North East
North Cumbria
Health & Care
Partnership

Healthier and Fairer Programme Update

August 2024

Purpose of report

- The following report provides an update on progress against the health and healthcare inequality metrics outlined within the following documents, and the requirements of the NENC ICB to report progress against these.
  - NENC ICB Joint Forward Plan 23-28 ("the plan“)
  - NENC Integrated Care Partnership (ICP) ICP Better Health and Wellbeing for All Strategy ("the strategy")
  - NHS England’s statement on information on health inequalities ("the statement")
  - NENC integrated Delivery Report (“the IDR”)

- The aim is to provide an understanding of current outputs and outcomes specific to the Core20plus5 aims for Adults and CYP included within “the IDR” and to provide an update and assurance on the measures of inequality included within “the statement”. This includes an update on the project work undertaken to ‘close the gap’ for each clinical area.

- The report also provides intelligence on the healthcare challenges for the population within the most deprived communities of NENC and potential future challenges to the system

National Health Inequalities agenda

- There are three main national drivers of the healthcare inequality agenda.
  - CORE20Plus5 for adults
  - CORE20Plus5 for children and young people
  - NHS England Legal Statement

- CORE20Plus5 frameworks for Adults and Children & Young People state aims for addressing performance across 10 clinical pathways, including the narrowing of the inequality gap associated with deprivation and ethnicity, no national direction or technical guidance was provided as to how these should be measured.

- The NHSE Legal statement that was published in November 2023 and updated in March 2024 provided information on how powers should be exercised in connection with health inequalities for the period 1 April 2023 – 31 March 2025. The statement will be reviewed periodically and is expected to evolve as the ability to collect and analyse inequality data is strengthened. The statement requires NHS bodies to report the extent to which they have exercised their functions in addressing health inequalities within their annual report, which in turn enables NHS England to conduct an annual assessment of ICBs, a statutory requirement. The previous update on health inequalities was contained in the 2023/24 ICB Annual Report and Accounts

Local Strategies, reporting requirements and progress

NENC ICB Joint Forward Plan

- Longer and healthier lives; Reduce the gap between our region and the England average in life expectancy and healthy life expectancy at birth, by at least 10% by 2030.
- Fairer outcomes for all; Reduce the inequality in life expectancy and healthy life expectancy at birth between people living in the most deprived 20% of neighbourhoods and the least deprived 20% - by at least 10% by 2030.
- Better health and care services; To ensure not just high-quality services, but the same quality no-matter where you live and who you are.
- Giving children and young people the best start in life; Increase the percentage of children with good school readiness at reception, especially for children from disadvantaged groups.

Integrated Delivery Report

- Within the ICB Integrated Delivery Report (IDR) the metrics aligned with the CORE20Plus5 clinical pathway ambitions have required updating. Whilst the CORE20Plus5 frameworks for Adults and Children & Young People stated aims in addressing performance across 10 clinical pathways, including the narrowing of the inequality gap associated with deprivation and ethnicity, no national direction or technical guidance was provided as to how these should be measured.
- Within the ICB Integrated Delivery Report (IDR) the metrics aligned with the CORE20Plus5 clinical pathway ambitions have required updating. Extensive work with Programme leads has been undertaken to ensure that the aims within the framework are represented by smart, meaningful metrics within the IDR which reflect the ongoing work for each clinical pathway.
- Following the work with the Programme leads on metric development, work has taken place between the ICB Insights Team and Healthier & Fairer Analytical support with ICB Managerial, Clinical and Director leads on ensuring that the reporting of these metrics is accurate, including reporting of the inequality gap for deprivation and ethnicity (where available)
- Specific Training sessions on Inequality reporting for all analytical support was delivered
- Following the review of the INB CORE20Plus5 Plan that was submitted in June this year as a requirement of the 2024/25 Operational Planning Guidance (https://www.england.nhs.uk/publication/priorities-and-operational-planning-guidance-2024-25/), NHSE specifically tasked NENC to set targets and milestones against the identified metrics. This has occurred across the 10 clinical pathways where it was possible to do so.

Clinical Conditions Strategic Plan

Where clinical outcomes and aims are cross cutting with the ICB Clinical Conditions Strategic Plan, work on metric development has been done in collaboration with the team working on the outcomes framework for the strategy, including meeting with NEQOS colleagues to ensure alignment and the avoidance of duplication. It is expected that this will continue over the coming months as one piece of work informs the other, and vice versa. Whilst the metrics within the Clinical Conditions Strategic Plan may report clinical and population outcomes, the healthier and fairer will report the inequality gap to monitor fairer outcomes for all.

NENC Healthcare Inequalities Future plans

- Inequalities in health and healthcare outcomes continue to be experienced by our communities across most aspects of consideration within this report. These inequalities can be demonstrated against both ethnicity and deprivation measures, and whilst progress within some of the metrics demonstrate improvement in the scale of the inequalities, there remain gaps within our understanding and robust plans to address these.
- Understanding of health inequalities associated with deprivation and ethnicity will improve as data flows become more robust and using alternative sources of intelligence where data flows cannot be established will support an understanding of the NENC position. Coding within routine healthcare sets can be improved, particularly relating to the accurate capture of Ethnicity.
- There is also an opportunity to review all plans against their impact on inclusion health groups, for example, how each of the clinical pathways within the CORE20Plus5 and legal statement are experienced by people with a Learning Disability.
- A road map to 2030 exercise will be undertaken to identify and highlight how the targets and ambitions set by programme leads will be achieved by 2030
- Further developments will be made to the ‘Healthier and Fairer insights dashboard’ to enable individuals across the system to access and interrogate the various metrics included within this report.
- Local Delivery Team insight packs will be produced using the framework set out in this report. Intelligence and narrative will be produced in partnership with individuals working with the Local Delivery Teams and Public Health.

Summary

- **Longer and Healthier Lives** – Three key contributors to the inequality gap in life expectance within NENC are CVD, Cancer and 'External causes' (which includes Suicide).
  - CVD prevention metrics continue to demonstrate an improvement at population level and in the inequality gap.
  - The early detection of cancer (at stage 1 or 2) is improving in NENC but remains lower than the England average. There is inequality gap in screening but there are targets set and plans in place to reduce this.
  - The Suicide rate in has reduced for both males and females. The gap between NENC and the England average is narrowing.

- **Fairer outcomes for all** - The NHS contribution to reducing social and economic inequalities programme contributes to the delivery of fairer outcomes for all through the health literacy, poverty proofing and digital inclusion projects, working with providers to ensure access to services and patient experience is considered through a wider determinants of health lens.
  - The proportion of individuals with Serious mental illness attending their 12 month physical health check is improving and is higher than the England average

- **Better Health and Care Services** - As part of the NHSE legal Statement, inequalities within the Elective Waiting list, and Urgent Care utilisation for children and young people are considered
  - A smaller percentage of those from Ethnic minority communities are shown to be waiting 18 weeks but if they do, a greater proportion wait over 52 and 65 weeks.
  - Those from the most deprived communities are shown to have a greater proportion waiting longer than 18 weeks but not 52 and 65 weeks.

- **Giving Children and Young People the best start in life** - The aim to increase the percentage of children with good school readiness at end of reception, especially for children from disadvantaged groups is supported by the work of the Children and Young Person CORE20PLUS5 programme of work addressing access and outcomes relating to 5 clinical pathways affecting children (Asthma, Mental Health, Oral Health, Epilepsy, Diabetes) and the work of the Local Maternity and Neonatal System.
  - Inequalities remain for babies born before 37 week gestation but the slope index of inequality for NENC has reduced in the latest reporting period.
  - Data sources required to provide assurance for the CYP CORE20PLUS5 pathways requires work in partnership with the Directors and Strategic leads supporting the clinical areas.
- Considerable work has been undertaken to improve the assurance process for inequalities. This has included collaboration with ICB Managerial, Clinical and Director leads as well as the Insight and Performance team. Further work is required, and an action plan is in place.

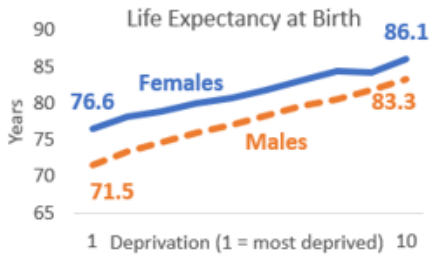
Population Overview

- 33% of the population within NENC reside within the 20% most deprived areas nationally. This is equal to approximately **1,000,000 people**. This population is what we define as the ‘core20’ population.
- The core20 population has a younger age profile compared with the overall ICB, much of this is driven by the lower life expectancy within the population.
- They are less likely to have a diagnosed long term condition, but those who do tend to have more than 2, leading to complex multimorbidity and increased need.
- The core20 population have a greater prevalence of modifiable risk factors such as smoking, alcohol use and drug misuse. Estimates also suggest the prevalence of obesity is also greater although the information held within GP records doesn’t reflect this at the moment.
- NENC have a relatively small proportion of the population with an ethnicity documented as ‘non-white’ (8%), however, within the core 20 population, 12% are of non white ethnicity. This highlights that there is a higher representation of ethnic minority groups residing within the most deprived areas.
- 35% of children in NENC are living within low income families, this has increased significantly since 2014/15 and has a direct impact on the healthy life expectancy and best start in life.
- Individuals within the core 20 population die at an earlier age but also spend a longer time in poor health, be that self-reported poor health or diagnosed illness. The national evidence suggests there is a 12 year gap between the point in which ill health becomes apparent and when major illness is diagnosed.
- The self-reported poor health (healthy life expectancy) is often influenced by boarder economic and social factors such as employment and income.
- By 2040, the number of people experiencing major illness is expected to grow, mostly driven by population growth. However, the inequalities in major illness is going to be unevenly distributed, particularly within the working age population. 80% in major illness for working age population is going to occur within the 50% most deprived communities.
- The conditions expected to contribute to the increasing health inequalities are Chronic Pain, Type 2 diabetes, Anxiety and Depression, Heart Failure and COPD. The prevalence of all these conditions may not increase but the variation in the number of people affected in the core 20 population compared with the least deprived will.

