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This first page is intended to be a short Exec Summary of the Chapter and should be no more than 1-2 sides

Introduction

The right to life is probably the most fundamental of human rights. Life expectancy measures the average number of years an individual can expect to live from birth in a given population. In the last ten years there have been noticeable improvements in life expectancy of almost three years for both men and women in Sunderland. In recent years, however, the rate of improvement in male life expectancy in Sunderland has slowed down.

A recent North East Public Health Observatory briefing identified that in 2008-10 life expectancy in Sunderland was significantly worse than the England average. For males this was 76.3 years compared with 78.6 nationally while for females it was 80.6 compared with an England average of 82.6. The gap between life expectancy in England and life expectancy in Sunderland was 2.3 years for men and 2.0 years for women

The Human Rights and Equality Commission identify the three greatest inequities in relation to life expectancy as the poorer life expectancy of men, the different life expectancy in different parts of the country and the relationship between social and economic disadvantage and poorer life expectancy. Within Sunderland this is reflected in inequalities within the city. Recent analyses have identified ten neighborhoods in Sunderland that have significantly poorer life expectancy than the Sunderland average. These are the City Centre, Hendon, Hetton Downs & Warden Law, Marley Potts, the Port & East End, Southwick, Success, Thorney Close, Thornhill and Witherwack.

The Marmot Review identified a number of social determinants which increase inequalities in life expectancy across the life course. The report identifies six key objectives to reduce health inequalities caused by these determinants. These are: -

- Give every child the best start in life
- Enable all children, young people and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Ill health prevention
- Create and develop healthy and sustainable places and communities.

To see a sustainable improvement in life expectancy for all of the population, including a reduction in inequalities, the wider determinants of health need to be addressed with a major focus on achieving the best start in life to break the cycle of health inequalities.

Ill health prevention is identified as a key component of addressing health inequalities, having an impact in the medium term. Locally, smoking, alcohol and obesity have the greatest impact on the development of disease that leads to poor life expectancy. Sunderland has higher levels of all three of these health damaging behaviours.

There are a number of diseases that lead to premature mortality in Sunderland. For years of life lost before the age of 75, the major causes of death are cancers (35.5%) and circulatory diseases (20.1%). When the life expectancy gap between Sunderland and England is considered three groups of diseases have the biggest impact: cancers,

circulatory diseases and respiratory diseases. These account for 20%, 36% and 25% respectively of the gap for men and 25%, 17% and 21% for women.

Key issues and gaps

For life expectancy in Sunderland there are three key issues: -

- The overall life expectancy gap between Sunderland and England
- The poor life expectancy of men
- The impact of social and economic disadvantage which leads to inequalities within Sunderland.

Although there is a recognition across organizations in Sunderland of the importance of many of the wider social and economic factors that impact on health throughout life (e.g. positive early years, educational attainment, skills, work and lifestyle choices or poor coping strategies that impact on health) the continued poor outcomes would suggest that there needs to be new approaches to addressing these issues.

For those who have made poor lifestyle choices, particularly in relation to tobacco, alcohol and obesity, there needs to be comprehensive early identification, treatment and support to enable healthier choices to be made – this needs to be available to all, particularly those segments of the population at highest risk.

For those who are at high risk of or who have developed cancer, circulatory diseases or respiratory diseases, there needs to be comprehensive programmes to identify them and provide treatment and support. Again the approach should be systematic, address variation between providers of services and target those at greatest risk.

Recommendations for Commissioning

- Ensure that all commissioned services that impact on life expectancy target men to ensure equity of access.
- Ensure that all commissioned services that impact on life expectancy target those neighbourhoods identified as having significantly poorer life expectancy.
- Undertake a health impact assessment in relation to all newly commissioned services to ensure that service developments do not inadvertently reduce life expectancy or systematically increase the gap in life expectancy between different populations and opportunities to improve health are not missed.
- Ensure that regular equity audits of services are undertaken to provide assurance that services are accessed in line with need.
- Continue to commission a range of evidence-based prevention and treatment services in relation to tobacco, alcohol and overweight/obesity
- Commission a range of evidence-based CVD, Cancer and COPD services to address prevention, early identification, treatment and rehabilitation and improve healthy life expectancy.
- Commission and evaluate a range of interventions to tackle some of the wider determinants of health.

