger age profile of this population (see 3.1.1 above) the overall figures suggest there may be under-recording of obesity by practices.

Recommendation

- The CCG should take steps to encourage practices to record BMI and ethnicity of all patients

4.3.5 Physical activity

Exercise and physical activity is not an issue for some cultures as people generally live active lives with active jobs. The cultural and religious issues of women and exercise have been identified by the refugee and asylum seeker community. While some men from the refugee and asylum seeker community can easily do some form of exercise through e.g. community football activities, it is harder for women from some parts of this community because of their cultural upbringing and family responsibilities.

In terms of being active, refugees and asylum seekers have said they wanted information about activities that aren't focussed on a gym, like yoga, but that these activities would need to be free. Financial allowances allocated to asylum seekers are received to purchase food only.

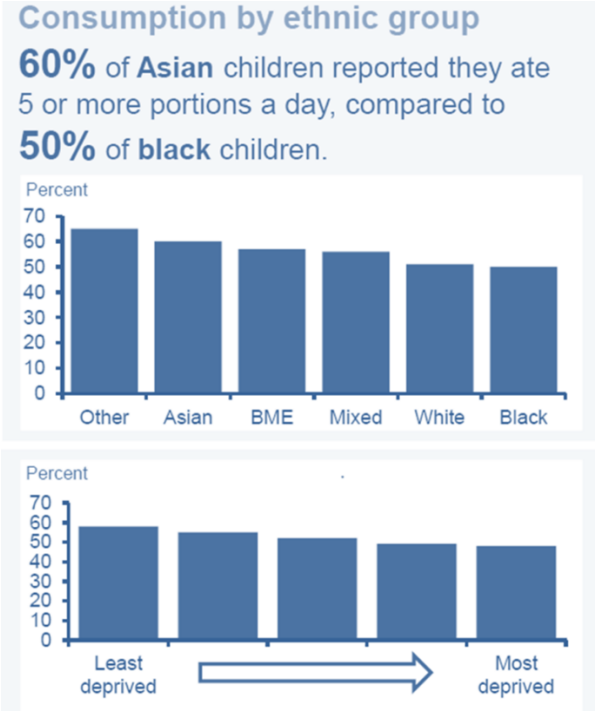
Regional refugee Forum NE reports that asylum policy has been cited frequently as barrier to being healthy. As people are not allowed to work while awaiting a decision on the asylum claim, they spend a lot of time indoors being inactive. Also simply walking around in some neighbourhoods is not an option because of hostile attitudes and instances of hate crime, so people stay indoors.

We have no specific local data on physical activity amongst the local BME population. National data shows that the Asian (not including Chinese) and Black ethnic groups are significantly less likely to achieve the recommended level of physical activity per week (150+ minutes) than the England average of 57.0% at 49.7% and 52.3% respectively.

4.3.6 Eating Habits

National data shows that the Black, Asian (not including Chinese) and Other ethnic groups are significantly less likely to consume the recommended 5+ fruit and vegetables per day than the England average of 52.3% at 36.4%, 40.0% and 46.7% respectively. We have no local data on diet.

Consumption of 5+ fruit and veg per day amongst 15 year olds by ethnicity in England



Source: What About YOUth? Survey 2014

The refugee and asylum seeker community have indicated that they would like more information about healthy food consumption as the messages weren't clear and caused confusion as they were often only relevant to common UK diets. People particularly wanted information about weight management and healthy ingredients.

Food banks are accessed by asylum seekers and access to food from this source is often greatly appreciated by the people receiving help. People accessing the food bank receive food which has been kindly donated by the public for distribution to people in who require access to food for 2-3 days. Types of food donated are non-perishable foodstuffs which are often tinned foods and dried foods. Such processed foods are often high in sugar, refined carbohydrates and low in fibre and contain artificial ingredients, for example, preservatives, artificial colours, and artificial flavours. Whilst additives are non-nutritive substances added intentionally to food, generally in small quantities to improve appearance, flavour, texture or storage properties, amounts used in food are usually regulated by law.

Cultural differences

Cultural differences have been identified in local discussions as a barrier to staying healthy in the UK. Being overweight in in some cultures is seen as a positive attribute because it is a sign that people can afford to live well. Many place high value on fast food and fizzy drinks because these are marketed as desirable and denote higher social status in their home countries. In the UK they are affordable and people indulge in them without knowing the health risks. For some people this also includes alcohol, which they find more affordable here.

Many asylum seekers and refugees who come to the UK from hot climates are used to a diet high in salt, sugar and fat. In their own countries this is not an issue as people are more active, burn more calories and sweat more. However, when people come to the UK the climate is colder and they are less active. Obesity and diabetes are an increasing concern among those who have been in the UK longer. NICE Guidance on BME: preventing ill health and premature death in black, Asian and other minority groups (PH46) is summarised in Appendix 2.

Recommendations

The Health and Wellbeing Board should:

- consider how best to work with local BME communities and community organisations to address health lifestyle issues;
- review whether NCMP data and QOF data in General Practice is consistently recorded and whether services are taking account of this.

4.3.7 Infectious Diseases

Tuberculosis: nationally Black Africans, along with the 'Other' ethnic group, have the highest rates of tuberculosis in the English regions. In Gateshead the incidence of tuberculosis is 6.8 per 100,000 – significantly below the

national incidence of 12 but higher than the regional level of 5.5. The total number of new cases remains small, and is not broken down by ethnicity.

HIV: the highest prevalence of HIV in the North East by ethnic group is amongst Black Africans, although the number of new infections in this group is falling. It is estimated there are less than 200 people living with HIV in Gateshead, and the number is not broken down by ethnicity. Gateshead is not considered to be an area of high HIV prevalence.

4.4 Long term conditions

In England and Wales as a whole (using standardised ratios) the following groups reported lower than average 'not good' health: White British, White Other, Chinese, Black African and the Other ethnic group. All other groups have higher than average 'not good' health.

The Pakistani and Bangladeshi group reported the highest ill health in England and Wales as a whole and in every region. The Chinese have the lowest ill health in every region, significantly lower than the average for England and Wales.

The pattern by region and ethnic group is complex. Generally the northern and midlands regions and London have higher ill health than the southern regions. However, even in the southern regions, some ethnic groups have higher ill health than the average for the total population of England and Wales: White & Black Caribbean, Pakistani, Bangladeshi, Black Caribbean and Black Other.

In the northern regions some have lower ill health than the average for the total population of England and Wales e.g. the Chinese.

Long Term Conditions (LTCs) are diseases that cannot currently be cured, but are controlled by medication and/or other treatment. They are health problems that require ongoing management over a period of years or decades and are often characterised by acute exacerbations of ill health resulting in repeated admissions to hospital.

National data shows the prevalence of long term conditions such as type 2 Diabetes, Cardiovascular Disease and Stroke is up to six times higher (and occurs at a younger age) among black, Asian and other minority groups. Multi layered determinants of Cardiovascular Disease would also indicate higher levels of Diabetes and obesity.

Nationally, the prevalence of long term conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. The evidence confirms that Asian, black African and African-Caribbean and other minority ethnic groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI measurement than the white European population. NICE and other sources highlight the importance of awareness raising for BMI measurement thresholds that can be used for recognising risk and as a trigger for intervention. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

However, the local data do not reflect this expected prevalence: practice disease registers (see Appendix 3) show a prevalence of every reported condition (asthma, cancer, coronary heart disease, chronic obstructive pulmonary disease, diabetes, epilepsy, osteoporosis, heart failure, hypertension, stroke, transient ischaemic attack, palliative care) that is at least 3 times higher in the White British population than amongst BME communities. This may be a result of under-reporting, under-recording or be because prevalence of many long-term conditions increases with age and the BME population in Gateshead is relatively young. Note the figures at Appendix 3 include 'White Other' in the BME total, although disease patterns may vary considerably between communities.

Uptake of health checks by the BME community is low at 6.7% compared to 15.9% of the White British population (see Appendix 3).

4.4.1 Haemoglobinophathies

Low levels of uptake (and apparent poor access to services) may be attributable to services for 'ethnic' diseases such as haemoglobinophathies i.e. sickle cell disease among people of West African origin and West Indian descent, and thalassaemia among people of Asian and Mediterranean origin. Access may be poor because they are not required by a majority white population. Also some diseases are rare in ethnic minority populations and therefore variation in need will affect the need for services in ethnic minority populations. Therefore, service provision should take account of the fact that diverse populations may still be at risk and also that their risk profile may change over time. This is particularly linked to conditions linked to lifestyle and environmental factors as well as genetic makeup. We have no local data on the incidence of such diseases.

4.4.2 Cardiovascular Disease (CVD)

Interventions to reduce the risk of CVD are documented based on the multi-layered determinants of this disease, such as smoking, diabetes, obesity, lack of exercise, poor diet, low socio-economic status and inequalities in health care. The increased risk of CVD in the South Asian population is well recognised, with various factors given as explanations for the disparity, including language barriers and cultural taboos.

A higher than average proportion of admissions due to coronary heart disease is found in the Pakistani, Bangladeshi, Indian and Mixed White & Asian ethnic groups, reflecting the higher prevalence of CHD in these groups. However, analysis of revascularisation procedures generally shows provision in proportion to need.

A number of community-based interventions for health education specific to these communities have been developed. NHS health checks have been part of public health screening strategy since 2008 and, although there is reference to faith and voluntary sector organisations being well-placed as a platform for checks for those "not in touch with organised health care", this strategy has limited worked examples. However Rao et al. (2012) recommended that "screening UK south Asians in religious settings is a feasible approach to identify a high proportion of individuals with vascular risk factors in this community" (p.266) as a route to identify CVD risk factors in members of this population who had not presented themselves anywhere else.

Men born in the Caribbean are 50% more likely to die of stroke than the general population.

Local data from the CCG reports CHD all-age prevalence of 1.4% amongst the BME (including White Other) population in Gateshead, compared with 5.5% amongst the White British population. This appears lower than may be expected for the BME communities, but could be explained by their younger age profile and the inclusion of 'White Other'.

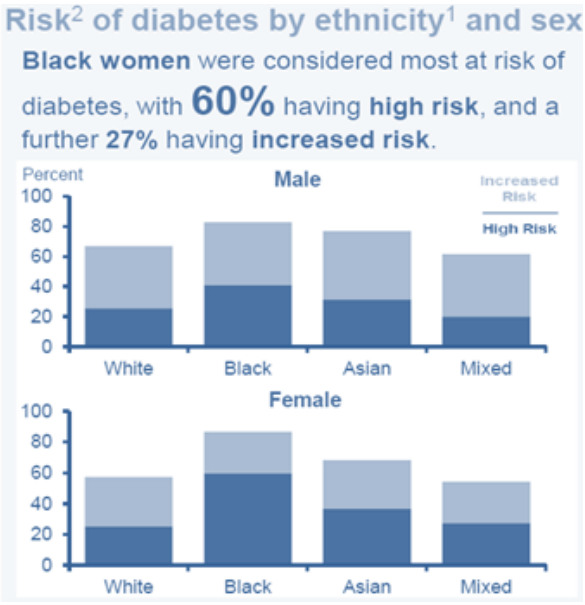
4.4.3 Diabetes

NICE Guidance (see Appendix 2) emphasises that members of black, Asian and other minority ethnic groups are at an increased risk of diabetes at a lower BMI (23 kg/m^2 to indicate increased risk and 27.5 kg/m^2 to indicate high risk) than the white population (25 kg/m^2 is still valid for white European adults).

Nationally, there is a higher prevalence of diagnosed non-insulin dependent diabetes among Asians and a raised rate among Black Caribbean. In addition several studies report inadequate quality of health care for Asian, Black African and Black Caribbean diabetics, and poor treatment compliance, which may therefore result in a higher than average number of hospital admissions.

Indian, Pakistani, Bangladeshi, Asian Other and Black Caribbean groups have a significantly high proportion of admissions due to diabetes in all regions (except for Black Caribbean in North East), reflecting the high prevalence of diabetes among these ethnic groups. Among the Black Other group all regions have high proportions except for the North East and the South East. The Indian and Pakistani groups have a higher than average proportion of hospital episodes for cataract surgery, reflecting reports of a higher prevalence of cataracts in these groups. This is consistent with their higher prevalence of diabetes, a known risk factor for cataracts.

The risk of diabetes derived from BMI and ethnicity (HSE 2014) is shown in the chart below.



Source: Health Survey England 2014

Type 2 diabetes is up to six times more common in people of South Asian descent than in the general population. According to the Health Survey for England 2014, doctor diagnosed diabetes is almost four times as prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men, compared with men in the general population.

A recent report from the Care Quality Commission (2016) recommended that education courses are developed and evaluated so that everyone, including those from black and minority ethnic groups (and with a learning disability), can gain the knowledge and skills they need to manage their diabetes.

Local data from the CCG (see Appendix 3) reports diabetes all-age prevalence of 1.7% amongst the BME (including White Other) population in Gateshead, compared with 6.1% amongst the White British population. This appears lower than may be expected for the BME communities, but this could be explained by their younger age profile and the inclusion of 'White Other' in the BME population numbers. We can anticipate that the numbers of local people from BME backgrounds diagnosed with diabetes will increase in the next few years.

Local guidelines on the management of impaired glucose regulation state that "High risk groups include people aged >25 of South Asian, Chinese, African-Caribbean, black African and other high-risk black and minority ethnic groups", but do not specifically advise that GPs should use the lower BMI thresholds to trigger intervention.

Recommendation

- The CCG should review its Management of IGR Guidelines to ensure they fully reflect NICE guidance PH46 in respect of BMI in black, Asian and other minority ethnic groups

4.4.4 Cancer

The British Journal of Cancer (July 2013) revealed a worrying rise in cancer rates among South Asian people in the UK. Their study showed a rise in cases of cancer in South Asians over a decade, which compares with an overall drop in the rates of non-South Asians. It is the younger generations of South Asians experiencing the most marked rise in number of cancer cases. This lifestyle change is most likely due to younger South Asians growing up and adopting western lifestyles, e.g. less fresh vegetables and more high fat processed foods. It is advised by Cancer Research UK that as cancer emerges as an important issue for South Asians it is important that they have access to information about cancer, including methods of prevention through lifestyle, diet and how to spot symptoms early.

Local data from the CCG (see Appendix 3) reports diabetes all-age cancer prevalence of 1.2% amongst the BME (including White Other) population in Gateshead, compared with 3.7% amongst the White British population. The younger age of the BME and White Other population may explain this.

Cancer Screening

Initial investigation of Gateshead practice data shows that those practices where screening uptake is lower tend to be based in the more deprived areas of Gateshead. Also these practices have a higher number of non-white ethnic (all groups included) with some practices having 9% of registered patients described as non-white ethnic group.