Health of the NENC population

Whole Population

Inequalities



Female **+9.5**
Male **+11.8**
Difference in Life Expectancy Between Most and Least Deprived Areas (Years)

20.8%
Gap in School Readiness Between Children Eligible And Not Eligible For Free School Meals

51% of children eligible for free school meals have not achieved a good level of school readiness

Most Prevalent Long Term Conditions (All Ages)

642,900 (21%) Have **Anxiety**

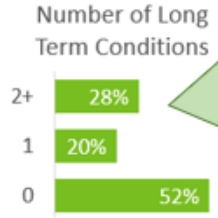
530,900 (17%) Have **Hypertension**

470,700 (15%) Have **Depression**

218,500 (7%) Have **Diabetes**

218,400 (7%) Have **Asthma**

Multi Morbidity



28% of People Live With 2 or More Long Term Conditions

Proportion of people with 2+ LTCs is **higher** in more deprived communities

Most Deprived **29%**
Least Deprived **25%**

Risk Factors

16% Are Smokers (Where Smoking Status Recorded)

38% Are Obese (Where BMI Recorded)

19% Have Increased or High Alcohol Risk (Where Alcohol Status Recorded)

Children and Young People

Most Prevalent Long Term Conditions (Aged Under 18)

23,000 (4%) Have **Autism**

23,000 (4%) Have **Asthma**

14,200 (2%) Have **Anxiety**

2,900 (0.5%) Have **Learning Disabilities**

2,100 (0.4%) Have **Epilepsy**

1,600 (0.3%) Have **Diabetes**

Obesity

12% of Children in **Reception** Are Obese

25% of Children in **Year 6** Are Obese

(Highest Rate in England)

Year 6 obesity rates are **higher** in more deprived communities

Most Deprived **40%** Least Deprived **15%**

Mental Health

31 Deaths by **Suicide** Aged 7 to 18 in NENC 2018/19 to 2022/23

Adults (figures for all ages)

Lung Cancer

93.6 per 100k Incidence of **Lung Cancer** (England 71.0)

Incidence of Lung Cancer is **higher** in more deprived communities

Most Deprived **142.3**
Least Deprived **51.8**

Respiratory

216,300 (9.5%) Have a **Respiratory Disease**

Back Pain

36,400 A&E Attendances For Back Pain In Last 2 Years

Of these:
37% have anxiety
31% have depression

60% of Adults Expected To Experience Back Pain During Lifetime (Nationally)

Anxiety and Depression (Age 18+)

Most Deprived **28%**
Least Deprived **21%**
Rates of **anxiety** are **higher** in more deprived communities

Most Deprived **23%**
Least Deprived **14%**
Rates of **depression** are **higher** in more deprived communities

Cardiovascular

616,000 (20%) Have 3+ Risk Factors For Circulatory Disease

Health of the Most Deprived 33% of NENC

Gender

Female 49.3% (484,326) — 0.5% lower than NENC overall

Male 50.7% (497,255) — 0.5% higher than NENC overall

Age Breakdown

Aged 0-19 24.5% (240,893) — 3.3% higher than NENC overall

Aged 20-64 59.7% (585,838) — 1.2% higher than NENC overall

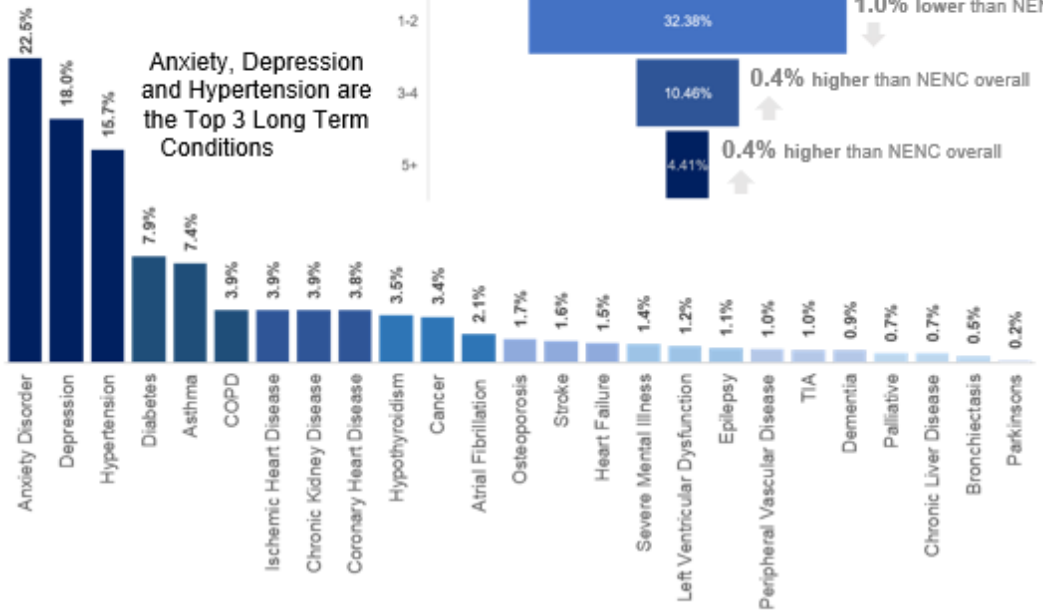
Aged 65+ 15.8% (154,882) — 4.5% lower than NENC overall

Long-Term Conditions

47.3% (463,920) have at least **1 Long Term Condition**

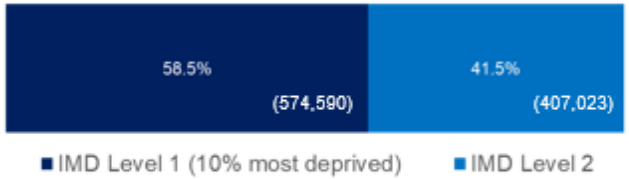
0.2% lower than NENC overall

Anxiety, Depression and Hypertension are the Top 3 Long Term Conditions

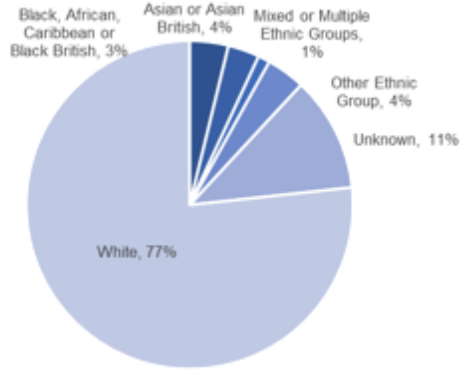


Number of Long-Term Conditions

IMD Deciles (Deprivation Levels)



Ethnicity



- **Asian or Asian British** have a **0.4%** higher representation when compared to NENC overall
- **Black, African, Caribbean or Black British** have a **1.5%** higher representation when compared to NENC overall
- **Mixed or Multiple ethnic groups** have a **0.2%** higher representation when compared to NENC overall
- **Other ethnic groups** have a **1.4%** higher representation when compared to NENC overall
- **White** has a **2.8%** lower representation when compared to NENC overall
- **Unknown** recording of ethnicity is **0.8%** lower when compared to NENC overall

Vulnerable Characteristics

Learning Disabilities	Frailty (Mild/Mod/Sev)	Housebound	Care Home Residents
1.0%	4.7%	1.5%	1.0%
0.3% higher than NENC overall	0.2% lower than NENC overall	0.1% higher than NENC overall	0.2% higher than NENC overall

Drug/ Alcohol Misuse

Drug Misuse	Alcohol Misuse
3.1%	3.9%
1.1% higher than NENC overall	1.1% higher than NENC overall

Smoking Status

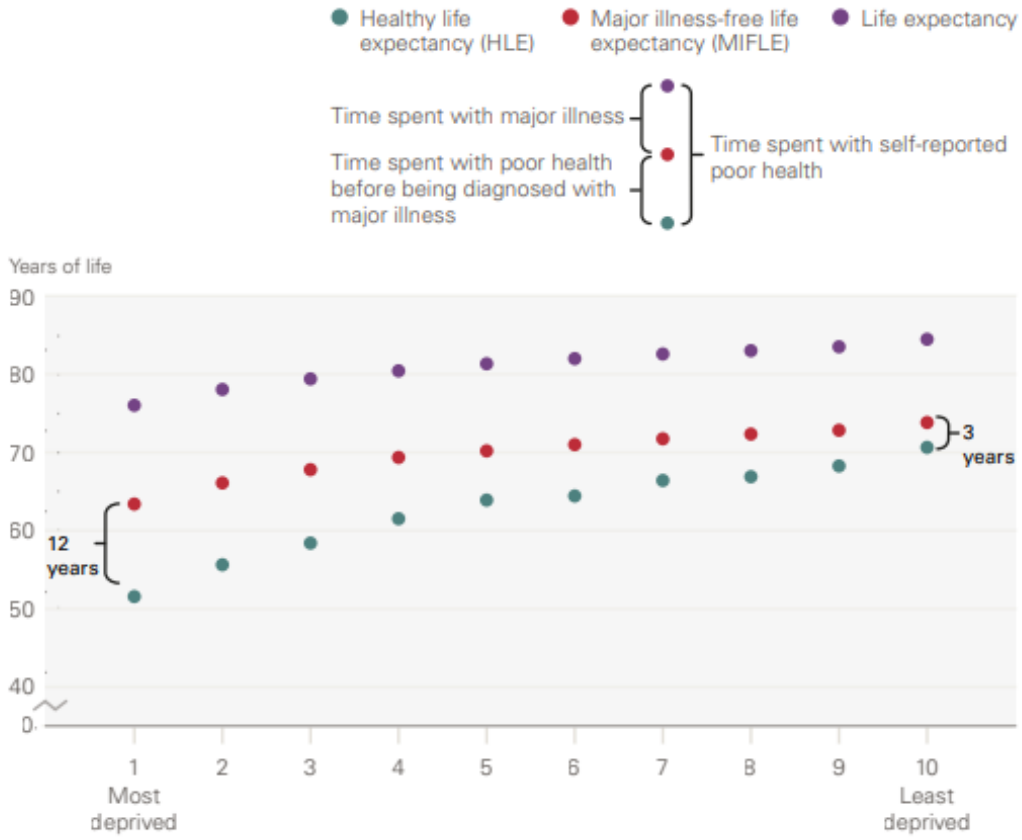
Smokers	Ex-Smokers	Non-Smokers
18.5%	18.9%	38.1%
5.9% higher than NENC overall	0.6% lower than NENC overall	9.2% lower than NENC overall

Weight Management

Underweight	Overweight/ Obese
1.0%	29.9%
0.1% higher than NENC overall	1.3% lower than NENC overall

Inequalities in disease identification

Figure 6: Healthy life expectancy, major illness-free life expectancy and life expectancy at birth, by decile of deprivation in England (2017–2019 average for healthy life expectancy, 2019 for major illness-free life expectancy and life expectancy)



Data Source: The Health Foundation – Health Inequalities in 2040

Major illness or major illness free life expectancy is an alternative method of measuring healthy life expectancy. This method is based upon diagnosed illness compared with the healthy life expectancy measure which is based upon self-reported description of health.