1) Who's at risk and why?

In the last ten years there have been noticeable improvements in life expectancy of almost three years for both men and women in Sunderland. In spite of this, however, average life expectancy in Sunderland is consistently poorer than the national average. It could be argued, therefore, that most, if not all, of the Sunderland population is at risk. There are, however, some specific groups who are at an increased risk of dying prematurely when compared with the rest of the population.

Men consistently have poorer life expectancy than women. This reflects, to some degree, the national and international picture. In recent years, however, the rate of improvement in male life expectancy in Sunderland appears to have slowed down which does not reflect trends elsewhere in the country. This has impacted on progress towards a target to achieve a 10% reduction in the life expectancy gap between England and Sunderland among both males and females between 1996 and 2010. Between 1995-97 and 2007-09 there was a 31% increase in the gap for males and an 8% reduction in the gap for females. The gap among females is very close to the trajectory required to reach the 10% reduction by 2010. From this it is clear that generally men are at greater risk of early death than women. In Sunderland the inequality is greater and the relative position of men has worsened in recent years.

Over the last 30 years there has been a series of national reports that have provided compelling evidence of the strong link between social and economic disadvantage and poor health outcomes, including life expectancy. The most recent of these, the Marmot Review, identifies the way in which experiences throughout the life course result in the poorest health outcomes for the most disadvantaged members of society. There is a clear social gradient to life expectancy which has also been identified by the Equality and Human Rights Commission with members of professional groups living significantly longer than unskilled manual workers. Locally, the impact of this gradient can be seen in the large variation in life expectancy experienced between some of Sunderland's neighbourhoods.

Recent analyses have identified ten neighborhoods in Sunderland that have significantly poorer life expectancy than the Sunderland average. These are the City Centre, Hendon, Hetton Downs & Warden Law, Marley Potts, the Port & East End, Southwick, Success, Thorney Close Thornhill and Witherwack. The scale of the variation is clear from the difference in male life expectancy of 23 years between the Port and East End (68.3) and Fatfield & Mount Pleasant (91.4).

The Marmot review identifies that experiences beginning before birth and continuing through the early years and on to school and working years lead to poorer health outcomes. These outcomes are caused by multiple factors including poorer educational attainment and lifelong training, higher levels of unemployment, poorer work with lower levels of safety and/or less control, poverty and a lack of sustainability of both place and communities. These often lead to poor individual and community resilience which tend to be a feature of unhealthy lifestyles and risk-taking behaviours such as smoking, unsafe alcohol consumption and obesity. Therefore, although it is possible to identify the direct causes of premature mortality that lead to the poorer life expectancy Sunderland, it is only by tackling the poorer life experiences that we will see sustained reductions in health inequalities that will lead to better health outcomes for all.

Tackling the wider economic and social determinants of health is critical for sustained reductions in health inequalities. There are, however, many people living in Sunderland today who already have developed behaviours which are likely to significantly reduce their life expectancy. If we are to see improvements in length of

life in the short to medium term then we need to address these issues too. In particular, tobacco, drinking unsafe levels of alcohol or being overweight or obese, while having a complex range of causes, have a high impact on the development of disease that leads to premature death.

Around 80% of lung cancer deaths in the UK are caused by smoking while overall it is estimated to be responsible for more than a quarter of all cancer deaths. Smokeless tobacco also increases the risk of a number of cancers, including oral cancer. Mortality from Coronary Heart Disease (CHD) is 60% higher in smokers and in 2000 about 1:8 deaths from CVD were attributed to smoking in the UK. Smoking is also the main risk factor for COPD. Estimates of the proportion of COPD cases caused by smoking ranges between 50% and 70%.