Local data from the CCG (see Appendix 3) reports uptake of cervical cancer screening as 60.3% amongst the BME (including White Other) population in Gateshead, compared with 74.0% amongst the White British population. For breast cancer screening, local uptake is 52.3% amongst the BME (including White Other) population in Gateshead, compared with 74.0% amongst the White British population. Age is not a factor given the eligible population is age-determined.

Recommendation

The CCG should work with the NHS England and PHE Screening and Immunisations team to better understand the uptake of breast and cervical cancer screening amongst women from BME (including White Other) communities, and to identify how rates might be increased.

4.4.5 General

We can expect the prevalence of long-term conditions amongst Gateshead's BME population will increase as this population continues to grow and to age. The CCG's long-term conditions strategy sets out a vision for shifting the focus towards prevention, early identification, supported self-management, pro-active management by clinical teams where required, and a positive approach to end of life care. To support implementation of the strategy amongst local BME communities, additional measures will be required.

Recommendations

The CCG should:

- Ensure practices record the ethnicity of all registered patients, in line with the Equality Act (2010)
- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions compared to the white population
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions
- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face.

4.5 Emotional and mental health

Good mental health and wellbeing is fundamental to ensuring that individuals can lead fulfilling lives, contribute to society and achieve their potential. Good mental health is also interlinked with good physical health, with individuals with poor mental health reporting higher rates of mental health problems, and individuals with mental health problems reporting higher rates of long-term conditions.

4.5.1 Serious Mental Illness

Serious mental illness includes conditions such as schizophrenia, bipolar disorder and personality disorders. Elevated incidence rates of schizophrenia in UK Black Caribbean's have been consistently reported. There is a higher rate of detention under the Mental Health Act for people from BME groups.

Some BME communities are less able to identify poor mental health or perhaps western concepts of ill health, which can contribute to a lack of awareness of sources of help (Keating, 2009). Cultural pressures and ideology can impact on some BME and religious groups' access to healthcare (Weerasinghe, 2012), for example, the imperative to 'save face' and maintain social status and moral reputation (Mereish, 2012). Fear of stigma can also be a barrier and there may be the feeling that care is a family responsibility (Cooper et al. 2012).

Negative perceptions of mental health services can stem from perceived racism, language barriers and doubts about the cultural competency of services (Cooper et al. 2012). All of these factors can result in a delay in seeking help with the consequence that some BME communities only access services at crisis point and are reluctant to engage indicates that rates of suicide and self-harm are higher than average among certain groups of Asian women and young African-Caribbean and Irish people (Keating et al. 2003).

Two people contributing to a focus group as part of this HNA stated that they had tried to commit suicide 3 times due to them being made homeless when they arrived in the country.

Data from the CCG notes recorded all-age prevalence for serious mental illness of 0.6% amongst BME communities and 1.1% amongst the White British population in Gateshead.

4.5.2 Common Mental Health Problems

Common mental health problems include conditions such as anxiety, depression and phobias. Some inequalities are not improving, including the poorer health of disabled people, higher levels of mental ill-health among people from LGB and BME groups, and lower life expectancy for people with a serious mental illness.

CQC's most recent Mental Health Act reported that the importance of providers working alongside commissioners in the local implementation of new guidelines to monitor and address long-standing inequalities in the experiences of Black and minority ethnic (BME) groups use of mental health services. Also, ensuring that care is flexible, and meets the needs of everyone including people from black and minority ethnic groups or people with a learning disability.

Locally in Gateshead, practices have recorded all-age prevalence of depression of 10.1% amongst BME (including White Other) communities and 18.9% amongst the White British population, and all-age prevalence of anxiety disorder of 8.7% amongst BME (including White Other) communities and 14.3% amongst the White British population.

Data from the Improving Access to Psychological Therapies (IAPT) service shows that recovery rates for the BME population (41.3%) are lower in NewcastleGateshead CCG area than for the White British population (48.6%). NewcastleGateshead's recovery rates are lower than the North of England averages (BME 43.9% / White British 50.2%)

Recommendation

The Mental Health Partnership Board should review whether the mental health needs of people from BME communities are being identified and recorded in General Practice, and whether services are responding effectively to the needs of local BME communities.

4.5.3 Post Traumatic Stress Disorder

There are specific and unique challenges facing refugees and asylum seekers that can result in deterioration of their mental health after they arrive in the region, caused by traumas experienced before their arrival. North East Regional Refugee Forum NE has recognised that there are also challenges that ARE NOT caused by traumas experienced before their arrival in the UK but arise from the stresses of living under the Asylum system once here for example, delays in accessing health services once someone is dispersed to the region.

During consultation with focus groups in the HNA a number of groups commented that :

"I need to repeat my story to a GP on many occasions as I cannot always see the same GP"

This was reported as causing more distress and not helping with mental health issues. Also some participants commented that time is restricted with GPs.

4.5.4 Hate Crime

One focus group participant stated that she was worried about raising issues of racism in case of repercussions of their name being mentioned*:*

"you wonder if you are in the right place or the wrong place"

Hate Crime and Incidents

The data shown below contains data relating to any crime that has been reported to Northumbria Police since April 2014. The data relate to Gateshead only and uses crimes or incidents that are deemed to have been linked to racism, religious hate, faith hate, gender and transphobic hate. Information is taken from iBase.

Hate Crime

Reported levels of hate crime have increased significantly since April 2014. This is shown in the table to the right. During the 2014/15 financial year, there were 98 crimes reported that were deemed to be hate-related. This increased by 47% in 2015/16 to 144 crimes (+46 crimes). In 2016/17, 203 crimes reported to Northumbria Police were classed as hate crimes. This is an increase of 41% compared to the previous 12 months and an increase of 107% since 2014/15.

	2014/15	2015/16	2016/17
Hate-related crime	98	144	203
All crime	9,378	12,801	17,807
% of crime	1.0	1.1	1.1

The proportion of recorded crime classed as hate crime in the last three years has remained steady. However, on average, there were 17 hate crimes reported per month during 2016/17 compared to an average of eight per month in 2014/15.

There were a total of 384 hate 'incidents' recorded on the ARCH reporting and case management system by Northumbria Police (who record hate crimes on the system), Gateshead Council, schools and The Gateshead Housing Company. Of these, 282 (73%) were race-related.

The Office for National Statistics (ONS) has advised caution when examining crime statistics. The ONS has stated that, although figures show there is an increase in crime, there has been a renewed focus on the quality of crime recording which has led to a greater number of crimes being recorded by the police. That said, there does

continue to be a concerted effort by partner agencies in Gateshead to increase awareness of hate crime and encourage reporting.

Responsibility for tackling hate crime rests with the Community Safety Board, which has a Hate Crime Strategy and action plan in place.

4.6 Use and Experiences of Health and Social Services

People from different equality groups perceive their experiences of health and social care in different ways, both positively and negatively, depending on a range of factors.

4.6.1 Health services

Primary Care

Registering with a GP practice and using GP services is the cornerstone of the NHS, as it helps people access a range of other health services. Analysis of the national 2015 GP patient survey results for different equality groups and found that Gypsies and Irish Travellers, Pakistani and Bangladeshi showed that people were less likely to say that they found GP practice receptionists to be helpful compared with people from other ethnic groups. The percentage of people saying they found receptionists to be helpful rose with age group from the 18 to 24 group to the 75 to 84 group (with a slight decrease after this age for the 85 and over group).

In the GP patient survey, there were similar findings to the NHS inpatient survey around patient experience and age. Positive responses increased with age, with a slight decrease for the oldest age group for questions on confidence and trust in nurses, doctors treating the person with care and concern, and overall experience of using the GP surgery.

People from Pakistani, Bangladeshi, Chinese and White non-UK ethnic backgrounds were also less likely to say that doctors and nurses treated them with care and concern and were less likely to have confidence and trust in nurses. People from all these groups were significantly less likely to report a good overall experience of using a GP surgery compared with White British people. Muslim, Sikh and Hindu people reported a poorer overall experience of GP surgeries than Christian people.

The worst patient experience was found in the Asian group across all English regions.

GP practices in Gateshead have only recorded the ethnicity of 54% of their patients. This varies across practices, ranging from a low of 11% and a high of 87%, as shown in Appendix 3. Approximately one third of those recorded as from the BME and White Other population is in the age range 25-39, which is consistent with the Census data shown in section 3.1.1 above.

Recommendation

The CCG should ensure practices record the ethnicity of all registered patients, in line with the Equality Act (2010).

Secondary Care

The 2015 NHS inpatient survey showed that age is an important factor in how people perceive their experiences of hospital care. Sample sizes may have some influence on differences between groups, but the following points are worth considering:

The NHS North of England Commissioning Support Business Information Service supplied data for secondary care activity (**Appendix 3**). The recording of ethnicity for secondary care is relatively high across all departments.

The overall standardised rates of use of hospital services – first outpatient attendances, elective in-patient admissions, non-elective in-patient admissions, and accident & emergency attendances – by BME (including White Other) communities across all ages are lower than for the White British population. However, there are some significant variations.

The Bangladeshi community, those recorded as 'Any other black background' as well as 'Any other ethnic group' have higher rates of use of Accident and Emergency than the total population.

The Bangladeshi, Pakistani and 'Any other ethnic' groups have higher rates of both elective and non-elective inpatient admissions than the total population.

There are a number of BME communities that are much lower than the total population rate of attendance for first outpatients appointments and elective in-patient admissions. In particular these groups are: Any other Asian, Chinese, Irish, White and Asian, White and Black Caribbean.

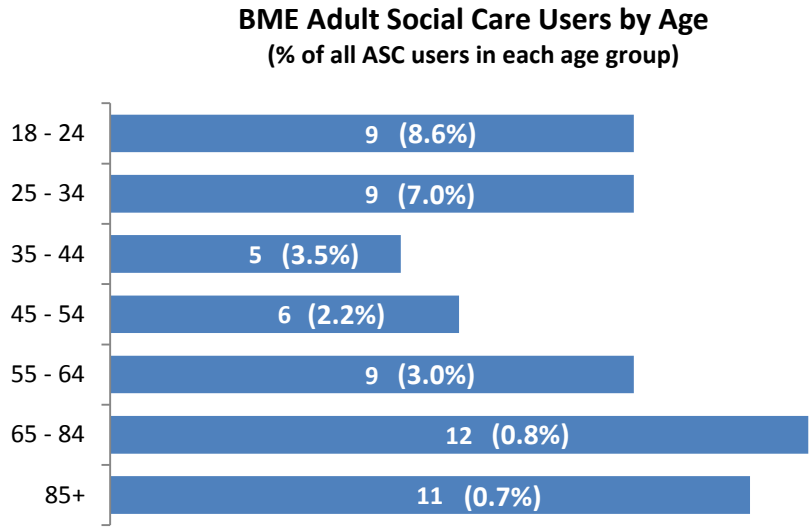
4.6.2 Long-term Social Care Support

In 2014/15, only 9.6% of adults receiving from local authorities were from a BME background, which is lower than the population percentage in England (14.6%). This could be due to factors such as differences in need – while 17% of people in White ethnic groups are aged over 65, only 5% of people in BME groups are in this age range nationally. However, the prevalence of disability is higher in some BME groups, so the level of need is not easy to compare from population data alone.

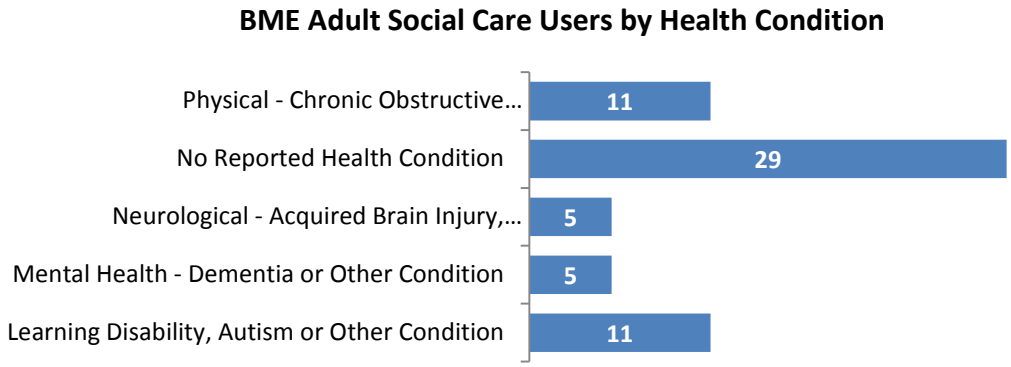
Greater difficulties in accessing appropriate care due to information barriers were observed in the 2014/15 survey of people who use adult social care services. It showed that people from BME groups were more likely than people from White ethnic groups to have tried to find information, but were also more likely to say that they found it fairly or very difficult to find information or advice.

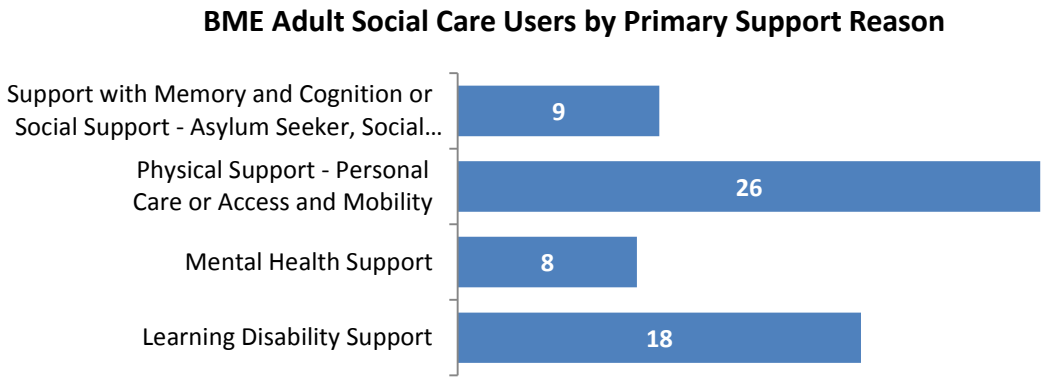
The information in the charts below relates to financial year 2015/16 and has been taken from the data set used to complete the Local Authority statutory return (the SALT return). The charts illustrate Long Term Service users in Gateshead by age group, health condition, primary support reason and location of service delivery.

The proportion of service users who are of BME background varies by age as shown below.