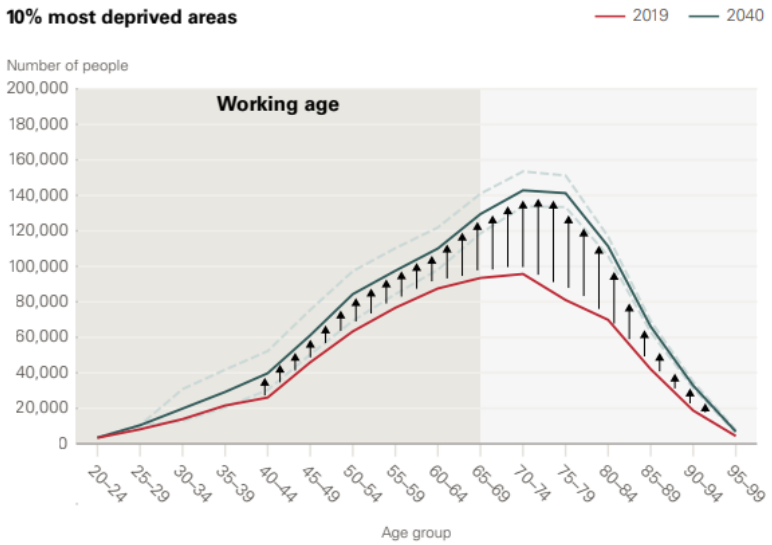
The chart (left) shows the relationship between Major illness free life expectancy, healthy life expectancy and life expectancy by index of multiple deprivation in England.

The data shows a social gradient for all three measures, with the most deprived reporting a younger age for all three. This highlights the fact that people within deprived areas not only die at a younger age but also spend longer in poor health.

The gap between healthy life expectancy and major illness free life expectancy for the most deprived communities is 12 years. This suggests that people within these are living on average, 12 years in self-reported poor health before being clinically identified as having major-illness. Within the least deprived communities, this gap is only 3 years.

33% of the NENC population reside within the most deprived communities, meaning a third of our population could be experiencing poor health but waiting more than a decade before being identified as having major illness. The self-reported ill health could be driven by a range of factors such as poverty, employment status, wider circumstances, leading to the feeling that their health and wellbeing is poor as well as the presence clinical conditions.

Health Inequalities in 2040



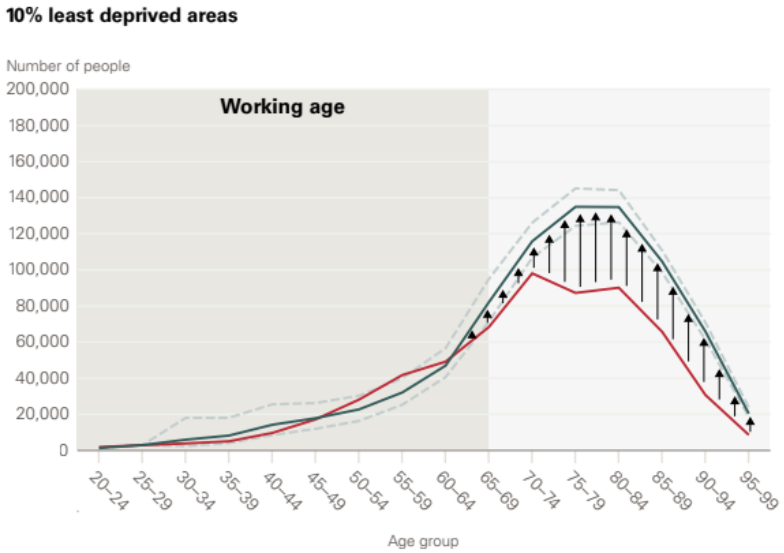
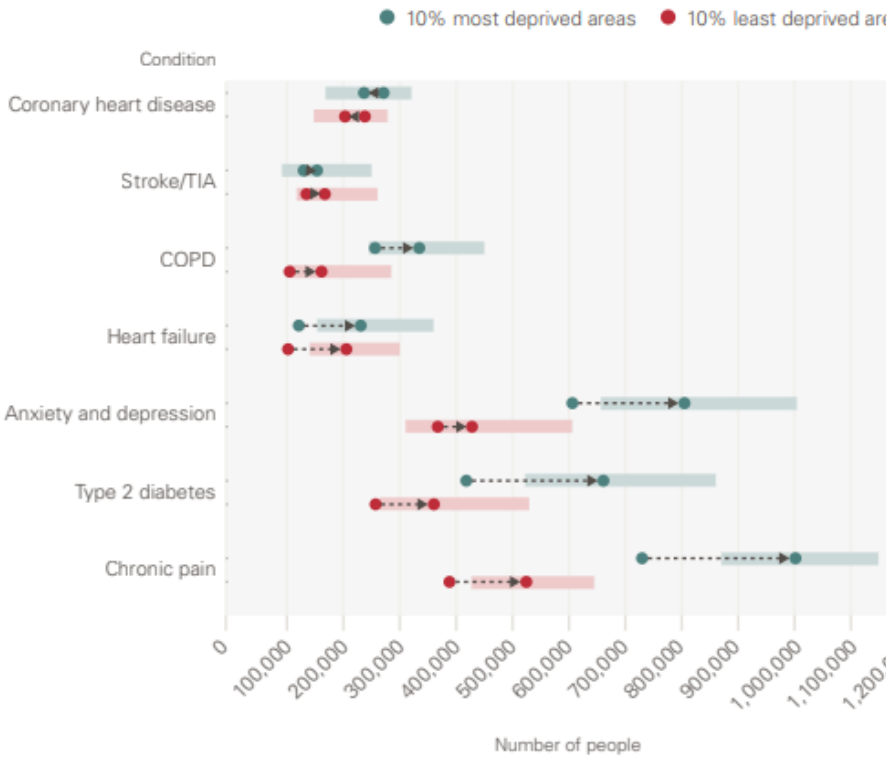


Figure 10: Projected change in the number of people living with a specific diagnosed condition between 2019 and 2040, 10% most and least deprived areas, England



People within the most deprived communities are reported as having a major illness free life expectancy of 63.7 years. Within the least deprived communities this is 74.1 years.

By 2040, the major illness free life expectancy age is not expected to change significantly. However, with population growth, it is expected that many more individuals will be affected by major illness.

For individuals over the age of 70, there is no apparently social gradient. However, for working age population (20 – 69), 80% of the increase will be for those residing IMD 1 to 5 (those most deprived)

Some of the specific conditions identified as driving the inequalities in major illness free life expectancy and the forecasted grown are Chronic Pain, Type 2 diabetes, Anxiety and Depression, Heart Failure and COPD.

Data Source: The Health Foundation – Health Inequalities in 2040

Social and Economic Factors impacting Healthy Life Expectancy

The population in NENC experience greater challenges in relation to the 6 social and economic measures highlighted as having the strongest correlation with Healthy Life Expectancy. The aim of the ICB to 'increase healthy life expectancy for our population' is significantly more difficult without wider system working and collaboration with partners to address these wider determinants!

The challenge across NENC is inequitable, with some Local Authorities disadvantaged more than others and additional inequalities present by Lower Super Output areas and for specific communities.

Economic inactivity due to sickness and disability

The average rate in NENC is **8.6%** ranging from **4.6%** in Darlington to **13.8%** in Hartlepool, which second highest rate within England

Income

The median monthly pay in NENC is approximately **£2,177**, ranging from **£2,135** in Middlesbrough and **£2,351** in Cumberland

Employment Rate

The rate of employment in NENC ranges between **61.6%** in Middlesbrough and **83%** in Cumberland. **11** of the Local Authorities have a lower than average rate and **Middlesbrough has the lowest rate in England**

Out of Work benefits

The out of work benefit rate for NENC ranges between **5.9%** in Westmorland and Furness and **14.7%** in Hartlepool. **Hartlepool has the second highest rate within England**

Children living in poverty

35% of children in NENC are living in poverty. This ranges from **24.4**% (North Tyneside) to **38.7**% (Middlesbrough). There has been an 8%pt increase since 2014/15 but a slight reduction between 2020/21 and 2021/22. **67%** of children living in poverty in NENC live in working households

Active Travel

Between **60.9%** (Middlesbrough) and **76%** (Westmorland and Furness) of people in NENC walk or cycle at least once per week. **8** Local Authorities in NENC have a lower-than-average rate of active travel

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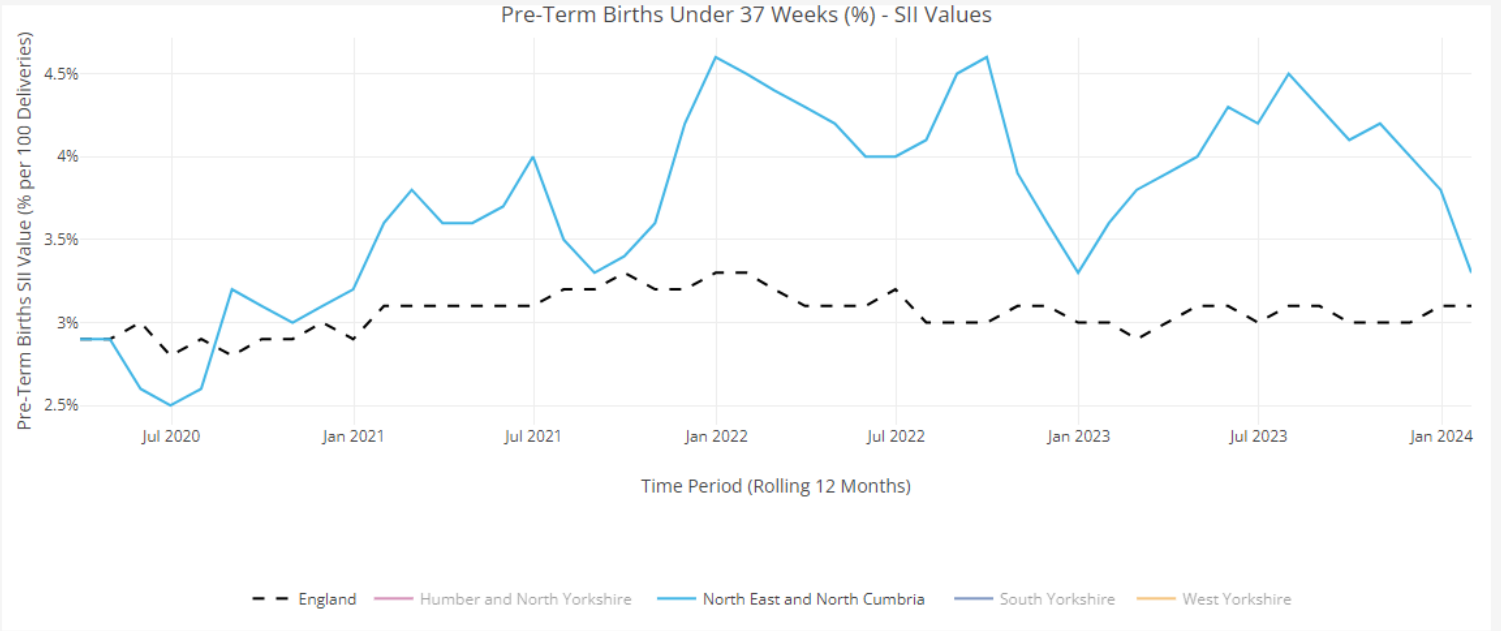
Data Source: The Health Foundation – Local Authority Dashboard

Maternal and Neonatal: Preterm births under 37 weeks

ICB Overall Position	**7.2%**
England Position	**7.1%**
Inequality Gap by deprivation	**3%pts**



Data Source: NHSE Health inequalities update
Reporting Period: February 2023 – January 2024 (12 month rolling period)

The data included above has been taken from the most recent NHSE Health inequalities report and relates to the position in February 2023 to January 2024 (12 month rolling period).
6.9% of babies in NENC were born at less than 37 weeks gestation. This is slightly lower than the England position of 7.2% and reduction compared with the previous reporting period.