Alcohol consumption also increases the risks of developing cancer. As would be expected, long-term heavy alcohol consumption increases the risk of liver cancer with a three to six-fold risk increase in the heaviest drinkers. Alcohol also, however, increases the risk of a number of other cancers including cancer of the bowel, breast, larynx, liver, oesophagus, oral cavity and pharynx. Smoking and drinking in combination increases the risk of cancer of the oesophagus, oral cavity, pharynx and larynx up to eighty-fold. Heavy drinking also increases the risk of hypertension which in turn is a risk factor for CVD. Heavy drinking increases the risk of all types of stroke. Men who drink five or more units a day have been shown to be twice as likely to die from a stroke as those who don't.

Overweight and obesity is a significant risk factor for a number of cancers. For example, for obese women, the risk of developing endometrial cancer increases by two to four-fold. Obesity also increases the risk of breast cancer in post-menopausal women by up to 30%. For men, the risk of colon cancer increases by about 25% in overweight men and about 50% in obese men compared to men with a healthy bodyweight. Obesity also increases the risk of CVD. Those with central obesity have over two times the risk of a heart attack.

The sum of people's life experiences can result in the development of diseases that lead to premature mortality. When years of life lost before the age of 75 are considered the following are identified as the major causes of death in Sunderland: -

- Cancers (35.5%)
- Circulatory diseases (20.1%)
- Accidents (6.6%)
- Suicide and injury undetermined (5.1%).

.When the life expectancy gap between Sunderland and England is considered it is not, therefore, surprising that two of these diseases, cancers and circulatory diseases, dominate the analysis, together with respiratory diseases.

These are all chronic diseases and so will impact not only of length of life but also the quality of life experienced. Once disease has been identified, these negative impacts can be minimized with appropriate disease management.

There are many factors involved in the development of these diseases. Some, such as age, race or genetic predisposition, are difficult to modify. Others are modifiable and have a major impact on the development of disease.

In summary, the majority of people in Sunderland are at risk of having a shorter life expectancy than the national average. There are however, some specific groups within the population who are at greater risk. These are: -

- Men living in most areas of the City;
- Those people living in the following neighbourhoods: City Centre, Hendon, Hetton Downs & Warden Law, Marley Potts, the Port & East End, Southwick, Success, Thorney Close Thornhilland Witherwack;
- People who have specific vulnerabilities to poor health due to the wider social determinants of health, environmental factors, existing health conditions or disabilities or a genetic predisposition. Although some of these people may be more difficult to identify, ensuring that commissioned services take these factors into account means that a range of vulnerable groups are provided for;
- Those who make unhealthy lifestyle choices especially those who smoke, drink unsafe levels of alcohol or who are overweight or obese.
- Those who have, or are at high risk of developing, CVD, Cancer or COPD.

2) The level of need in the population

A recent briefing by the North East Public Health Observatory identified that in 2008-10 life expectancy in Sunderland was significantly worse than the England average. Male life expectancy in Sunderland was 76.3 years compared with 78.6 nationally while females lived, on average, until the age of 80.6 compared with an England average of 82.6. The gap between life expectancy in England and life expectancy in Sunderland was, on average, 2.3 years for men and 2.0 years for women. Life expectancy in Sunderland was also poorer than the north East average of 77.2 years for men and 81.2 years for women.

The Equality and Human Rights Commission has identified the national variation in life expectancy by socio economic group. This is detailed in the table below.

	Life Expectancy at Birth 2001-05	
	Males	Females
Professional	80.0	85.1
Managerial & technical	79.4	83.2
Skilled non-manual	78.4	82.4
Skilled manual	76.5	80.5
Partly skilled	75.7	79.9
Unskilled	72.7	78.1

Although now quite out of date, the 2001 Census identified that in Sunderland 16% of people of less than pensionable age were in unskilled occupations compared with 14% in the North East and 11% nationally. Conversely, the percentage in higher management and professional occupations was only half of that nationally – 7% in Sunderland compared with 14% nationally.

As described in the previous section, the inequality in life expectancy among different socio-economic groups means that the majority of communities in Sunderland suffer from poorer life expectancy than the national average. Only four neighbourhoods have a higher life expectancy than the England average for both men and women.

These are: Elstob Farm & Queen Alexandra Road, Fatfield & Mount Pleasant, High Barnes and Seaburn & South Bents.