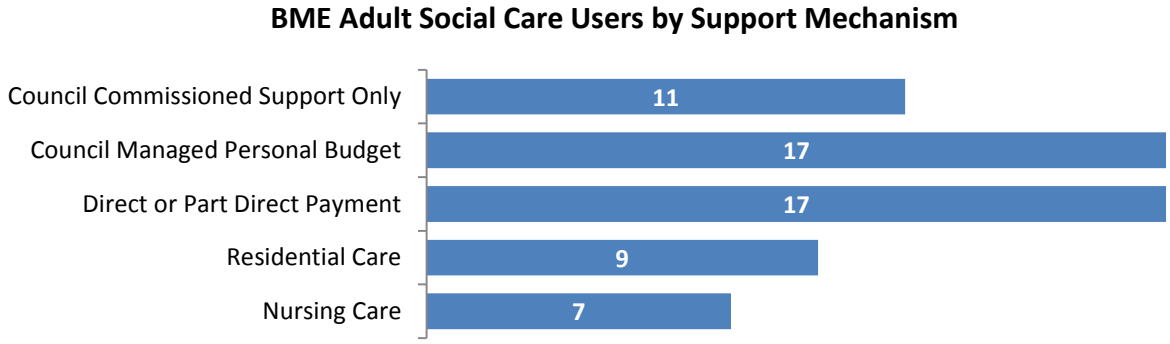


The charts below show the number of people in Gateshead who are recorded as BME who are receiving Social Care services for long term conditions and their primary support reason.





The support that people receive varies across care settings as illustrated in the chart below.



4.6.3 Carers

A separate health needs assessment has been undertaken in respect of carers, but its findings in respect of carers from BME communities are summarised here. The 2011 Census gathered information on the provision of unpaid care.

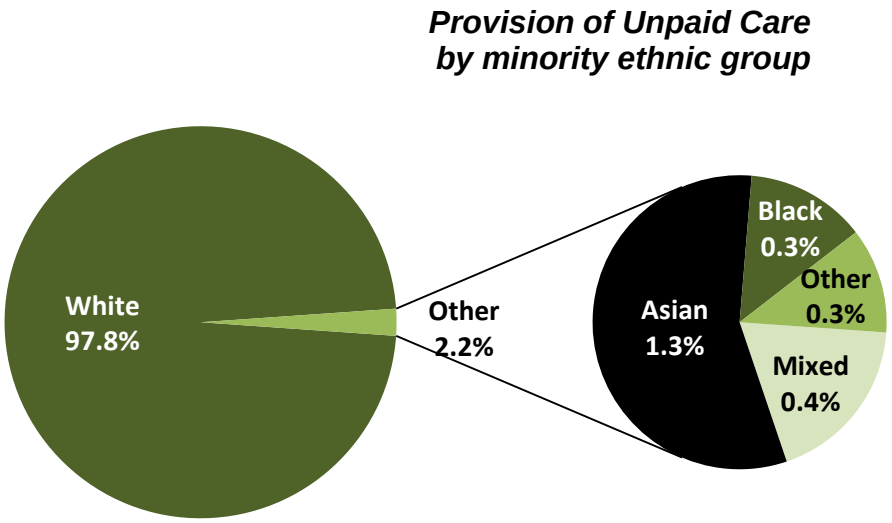
Provision of Unpaid Care by Ethnicity

Source: Census 2011, ONS

Ethnic Group	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care	Provides 20 to 49 hours unpaid care	Provides 50 or more hours unpaid care
White	21, 728 (97.8%)	12,318 (97.9%)	3,261 (96.5%)	6,149 (98.4%)
Mixed	92 (0.4%)	49 (0.4%)	14 (0.4%)	29 (0.5%)
Asian	278 (1.3%)	155 (1.2%)	72 (2.1%)	51 (0.8%)
Black	65 (0.3%)	35 (0.3%)	19 (0.6%)	11 (0.2%)
Other	57 (0.3%)	31 (0.2%)	15 (0.4%)	11 (0.2%)
Total	**22,220**	**12, 588**	**3,381**	**6,251**

This showed that 2.2% of carers were from minority ethnic groups (BME communities comprise 3.7% of the total population).

Data from Gateshead's social care services shows the ethnicity of carers who have had a joint or separate assessment or review, or were supported via a carers service during 2015/16. Only 1.1% of carers were reported as being from minority communities, around half the rate from the Census. The reasons for the lower prevalence of BME carers are not clear. This may simply be a random variation given the small numbers, it may be a result of recording (note the 317 carers where ethnicity was not obtained), it may arise from cultural factors or it may be related to lack of awareness of the support that could be available.



Carers who had a joint or separate assessment or review, or were supported via a carers service during 2015/16 by ethnicity

Carers Ethnicity	No.	%
White British	1813	84
White Other	6	0.3
Asian	15	0.6
Black, Other or Ethnicity Not Disclosed	8	0.2
Ethnicity not obtained	317	14.7
Total	2159	100

N.B. Local survey data collated by Gateshead Carers about their clients in 2014 is also available and is outlined in the 'Health Needs Assessment for Carers 2016'.

4.6.4 Gateshead Advice Centre

In 2015/16 1,277 people from BME or White Other groups were supported through the Gateshead Advice Centre. This equates to 13% of the total number of clients seen throughout the year.

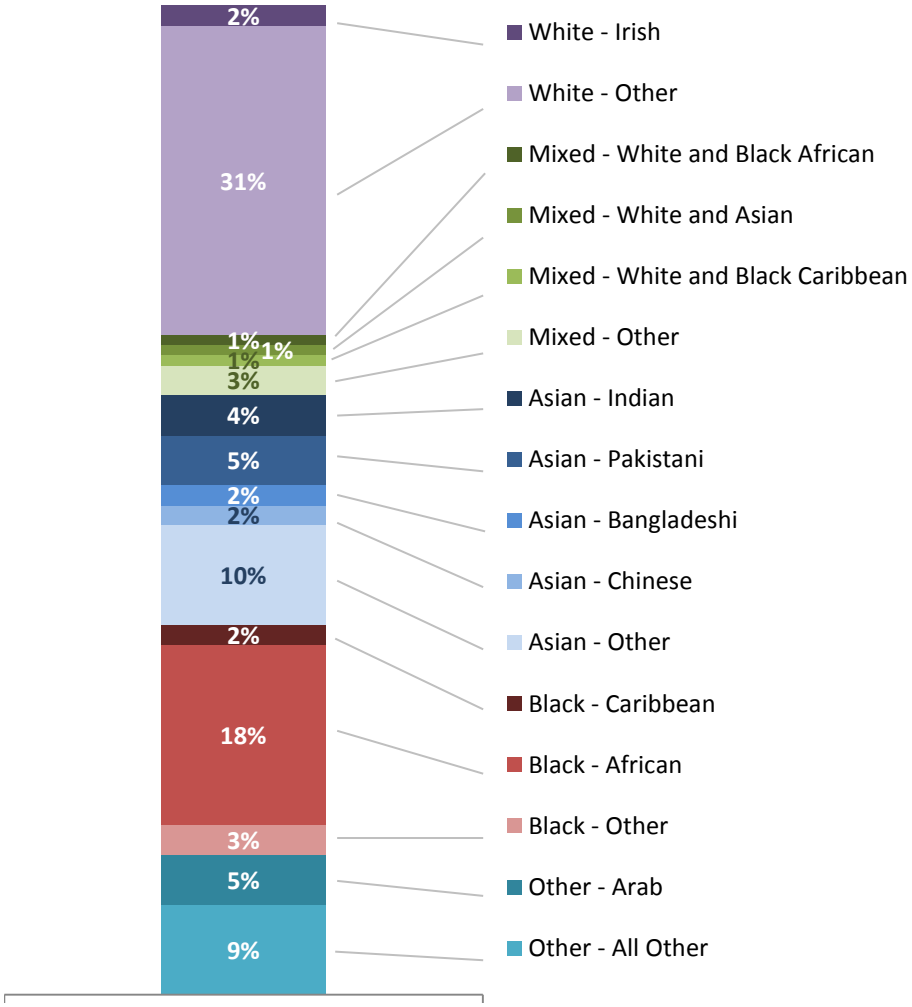
The groups that were supported the most during the year were White Other (31% of clients), Black African (18%), Other Asian (10%), and Other (9%).

Almost half of all enquiries by individuals from BME or White Other groups come from the wards of Dunston and Teams, Deckham, Bridges, and Felling. These wards are close to the centre of Gateshead and so the geographical distribution of enquiries tends to reflect the distribution of the BME and White Other groups. However, it should be noted that these wards are also close in proximity to Gateshead Advice Centre.

There are two levels of advice provided by the Centre. 'Full advice' is detailed advice and ongoing casework with appointments that may last at least an hour and many requiring several appointments. 'Gateway advice' is information, signposting and referral and is usually a short appointment of around 15-20 minutes.

The top 5 'full advice' categories for the BME and White Other groups are debt (42%), benefits and tax credits (30%), financial capability (17%), utilities and services (4%), and other (3% - including foodbank food parcels and

grants from charitable trusts). The top 5 'gateway advice' categories are benefits and tax credits (41%), immigration (10%), debt (9%), housing (9%) and employment (8%).



BME and White Other Clients Supported

Lots of health information is only available in English. It is widely acknowledged in the refugee and asylum seeker community that leaflets are not the best way of finding out about information when English is not your first language. Information spreads in this community by word of mouth and peer learning.

Recommendations

It is recommended that the Health and Wellbeing Board members:

- ensure that their respective organisations and organisations who they commission with are actively aware of their requirement to collect and analyse data across workforce and delivery areas in their performance measurements and monitoring
- make use of equality impact assessments to understand the implications of service and policy developments for local BME communities

4.7 Satisfaction with services

CQC (2016) reports that even within a single provider there can be large differences in the quality of care. There is also wide variation across our five key questions, with services consistently rated good or outstanding for caring across all sectors, but not necessarily for other areas of our inspections. Some groups of people say they experience lower quality care than others. For example, people with mental ill-health and younger people reported significantly poorer experiences when using NHS acute hospitals, while Black and minority ethnic groups and older people were less likely to be satisfied with adult social care services. CQC evidence continues to show that good leadership in a service can minimise the amount of variation that people experience.

The 2015 NHS inpatient survey showed that age is an important factor in how people perceive their experiences of hospital care. Sample sizes may have some influence on differences between groups, but the following points are worth considering:

Younger people (aged 16 to 35) were significantly less likely to report being treated with dignity and respect than older people (aged 66 to 80). They also reported significantly less confidence and trust in both nurses and doctors. These results show that the self-reported experience of inpatient care continues to be poorer for certain groups of people.

A number of groups were less likely to say that they received enough emotional support from hospital staff during their stay, including younger people, Muslim people, people with a mental health condition, and Asian, Asian British, and Chinese people.

We have not reviewed any local quantitative data on the satisfaction of service users from Gateshead's BME communities.

4.8 Focus Groups – Strengths, Weaknesses, Opportunities and Threats

The strengths, weaknesses, opportunities and threats regarding services in Gateshead are documented in the table below.

This information has been collated following a thematic analysis of information which has been documented from meetings with BME communities that have assisted with arranging focus groups attended by BME population groups (**Appendix 4**).

The thematic analysis highlighted how individuals within BME communities felt they were not aware of the range of services available to them.

Recommendations

Partners in the Health and Wellbeing Board should:

- Consider how to raise awareness of local services for individuals within BME communities by better publicising what support is already available and how to best access it. Research recommends family based educational interventions as a means of building on existing beliefs, attitudes and behaviours, with a community-based, word of-mouth approach.
- Consult families from BME communities about their specific needs when commissioning services
- Consult families from BME communities about information in appropriate languages and ways of promoting to BME communities
- Ensure service providers' information on services is readily available in appropriate languages and is promoted to BME communities
- Commission services that are accessible for local BME communities, including in appropriate locations and at appropriate times
- Commission peer support forums for parents and carers from local BME communities and, where appropriate, tailored support services
- Provide advocacy, translation and interpretation services for families from BME communities who require support during and health and social care pathways
- Ensure that the BME communities chapter of the Health and Wellbeing Board's Joint Strategic Needs Assessment is 'linked to all other chapters.
- Promote accessible services to teach English as second language

Strengths	Weaknesses
GP recognised as the first contact to access services (illness, children) Positive experiences received from hospital support/ cancer services Carer services accessed however, some cultures accept that it is a family responsibility to care for relatives and do not look for help. Social care/ domiciliary care, A&E staff and medical staff were found to be very helpful. Access to dentist and opticians is positive People over 40yrs indicated that they would take up a health check. Some refugees and asylum seekers have accessed counselling services. The race of the GP is not an issue. People indicated that they will be willing to use any service to get help to meet their needs Having a support worker to take people to find their way is important. Support worker helps individuals and families with Bus No etc. Once they access the services they find it a positive experience Better to have an independent interpreter not a friend The first impression from a service can make all the difference i.e. were they welcomed? Customer Service should be a priority	Unaware of walk in centres Unaware of 111 Unaware of GP out of hours service Most of the services users do not have a full picture of what they are entitled to in Primary and Secondary Care i.e. Core NHS services Tend not to use 111 due to language problems and general understanding Tend not to use any out of hours service If GP is closed people go to hospital Unaware of health checks for 40 -74 year old people. Unaware of mental health services. Signposting is generally at crisis point. Referrals generally would come from organisations like MIND Not aware of advice on childrens development Access to appointments at the GP can be an issue People who had accessed the walk in centre had stated that interpreter services were not available There are long waiting times to access an interpreter with suitable language when making an appointment at the GP. It is also recognised that when interpreters are present in a consultation with a GP or health care professional some people raised that there is a lack of privacy when interpreters are present. Doctors prescribe cheapest drugs that don't always work, and raise anxieties around health. Some communities reported returning to there home country to access appropriate health care assessment. Waiting times in A&E is reported as a problem, particularly for children Some people had experienced racism and poor attitudes from ambulance service No Chinese centre in Gateshead. The Chinese community meets in Newcastle. The asylum process has a detrimental effect on children and can be a stigma. Experience of bullying at

Strengths	Weaknesses
	school reported. With little financial support children can feel isolated and not part of the community i.e. any new trainer's games etc. No general information for BME community for NHS Health Checks. There are many older refugees aged 55 – 60

Opportunities	Threats
Telephone interpreting services may be appropriate in some situations Support for isolated older people is becoming an issue in communities. Respect for elderly Surveys can be completed if delivered by an interpreter or written in appropriate language. Also translated information. Access to information in a range of languages More information on how to access health checks and child development. Use of football/sports clubs to promote health checks Giving information in different ways e.g. Living notice boards, presentations to community groups, digital stories, films & DVD to deliver health messages. Giving information via community organisations Community healthy living centres can be used to get messages to communities and support wellbeing e.g. impact of religious fasting for people who have diabetes. Access to English classes Subsidies for refugees /asylum seekers Refugee Service would be used as good advice is always given and holds a Quality Standard Cultural influence and how other people tell them how the service treated them Informal carers are common younger people support parents etc. Neighbours can also be very helpful (a neighbour in the same predicament i.e. an Asylum seeker or refugee) More supportive access to service i.e. face to face	Cases of asylum seekers not being diagnosed: i.e. female with abnormal smears: who passes this information on to for possible action? Clients have a fear of speaking out due to treatment at detention centres. Phone lines for help can be very expensive (it cost one client £18 for one phone call from a mobile telephone) Information on the content of some medication is important i.e. Gelatine Information on the impact of fasting on Diabetes Fasting can lead some people to have increased paranoia. Accommodation can be substandard having a detrimental effect on people's health Leisure centres are difficult to join because of lack of finances Some people could have suffered from injuries and torture may not want to show these in public changing rooms Failed asylum seekers get a card for food, not cash Travel costs are a big issue with this group Food bank food is welcomed but over a long period of time it is very unhealthy i.e. processed food etc. Isolated older refugees without family support will impact on services eventually. There are worries that information regarding an individual who is using an NHS service that this information would be passed to the Home Office this can put people off accessing services.