For women from the most disadvantaged communities, 8% have babies born before 37 weeks gestation, compared with 4.8% in the least disadvantaged. Both the most and least disadvantaged communities have experienced a reduction in rate since the last reporting period, but the reduction has been greater in the least deprived communities.

Using the slope of inequality index, NENC currently has greater inequalities for this indicator than the England average (3.3 compared with 3.1).

This data is currently not reported by Ethnicity.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	**Giving children and Young People the best start in life**
National guidance	**Core 20 plus 5 / NHS Legal Statement**
Lead Team	**LMNS**

The causes for the inequality gap

- Level of patient acuity at time of booking and during the antenatal period
- Smoking rates at booking and time of delivery
- Language and communication barriers
- High Index of Multiple Deprivation imposes restrictions on the ability to attend appointments and care
- Lack of data recorded by postcode and ethnicity
- A systematic review identified possible mediators of pre-term birth which include:
- maternal smoking,
- maternal mental health,
- maternal physical health,
- maternal lifestyle,
- healthcare and maternal working environment

These mediators only partly explain the substantial socioeconomic inequalities in pre-term birth and further research and evaluation is needed to understand and address inequalities (McHale et al, 2022)

The work currently being undertaken to address the gap

- Smoking at time of Delivery
- All NENC Provider Trusts are now providing in-house support to 100% of our pregnant women and people by using a holistic, client-centred approach. Underpinned by the NENC Tobacco Dependency in Pregnancy and Postnatal Period (TDIPPP) pathway, NCSCT Level 2 trained Maternity Support workers are working closely with women and pregnant people to overcome the barriers of quitting and subsequently having a positive impact on the overall health and well-being of families.
- Pregnancy Anticipatory Care (PAC) Model
- · Re-establishment of the Pre-Term Birth Clinical Expert and Advisory Group
- Establishment of the NENC LMNS Maternal Healthy Weight Delivery Group
- Patient Information Translation

Plans for narrowing the gap

- Communication and engagement across the system and with women and families
- · Implementation of the maternity migrant pathway which is designed to identify specific additional needs for migrant women using NENC maternity services
- · Continued focus on the reduction of smoking in pregnancy rates, including the development of data sets by postcode to understand impact on most disadvantaged communities
- · Consider how to monitor and tackle disparities and inequalities within Maternity and Neonatal Units and across NENC, which will include recording or postcode where possible.
- · To review PTB patient and public voice representation following transfer of the Pre-Term Birth Clinical Expert and Advisory function to the NENC LMNS and release of the Maternity and Neonatal Voices Partnership Guidance to ensure women and families views and feedback and heard from the most disadvantage communities.

Cardiovascular Disease : CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold.

ICB Overall Position	70.1%	↓
England Position	67.2%	↑
Inequality Gap by deprivation	3.1%pts	↓
Inequality Gap by Ethnicity	14.1%pts	↓

Cardiovascular Disease : CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

ICB Overall Position	63.4%	↑
England Position	60.8%	↑
Inequality Gap by deprivation	-7.5%pts	↔
Inequality Gap by Ethnicity	-8.6%pts	↔

Cardiovascular Disease : CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy

ICB Overall Position	91.7%	↑
England Position	90.6%	↑
Inequality Gap by deprivation	-0.65%pts	↓
Inequality Gap by Ethnicity	6.9%pts	↑

Data Source: CVD Prevent
Reporting Period: Snapshot December 2023

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure

Up to December 2023, 70.1% of patients (aged 18 and over) with hypertension in NENC had a blood pressure reading below the age-appropriate threshold, a slight reduction compared with the previous reporting period. Although this is slightly below the ambition of 77%, NENC have a rate higher than the England average.

The proportion is lower for those from the most deprived communities and those of Black Ethnicity.

63.4% of patients (aged 18 and over) with no GP recorded CVD diagnosis and a QRISK score of 20% or more were receiving lipid lowering therapy. This is in line with the ambition of 60% and is higher than the England average.

The proportion of patients on lipid lowering therapy is lower for those within the **most** affluent communities

91.7% of patients in NENC (aged 18 and over) with Atrial Fibrillation and a record of a CHA2DS2-VASc score of 2 or more were shown to be treated with anticoagulation therapy. Although this is slightly below the ambition of 95%, NENC have a rate higher than the England average.

The proportion is slightly higher for those from the most deprived communities but low for those recorded as mixed ethnicity.

Primary IBC Outcome	**Longer and Healthier lives**
National guidance	**Core 20 plus 5 / NHS Legal Statement**
Lead Team	**Long Term Conditions**

The causes for the inequality gap

- CVD is the largest contributor to the gap in life expectancy between the most and least deprived. Additionally, ethnic minority populations generally have a higher risk of developing CVD (due to a combination of genetic and environmental factors).
- Overall health status within our deprived and ethnic minority populations plays a role in the inequality gap. Combined with the higher prevalence of CVD, our populations in the most deprived populations also have the highest prevalence of associated risk factors such as being classified as obese or overweight, physically inactive, and smoking.
- Healthcare access is key to facilitating the detection and management of the ABC conditions for CVD Prevention. Some of our deprived and ethnic minority populations face barriers in accessing healthcare services which can be a major contributor to the inequality gap. Recent insight work has provided us with valuable intelligence as to what some of the barriers are. These generally include travel, time and financial barriers, attitudes of staff, appointment availability, and language barriers. Health literacy is also a contributing factor negatively impacting how we educate, communicate and empower our patients.
- The knowledge and understanding of CVD and its associated risks within our deprived and ethnic minority communities plays a role in this, as do health beliefs, which may subsequently impact health behaviours.

The work currently being undertaken to address the gap

- Community blood pressure kiosk project – this project aims to improve access to blood pressure checks, and subsequently hypertension case finding and management, in deprived and ethnic minority populations.
- Blood pressure champion training – this training supports the blood pressure kiosk project, but also wider community champions based within a number of community venues. A CVD resource is also being developed for the 'MECC gateway' for champions and the public to utilise.
- Targeted improvement work with Primary Care – we have utilised data to identify poorer performing practices in relation to the diagnosis and management of the ABC conditions. These GP Practices have been offered support and education via our CVD Prevention Clinical Leadership team. A number of the GP Practices were within the lowest IMD deciles.
- Regional Lipid Clinic Survey – intelligence gathered to understand the variation in services delivered within NENC lipid clinics.
- Health Literacy – we have worked with the Health Literacy team to develop patient resources for the community blood pressure projects

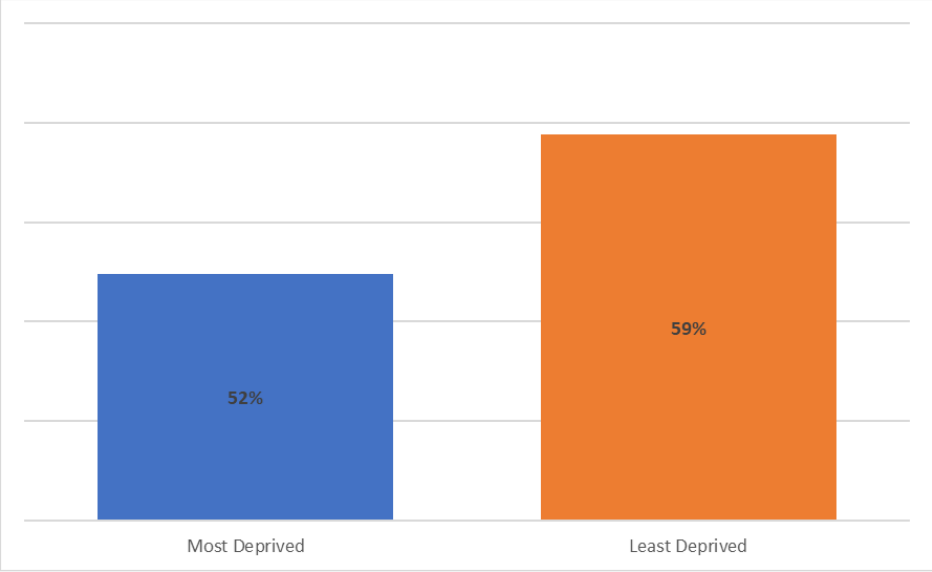
Plans for narrowing the gap

- Development of a CVD work plan under the LTC group which will support the ICB Clinical Strategy and will include deliverables related to addressing health inequalities.
- Targeted public communications aimed at the relevant demographics and areas informed by data. Communications to be tailored to the audience, I.e., having a key message video from a south Asian clinician aimed at South Asian populations.
- Piloting of innovative projects where funding is available to address health inequalities (further community based projects, social prescribing/HCA outreach to support non-engagers,).
- Utilisation of learning from previous projects to prioritise the work which addresses the variation within our services and tackles health inequalities.

Cancer : Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex (2022/23)

ICB Overall Position	55%	⇧
England Position	58%	⇧
Most deprived	52%	
Least Deprived	59%	
Inequality Gap by deprivation	7%pts	⇔

Figure 1 - % of cancers diagnosed at stage 1 and 2



Data Source: Rapid Cancer Registration Data
Reporting Period: 2023/24

Two output measures have been included for Cancer; % of cancer diagnoses detected at stage 1 or 2 and Cancer screening rates. The first is the measure suggested by NHSE within the Core20plus5 framework but measurement of this is difficult due to the capture of staging within the available dataset.