A Health and Lifestyle Survey undertaken by NHS South of Tyne and Wear in 2008 demonstrated that the percentage of people smoking in Sunderland was considerably higher than the national position at 25.0% compared with 21.7% for England. Within Sunderland, of those living in the most disadvantaged areas 31.9% smoked while in the least disadvantaged areas the comparable figure was only 17.2%.

There are high levels of harmful drinking in Sunderland. The 2008 Lifestyle Survey showed that 28.3% of people drink above weekly recommended safe limits (more than 14 units for women and more than 21 for men), 38.5% of men drinking more than 21 units. Very harmful drinking is most prevalent in men with 10.8% of men drinking more than 50 units, rising to 27.2% of men aged 18-24. There are also high levels of binge drinking when compared with the national average – 31.3% of people in Sunderland drink more than 6 units for women or 8 units for men on a single occasion. This compares with 19.9% nationally.

The available information suggests that adult obesity is also more prevalent in Sunderland. Synthetic estimates show that 22.6% of adults in Sunderland are obese compared with 17.2% nationally. This is reflected in actual data from the national child measurement programme which shows that 11.2% of reception age children in Sunderland are obese compared to 9.8% nationally. In year 6 this increases to 21.1% in Sunderland compared with 18.7% nationally.

The impact of different diseases on the life expectancy gap is detailed in the table below.

	Percentage of Life Expectancy Gap	
	Males	Females
Circulatory diseases	36% (69% of which is CHD)	17% (71% of which is CHD)
Cancers	20% (37% of which is lung)	25% (57% of which is lung)
Respiratory diseases	25% (46% of which is COPD)	21% (63% of which is COPD)

Compared to England the population of Sunderland has a similar proportion of older people. 20% of the population is currently above state pension age (60 years for women, 65 years for men) compared with 19% across England and 20% across the North East. Older people use health and social care services more intensively than any other population group and so the absolute number of older people in Sunderland as well as the percentage of the total population has strong implications for the planning of health and care services.

Life expectancy is rising over time, and so the absolute size of the older population, and the size in proportion to the population as a whole, will grow. In Sunderland, it is forecast that the number of older people above 65 years of age will rise from 46,000 in 2009 to 68,000 in 2030 – an increase of 46%. The number of people in Sunderland aged over 85 years - those with the greatest care needs – will more than double from 5,000 to 11,000 over the same period. As a result of an ageing

population the numbers of people with dementia has been predicted to rise significantly by 2025. Feedback from the Action on Dementia local organisation has highlighted the importance of carers, 11% of the population in Sunderland according to the 2001 census, in an ageing population. A large proportion of whom, themselves are likely to be in poorer health and financial hardship than non-carers. This can be a particular issue amongst carers of people with dementia, with a significant number aged 65 and over who as a result have their own health problems.

Information obtained from a voluntary and community sector organisations within the City, highlighted the importance of social interaction amongst older people and the positive effect this can have on prolonging an active life.

3) Current services in relation to need

Given the impact of people's life experiences on life expectancy, it can be seen that a wide range of services commissioned by the council and the NHS have an impact on life expectancy, although there are variations in both the size and immediacy of the impact. Of greatest importance in increasing life expectancy and reducing variation in the longer term, however, are those services which address the wider determinants of health. Particularly important in reducing health inequalities is ensuring that all children have the best start in life. Equitable access to services that prevent or provide support that address the wider determinants of health will impact on overall life expectancy. In addition, they will reduce the gap between health outcomes for communities and groups of individuals who are more vulnerable to poor health and reduced life expectancy. In the current economic climate, services that address the availability of good employment and work to reduce levels of poverty are particularly crucial.

In the medium to short term, services which address the risk factors for the main diseases that lead to premature death but particularly those that address tobacco use, alcohol misuse and obesity will have greatest impact on increasing life expectancy. There is currently a comprehensive range of evidence-based prevention and treatment services commissioned by the PCT to address these issues. Ensuring that these services are accessed equitably will address some of the variations in life expectancy that are described above. Given the major impact these lifestyle and behaviour issues are having on life expectancy in the short to medium term it is crucial that services addressing these issues continue to be commissioned locally.