Opportunities	Threats
Can the community incentive scheme be used in BME community for NHS Health Checks? This could be used as a stepping stone to other services Isolated people would need support and signposting. Adults with children are treated differently than single adults – equity issue? Training on how to recognise stress in children Access to ICT Giving information : 1. Presentations/Informal 2. Must be accurate and clear 3. Texting would be used by the group 4. Visual repetitive sessions are very useful 5. Simple language i.e. bullet points 6. Digital interviews i.e. recording or video 7. Use of practical aids 8. Relaxed environment always helps 9. Surveys sent to BME communities can worry them as they think this is could be a sign of an possible underlying condition Key areas for information 1. Support 2. Access 3. Knowledge 4. Information 5. Availability 6. Transport i.e. high bus fares for their budget	

5. Limitations of the Health Needs Assessment

Most UK studies concerning health promotion interventions within minority ethnic groups focus on South Asians, possibly due to the fact that many South Asians are still first and second generation immigrants, whereas the Black American population is a long-established group in the US. The UK literature therefore deals with individual studies rather than having the benefit of reviews of many studies over time. Lessons can be learned from both of these bodies of literature, with keys to success being associated with factors such as: careful attention to partnership development and building trust.

However it is accepted that some data is not available for this population group, particularly at the local level, and data is suppressed at times due to low numbers and potential risk to anonymity. We have not been able to assess the quality of the local data that is available, but we would highlight the low level of recording of ethnicity in some practices.

Local qualitative data is rich in information; however it would have been preferable if more communities could have been consulted with.

During the duration of writing the assessment members of the working group attendance dwindled, predominantly due to other priorities within the Voluntary Sector groups. It is recognised that the Voluntary Sector groups have been hit hard by the austerity measures and suffered financial cuts, and therefore have had limited capacity to give time to working group priorities.

6. Appendices

Appendix 1

Definitions and Abbreviations

BME	Black and minority ethnic (used to refer to members of non-white communities in the UK
BMI	The body mass index (BMI) is a measure that uses your height and weight to work out if your weight is healthy. The BMI calculation divides an adult's weight in kilograms by their height in metres squared. For example, A BMI of 25 means 25kg/m2.
FFT	Friends and Family Test. Friends and Family Test (FFT) is available in 12 languages, all in audio and video BSL. It's multi-channel, and comes with a suite of advanced real-time reporting tools
FGM	Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, but where there's no medical reason for this to be done.
Health and Well-being Board	The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.
I base	A data collection system used by Gateshead Council
MIND	A charity that provides advice and support to empower anyone experiencing a mental health problem.
WHO	World Health Organisation. The WHO staff work side by side with governments and other partners to ensure the highest attainable level of health for all people. Their goal is to build a better, healthier future for people all over the world, working through offices in more than 150 countries.

National Institute for Clinical Excellence (NICE) Guidance

Information documented from key NICE guidance is summarised below:

BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46) July 2013

NICE guidance aimed to determine whether lower cut-off points should be used for black, Asian and other minority ethnic groups in the UK as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke.

The evidence confirms that these groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population, but it was not sufficient to make recommendations on the use of new BMI and waist circumference thresholds to classify whether members of these groups are overweight or obese.

As a result, this guidance supports previously published NICE recommendations on diabetes prevention and extends them to black African and African-Caribbean groups. It also highlights recommendations from NICE and other sources in relation to awareness raising, BMI measurement and thresholds that can be used as a trigger for intervening.to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK.

Preventing type 2 diabetes

NICE recommendations include:

- using lower thresholds (23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk) for BMI to trigger action to prevent type 2 diabetes among Asian (South Asian and Chinese) populations
- identifying people at risk of developing type 2 diabetes using a staged (or stepped) approach
- providing those at high risk with a quality-assured, evidence-based, intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes.
- Extend the use of lower BMI thresholds to trigger action to prevent type 2 diabetes among black African and African-Caribbean populations.
- Raise awareness of the need for lifestyle interventions at a lower BMI threshold for these groups to prevent type 2 diabetes. For example, in particular, use the public health action points advocated by the World Health Organisation (WHO) as a reminder of the threshold at which lifestyle advice is likely to be beneficial for black and Asian groups to prevent type 2 diabetes.

BMI assessment, multi-component interventions and best practice standards

NICE recommendations on BMI assessment, and how to intervene, is set out in Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (NICE clinical guideline 43). Specifically:

- Clinicians should assess comorbidities, diet, physical activity and motivation along with referral to specialist care if required.
- Weight management programmes should include behaviour-change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake
- Primary care organisations and local authorities should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice.

General awareness raising

- Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m2).
- Ensure members of black, Asian and other minority ethnic groups are aware that they face an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m2).

- Use existing local black and other minority ethnic information networks to disseminate information on the increased risks these groups face at a lower BMI.

NICE advice Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups (LGB13)
The prevalence of chronic conditions such as type 2 diabetes, coronary heart disease and stroke is up to 6 times higher (and they occur from a younger age) among black, Asian and other minority ethnic groups. In addition, these groups progress from being at-risk to being diagnosed with these conditions at twice the rate of white populations. So tackling this issue will help tackle health inequalities and satisfy public sector obligations under the Equality Act 2010.

Action now will result in significant social care and health savings, by delaying and improving the management of complications associated with limiting long-term illnesses. It could result in particularly high savings for local authorities with a high proportion of black, Asian and other minority ethnic groups. (See Make significant cost savings.)

Lifestyle interventions targeting sedentary lifestyles and diet have reduced the incidence of diabetes by about 50% among high-risk individuals (Pharmacological and lifestyle interventions to prevent or delay type 2 diabetes in people with impaired glucose tolerance: systematic review and meta-analysis). This includes people from South Asian, Chinese, black African and African Caribbean descent with a BMI of 23 kg/m2 or more, where interventions to identify and manage pre-diabetes have been found to be cost effective.

Diabetes is the most common cause of visual impairment and blindness among people of working age and the most common cause of kidney failure and non-traumatic lower limb amputations. See Reduce future demand on health and social care services. Interventions to prevent type 2 diabetes will also reduce the risk of other major health problems including Alzheimer's disease, coronary heart disease, hypertension and stroke.

Council scrutiny activities can add value to strategies and actions to improve the public's health. Effective scrutiny can help identify local health needs and check whether local authorities are working in partnership with other organisations to tackle the wider determinants of health. NICE guidance and briefings provide a useful starting point, by suggesting useful 'questions to ask' during the scrutiny process

HIV testing: increasing uptake in black Africans (PH33) March 2011
The focus of this guidance is on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission.

The recommendations include advice on:
- community engagement and involvement
- planning services, including assessing local need, developing a strategy and commissioning services in areas of identified need
- promoting HIV testing and reducing barriers to testing among black African communities
- offering and recommending an HIV test
- HIV referral pathways

This guideline was previously called increasing the uptake of HIV testing among black Africans in England.

It is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, increasing the uptake of HIV testing among black African communities. This includes those working in local authorities and the wider public, private, voluntary and community sectors. It will also be of interest to members of the public, in particular black Africans living in England.

It is one of two pieces of NICE guidance published in March 2011 on how to increase the uptake of HIV testing. A second publication covers HIV testing among men who have sex with men.

Community engagement and involvement

- Directors of public health and others with a remit for HIV prevention or with responsibility for the health and wellbeing of black African communities should take action to:
- Plan, design and coordinate activities to promote the uptake of HIV testing among local black African communities, in line with NICE guidance on community engagement. Seek to develop trust and relationships between organisations, communities and people. Communities should be involved in all aspects of the plan, which should take account of existing and past activities to address HIV and general sexual health issues among these communities.
- Work in partnership with those running existing community activities to promote HIV testing and the benefits of early diagnosis and treatment, and to raise awareness of local services and how to access them. This includes addressing any misconceptions about HIV testing and treatment (for example, in relation to life expectancy following a positive diagnosis – or related to HIV treatment costs). It also includes reducing the stigma (real or perceived) associated with HIV testing and living with HIV, both among black Africans and health professionals.
- Recruit, train and encourage members of local black African communities to act as champions and role models to help encourage their peers to take an HIV test. This includes helping to plan awareness-raising activities or acting as a link to specific communities that are less likely to use existing services.

Planning services – assessing local need

- Directors of public health, public health specialists and commissioners with a remit for sexual health and local sexual health networks should take action to:
- Collect and analyse local data to estimate the prevalence and incidence of HIV among black African communities.
- Collect information about the composition of local black African communities, including groups that are less likely to use services. Ensure there is an understanding of the particular needs of different groups.
- Gather the views and experiences of local black African communities to understand their specific concerns and needs in relation to HIV testing.
- Collect information about HIV-testing services. This includes data on where they are offered (for example, in genitourinary medicine clinics and GP surgeries), access times and general accessibility. In addition, determine the types of test offered and how frequently, the take-up rates and how quickly results are given. Note variations in factors such as waiting times and staff provision. Also gather information on service users (identified by gender, sexuality, age, ethnicity and date of last HIV test).
- Collect information about current HIV diagnoses, including the proportion of people being diagnosed late (that is, after treatment should have begun), broken down by gender, age and country of origin. Take note of the CD4 count on diagnosis, the settings where people are being diagnosed and the suspected transmission route. (This includes detail on whether or not the infection probably occurred abroad or in the UK.)
- Carry out an appraisal of local interventions that aim to increase the number of black Africans who choose to take an HIV test. Information should be gathered on where, when and how often HIV testing is promoted to these communities and by whom.

Planning services – developing a strategy and commissioning services in areas of identified need

- Directors of public health, public health specialists and commissioners with a remit for sexual health and local sexual health networks should take action to:
- Ensure there is a local strategy to increase the uptake of HIV testing among local black Africans. It should encourage them to undergo HIV testing. It should also encourage professionals to offer and recommend HIV testing to them, where appropriate.
- Ensure the strategy is planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local black African communities .
- Ensure the strategy takes into account the needs of people from different black African communities. In particular, it should pay attention to groups that are less likely to use existing services.
- Ensure the strategy is regularly monitored and evaluated.
- Ensure HIV testing is available in a range of healthcare and community settings (for example, GP surgeries and community centres) based on the outcomes of a needs assessment. These should be accessible and

acceptable to the target population, in terms of both geographical setting and service design (for example, in terms of appointment systems, opening hours and cultural sensitivity).

Promoting HIV testing for black African communities

Commissioners and staff in public health, primary care (including GPs), local authorities and the voluntary sector with a remit for health promotion, education and advice for black African communities (including providers of HIV testing) should take action to ensure:

- Other local and national organisations that produce, or are responsible for providing, information about HIV, HIV testing and treatment for black Africans.
- Produce promotional material tailored to the needs of local black African communities. It should:
    - provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment
    - emphasise that early diagnosis is a route into treatment and a way to avoid complications and serious illness in the future
    - detail how and where to access local HIV testing services, including services offering rapid testing and genitourinary medicine clinics (where people do not have to give their real name)
    - dispel myths and common misconceptions about HIV diagnosis and treatment
    - present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status
    - address the needs of non-English-speaking black African communities, for example through translated information.
- Work with black African community organisations to promote HIV testing.
- Use venues that local black African communities frequent (for example, prayer groups or cultural events).

Reducing barriers to HIV testing for black African communities

Commissioners and providers of health services should take action to:

- Ensure staff offering HIV tests emphasise that the tests are confidential. They should be able to direct those who are concerned about confidentiality to a genitourinary medicine clinic, where people do not have to give their real name.
- Ensure staff are able to recommend HIV testing and have the ability to discuss HIV symptoms and the implications of a positive or a negative test.
- Ensure staff are familiar with existing referral pathways so that people who test positive receive prompt and appropriate support.
- Ensure staff can provide appropriate information, including details of where to get free condoms or training in negotiation skills, if someone tests negative.
- Ensure primary care staff can recognise the symptoms that may signify primary HIV infection or illnesses that often co-exist with HIV. In such cases, they should be able to offer and recommend an HIV test.
- Ensure HIV testing services are staffed by people who are aware of and sensitive to, the cultural issues facing black Africans. (For example, black Africans may be less used to preventive health services and advice or may fear isolation and social exclusion should they test positive for HIV.) Staff should also be able to challenge the stigma of, and dispel any myths surrounding, HIV and HIV testing and be sensitive to the individual needs of people.
- Ensure HIV testing services can offer rapid tests to people who are reluctant to wait for results (or can refer people to a service that provides rapid tests). If people are unwilling to have a blood test, they should be offered less invasive options (such as a saliva test), or should be referred elsewhere for such a test.

Healthcare settings: offering and recommending an HIV test

Commissioners and providers of healthcare in both primary and secondary care. This includes those in: accident and emergency departments, antenatal services, general practice, genitourinary medicine, outpatient departments, sexual health clinics and other healthcare settings should take action to ensure:

- In line with British HIV Association (BHIVA) guidelines all health professionals should routinely offer and recommend an HIV test to:
    - men and women known to be from a country of high HIV prevalence

    - men and women who report sexual contact abroad or in the UK with someone from a country of high HIV prevalence
    - patients who have symptoms that may indicate HIV or where HIV is part of the differential diagnosis (see the BHIVA guidelines for a list of indicator diseases)
    - patients diagnosed with a sexually transmitted infection
    - the sexual partners of men and women known to be HIV positive
    - men who have disclosed that they have sexual contact with other men
    - the female sexual contacts of men who have sex with men
    - patients reporting a history of injecting drug use.
- In addition, health professionals should (regardless of local HIV prevalence), routinely offer and recommend an HIV test to all those who may be at risk of exposure to the virus. For example, this may be as a result of having a new sexual partner or may be because they have previously tested negative during the 'window period'.
- In line with BHIVA guidelines, all health professionals should routinely offer and recommend an HIV test to all patients attending:
    - genitourinary medicine or sexual health clinics
    - antenatal services
    - termination of pregnancy services
    - drug dependency programmes
    - tuberculosis, hepatitis B, hepatitis C and lymphoma services.
- In areas where more than 2 in 1000 population have been diagnosed with HIV:
- primary care and general medical admissions professionals should consider offering and recommending an HIV test when registering and admitting new patients (this is in line with BHIVA guidelines)[1]
- all health practitioners should offer and recommend an HIV test to anyone who has a blood test (regardless of the reason).