The second measure has been included locally as a more proxy measure for staging due to more robust data quality.

Based upon available, unvalidated data, the estimate proportion of cancers identified at stage 1 or 2 in NENC is 55%, a slight increase compared with the previous reporting period. This proportion is lower than the England average of 58%.

The rate for the most deprived population is 52% and for the least deprived it is 59%, resulting in a 7%pt inequality gap for NENC.

There is also an inequality gap in screening for both breast and bowel cancer. The most recent slope index of inequality for screening of these cancers are 13.4 (breast) and 13.1 (bowel). In both cases, the inequality gap in screening is smaller in NENC compared with England but still considerable. NENC is the only ICB locally who have not experienced a widening of these inequalities over the last few years.

National guidance	**Core20 plus 5 / NHS Legal Statement**
Lead Team	**Cancer Network**

The causes for the inequality gap

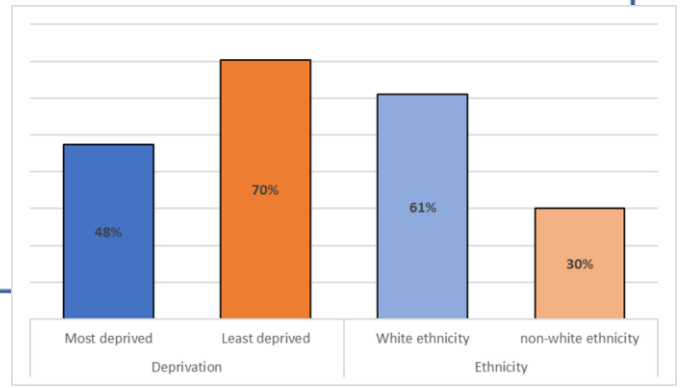
- In NENC there is a higher burden of disease in all tumour sites, particularly in Lung Cancer, and cancer is diagnosed later in our communities of health inequality due to health literacy and health behaviours, and poorer access to primary and other care services (profile of deep end practices).
- The work currently being undertaken to address the gap
- NCA has a comprehensive early diagnosis workplan focuses on addressing the gap at all stages of the cancer pathway; from prevention, cancer screening, awareness, and timely presentation (link to other ICB workstreams here), targeted case finding and innovation, including the NHS Galleri clinical trial.
- The Cancer Programme is nationally funded and assured, and locally we use a proportional universalist approach to allocating cancer transformation funding to projects and organisations that can target the most support where it is most needed to narrow the inequality gap. Early diagnosis projects are targeted at communities and PCN's by triangulating health inequality indicators (such as CORE20/IMD scores) cancer incidence (including rates of emergency presentation which usually map to both later presentation and health inequalities) and uptake rates for screening and case finding initiatives.
- We are aware that even high performing programmes that exceed the national standard for uptake (eg bowel cancer screening) will mask poorer uptake in communities of health inequality and seek to address this by cohorting and targeting our engagement efforts at those who will experience the most barriers to uptake of screening (examples include the siting of mobile cervical sampling, targeting of behavioural science projects and geospatial mapping to utilise PCN engagement and cancer awareness staff capacity).

Plans for narrowing the gap

- NCA have ambitious plans to narrow the gap, and in 24/25 cancer delivery plan we continue to target our work as outlined above and ensure that all projects in the cancer workplan address health and healthcare inequalities. NCA has developed a 5 year Lung cancer strategy to address the particular challenges and health inequalities in that tumour site.
- Specifically on screening there are a number of projects aimed at reducing inequalities in access and uptake of screening for populations with poor outcomes and a history of later diagnosis, including improving access to breast screening and self-examination for South Asian women, mobile cervical screening targeting populations living in areas of high deprivation, the targeted lung health checks with a focus on areas of high deprivation, and participation in the NHS Galleri clinical trial. Although the Grail test is not now moving to early implementation, the national cancer team advise that other multi-cancer early detection (MCED) tests will follow.
- Confounding factors include lack of workforce to deliver these interventions and in some cases the extra costs needed to make services truly accessible to those who need it most (example mobile cervical screening provision versus cost of provision in primary care).
- Nationally we are on trajectory with the best performing areas (those starting with less burden of disease and a less stark health inequality profile) in achieving a 1-2% improvement in early
- diagnosis rates; however, proceeding at that trajectory would only take NENC to 68% early diagnosis by 2030.
- Further improvement on that standard would be dependent on innovative filter tests (such as other MCED tests) becoming available, the longer-term resourcing/targeting of early diagnosis projects such as the lung health checks programme, and a comprehensive costed workforce plan.

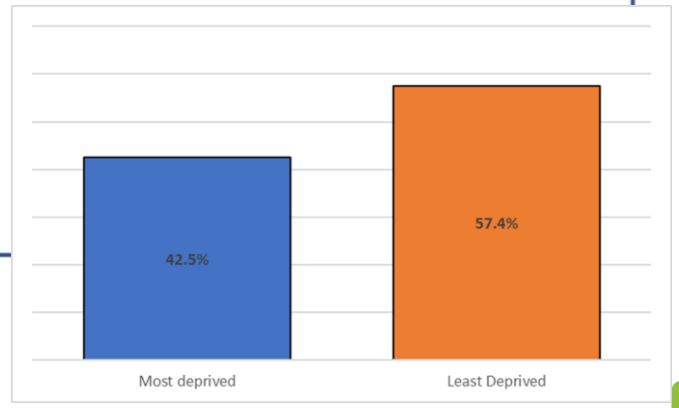
Respiratory : Uptake of COVID vaccination by socio-demographic group

ICB Overall position 2023/24	52%
ICB Overall position 2022/23	64%
Most deprived 2023/24	48%
Least deprived 2023/24	70%
White Ethnicity 2023/24	61%
Non-white ethnicity 2023/24	30%



Respiratory : Uptake of Flu vaccination for COPD population by socio-demographic group

ICB Overall position 2023/24	48.2%
Most deprived 2023/24	42.5%
Least deprived 2023/24	57.4%



Data Source: COVID vaccination data -foundry and NENC Primary Care Data
Reporting Period: 2023/24

The data above has been taken from two sources, COVID vaccination data is via foundry and the COPD flu vaccination is from the NENC GP assurance dashboard (NECS BI Portal (necsu.nhs.uk))

Both sets of data are based upon the delivery of vaccines during the winter period.

There has been a 12%pt reduction in the uptake of COVID vaccination across the NENC population compared with 2022/23. Inequalities in uptake are present by both socio-economic factors and ethnicity where less than half of the eligible population within the most deprived groups received the vaccination in 2023/24 and less than a third of non-white population.

The uptake of Flu vaccinations in the COPD population is based upon the proportion of patients with a COPD diagnosis on their primary care record who received a flu vaccination this winter. Again, there are inequalities based upon socio-economic status, with a 14.9%pt gap in uptake between the most and least deprived patients.

There is also variation by GP practice, ranging from 3% uptake to 94% uptake.

Primary IBC Outcome	**Longer and Healthier lives**
National guidance	**Core20 plus 5 / NHS Legal Statement**
Lead Team	**Screening and Immunisation**

North East North Cumbria Health & Care Partnership

The causes for the inequality gap

There are a number of causes for the inequalities gap. These vary between population and geography. The main themes are:

- Some vaccine hesitancy and fatigue
- Lower health literacy and understanding the benefits and risks of getting vaccinated
- Some digital deprivation
- Increased challenges for access
- Differential understanding and access issues for non-white British and more mobile population
- Most deprived populations more likely to DNR health appointments generally
- Flu is accessible in all GPs and community pharmacies, whereas COVID is delivered through a narrower range of PCN/Pharmacy outlets. COVID is not part of core contract for GPs.
- Lack of time and priority and financial resources within the lives of people in most deprived groups to take up the offers.

The work currently being undertaken to address the gap

- To add to the evidence base of why patients do not attend for flu vaccination, we undertook a patient level survey of patients who are in the clinical at-risk groups and DNA'd. The main themes for this were: patients thought flu vacc might make them ill; did not think they needed it to protect themselves, even though they knew that they had been invited because of a defined clinical risk group; and
- We are building this and other evidence in to the ICB Comms campaign which supplements the national campaign. The ICB Comms team has developed two campaigns – "Trusted voices" for Vaccines in Pregnancy and the Autumn/Winter vaccination campaign.
- We are communicating these and other findings to Practices and others involved in the campaigns
- Collaboration between the parts of the system that lead on flu and COVID (NHSE and SVOC)
- Setting up local immunisation groups to ensure services are shaped for "place" and local populations.
- Hyper-local and granular data for population and uptake analysis. Local Place Leads shape GP/PCN/CP offer towards these inequalities.
- Advised Trust clinicians to routinely recommend vaccinations to their patients in all patient letters
- Developing region-wide COPD guidance that references need for flu and COVID Vaccs
- Balance COVID operational waste of vaccines priorities with low throughput clinics, but which are serving areas of have high deprivation

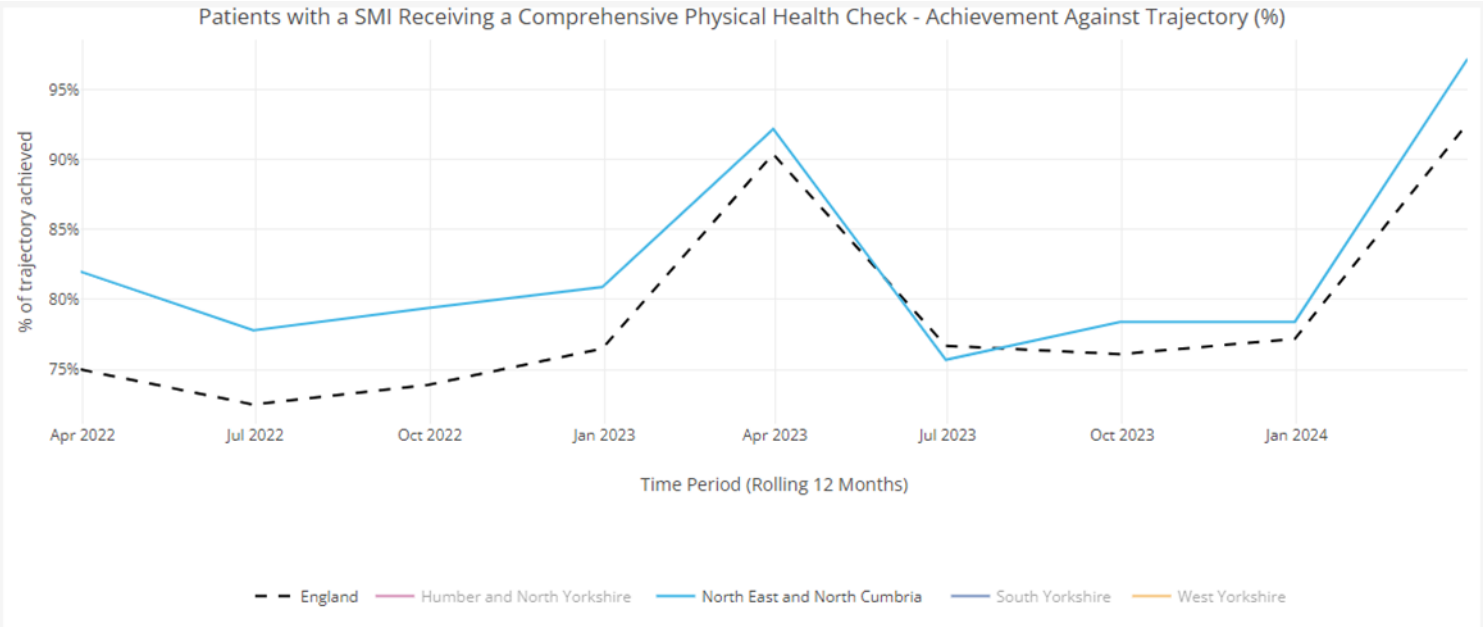
Plans for narrowing the gap

- Continue with ongoing work

Mental health : Overall number of severe mental illness (SMI) receiving physical health checks