In the short term the provision of evidence-based services identifying, managing and supporting people with cardiovascular disease (CVD), cancer or Chronic Obstructive Pulmonary Disease (COPD), particularly for the older population, are likely to have the biggest impact on increasing life expectancy.

Voluntary and Community organisations within the City deliver a number of services which help to promote and sustain healthy lifestyles. This includes;

- Nexus who work in partnership to deliver a smarter choices scheme which provides, walking, cycling and public transport as a healthy alternative to the car and also in adopting healthier attitudes/ways of living;
- Age UK, who deliver prevention services for depression, dementia, anxiety, suicide and quality of life these are all important factors, in maintaining healthy ageing;
- Hetton New Dawn, who organise and facilitate activities for older people which promote social interaction;

A range of interventions are required in order to address the complexity of increasing

life expectancy. In two areas of Sunderland, Washington and the West, a partnership between the Area Committees and the TPCT has led to a programme of *Sunderland Health Champions*. The programme has been developed to have a more integrated approach to increasing life expectancy and reducing health inequalities. The programme trains front line staff and volunteers of the council and its partners in the main health issues in Sunderland and in some of the determinants of health. The five training modules give a basic understanding of health improvement with specific training in smoking and alcohol as well as emotional health and resilience and addressing financial issues. This is an innovative approach which will be regularly evaluated to add to the evidence base on addressing health inequalities.

4) Projected service use and outcomes in 3-5 years and 5-10 years

Nationally, life expectancy is expected to increase over the next ten years. The ONS 2010-based period and cohort life expectancy tables identify the scale of this as detailed in the table below.

	2005	2010	2015	2010
Male Period Life Expectancy				
At birth	77.2	78.8	80.0	81.2
At age 65	17.1	18.3	19.4	20.3
Female Period Life Expectancy				
At birth	81.5	82.7	83.7	84.8
At age 65	19.8	20.9	21.8	22.7

Source: Office for National Statistics

Nationally, male life expectancy has seen the greatest increase in the last 25 years due to faster improvements in male mortality rates than female mortality rates in recent years. The projections above are based on a predication that the rates of improvement for males and females will converge between 2010 and 2035.

As mentioned in previous sections, this increase in male life expectancy has not been entirely reflected in Sunderland. While there has been a closing of the female life expectancy gap between Sunderland and England, the male gap has actually increased from 1.7 years in 1995-97 to 2.4 years in 2007-09. As a result, if the life expectancy gap is to close there will need to be continued significant investment in services which address smoking, alcohol and obesity and the early identification and treatment of cancer, CVD and COPD. Further details are included in the specific profiles addressing these issues.

5) Evidence of what works

There is a range of evidence as to what works to reduce mortality and increase life expectancy. These range from intervention in relation to prevention, identification of early disease and treatment of established disease to interventions that consider the wider determinants of health. All of these interventions are required if we are to see a sustained improvement in life expectancy in Sunderland.

The Marmot Review, *Fair Society, Healthy Lives* identified a number of social determinants which increase inequalities in life expectancy.
<http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf>

In addition to ill health prevention as described above, the report identifies five key objectives to reduce health inequalities caused by the social determinants of health.

These are: -

- Give every child the best start in life
- Enable all children, young people and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities.

The report introduces the concept of “proportionate universalism.” This recognizes that most of the population suffers from health inequalities but that some communities suffer much more than others. Resources should, therefore, be focused proportionately on those communities where need is greatest. In Sunderland, there are very few people who have health needs that equate to the best nationally and so it is helpful to consider this principle when addressing need.

There is a growing body of evidence of effective interventions in relation to services to support stopping smoking, reducing alcohol misuse and reducing levels of overweight and obesity in populations. This evidence is incorporated into NICE guidance which is regularly reviewed as part of service evaluations. Again, services should be equitable with communities, including communities of interest, accessing services in line with need.

The table below describes a range of interventions in relation to prevention, identification and treatment of diseases that contribute most to reduced life expectancy. It also describes their potential impact on the life expectancy of the population.