HIV referral pathways

Commissioners and providers of HIV testing services in both the statutory and voluntary sector should take action to:

- Ensure there are clear referral pathways for people with positive and negative HIV test results.
- Ensure people who test positive are seen by an HIV specialist at the earliest opportunity, preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with British HIV Association guidelines). They should also be given information about the diagnosis and about local support groups.
- For people with positive and negative HIV test results, if appropriate, offer or provide information about further behavioural or health promotion interventions available from both voluntary and statutory services (for example, advice on safer sex, training in negotiating skills and providing condoms).
- Encourage repeat testing after a negative result for those who are at risk of infection (for example, for those who have new or multiple partners).
- Ensure people who choose not to take up the immediate offer of a test know how to access testing services.

Smokeless tobacco: South Asian communities (PH39) September 2012

This guidance aims to help people of South Asian origin who are living in England to stop using traditional South Asian varieties of smokeless tobacco. The phrase 'of South Asian origin' refers here to people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

The term 'smokeless tobacco', as it is used in this guidance, refers to 3 broad types of products:

- Tobacco with or without flavourants, for example: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers, for example: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut, for example: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

Products, like ‘snus’ or similar oral snuff products are not included.

The guidance is for commissioners and providers of tobacco cessation services (including stop smoking services), health education and training services, health and wellbeing boards and health and social care practitioners.

It is also for all those with public health as part of their remit, in particular, the health of South Asian communities. The guidance may also be of interest to local authority elected members and members of the public.

The 6 recommendations cover:

- assessing local need
- working with local South Asian communities
- commissioning smokeless tobacco services
- providing brief advice and referral: dentists, GPs, pharmacists, and other health professionals
- specialist tobacco cessation services (including stop smoking services)
- training for practitioners.

Assessing local need

Local authority specialists and public health commissioners responsible for local tobacco cessation activities, health and wellbeing boards, clinical commissioning groups, dental public health consultants managers of tobacco cessation services should take action:

- As part of the local joint strategic needs assessment (JSNA), gather information on where, when and how often smokeless tobacco cessation services are promoted and provided to local South Asian communities – and by whom. Aim to get an overview of the services on offer.
- Consult with local voluntary and community organisations that work with, or alongside, South Asian communities to understand their specific issues and needs in relation to smokeless tobacco.
- Collect and analyse data about the use of smokeless tobacco among local South Asian communities. For example, collect data from local South Asian voluntary and community organisations, dental health professionals and primary and secondary care services. These data should provide information on:
    - prevalence and incidence of smokeless tobacco use and detail on the people who use it (for example, their age, ethnicity, gender, language, religion, disability status and socioeconomic status)
    - people who use smokeless tobacco and do not use cessation services
    - types of smokeless tobacco used
    - perceived level of health risk associated with these products
    - circumstances in which these products are used locally
    - proportion and demographics of people who both smoke and use smokeless tobacco products.
- Consider working with neighbouring local authorities to analyse routinely collected data from a wider geographical area on the health problems associated with smokeless tobacco among local South Asian communities. In particular, collect and analyse data on the rate of oropharyngeal cancers. Note any demographic patterns. Data could be gathered from local cancer registers, Hospital Episode Statistics, public health observatories and local cancer networks.
- Collect any available information from tobacco cessation services on the number of South Asian people who have recently sought help to give up smoking or smokeless tobacco. Depending on the level of detail available, data should be broken down demographically (for example, by age, ethnic suborigin, gender, religion and socioeconomic status).
- Use consistent terminology to describe the products, as specified in the Local Government Association's Niche tobacco products directory website. Note any local variation in the terminology used by retailers and consumers.

Working with local South Asian communities in areas of identified need

Directors of public health, local voluntary and community organisations with a responsibility for tobacco cessation or that work with South Asian communities. Managers of tobacco cessation services, people who work with children and young people, faith leaders and others involved in faith centres and health and social care practitioners, for example, midwives, health visitors and youth workers. Health and wellbeing boards, clinical commissioning groups, dental health professionals including dentists, dental hygienists and dental nurses and others with a remit for managing tobacco cessation services or with responsibility for the health and wellbeing of South Asian communities should take action to:

- Work with local South Asian communities to plan, design, coordinate, implement and publicise activities to help them stop using smokeless tobacco. Develop relationships and build trust between relevant organisations, communities and people by involving them in all aspects of planning. Take account of existing and past activities to address smokeless tobacco use and other health issues among these communities.
- Work with local South Asian communities to understand how to make services more accessible. For example, if smokeless tobacco cessation services are provided within existing mainstream tobacco cessation services, find out what would make it easier for South Asian people to use the service.
- Work in partnership with existing community initiatives to raise awareness of local smokeless tobacco cessation services and how to access them. Ensure any material used to raise awareness of the services:
    - uses the names that the smokeless tobacco products are known by locally, as well as the term 'smokeless tobacco'
    - provides information about the health risks associated with smokeless tobacco and the availability of services to help people quit
    - challenges the perceived benefits – and the relative priority that users may place on these benefits (compared with the health risks). For example, some people think smokeless tobacco is an appropriate way to ease indigestion or relieve dental pain, or helps freshen the breath
    - addresses the needs of people whose first language is not English (by providing translations)
    - addresses the needs of people who cannot read in any language (by providing material in a non-written form, for example, in pictorial, audio or video format)
    - includes information for specific South Asian subgroups (for example, older Bangladeshi women) where rates of smokeless tobacco use are known to be high
    - discusses the concept of addiction in a way that is sensitive to culture and religion (for example, it may be better to refer to users as having developed a 'habit', rather than being 'addicted')
    - does not stigmatise users of smokeless tobacco products within their own community, or in the eyes of the general community.
- Use existing local South Asian information networks (including culturally specific TV and radio channels), and traditional sources of heath advice within South Asian communities to disseminate information on smokeless tobacco.
- Use venues and events that members of local South Asian communities frequent to publicise, provide or consult on cessation services with them. (Examples include educational establishments and premises where prayer groups or cultural events are held.)
- Raise awareness among those who work with children and young people about smokeless tobacco use. This includes:
    - providing teachers with information on the harm that smokeless tobacco causes and which also challenges the perceived benefits – and the priority that users may place on these perceived benefits
    - encouraging teachers to discuss with their students the reasons why people use smokeless tobacco. This could take place as part of drug education, within personal, social, health and economic (PSHE) education, or within any other relevant part of the curriculum.

Commissioning smokeless tobacco services in areas of identified need

Directors of public health, public health commissioners and local authority specialists responsible for local tobacco cessation services, health and wellbeing boards, clinical commissioning groups, managers of tobacco cessation services should take action:

- If local needs assessment shows that it is necessary commission a range of services to help South Asian people stop using smokeless tobacco. Services should be in line with any existing local agreements or local enhanced service arrangements.
- Provide services for South Asian users either within existing tobacco cessation services or, for example, as:
    - A stand-alone service tailored to local needs (see recommendation 5). This might cater for specific groups such as South Asian women, speakers of a specific language or people who use a certain type of smokeless tobacco product (the latter type of service could be named after the product, for example, it could be called a 'gutkha' cessation service).
    - Part of services offered within a range of healthcare and community settings (for example, GP or dental surgeries, community pharmacies and community.

- Ensure local smokeless tobacco cessation services are coordinated and integrated with other tobacco control, prevention and cessation activities, as part of a comprehensive local tobacco control strategy. The services (and activities to promote them) should also be coordinated with, or linked to, national stop smoking initiatives and other related national initiatives (for example, dental health campaigns).
- Ensure services are part of a wider approach to addressing the health needs facing South Asian communities. They should be planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local South Asian communities.
- Ensure services take into account the fact that some people who use smokeless tobacco products also smoke tobacco.
- Ensure services take into account the needs of people:
    - from different local South Asian communities (for example, by using staff with appropriate language skills or translators, or by providing translated materials or resources in a non-written format)
    - who may be particularly concerned about confidentiality
    - who may not realise smokeless tobacco is harmful
    - who may not know help is available
    - who may find it difficult to use existing local services because of their social circumstances, gender, language, culture or lifestyle
- Regularly monitor and evaluate all local smokeless tobacco cessation services (and activities to promote them). Ensure they are effective and acceptable to service users. Where necessary, adjust services to meet local need more effectively. The following outcomes should be reported:
    - number of quit attempts
    - percentage of successful quit attempts at 4 weeks
    - percentage of quit attempts leading to an adverse or unintended consequence (such as someone switching to, or increasing, their use of smoked tobacco or areca nut-only products).

Providing brief advice and referral: dentists, GPs, pharmacists and other health professionals

Primary and secondary dental care teams (for example, dentists, dental nurses and dental hygienists), primary and secondary healthcare teams (for example, GPs and nurses working in GP practices). Health professionals working in the community, including community pharmacists, midwives and health visitors should take action to:

- Ask people if they use smokeless tobacco, using the names that the various products are known by locally. If necessary, show them a picture of what the products look like, using visual aids. (This may be necessary if the person does not speak English well or does not understand the terms being used.) Record the outcome in the patient notes.
- If someone uses smokeless tobacco, ensure they are aware of the health risks (for example, the risk of cardiovascular disease, oropharyngeal cancers and periodontal disease). Use a brief intervention to advise them to stop.
- In addition to delivering a brief intervention, refer people who want to quit to local specialist tobacco cessation services. This includes services specifically for South Asian groups, where they are available.
- Record the response to any attempts to encourage or help them to stop using smokeless tobacco in the patient notes (as well as recording whether they smoke).

See also NICE guidance on brief interventions and referral for smoking cessation and smoking cessation services for more information.

Specialist tobacco cessation services in areas of identified need

Providers of tobacco cessation services. This may include those working in general practice, dental practices and pharmacies should take action as part of a comprehensive specialist tobacco cessation service to ensure:

- Staff provide advice to people who use smokeless tobacco (or recommend that they get advice to help them quit).
- Staff know the local names to use when referring to smokeless tobacco products.
- Staff can advise people on how to cope with the potential adverse effects of quitting smokeless tobacco. This includes, for example, knowing how to refer people for help to cope with oral pain, as well as general support to cope with withdrawal symptoms.

- Staff offer people who use smokeless tobacco help to prevent a relapse following a quit attempt. If possible, they should also validate the quit attempt by using a cotinine test (saliva examination) and monitor for any possible increase in tobacco smoking or use of areca nut.
- Services reach people who may not realise smokeless tobacco is harmful, or who may not know that help is available should they need it.
- Services reach people who may find it difficult to use existing local services because of their social circumstances, gender, language, culture or lifestyle. For example, a home outreach service might be considered for older people or women from South Asian groups.
- Staff check whether smokeless tobacco users also smoke tobacco and, if that is the case, provide help to quit them both.

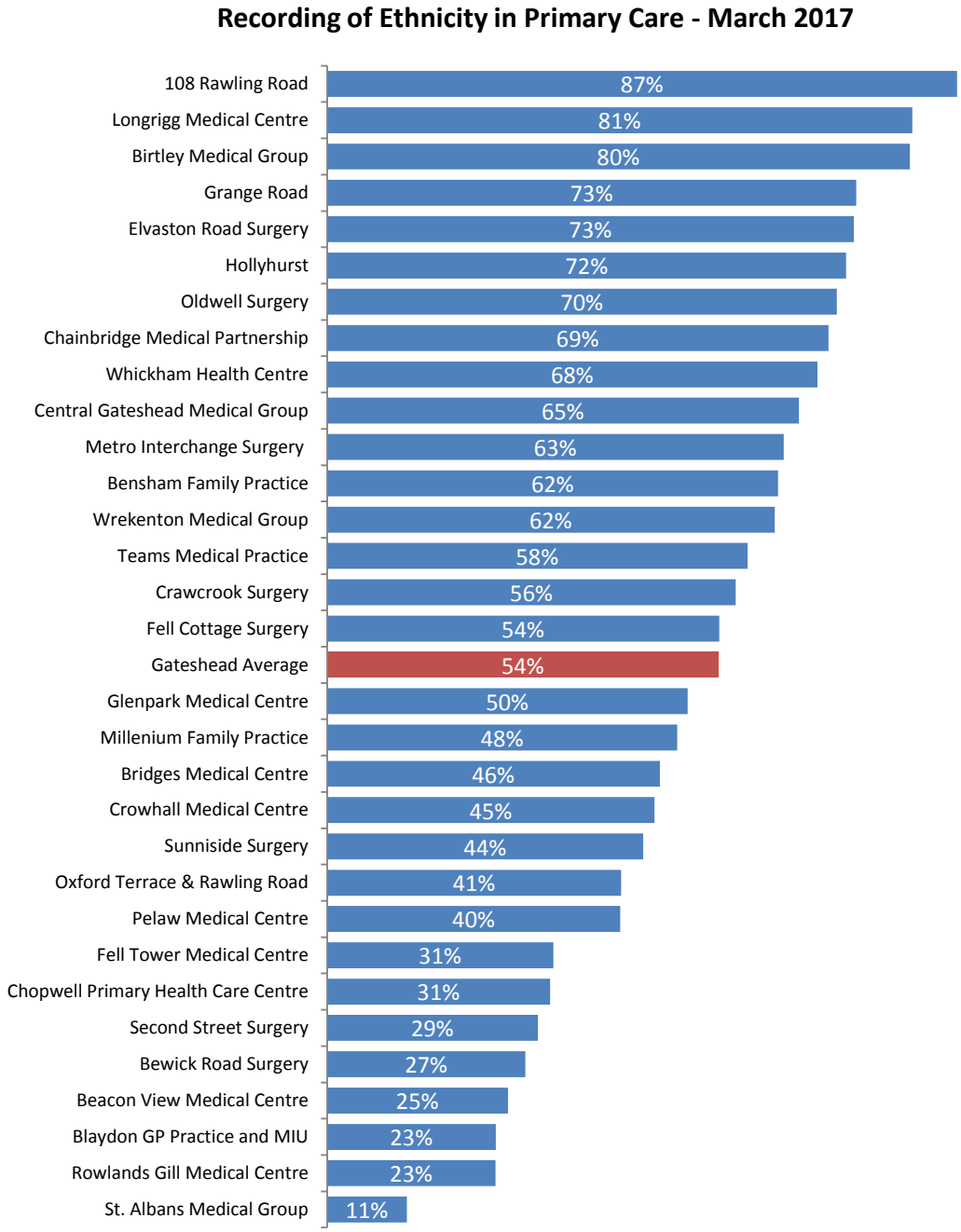
Training for practitioners in areas of identified need

Commissioners of health and dental services, commissioners of health education and training services should take action to:

- Ensure training for health, dental health and allied professionals (for example, community pharmacists) covers:
  - the fact that smokeless tobacco may be used locally – and the need to keep abreast of statistics on local prevalence
  - the reasons why, and how, members of the South Asian community use smokeless tobacco (including the cultural context for its use)
  - the health risks associated with smokeless tobacco
  - the fact that some people of South Asian origin may be less used to a 'preventive' approach to health than the general population
  - the local names used for smokeless tobacco products, while emphasising the need to use the term 'smokeless tobacco' as well when talking to users about them.
- Training should also ensure practitioners:
  - can recognise the signs of smokeless tobacco use
  - know how to ask someone, in a sensitive and culturally aware manner, if they use smokeless tobacco
  - can provide information in a culturally sensitive way on the harm smokeless tobacco causes. (This includes being able to challenge any perceived benefits – and the relative priority that users may place on these benefits)
  - can deliver a brief intervention and refer people to tobacco cessation services if they want to quit

Primary Care Data (supplied by NHS North of England Commissioning Support Business Information Services [NECS])

The following data supplied by NECS is a snapshot taken in March 2017:



Ethnic Group (People with a recorded ethnicity in primary care - March 2017)

Ethnicity	0 to 4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85+
BME Total	785	2,071	1,698	1,828	2,290	2,884	3,181	2,840	2,178	1,820	1,463	1,161	830	606	405	348	301	226
White British	2,290	3,691	3,253	3,440	4,537	5,333	5,240	5,031	5,086	6,492	7,190	6,742	6,093	6,418	5,318	4,341	3,137	2,655

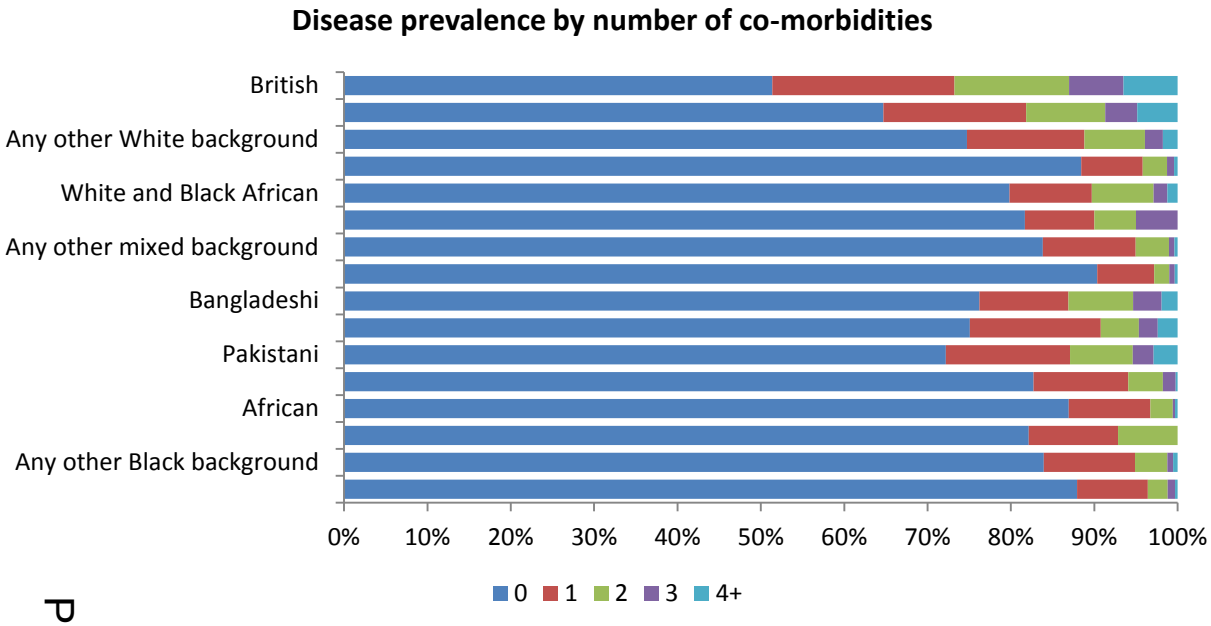
Disease Prevalence (People with a recorded ethnicity in primary care - March 2017)

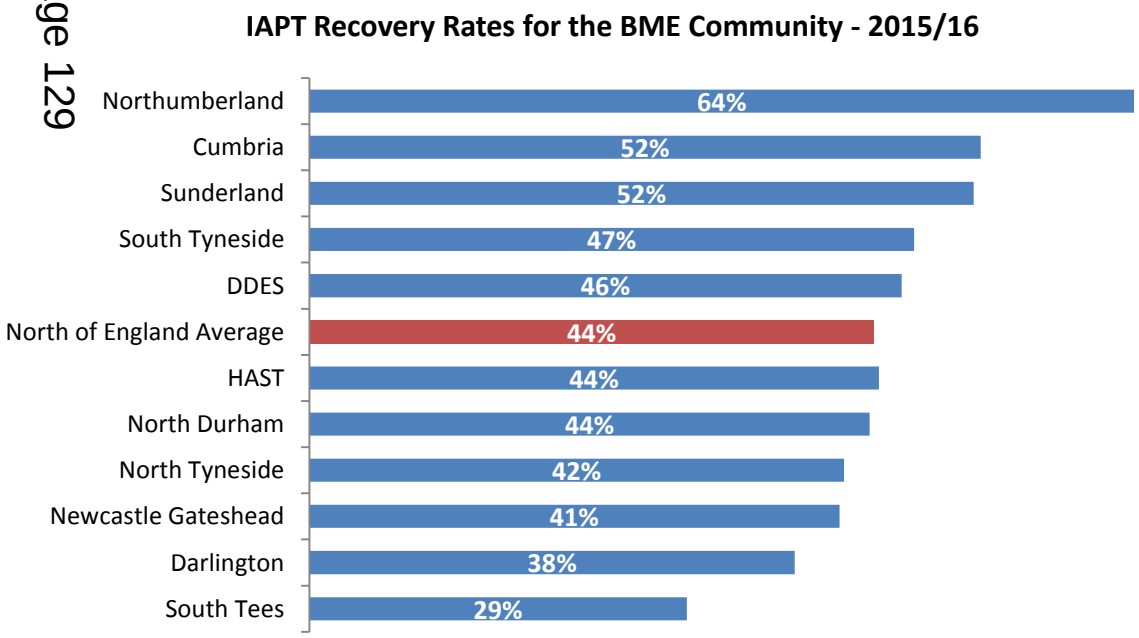
Population Group	*Asthma*		*Cancer*		*CHD*		*COPD*		*Diabetes*		*Epilepsy*	
	Number on Register	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*
White British	2,294	2.7%	3181	3.7%	4735	5.5%	3419	4.0%	5298	6.1%	737	0.9%
BME Population	168	0.6%	328	1.2%	378	1.4%	209	0.8%	448	1.7%	86	0.3%
Total	2,462	2.2%	3509	3.1%	5113	4.5%	3628	3.2%	5746	5.1%	823	0.7%

Population Group	*Osteoporosis*		*Heart Failure*		*Hypertension*		*Stroke*		*TIA*		*Palliative Care*	
	Number on Register	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*	*Number on Register*	*All Age Prevalence*
White British	2,790	3.2%	1123	1.3%	18912	21.9%	1647	1.9%	1010	1.2%	246	0.3%
BME Population	276	1.0%	105	0.4%	1644	6.1%	133	0.5%	67	0.2%	29	0.1%
Total	3,066	2.7%	1228	1.1%	20556	18.2%	1780	1.6%	1077	1.0%	275	0.2%

Mental Health Register Prevalence (People with a recorded ethnicity in primary care - March 2017)										
Population Group	***Dementia***		***Depression***		***Learning Disability***		***Serious Mental Illness***		***Anxiety Disorder***	
	Number on Register	***All Age Prevalence***	***Number on Register***	***All Age Prevalence***	***Number on Register***	***All Age Prevalence***	***Number on Register***	***All Age Prevalence***	***Number on Register***	***All Age Prevalence***
White British	912	1.1%	16,267	18.9%	522	0.6%	921	1.1%	12,346	14.3%
BME Population	69	0.3%	2,722	10.1%	69	0.3%	166	0.6%	2,348	8.7%
Total	981	0.9%	18,989	16.8%	591	0.5%	1,087	1.0%	14,694	13.0%

Lifestyle Indicators (People with a recorded ethnicity in primary care - March 2017)												
Population Group	***Obese Adults***		***Smokers (Adult)***		***Uptake of Cervical Screening***		***Uptake of Breast Screening***		***Housebound***		***Health Checks***	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
White British	12,896	17.2%	8,191	10.9%	10,306	74.0%	8,515	61.8%	1,390	1.6%	2,549	15.9%
BME Population	1,640	7.7%	1,734	8.1%	3,732	60.3%	1,129	52.3%	109	0.4%	362	6.7%
Total	14,536	15.1%	9,925	10.3%	14,038	69.8%	9,644	60.5%	1,499	1.3%	2,911	13.6%


Disease prevalence by number of co-morbidities
British
Any other White background
White and Black African
Any other mixed background
Bangladeshi
Pakistani
African
Any other Black background
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
0
1
2
3
4+


IAPT Recovery Rates for the BME Community - 2015/16
Northumberland
64%
Cumbria
52%
Sunderland
52%
South Tyneside
47%
DDES
46%
North of England Average
44%
HAST
44%
North Durham
44%
North Tyneside
42%
Newcastle Gateshead
41%
Darlington
38%
South Tees
29%

Secondary Care Activity 2015/16

Practice Name	First Outpatient Attendances		Elective Inpatients (incl Day Case)		Non-Elective Inpatients		Accident and Emergency	
	Attendances	*Directly Standardised Rate per 100,000*	*Admissions*	*Directly Standardised Rate per 100,000*	*Admissions*	*Directly Standardised Rate per 100,000*	*Attendances*	*Directly Standardised Rate per 100,000*
African	**573**	**188,238**	53	14,906	118	15,399	362	46,281
Any other Asian background	**175**	**18,918**	**32**	**8,142**	**73**	**6,823**	**253**	**26,924**
Any other Black background	43	47,561	14	18,042	18	16,150	**81**	**90,667**
Any other ethnic group	**524**	**84,302**	**141**	**34,272**	**250**	**36,885**	**874**	**118,332**
Any other mixed background	113	32,765	35	10,574	72	11,042	274	56,587
Any other White background	**944**	**25,647**	**201**	**7,375**	492	12,271	**1,693**	**45,738**
Bangladeshi	**120**	**60,010**	**44**	**27,181**	**52**	**24,687**	**162**	**76,166**
Caribbean	22	31,813	5	14,956	**5**	**6,631**	27	39,000
Chinese	**150**	**15,051**	**65**	**8,868**	**59**	**7,677**	**215**	**28,559**
Indian	256	35,711	77	13,712	**82**	**9,213**	**247**	**28,829**
Irish	**121**	**27,146**	**55**	**9,937**	41	13,336	180	50,686
Pakistani	**200**	**45,236**	**68**	**19,430**	**88**	**19,820**	**230**	**41,847**
White and Asian	**74**	**18,662**	*	**1,474**	**36**	**3,455**	**147**	**24,997**
White and Black African	64	32,360	**15**	**5,936**	59	17,212	125	46,874
White and Black Caribbean	**18**	**5,225**	**6**	**1,615**	**18**	**4,636**	**39**	**9,610**
White British	73,268	33,870	31,840	13,845	28,018	13,199	**93,448**	**50,445**
Total Gateshead	76,665	33,721	*	13,661	29,481	13,197	98,357	49,709
BME Aggregate	***3,397***	***33,287***	*	***9,911***	***1,463***	***11,858***	***4,909***	***41,187***

Significantly Lower than the Gateshead Aggregate | **Significantly Higher than the Gateshead Aggregate**

**Numbers less than 5 have been suppressed*

Comments from Asylum Seekers

- Everyone confirmed that they are registered with a GP
- Some have used a walk in centre in the past, however feel that the waiting time is too long so they go to the one in Newcastle (Westgate Road) which is quicker.
- Come into country three months ago – had to wait three months to get my father seen who has a heart problem.
- Hand injured – took a long time to get appointment at Freeman hospital – hand got better before appointment came in the post.
- When you wait at the QE for 4 hours there is no interpreter – you don't get an update. Had to wait for husband coming from work to interpret problem which caused a delay in being seen.
- Interpreter must have knowledge about human body (especially for women)
- Language barriers – paper and face to face. Letters can be complicated, too many words to read – need to be shorter and clearer.
- Need to be taught key words for health issues e.g. headache so we can communicate this.
- Nobody was aware of the NHS 111 number – PM explained that this is for non-emergencies but that they would still need to ring 999 for an emergency. Issues were raised about not being able to understand the person on the telephone (the asylum seeker not being able to understand the worker). Clear, simple words needs to be used and the pace needs to slow down.
- One participant mentioned that her father had heart problems. They had been in the country for 3 months but her father had not been seen for this yet. However she confirmed that she had an imminent appointment at the hospital for her father.
- Project worker commented that there is a delay in people getting diagnosed with serious illnesses or conditions e.g. type 2 diabetes, however once Asylum Seekers receive 'Leave to Remain' they then get their health issues looked at and people get diagnosis.
- Participants felt that they have to wait too long for appointments with their GP.
- Some participants confirmed that they had been given a health check and that improvements to their health had been made.
- There were some concerns that GPs weren't doing regular health checks.
- Mental health issues – concerns were raised by project worker and participants that GPs were prescribing medication only and not referring people for counselling. They felt that it was difficult to get one to one therapy.
- Only one person in the group had heard of talking therapies. However, she was told that her issues were not for this service. Talking therapies could present problems as initial consultations with talking therapies can be over the telephone (comment made by PM – facilitator). Participants were not aware that they can self-refer to talking therapies.
- Asylum seekers need a support worker – someone they can trust and give information to (project worker highlighted the need for this).
- Is there an anonymous reporting line for mental health issues?
- It was raise by project worker and participants that you have to keep repeating the same traumatic story to GPs as they cannot always see the same one. This was highlighted as causing more distress to asylum seekers and not helping mental health issues.
- One participant stated that she was worried about raising issues of racism in case of repercussions or her name being mentioned. "You wonder, are you in the right place or the wrong place".
- Two participants mentioned that they had tried to commit suicide 3 times. The project worker mentioned that this can be due to them constantly being made homeless when they arrive in the country, having an effect on mental health.
- One participant mentioned that she attends Prince Concert Road Medical Centre and that they meet her needs as an Asylum Seeker and a patient – a nice place to go and feel comfortable going.
- Two participants mentioned a positive experience at the Q. E. Hospital. They both had needed emergency services for themselves or a relative and had both had a positive experience.
- Most in the group confirmed that they would be happy to complete a survey if they were given one (they would help each other).
- It came across that some participants weren't clear who to contact in an emergency.