ICB Overall Position 2023/24	**97.2%**
ICB Overall Position 2022/23	**92.2%**
England Position 2023/24	**92.6%**

Figure 1 – SMI annual health checks in last 12 months



Data Source: NHSE Health inequalities update
Reporting Period: April 2023 – March 2024 (12 month rolling period)

North East North Cumbria Health & Care Partnership

The data above is taken from NHSE health inequality analysis report released May 2024 and the Office for national statistics annual publication on Suicides,. The data relates to 2022.

In 2023/24, 97.2% of the expected number of SMI patients in NENC received a physical health check. This was an increase compared with the previous year and higher than the England average.

The health checks are comprised of 6 components and the output reported reflects individuals who have received all 6. There are also individuals who have received health checks but not all 6 components were complete. Almost all individuals had blood pressure and smoking status documented but fewer had lipids included within their health checks.

At present, the published data is not segmented by deprivation or ethnicity.

Primary IBC Outcome	**Fairer Outcomes for all**
National guidance	**Core 20 plus 5**
Lead Team	**Mental Health**

Learning disability and autistic people : Learning Disability Annual Health Checks

Most deprived communities	**64.3%**
Least deprived communities	**66.2%**
Inequality gap by deprivation	**2.1%pts**
White Ethnicity	**65.3%**
Ethnic Minorities	**44.2%**
Inequality gap by Ethnicity	**21.1%pts**

Figure 1 – Learning disability annual health checks by Ethnicity

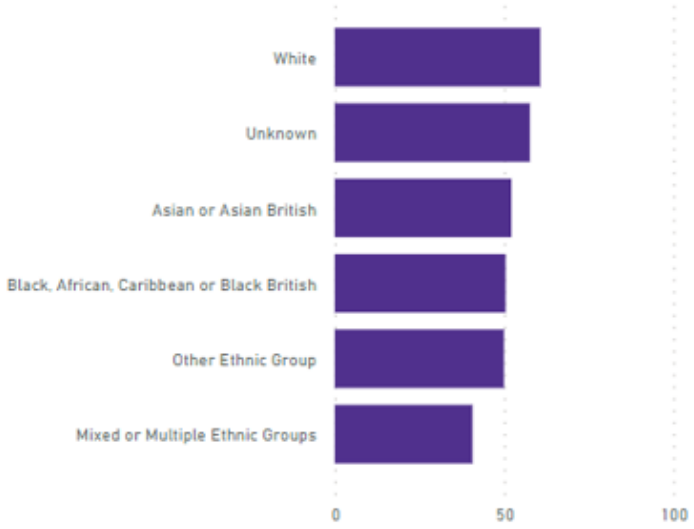
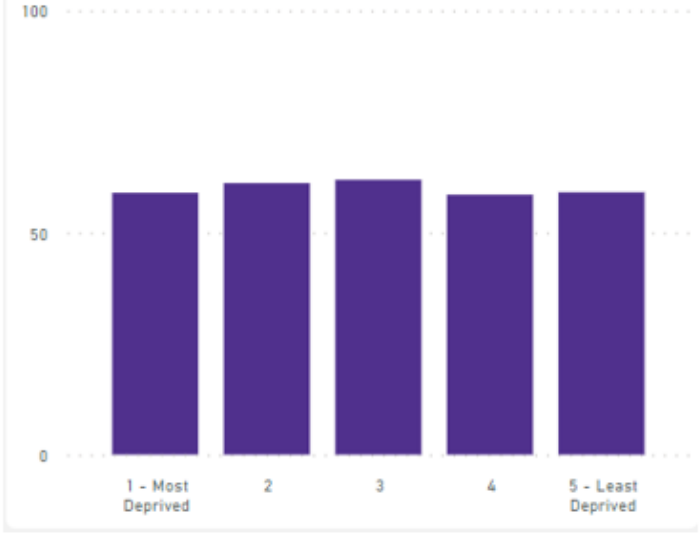


Figure 2 – Learning disability annual health checks by deprivation



The data above has been taken from NENC Healthier and Fairer dashboard, primary data source used is Primary Care data.

There is a 2.1%pt inequality gap in the proportion of individuals from the most deprived communities receiving their annual health checks compared with those from the least deprived.

There is a larger inequality gap for those from ethnic communities, in particular those of mixed or multiple ethnic groups, equating to a 21.1%pt difference compared with people of white ethnicity.

Data Source: NENC Primary Care data via the Healthier and Fairer Insight Dashboard
Reporting Period: April 2023 – February 2024 (12 month rolling period)

North East North Cumbria Health & Care Partnership

Primary IBC Outcome	**Fairer Outcomes for all**
National guidance	**Core 20 plus 5**
Lead Programme	**Learning Disability Network**

The causes for the inequality gap

- Nationally the number of people on the register of people with a learning disability in primary care does not reflect the expected prevalence despite much work to improve it nationally. Learning disability annual health checks are provided under national IIAF funding to PCNs.
- Patients and carers are not always aware of the label, the offer of an annual health check and the enhanced offer from practices about their care e.g. vaccinations, particularly those in special schools and aged 14-18.
- Patients, parents/carers and professionals are not always aware of reasonable adjustments needs and pathways are not smooth across primary and secondary care interfaces.
- Increased prevalence of hearing, sight loss and early onset of dementia can cause additional barriers to care / support.
- Patients without English as a first language and with low literacy and learning disability do not always have access to suitable materials proving explanation, information and support.
- Inclusion in the register does not mean automatic care or learning disability nurse support.
- Health conditions, medications used in learning disability and inequity of reasonable adjustments contribute to ill health and early mortality, the national annual health check framework currently does not reflect all needs or complexity.

The work currently being undertaken to address the gap

- Published the NENC Prevention of Adult Not Brought Strategy Prevention of Adult Not Brought Strategy « Learning Disability Network (necldnetwork.co.uk) to enable awareness raising of reasonable adjustments across health and social care. Rolled out widely Reasonable Adjustment campaign Reasonable Adjustment Campaign « Learning Disability Network (necldnetwork.co.uk) for NHS, social care, people with learning disability & family carers to raise awareness of people's rights to reasonable adjustments & NHS & social care's legal obligation to provide them.
- Rolled out widely AHC 'prompt sheets' to enable person with learning disability to prepare well for their AHC, e.g. think about what they'd like to discuss at their AHC. Work was co-produced with people with learning disability LDN_Annual_Health_check.pdf (necldnetwork.co.uk)
- Revised and rolled out widely 'easy read invite letter' for general practice to use to encourage full take up of AHC V1-AHC-Invite-Letter.docx (live.com)
- Shared widely new films made to demonstrate what good reasonable adjustments look like, made as part of workforce education & for people with learning disability & families to see what it should look like Reasonable Adjustment Film 1 - text message vs phone call (youtube.com) Reasonable Adjustment Film 2 - display board vs nurse (youtube.com) Reasonable adjustment film 3 - literal language vs clear instruction (youtube.com) Reasonable Adjustment film 4 - written explanation vs verbal (youtube.com) Reasonable Adjustment Film 5 - medical jargon vs simple language (youtube.com) Reasonable Adjustment film 6 - supporting me to understand my appointment (youtube.com)

Plans for narrowing the gap

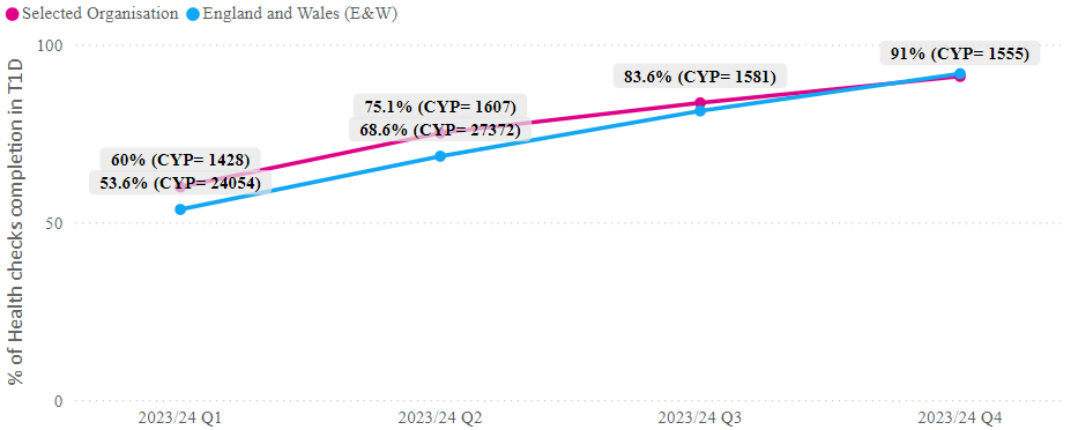
- Full implementation of the Reasonable Adjustment Digital Flag across NENC, health and social care Reasonable Adjustment Flag « Learning Disability Network (necldnetwork.co.uk)
- Moving AHC delivery from 'within QoF' year to 'birthday month' of the person with learning disability
- Fully refresh the 'Learning Disability Population Health Management Profiles' to enable targeted improvement work on importance of AHCs and quality of AHCs in most disadvantaged places
- Improving 'learning disability GP registers' working with national team on standardising how to identify a cyp with learning disability.