Intervention	Factor addressed		
	Potential impact	Timescale	Certainty
Ca Awareness/prevention	3		3
Ca Screening Programmes	3	1	3
Ca early recognition and referral	3	2	3
Obesity treatment in Adults nonsurgical	3		2
tobacco control	3	2	2
CVD -disease mgt of symptomatic individuals	3	3	2
Obesity treatment in Children- nonsurgical	3		2
Obesity Prevention	3		1
hypertension treatment (asymptomatic)	2	2	3
COPD - smoking & hypertension and cholesterol screening	2	2	3
Hypertension management in asymptomatic individuals	2	3	3
Including more people in AF, diabetes, COPD in disease mgt	2	3	3
Patients with TIA referred for investigation	2	2	3
Disease management of stroke/ TIA patients	2	2	3
Anticoagulant therapy for AF patients over 65	2		3
COPD -treatment with inhaled corticosteroids,	2		3
NHS Health Checks (assuming 75% over 5 years)	2	2	2
nonsurgical Obesity symptomatic Adults	2	1	2
Reducing blood sugars(HbA1c) over 7.5 by one unit	2	2	2
Systematic cardiac rehabilitation programmes	2	2	2
surgical obesity intervention- adults	1	3	3
promote stop smoking service	1	2	3
Treatment for a heart attack- PCI for heart attack	1	2	3
Cancer Waiting Time targets	1	3	2
Stroke management on stroke unit	1	2	2
Ca Peer review (MDT planning etc)	1	3	1

As can be seen, a wide range of interventions are required to develop sustained impact on life expectancy. The following table identifies specific numbers of deaths that can be averted if evidence-based interventions are implemented consistently.

Intervention	Achievable number of averted deaths in one year*		
	Males	Females	Total
Cardiovascular disease			
Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with a previous CVD event			
CHD deaths averted	76	51	127
Stroke deaths averted	28	39	66
Additional treatment for hypertensives with no previous CVD event			
Additional hypertensive therapy	35	42	77
Adding a statin to treatment	19	18	37
Treatment for heart attack			
Primary angioplasty (PCI) for heart attack	3	2	4
Anticoagulant therapy (Warfarin) for all patients over 65 with atrial fibrillation			
Stroke deaths averted	8	15	23
Diabetes			
Reducing blood sugars (HbA1c) over 7.5 by one unit	14	5	19
Chronic obstructive pulmonary disease (COPD)			
Treatment with inhaled corticosteroids for all patients	21	40	61
Harmful alcohol consumption			
Brief intervention for 10% of harmful drinkers	2	1	3
Total	205	212	417

*Possible reduction in the number of deaths compared to the average number of deaths each year from 2005-07

These interventions alongside a sustained strategy to address the wider social and economic determinants of health should lead to significant improvements in life expectancy.

6) User Views

In July 2010, a Sunderland TPCT Local Engagement Board asked local people the following question: -

Whilst working to improve health overall how do we target additional resource and effort where life expectancy is lowest in Sunderland?

There were a wide range of responses. Some identified the importance of the wider determinants of health: -

Create more working opportunities

Regenerate the most deprived areas.

Many, however, identified the importance of lifestyle issues and the need to address them in a more integrated way, building on networks already in place: -

People know that they are unhealthy but don't know what to do about it

Educate, motivate and support

Challenge people's dependency – helping people to help themselves

Go where the people are

Volunteers and community groups need to know who and where to signpost people to – a coordinated and joined up approach working together with all partners

Passing knowledge onto those who have the relationship built

Infrastructure to support peer education and support

7) Equality Impact Assessments

The Equality and Human Rights Commission undertook an assessment of equalities in relation to life expectancy in 2010 in the report *How Fair is Britain*. The commission identified the greatest inequalities in relation to life expectancy as follows: -

- differences between different parts of Britain
- differences between men and women and
- differences between members of different socio-economic groups.

The impact of these inequalities has been discussed in relation to the local picture above and actions to address these differences have been identified.

There is an absence of local data in relation to the other characteristics and so the remainder of this section is based on the findings identified in *How Fair is Britain*.