- Some commented that time is restricted with GPs. Others mentioned that they should book a double appointment.
- Some participants had been given a health check by their GP and conditions such as high cholesterol had been improved, however others didn't know what this was.
- Some knew what diabetes was as it was common in their country, others did not understand this condition.
- Project worker felt that things happen to this group of people/barriers are there in accessing services which aren't there for others.
- None of the participants had access to a computer and some didn't even have a TV (depending on where they were living)
- Asylum seekers may be sharing rooms with others who have nightmares which affects their mental health, rooms may also be damp and they can also have fleas.
- Comments from project worker – Asylum Seekers need support workers to help with other issues including health. Someone they trust and have confidence in talking to. This person also needs to be someone who knows systems and aware of guidelines/procedures for asylum seekers.

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8. Acknowledgements

Citizens Advice Bureaux
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Gateshead Healthwatch
Gateshead Housing Company
Gateshead Muslim Society
Gateshead Peace of Mind
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GemArts Gateshead
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Gateshead Council

Health and Lifestyle Survey 2016

Feeding back to you

Why we consulted

Good health is important for happiness and a general feeling of well-being. A healthy population is in a better position to enjoy life, to live longer, to be more productive and to contribute towards economic growth. Conversely, poor health can have a negative impact on life, can affect life chances, and can put a strain on health services. The Council is responsible for providing public health services, and this survey was designed to explore attitudes to making healthy lifestyle choices, future areas of health promotion and to identify inequalities in health.

When we consulted

Phase one: 16th March – 30th April 2016
Phase two: 1st November – 18th December 2016

How we consulted

The consultation was run exclusively with Viewpoint ONLINE members using the Council's online consultation portal.

Feedback

The survey was run in two phases. Phase one was completed in April 2016 at which point the survey had been completed by 628 Viewpoint ONLINE members. The second phase was completed by a further 253 members in December 2016. The total number of Viewpoint ONLINE members taking part was therefore 881. The data has been weighted by the respondents' characteristics of age, gender and ethnicity. The reason for weighting the data is so that the survey results better represent the views of the entire population of Gateshead. Note, in some instances figures may not sum due to rounding.

General health and fitness

73% of respondents said they were in good or very good health, with a further 20% who said their health was fair. 7% said they were in poor or very poor health (This compares to the Census 2011 data for Gateshead of 77% in good health, 15% with fair health and 8% in poor health). The perception of being in poor health increases with age. For example, only 2% of those aged under 35 said they were in poor health compared to 15% of those aged 65 and over – that's more than twice as high as the average. Respondents who don't get the recommended level of exercise (150+ minutes per week) and those who have excess weight are significantly less likely to say they have good health than on average (61% and 64% respectively vs 73%).

In good health

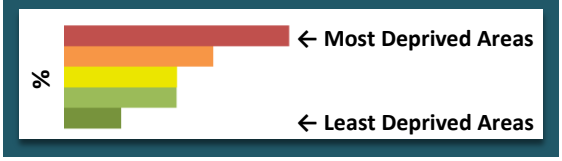
Although 73% said they were in good health, only 64% thought they were fit. Respondents who smoke, who do not get the recommended level of exercise or who have excess weight are significantly less likely to feel fit than on average (37%, 40% and 51% respectively vs 64%). The perception of fitness differs by gender, with 41% of women saying they feel unfit, compared with 31% of men. Interestingly, there is an indication (though not definitive) that men may feel less fit as they grow older, whereas women are the opposite and actually feel fitter the older they get. This may reflect that the data indicates more women get the recommended level of exercise (150+ minutes per week) the older they get, whereas less men do (although again this is indicative only). Overall, 73% of our respondents get the recommended level of exercise. This is much higher than the 46% reported for Gateshead in the national 2015 Active People Survey. Respondents who smoke are significantly less likely to get the recommended amount at 52%. This may be linked to known factors affecting smokers such as decreased lung capacity and poorer blood circulation which leads to less energy.

There appears to be a social gradient linked to getting the recommended level of exercise (150+ minutes per week). Respondents living in the 20% most deprived areas (based on area classification by Index of Multiple Deprivation 2015) are more likely to get the recommended amount of exercise than those in less deprived areas, and in particular are significantly more likely than those in the 40% least deprived areas (80% compared with 64%).

What is a 'social gradient'?

Some results from the survey may show a 'social gradient' which means that people living in the most deprived areas e.g. low income areas, are more likely to have a particular lifestyle behaviour than those from less deprived areas.

For example the chart below shows that respondents are more likely to smoke if they live in the most deprived areas (the red bar) and less likely to smoke the less deprived the area they live in.

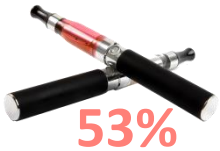


Smoking and E-Cigarettes

Only 9% of respondents said they smoke regularly or occasionally. This is very low when compared with national smoking prevalence surveys and suggests that the Viewpoint Panel is biased towards non-smoking. For example, the 2015 Annual Population Survey estimated Gateshead's smoking population was around 18%. A further 33% said they used to smoke but do not smoke at all now. These figures are a positive reflection of our current priority to reduce the harmful effects of tobacco.

Thinking about or trying to stop smoking

Young people are more likely to smoke than older ones, with 12% of those aged under 35 currently smoking, compared with 3% of those aged 65 or over. There is also a significant 'social gradient' for smokers, with a gap of 11 percentage points between those living in the most and least deprived areas.



of e-cigarette use is to help stop smoking

When those who did smoke were asked how they felt about it, exactly half are thinking about or actively trying to stop smoking at the moment. This is particularly evident in younger people with 64% feeling that way, compared to just 9% of those aged 65 or over.

Just 5% of respondents use e-cigarettes. As with smoking, there is a social gradient, with those in the 20% most deprived areas more likely (9%) to use e-cigarettes than those in the 20% least (1%) or 40% least (2%) deprived areas.

Half (53%) of e-cigarette users are doing so to help them stop smoking cigarettes completely and a quarter (24%) to reduce the amount they smoke. 36% said they used e-cigarettes to reduce harm to themselves from smoking and 20% to avoid harming others around them. 30% said they just wanted to give it a try and 25% wanted to save money compared with smoking.

Alcohol

90% of respondents drink alcohol, but younger people under the age of 35 are significantly less likely to drink weekly or more often at just 32% compared with 62% of those between the ages of 35 and 64 and 67% of those aged 65 or over. Men, are significantly more likely to drink weekly or more often than women, and this is particularly the case for those aged 65+, with 82% of older men drinking that regularly compared with 47% of older women. There is a social gradient evident in those who drink weekly or more often, with those in the 20% most deprived areas significantly less likely to do so (39%) than those in the 40% least deprived areas (71%).

7% of respondents drink alcohol on five or more occasions every week. Again, the profile of these drinkers tends to be older people and in particular older men, with one in five (21%) men aged 65 or over drinking 5 or more times a week.

Are increasing or higher risk drinkers

Based on the amount of alcohol drunk in a typical week, the drinking patterns of our survey respondents mean that one in four (27%) are what's known as 'increasing or higher risk drinkers', that is they are drinking more than 14 units of alcohol every week – the equivalent of 6 pints of average strength beer or 10 small glasses of low-strength wine (This compares to an average figure for Gateshead of 38% recorded in the Health Survey for England 2011-14).

34% of respondents are 'binge drinking', that is drinking 6 or more units for women or 8 or more units for men on a single occasion in the last week – 6 units is the equivalent of just over two large glasses of 13% strength wine and 8 units is just over three pints of 4% strength beer (This compares to an average figure for Gateshead of 28% recorded in the Health Survey for England 2011-14). The survey results show that it is those aged 35 to 64 who are more prone to binge drink, and in particular men of that age, with 49% binge drinking. Studies have found that people who smoke are much more likely to drink alcohol than those who don't. Our survey found that 52% of smokers binge drink compared to the average of 34%.

The majority of people (57%) said they were drinking about the same amount as they were 12 months ago, but 38% were drinking less and only 6% were drinking more.

Diet

Fruit and vegetables are a vital source of vitamins and minerals and should make up just over a third of the food we eat each day. It's recommended that we eat at least five portions of fruit and vegetables every day. Pure fruit juice does count, but regardless of how many glasses you drink, the

Have 5+ fruit and veg a day

current guidelines say that it only counts as one of our five a day. Just under half (48%) of respondents are eating 5 a day (This compares to an average figure for Gateshead of 48.5% recorded in the Active People Survey by Sport England for 2015). A further 38% are close, eating 3 to 4 portions a day. 11% have 1 or 2 portions and just 4% say they have none (although this means 1 in 25 people do not have any fruit or veg on a typical day). Indicatively, women are more likely to have 5 a day than men, and this is definitely the case for older women aged 65 or over. 73% of older women have 5 a day, which is significantly higher than any other age and gender group. In comparison, only 44% of older men have 5 a day. Respondents who get less than the recommended level of exercise and those who smoke are significantly less likely to eat 5 a day than on average (32% and 33% respectively vs 48%).

Eat takeaways at least once a week

One in five (20%) of respondents said they eat takeaways once a week or more often, 70% eat them a couple of times a month or less often, and 10% never eat takeaways. Working age people are far more likely to eat takeaway food weekly or more often (24% aged under 35 and 22% aged 35 to 64) than those aged 65 or over (6%). In fact, 31% of 65 or overs said they never eat takeaways, compared with 9% aged 35 to 64 and 2% aged under 35. Respondents who eat less than 5 fruit and vegetables each day are significantly more likely to eat takeaways once a week or more often (30% vs 20%).

Of those who do eat takeaway food, more usually choose to collect it from the takeaway premises, at 43%, than who would usually have it delivered, at 31%. A further 25% sometimes collect it, but sometimes have it delivered. Those who live in less deprived areas are more likely to collect takeaway food, for example only 34% of those in the 20% most deprived areas collect compared with 52% in the 20% least deprived areas. This is useful information as Public Health England's "Healthy people, healthy places briefing - Obesity and the environment: regulating the growth of fast food outlets" points to the strong association between deprivation and the density of fast food outlets, with more deprived areas having a higher proportion of fast food outlets per head of population than others.

Weight and Body Mass Index (BMI)

Based on the height and weight measurements provided by survey respondents it is possible to calculate a Body Mass Index (BMI). A BMI above the healthy weight range or too much fat around your waist can increase your risk of serious health problems like heart disease, type 2 diabetes, stroke and certain cancers.

The majority of respondents fall into the overweight or obese categories. 36% are overweight and 23% are obese. This is a combined overweight and obese proportion of 58% - figures do not sum due to rounding (This compares to an average figure for Gateshead of 69% recorded in the Active People Survey by Sport England for 2013-15). 41% are in their healthy weight zone, and just 0.3% are underweight.

58%

Are overweight or obese

The likelihood of being overweight or obese increases for men aged 35 or over. For example, 75% of men aged 35 to 64 and 74% aged 65 or over are overweight or obese compared with 40% of those under 35. Conversely, the proportion of women who are overweight and obese does not differ with age. This may link to the earlier observations that unlike women, men tend to get less exercise the older they get, drink more calorie containing alcohol and their consumption of 5 fruit and vegetables per day does not improve. Respondents who smoke are significantly more likely to be overweight or obese (73% vs 58%).

Although inequalities studies suggest that overweight and obesity is more prevalent in more deprived areas, this survey data is inconclusive.

We also asked our respondents about their own perception of their weight. Interestingly, 67% thought they were overweight, which is more than the actual proportion who are overweight or obese of 58%. Of those who are actually overweight or obese (based on the measurements they provided), 92% realised they were in that weight zone. Of those who were underweight, 80% realised they were in that weight zone. However, of those who were actually of healthy weight, only 55% realised they were in that weight zone – of the other 45% the vast majority thought they were slightly overweight.

Would like to lose weight

Following this, we asked if respondents would like to change their weight. 3 in 4 people (74%) said they would like to lose weight, 1 in 4 (24%) said they would like to stay the same and only 2% wanted to gain weight. Of those who actually needed to lose weight to reach their healthy weight zone, 92% said they would like to lose weight. Of those who actually needed to gain weight to reach their healthy weight zone, 60% said they would like to gain weight. However, of those who were actually of healthy weight, only 44% said they wanted to stay the same weight – of the other 56% the majority wanted to lose weight.

Emotional Health and Wellbeing

We asked four questions to help us understand more about our respondents' personal wellbeing. The questions asked were around satisfaction with life, happiness, anxiety and feelings of doing things that are worthwhile. The headline results from these indicators are as follows:

(Overall, how satisfied are you with your life nowadays?)	**49%** satisfied / dissatisfied **20%**
(Overall, how happy did you feel yesterday?)	**50%** happy / unhappy **23%**
(Overall, how anxious did you feel yesterday?)	**65%** not anxious / anxious **20%**
(Overall, to what extent do you feel the things you do in your life are worthwhile?)	**58%** worthwhile / not worthwhile **15%**

(Comparative figures from the national Annual Population Survey by the Office for National Statistics show that in Gateshead for 2015/16 the percentage dissatisfied was 4%, unhappy 10%, anxious 21%, and for 2014/15 not worthwhile 4%)

Across all four indicators, those aged 65 and over score better than younger people, and in particular they are significantly more likely to be 'satisfied' (62%) and 'happy' (63%).

In our survey, the lifestyle factor that appears to have the biggest impact on emotional health and wellbeing is smoking. Smokers are significantly less likely to feel satisfied with life (31%), happy (28%), or to feel that the things they do are worthwhile (31%) than on average (49%, 50% and 58% respectively). This reflects current health messages that stopping smoking can result in significant benefits to personal wellbeing. Our survey results show that getting less than the recommended level of exercise and not eating 5 fruit and vegetables each day also have a significant detrimental effect on emotional health and wellbeing.

Next Steps

The final results will be reported to the Director of Public Health and Gateshead's Health and Wellbeing Board to inform future service planning, for example as evidence for commissioning and delivering services. The results will also be used as evidence in Gateshead's Joint Strategic Needs Assessment which identifies key strategic priorities to improve the health and wellbeing of the population. The JSNA can be accessed at **www.gateshead.gov.uk/jsna**

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Gateshead Council

HEALTH AND WELLBEING BOARD
21 July 2017

TITLE OF REPORT: **A Year of Action on Tobacco and Smoking: Five by Twenty Five**

Purpose of the Report

1. To seek the views of the Health & Wellbeing Board on undertaking a "Year of Action" to highlight the harms arising from tobacco use, and what's happening in Gateshead to counteract them.

Background

2. The Annual Report of the Director of Public Health for 2015/16 focused on the harms and inequalities arising from tobacco use in Gateshead. The Report recommended maintaining momentum on action to minimise these harms.
3. In keeping with that recommendation, the Public Health team has outlined a "Year of Action" to highlight the harms arising from tobacco use, and what's happening in Gateshead to counteract them.
4. The purpose of this Year of Action is to maintain and raise the profile of the impact of tobacco in Gateshead, and to galvanise action at all levels (ie. community, organisational, sector-specific) to combat harms.