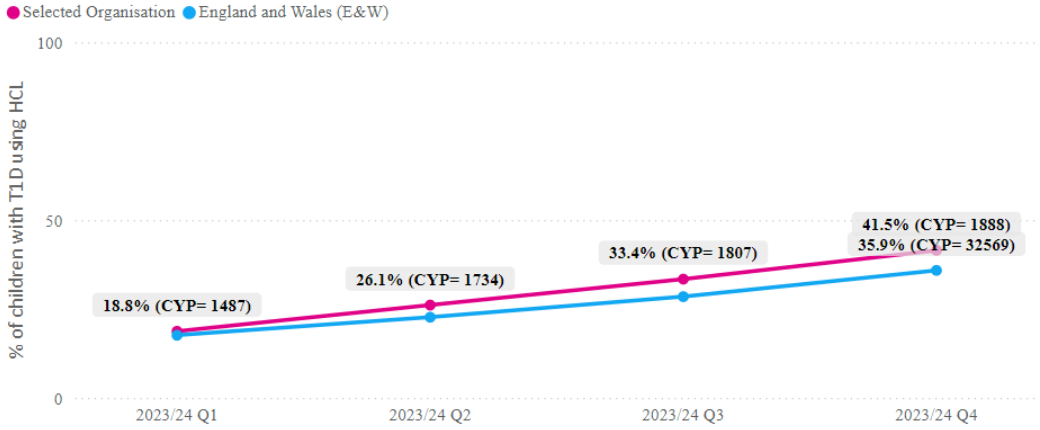
CYP Diabetes : % of Diabetic children receiving all six care processes	
ICB Overall Position (2023/24) type 1	91%
ICB Overall Position (2023/24 type 2	62%
Most deprived type 1	91.3%
Least Deprived type 1	91.4%
White ethnicity type 1	91.2%
Non-white ethnicity type 1	87.7%

Figure 1 – % Type 1 receiving all 3 care processes

CYP Diabetes : % of Diabetic children accessing hybrid closed loop technology	
ICB Overall Position (2023/24) type 1	41.5%
Most deprived type 1	38.6%
Least Deprived type 1	46.9%
White ethnicity type 1	42.1%
Non-white ethnicity type 1	49%

Figure 2 – % of type 1 diabetic children accessing Hybrid closed loop





Data Source: National Paediatrics Diabetes Audit Dashboard
Reporting Period: 2023/24

The information included above is taken from the National Paediatric diabetes audit dashboard and reflects the outputs for 2023/20.
A greater proportion of children with type 1 diabetes receive their ‘3 care processes' or 'health checks' compared with the children with type 2 diabetes. This is the case both locally within NENC and nationally, but the variation is greater for children in NENC.
There is currently little to no variation in the proportion receiving the 3 care processes by deprivation but there is by ethnicity. A lower proportion of children with non-white ethnicity were recorded as receiving all three checks in 2023/24 than children with white ethnicity.
For children accessing Hybrid Closed loop, the inequality areas of interest are the opposite. There is a gap between children from the most and least deprived communities but not for non-white ethnicity.

Clinical Conditions Strategy Measure

Primary IBC Outcome	**Giving Children and Young people the best start in life**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Child Health and wellbeing Network**

The causes for the inequality gap

- CYP with Type 2 Diabetes receiving key health checks – The incidence of CYP with type 2 diabetes is rising, however we still have a very small number of patients (50 patients reported in 22/23 NPDA) therefore only 1 or 2 patients that miss their key checks will have an impact on the data.
- In terms of inequalities in accessing key health checks, there is a small gap (3.5%) between white and non-white ethnicity and no gap between the most and least deprived. Ethnicity should not be a barrier to accessing key health checks however -
- 1) some families who don't speak English as a first language find accessing healthcare more difficult than English speaking families
- 2) T2 patients often have more complex social needs and therefore data may be missing due to patient moving in and out of area
- 3) accuracy of the ethnicity coding
- CYP with type 1 diabetes accessing Hybrid Closed Loop technology – Access to HCL technology has recently (late 2023) been made mandatory for anyone living with type 1 diabetes via a NICE Technology Appraisal (TA943), the data therefore reflects a very current change in diabetes care.
- Prior to this, the two component parts of HCL, insulin pumps and continuous glucose monitors (CGMS) were accessed under different NICE guidelines, in the case of insulin pumps the access was limited to children and young people under 12 years. Following all available guidance, MDTs across NENC have always strived to achieve equitable access to all diabetes technologies and we have consistently led the way when compared with other areas of England and Wales. Since the publication of TA943, MDTs offer HCL to ALL families (no age limiting criteria) and we do expect to see a sharp increase in overall access to HCL in the next quarterly report (30.08.2024).
- However, we know that 49% of our population live in the most and second most deprived quintiles and this is creating a barrier for those looking to access diabetes technology -
- 1) as the diabetes technology advances, the requirement to have access to a compatible mobile phone and laptop is essential to access the full functionality of the technology.
- 2) diabetes technology is complex to manage, and we know there is a connection between levels of literacy and deprivation.
- 3) accessing the required healthcare to manage diabetes, including additional hospital appointments needed to commence diabetes technology can present a challenge for some families.
- The data shown above does however represent a reduction in the deprivation gap since the 21/22 NPDA report which showed a 11.1% gap between most and least deprived accessing insulin pumps and 13.8% gap between the most and least deprived accessing CGMs.

The work currently being undertaken to address the gap

- CYP with T2 diabetes receiving key health checks (gap shown in terms of ethnicity) – earlier this year the CYP NENC Diabetes Network commenced a Type 2 Diabetes peer support forum and identified lead HCPs from each Trust to participate in regular support meetings with a focus on sharing best practice, upskilling, case study presentation and data analysis. Whilst our cases remain low, we acknowledge the Diabetes UK state of the nation report and the 'The Health Foundation REAL Centre Health inequalities in 2040: current and projected patterns of illness by deprivation in England' and know that this is an increasing area of work for our clinical teams to tackle now and in the coming years.
- The NPDA are currently collecting data for a T2 spotlight audit with a submission deadline of 13th Sept 2024, the data in the report will highlight areas of need and support the development of work programmes for the T2 Diabetes peer support forum.
- HCL and deprivation (gaps shown in terms of deprivation) – following a full programme of Poverty Proofing© which took place with the Gateshead CYP diabetes team, all HCPs working in CYP diabetes were given the opportunity to attend Poverty Proofing© training in 2023. A common themes report was published, and teams have been supported to make changes to improve access to CYP diabetes services within their locality. This includes (but not limited to) – QR code directory for financial and social support, availability of healthy snacks at clinic appointments, flexible clinic appointment times, free hospital parking and public transport travel cards.
- Further to this, in late 2022 the CYP NENC Diabetes Network were awarded funding to pilot a project to refurbish NHS phones and laptops and give them to families so they can access diabetes technology. During the pilot year (Mar 2023-Mar 2024) 297 mobile phones and laptops were given to families across the NENC, with 60% being given to families living in deciles 1-3, this has helped us to narrow the deprivation gap. Now the pilot is complete, and we have shown proof of concept and proof of value, the project is continuing with a new business as usual approach, and we expect to see the deprivation gap continue to narrow.
- For both these areas of inequality -
- The NENC Children and Young Adult Diabetes System GIRFT review is taking place on 20th January 2025, technology and type 2 will be areas of focus for the GIRFT team and we will support any recommendations that follow the review and the publication of their findings.

Plans for narrowing the gap

- Identifying and appropriately allocating Best Practice Tariff within Trusts is vital in narrowing any inequality gaps; MDTs need to be adequately staffed to manage the increase in caseloads
- (including managing increasing cases of T2 diabetes) and the increase in diabetes technology, whilst also tackling the increase in social pressures including safeguarding, learning disabilities and mental health. HCPs need to be trained and confident in the use of new technologies and continuously develop their skills as the technology advances whilst also upskilling in the management of children and young people living with T2 diabetes.
- We plan to support teams to ensure that the BPT is identified and is appropriately allocated to them to manage the ongoing and increasing demand which will ultimately positively support reducing all inequalities in CYP diabetes care.

Clinical Conditions Strategic Plan measure

CYP Oral Health

Data Position

The Core20 plus 5 framework for children and young people includes a specific aim to reduce the back log for tooth extractions in hospital. This indicator was previously being reported using hospital admission data (SUS), specific to a procedures coded as ‘Tooth extraction’. Upon further consultation with David Gallagher and colleagues who are leading on the Oral health agenda, we have been advised that this data is not fully inclusive of all activity, therefore not providing a true representation of the position in NENC.

At present, the ability to triangulate the various data sources needed to provide insight and assurance on this is not available. There are plans to in the coming months, for the colleagues working on oral health to identify data sources to be used and to ensure that this flow of data is available for inclusion going forward.

North East North Cumbria Health & Care Partnership

Primary IBC Outcome	**Giving children and young people the best start in life**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Child Health and wellbeing Network**

The causes for the inequality gap

- Oral health inequalities are stark in all NENC areas and closely linked to deprivation. The 2016/17 census survey data analysis for local authorities at ward level showed a strong relationship between deprivation and the severity of dental disease in 5-year-old children. In some local authority areas, there is a 10-fold difference in children who had the highest levels of decayed, missing or filled teeth in the most deprived wards compared with the least deprived wards.
- In summary deprivation, ethnicity (Asian/Asian British) and lack of optimal fluoride levels are factors affecting inequalities in dental disease for 5 year old children. Prevention interventions are key to reducing dental decay rates and thus obviating the need for general anaesthetic (GA) extractions.

The work currently being undertaken to address the gap

- Commissioning of evidenced based population prevention programme to reduce the prevalence of dental decay, ie supervised toothbrushing programme across some LAs and Health Visitor distributed toothbrushing packs to young children and their families.
- Dental Access Referral Pathway piloted in Tees Valley – awaiting evaluation to inform roll out across other parts of the NENC.
- Incentivised access scheme commissioned which provides additional appointments from NHS practices which prioritises patients with an urgent dental care as well as vulnerable groups such as children in care.
- Increase in the minimum UDA rate locally to £31.46 (£3.46 above the national mandated minimum rate) to help stabilise NHS dental provision and reduce contract hand backs, as well as a discretionary offer to take part in an audit to assess the true cost of delivering NHS Care prioritising "at risk" practices in the most deprived parts of our region and/or where there are significant access challenges.
- Offer to practices who have the workforce and surgery capacity to deliver up to 110% of their contracted activity (UDAs), subject to agreement of an action plan.
- NHS practices locally benefiting from the national new patient premium where they receive activity credits equating to £15-£50 (depending on treatment need) for seeing new patients.
- Additional funding made available to increase out of hours urgent dental treatment capacity.
- Two short term urgent Dental Access Centres (UDACs) commissioned as pilots in Darlington (opened June 2024) and Carlisle (due to open in September 2024). The UDAC model could provide an enhanced and more reliable solution to the provision of directly accessible in-hours urgent dental care for patients. If successful, the ICB would look to expand this concept across NENC.
- Using local commissioning from existing practices and the flexibilities available from the new Provider Selection Regime (PSR) to replace capacity lost through contract hand-backs.
- Work being undertaken to establish a complete and robust dataset to have oversight/ monitor general anaesthetic referrals into the CDS services for dental extractions due to caries, waiting lists, waiting times and the profile of referrals, e.g. ethnicity, as well as measure the progress and impact of other initiatives aimed at improving access and the oral health of children across NENC.
- Consultation to extend water fluoridation within he North East to improve oral health and reduce inequalities.