Disability

There is no information available locally on the impact of disability on life expectancy due to information not being collected through the death certification process. Research suggests, however, that people with learning disabilities have a shorter life expectancy than the general population, with one study in the 1990s having found that people with learning disabilities are 58 times more likely to die before the age of 50 than the general population. A second study in 2009 based on a small sample of people with learning disabilities in three counties in a region of England found the mortality rate to be over two times the average for men and over three times for women.

While these outcomes may in part link to physical health issues and disabilities experienced by some people with learning disabilities it is important to ensure that access to services is not denied to people with learning disabilities. In addition, the annual health check for people with learning disabilities may enable the early identification of some diseases.

Ethnicity

As with disability, ethnicity is not documented on death certificates. Some studies have attempted to estimate mortality rates based on country of origin data while other studies have estimated life expectancy by ethnicity based on illness rates. Although the results of these studies should be treated with caution they appear to show that men and women born in Ireland, Scotland and Africa, and men born in south Asian countries have the lowest life expectancy. It is important therefore that services including preventative services and those aimed at some of the wider determinants of health should be accessible to all in relation to both language and culture. Ethnicity

should be considered in service equity audits and equity impact assessments.

Religion/belief, sexual orientation, transgender

There is very limited research data for groups defined by these characteristics.

8) Unmet needs and service gaps

A range of comprehensive services are in place to improve life expectancy. There still, exists, however, many variations in provision and uptake in services which are not related to need and are, therefore, inequitable

For many of the wider determinants of health there is a need to assess policies and services to ensure that the potential health benefits are maximized. For example, policies which aim for new employment opportunities which are well paid and where hazards and stress are minimized and workers have more control over their working conditions may have a greater impact on increasing life expectancy than purely aiming to increase levels of employment. There is also a need to consistently adopt the principle of “proportionate universalism.” In times of budgetary pressures such a principle can help to ensure that scarce resources are focused on those in greatest need.

A comprehensive range of services relating to stopping smoking, reducing obesity and tackling unsafe levels of alcohol consumption have been developed across South of Tyne and Wear. Although the level of investment in these services needs to be sustained so that they continue to be commissioned at an appropriate level, there are gains to be made through improved integration which could improve access as well as potentially leading to greater service efficiencies. Pathways into and through these services need to be constantly reviewed to ensure that services are accessible and easy to navigate by those requiring help and support. The Health Champions programme is the first step towards achieving this but there needs to be greater integration throughout many of these services.

As with the wider determinants of health, services should be focused on being responsive to local need. Equity audits need to identify equity of access and make recommendations for reducing any inequities identified.

For those diseases are the greatest contributors to premature death or inequalities in life expectancy there are often improvements to be gained through early awareness and hence early intervention. This needs to be addressed in an integrated way, recognising that often the same populations are at greatest risk from each of these diseases and that, due to shared risk factors, individuals often suffer from more than one of these diseases. Once people begin to access services there is a need to reduce variations in diagnosis and management of these patients to ensure access to evidence-based treatment.

Most of the gaps, therefore, relate not to the need to commission new services but to reduce unexplained variation in service provision and to reconfigure services so that they are more accessible to those who need them most, particularly those living in disadvantaged communities or members of lower socioeconomic groups, the members of some BME groups and men.

9) Recommendations for Commissioning

- Ensure that all commissioned services that impact on life expectancy target men to ensure equity of access.
- Ensure that all commissioned services that impact on life expectancy target those neighbourhoods identified as having significantly poorer life expectancy.
- Undertake a health impact assessment in relation to all newly commissioned services to ensure that service developments do not inadvertently reduce life expectancy or systematically increase the gap in life expectancy between different populations and opportunities to improve health are not missed.
- Ensure that regular equity audits of services are undertaken to provide assurance that services are accessed in line with need.
- Continue to commission a range of evidence-based prevention and treatment services in relation to tobacco, alcohol and overweight/obesity
- Commission a range of evidence-based CVD, Cancer and COPD services to address prevention, early identification, treatment and rehabilitation and improve healthy life expectancy.
- Commission and evaluate a range of interventions to tackle some of the wider determinants of health.

10) Recommendations for needs assessment work

A suicide needs assessment should be undertaken following the publication of the national suicide prevention strategy in early 2012.

Key contacts

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