Proposal

5. The proposal is to undertake a series of monthly activities that would be used to generate press/media interest and provide a platform for the communication of key messages.
6. Key messages would include the impact on health and financial inequalities and harm reduction, encouraging people not to start smoking, protecting others from second-hand smoke, and promoting support for those wanting to stop smoking. The overall message is the desire to achieve a smoking rate in Gateshead of 5% by 2025 – "five by twenty five".
7. Activity each month would be promoted through the production of press releases, short videos and other activity that would be made available through Gateshead Council's social media and the Public Health Team's "One You Gateshead" social media channels. Suggestions for these are included in Appendix 1.
8. The impact of the "Year of Action" would be determined by information gathered from social media sources (ie. unique views, shares, likes, retweets etc), by comments received, and by changes in access to/uptake of stop smoking services.

Recommendations

9. The Health and Wellbeing Board is asked to consider the potential benefits arising from a sustained and constant campaign.

Contact: Paul Gray (0191) 4332929

Potential Partners

Potential partners who would support the “Year of Action” include

- FACT (local cancer charity)
- Mental health charities/organisations
- Secondary care providers
- Long Term Condition organisations
- Community organisations
- Schools
- Retailers
- Maternity team
- Green space interest groups
- Fresh NE
- Black, Asian and minority ethnic groups
- Trades unions
- Credit union/s
- Gateshead Advice Centre

Potential activities

Where possible, activity would link with existing national and regional campaigns promoted by PHE and/or Fresh NE. Other activity would be exclusively local and possibly based on celebrating significant achievements in the history of tobacco control:

Month	Proposed activity/activities
July	• Celebration of Ten Years of Smokefree legislation • Uplift of Fresh NE’s “Secondhand Smoke is Poison” campaign
August	• Ban on advertising cigarettes on television introduced (1965). • Interviews with retailers
September	• Labour Motion to Council • Stoptober launch
October	• Stoptober: press releases, uplift of Fresh activity.

	• "Stop or Swap".
November	• Illicit tobacco theme: "bonfire"
December	• "Burning Injustice" – tobacco poverty. Cost to social care and NHS. • Links with Credit Union/Gateshead Advice Centre
January	• Promotion of rebranded Gateshead Stop Smoking Service. • "Meet the Stop Smoking Service"
February	• Focus on maternity services and smoking in pregnancy • Interviews with community midwives
March	• No Smoking Day • Uplift for Fresh campaign "Second Hand Smoke is Poison"
April	• Smoking and mental health. • Interviews with NTW and voluntary sector staff incl. service user reps
May	• Smoking in green spaces. • Reconfirmation of Gateshead Council support for smokefree children's play parks
June	• "Die in" • "Meet the QE specialist respiratory team"
July	• Field of Celebration and Remembrance in collaboration with FACT

Item 8

HEALTH AND WELLBEING BOARD
21 July 2017

TITLE OF REPORT: BCF Quarter 4 Return 2016/17 - Follow-up Report

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Purpose of the Report

1. To update the Health & Wellbeing Board on action being taken to progress work linked to particular Better Care Fund (BCF) national conditions and metrics where the need for further progress has been highlighted within the quarter 4 return.

Background

2. The BCF Quarter 4 return for 2016/17 was on the agenda of the last Board meeting on 23rd June. However, there was insufficient time to consider the item due to time pressures linked to the Board's consideration of substantive items on its agenda.

3. At the request of VCS representatives, a follow-up report has been prepared focusing specifically on areas identified within the return where further progress is most required. In particular, the report focuses on BCF national conditions and key metrics.

BCF National Conditions

4. Work to progress each of the BCF national conditions was undertaken in 2016/17. Areas identified where further progress is most required as well as planned action is set out below:

   National Condition 4 ii) - Are you pursuing Open APIs (i.e. systems that speak to each other)? - *'No' (condition not fully met) entered in Q4 return.*

   Under progress commentary, the following was entered in the Q4 return:
   Following initial stakeholder events held in 2015, significant progress has been made to develop more robust plans for delivering information sharing between stakeholders, including across health and social care. The CCG has co-ordinated the development of the Newcastle Gateshead Local Digital Roadmap, which outlines the ambition across Newcastle Gateshead to deliver a paper free care system by 2021. Stakeholder organisations were involved in developing this joint plan which was completed in June 2016. The Newcastle Gateshead Local Digital Roadmap sets out ambition across several universal capabilities for shared information across care settings. The deployment of the Medical Interoperability Gateway (MIG) and Messaging Exchange for Social Care and Health (MESH) are key systems needed to achieve successful sharing of information between Gateshead Social Care and NHS partners.

   The local Gateshead Information Network (GIN) continues to meet regularly and covers a range of health, social care and third sector providers. Recently it has been agreed to hold joint meetings with Newcastle, to form the Newcastle

Gateshead Information Network, who will oversee the implementation of the Local Digital Roadmap. Progress has been made in provision of patient communications at a regional level, with posters, leaflets and a patient helpline for queries around information sharing going live in September 2016.

Implementation of projects to deliver this agenda continues:
Sharing of patient records from primary care to our local Mental Health provider has made progress, with engagement work currently being carried out with practices. This will involve sign up to an Information Sharing Gateway – a single portal to allow organisations to easily manage their information sharing agreements. This will provide a direct link between mental health care and GP records established at the point of direct care with the patient, using a solution called the Medical Interoperability Gateway (MIG). Information sharing is also being established for all local acute trust providers, who each have plans in place to begin accessing primary care records at the point of care (with urgent and emergency care settings being a high priority).

In addition, Gateshead and Newcastle Councils are working with Health Care Gateway (MIG supplier) and the Social Care system suppliers on an integration piece with the aim of presenting Social Care practitioners with GP record information via an agreed dataset and conversely, GPs with Social Care record information. Building on the work being undertaken across organisations to facilitate the use of the MIG into social care services, officers are considering options in terms of smaller scale pilots, which will be able to test the system; identify benefits and address any operational issues. There is a view that linking this with the existing Care Homes Vanguard work may be beneficial.

The GIN meetings bring together technical experts alongside frontline staff to discuss to map the systems currently in use across the health and social care. Through this network there will is regular discussion of how to move towards system integrations, including a working towards the Open API standards.

All NHS organisations use the NHS Number as the main identifier, all organisations have processes in place to identify and fill gaps relating to the NHS number. Usage of NHS number as the single identifier in Social Care is increasing with 90% of active social care clients in Gateshead having a matched NHS number. Work is ongoing within social care to increase this by mapping business processes and working with frontline staff to promote its use.

In the last six months, Newcastle Hospitals NHS Foundation Trust and Northumberland Tyne and Wear Mental Health Trust have both been identified as Global Digital Exemplar sites. This may present opportunities to further this area of work and this is being explored.

Planned Action:
The long term next steps are in the further development of the Great North Care Record, which is being developed at a regional level but with significant input from health and social care organisations from Newcastle and Gateshead. We will soon be able to make use of open APIs for Primary Care clinical systems as part of the national GP Connect Programme. This will provide opportunities to connect systems together in new ways.

Health & Social Care Network (formerly N3) connectivity is being explored and an initial fact finding meeting has taken place, led by the Council's ICT services. This

is as a result of the proposed co-location of the 0-19 public health nursing service and the Council Children's services. This will facilitate joint working between the Provider of the 0 to19 services and Council staff.

If HSNC is put in place, it will allow for further / easier information sharing between the Council and NHS, specifically in line with the Great North Care Record.

National Condition 4 iv) - Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights? - *'No' (condition not fully met) entered in Q4 return.*

Under progress commentary, the following was entered:
The local information networks are working with other CCGs and providers at a regional level to develop patient communications at a regional level. Posters, leaflets and a patient helpline for queries around information sharing went live in September 2016. Leaflets are available in all practices and soon in all foundation trusts.

Broad communication has happened through local media, such as the Evening Chronicle, Gateshead Council News.

Further work is scheduled to be undertaken around patient engagement and local communications to support implementation of the information sharing agenda.

Planned Action:
This is an ongoing piece of work which will need to be a regular feature of communications to the people of Newcastle Gateshead. We are currently seeking case studies to help us explain messages about data and technology in ways which are relevant to our population and professionals. These may include patient stories or views of frontline staff. Locally, we will make use of channels such as Council news, social media as well as through practices.

The next step is to develop a clearer plan in relation to communications which will happen at a local level to complement communications from the regional Great North Care Record level.

National Condition 6) - Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans. - 'No' (condition not fully met) entered.

Under progress commentary, the following was entered:
Newcastle Gateshead has well established governance arrangements supporting 'Better Care'. There is joint ownership across both Health and LA commissioners and providers to lead on the development and implementation of the plans.

Ongoing discussions around service redesign with a shift in 'closer to home' provision are transparent and as such implications for acute and non-acute providers both in Health and Care are understood. A shift in the 'national conditions' to explicit funding to support community health (including social care) underpins the ethos to Better Care, coupled with ring-fenced investment.

The current governance arrangements in 'Better Care' and wider system contractual and planning discussions (STP development) have enabled us to collectively understand the consequential impact on providers of our strategic plans

and sign off is undertaken in the Accountable Officers Forum; this being a meeting of all of the NHS and LA Chief Executives in the health and social care economy.

Planned Action:
As a Care Home Vanguard Programme, we are currently identifying what developments will be completed and what will be progressed further at the end of the Vanguard period. In particular, we are focusing on taking the learning from providing enhanced care to older people living with frailty in care homes to their own homes. This already involves much of our BCF initiatives and will continue to be improved upon whenever necessary.

National Condition 7) - Agreement to invest in NHS commissioned out-of-hospital services. - *'No' (condition not fully met) entered.*

Under progress commentary, the following was entered:
Through the STP process, there is a recognition that investment in Out of Hospital services is fundamental to sustainability of the whole system; therefore, modelling and redesign will prioritise what level of investment is required to deliver this shift. Following submission of the STP on 21st October, workshops took place to start to agree the Out of Hospital model for the STP footprint and representatives from health and social care have been involved in this key piece of work. Recognising the link to the 'Optimal use of the acute sector' workstream, the Mental Health and Upscaling Prevention, Health and Wellbeing workstreams, key personnel will represent their organisations across the workstreams to maintain continuity.

Planned Action:
As with the frailty developments identified above, this will involve many of our BCF initiatives and will continue to be improved upon whenever necessary. This includes a whole system integrated approach that ensures the voluntary care sector is also appropriately involved.

Supporting Metrics

5. The quarter 4 BCF return either reported 'no improvement in performance' or 'on track for improved performance, but not to meet full target' for the following metrics:

Estimated diagnosis rate for people with dementia – *'On track for improved performance, but not to meet full target' was entered.*

Under progress commentary, the following was entered:
Final end of year performance for 2016/17 was 69.9% which is marginally short of the trajectory of 70%. Last year's full year performance was 69.2% so there has been an improvement in year.

Planned Action:
It is understood, however, from a clinical audit completed as part of the Care Home Vanguard Programme that around 7% of care home residents are likely to have dementia but are not yet formally diagnosed. As a result a bespoke diagnosis pathway has been developed in order to address this.

Delayed Transfers of Care (DTOC) – '*No improvement in performance' entered.*

Under progress commentary, the following was entered:
Total delayed days for 2016/17 was 6,372 against a trajectory of 3,330. The plan for the year has therefore not been achieved. There appears to be a range of issues that are contributing to the lack of improvement in performance in delayed transfers, which we will be reviewing as a matter of urgency. This will include an analysis of the patient profile of this cohort.

Planned Action:
Work has been undertaken between the Council and the Trust to ensure that there is a coordinated and agreed approach to DTOC (as analysis identified that there had been some changes to recording, which had not been agreed across the system).

The CCG, LA and Trust worked together during the winter period to develop a different approach to facilitating home care packages from hospital. This was piloted as the "bridging service", and is in the process of being evaluated. The high level feedback, however, was positive and we are looking to develop a longer term model, through the improved Better Care Fund.

Patient/Service User Experience metric – *'On track for improved performance, but not to meet full target' was entered.*

The relevant patient/service user experience metric was 'Improve the percentage of patients who responded "Yes Definitely" to the following question from the GP patient survey:
"For respondents with a long-standing health condition: In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health"

Under progress commentary, the following was entered:
Aggregate results for the GP practice surveys conducted mid-year between July and September 2016 show that 43.8% of patients registered with a Gateshead practice answered 'Yes, Definitely' to the question in the last 6 months have you had enough support from local services or organisations to manage your long term condition. If this continues, the 2016/17 target of 48% will be missed but it is an improvement on the previous score at the end of 2015/16.

Planned Action:
In 2017, NG CCG in partnership with their key stakeholders have developed a Long Term Condition Strategy which seeks to improve care delivery and self-management of LTCs right across disease progression from diagnosis to end of life, including a specific focus on frailty.

Reablement – 'No improvement in performance' entered.

Under progress commentary, the following was entered:
The indicator value for quarter 4 of 2016/17 stands at 80.8% (147 out of 182) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later, for the 3 month period January to March 2017. The value is lower than the same period last year, which was 85.6% (184 out of 215) and is also below the challenging target of 87.5%.

We are aware that performance has deteriorated, and are taking actions to address this. Examining the data we can see:

- 13% of people had died – this represented the fact that we had accepted people with limited life expectancy onto the service, in order to meet urgent need and facilitate appropriate discharge from hospital.
- There were a number of people who had experienced a significant health change, post discharge (such as CVA), and as such their health and social care needs were very different.
- Some people accessed the service as a means of preventing an admission to hospital; their needs then deteriorated and they were admitted, so there is a need to consider whether these were appropriate referrals in the first place.
- The age of the people accessing the service was considered, with 41% being over 85 years of age, 42% between 75 and 84 and 17% were aged 65 to 74. The mean age for someone accessing a reablement / rehab service is 82 years old for the 3 month reporting period.

Planned Action:

Going forward, where there is a requirement to provide urgent support (e.g. to support discharge from hospital or end of life care) and only the reablement service can provide this, we will look to make sure that such referrals are not recorded as reablement, as they are not truly reflective of the service and therefore should not be counted as such.

From the analysis of those people who were admitted to reablement in order to prevent a hospital admission but subsequently deteriorated and were then admitted to hospital, we will ensure that the lessons learned from the analysis are developed into an action plan.

Within any changes, we need to balance our approach in order to prevent a situation occurring whereby the system becomes risk averse and does not accept referrals from those people with higher level needs.

Proposal

6. It is proposed that the Board note the action being taken to progress areas of work linked to the BCF set out in this report. The BCF submission for 2017-19 will also set out plans to progress these areas of work which will be coming to the Board in September.

Recommendations

7. The Health and Wellbeing Board is asked to note the progress update set out in this report.

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