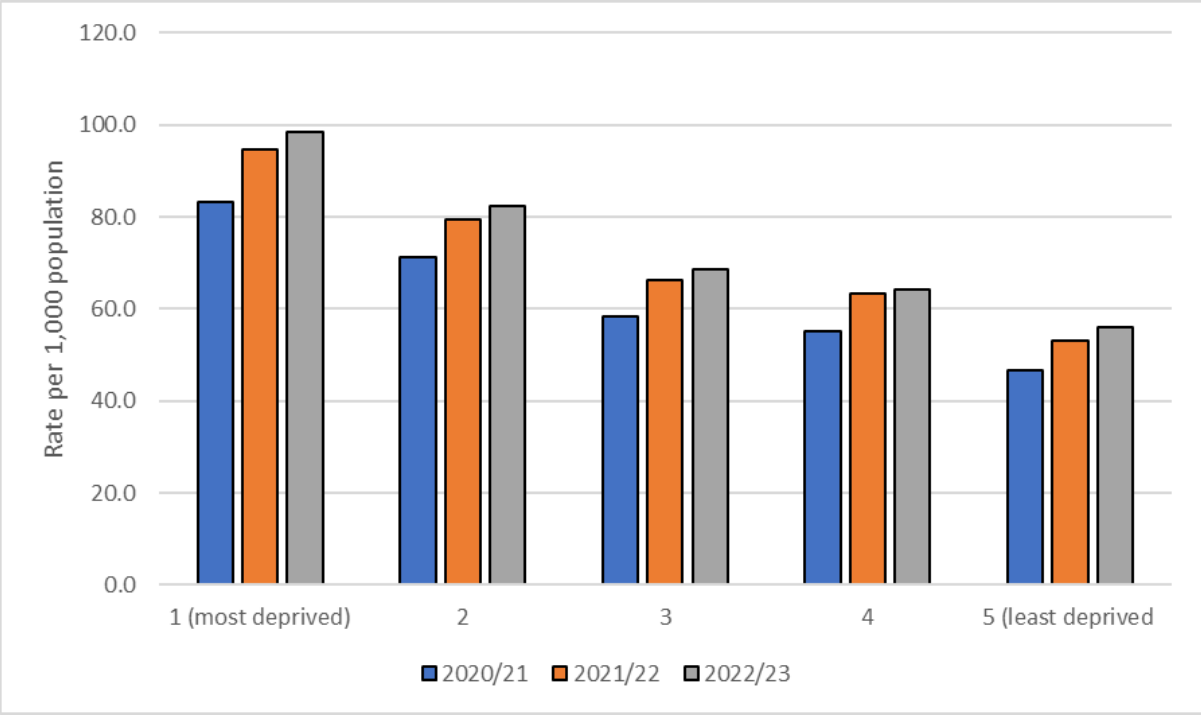
Plans for narrowing the gap

- Working with our partner organisations to develop a system wide oral health strategy prioritising oral health population-based access and prevention programmes to improve oral health and reduce the need for extractions, building on the current ICB and Local Authority strategies and plans – key priorities identified so far include:
  - Stabilising and increasing access to NHS dental care prioritising patients with greatest clinical need, e.g. expansion of UDAC model subject to evaluation of pilots.
  - Expansion of oral health promotion/prevention initiatives, aimed at reducing decay levels, e.g. supervised toothbrushing programmes and school-based fluoride varnish programmes in targeted deprived communities.
- Work with our NHS Trusts and community dental services to reduce waiting times for community referrals for dental GAs to ensure current long waiting times are addressed.
- Progress mutual aide discussions with Community Dental Services/NUTH to validate GA waiting lists, and where possible reallocate patient referrals to ensure patients are seen in services closest to home and reduce waiting times.
- Monitor and explore opportunities to improve fluoride varnish application rates in dental practices as part of a dental quality assurance framework.
- Await the outcome of the water fluoridation consultation in the North East and work with DHSC and as a NENC system to implement any recommendations.

Mental health : Children and young people's mental health access

ICB Overall Position 2021/22	89 per 1,000 population (51,545)
ICB overall Position 2022/23	92 per 1,000 population (53,570)
Rate – most deprived	98.5 per 1,000 population (22,875)
Rate - least deprived	55.9 per 1,000 population (4,545)

Figure 1 – Crude rate of CYP supported through NHS funded mental health with at least one contact by IMD (per 1,000 population



North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure

The data included above has been taken from published NHS Digital Mental health bulletin dashboard. The data relates to 2022/23 activity and reports the crude rate of access at ICB level and how that is reflected in the most and least deprived communities.

In 2022/23 there were 53,570 children and young people referred to mental health services who had at least 1 contact, an increase compared with 2021/22.

For every 1,000 children residing in the most deprived communities in NENC, approximately 98 accessed mental health services in 2022/23 compared with 60 in the least deprived communities.

The data shows that the greatest volume of activity within CYP mental health services is coming from the most deprived communities but without a comprehensive understanding of the actual levels of need, it is difficult to determine if needs are being adequately met.

Since 2020/21, the access rate for the most deprived communities has increased by 18% but in the least deprived communities, the increase has been 20% (albeit, relating to a smaller number of children

Primary IBC Outcome	**Giving children and young people the best start in life**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Mental Health**

Clinical Conditions Strategic Plan measure

CYP Epilepsy

Data Position

The CYP core20 plus 5 aim for Epilepsy is to provide assurance that children with Learning Disability and/or Autism with a co-occurring condition of epilepsy have access to the specialist nurse within 12 months of diagnosis.

At present, there is no data which can provide this information. We know from Practice data, approximately 10% of children with a diagnosis of Learning Disability also have a diagnosis of Epilepsy, compared with <1% within the general CYP population.

Information is available via the Epilepsy12 audit but this is annual information, provided at Trust level. It does not report on the access for children specifically with Learning Disabilities. This audit does provide information on the number of trusts with clinical pathways in place to link with Learning Disability Services, but it cannot provide intelligence on the variation access between different populations.

Until we have robust data on this metric, it is not possible to provide a quantitative output

North East North Cumbria Health & Care Partnership

Primary IBC Outcome	**Giving children and young people the best start in life**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Child Health and Wellbeing Network**

The causes for the inequality gap

- NHSE reports that epilepsy is also more common in people with a learning disability than in the general population. Around 1 in 3 people (32%) who have a mild to moderate learning disability also have epilepsy. The more severe the learning disability, the more likely it is that a person will also have epilepsy. Epilepsy Action estimate that this could be around 2 in 5 people (40%) with epilepsy also have a learning disability. Anecdotally paediatric epilepsy services report that the proportion of children with epilepsy and learning disability is significantly higher than this in practice.
- It is difficult to determine why this is however in consideration of the causes of the epilepsies, some of them affect the structure of the brain or have an effect on networks in the brain which guide the way it works, which could also cause a learning disability. The Epilepsy Society says both epilepsy and learning disability "may be caused by the same underlying problem in the way their brain works"
- A recent study (Pickrell et al, 2015) indicates that epilepsy incidence and prevalence rates are twice as likely in the most deprived deciles compared to the least deprived deciles and this was factored into the calculations.
- Epilepsy 12 data (assigned to Round 3, Cohort 2) shows that localities in the NENC ICS footprint have the highest proportion of CYP that are under review with epilepsy and live in the most deprived quintile across all the localities within the regional networks. Recent data demonstrates that our region houses a large and expanding number of young people and families facing multiple disadvantages, including poverty, poor mental health and family breakdown.

The work currently being undertaken to address the gap

- A whole scheme of work has been undertaken since September 2021 to support the delivery of improvements in paediatric epilepsy provision with a particular focus on narrowing the gap for those young people who are most vulnerable
- Initial baselining work with published report, scoping of current position and identifying and escalating local challenges, understanding local need – findings shared through Paediatric Epilepsy Network North East and North Cumbria (PENNEC) Alliance and at British Paediatric Neurology Association (BPNA) annual international conference.
- Education and awareness for trainees, nurses and consultants through PENNEC education forum and wider awareness through Child Health and Wellbeing Network (CHWN) Huddle
- Establishment of the multi-agency PENNEC Alliance
- Education and capacity building in wider community through Alliance and also the MH mapping project (families to be supported in the community to reduce the need to access urgent care as needs are better managed with the support they need)
- Islacare digital file transfer pilot to expedite diagnosis, support ongoing management and improve experience and outcomes
- Epilepsy Specialist Nurse (ESN) pilot. Increased local capacity to enable resources to target those most vulnerable and to reduce variation and address health inequalities in local population
- Implementation of the 8a Regional ESN lead role to develop and embed pathways (secondary to tertiary, healthcare transition, referral to statutory mental health services) and to champion the ESN role.
- NENC Healthier Together (HT) Epilepsy information has been developed and published, signposting to credible national resources
- Young persons and family engagement session – RCPCH Innovation Lab Day and evolving stakeholder engagement platform
- Voluntary Community Sector (VCS) MH service mapping provision, also providing education and capacity building in wider community (families to be supported in the community to reduce the need to access urgent care as needs are better managed with the support they need)
- Youth Mental Health First Aid (YMHFA) training for ESNs and secondary care teams has been offered and taken up by 3 Trusts
- Roll out of the National Epilepsy Care Bundle (NECB) published Oct 23
- Service Improvement Planning programme locally with Trusts to improve access for CYP and to facilitate delivery of the NECB requirements (5/8 services completed Aug 24)
- Developing comprehensive care plan template
- Work with all age NENC Learning Disability Network on transitions (developmentally appropriate healthcare) implementation of the NENC pathway (NENC Regional Transitions Core Steering Group)
- Core 20 projects focussing on CYPwE and Learning Disability (LD) or Special Educational Needs (SEND) CYPwE and Mental Health (MH) needs and CYPwE from black minority ethnic (BME) communities is currently underway
- Various education opportunities are planned, HealthStarters, Operational Delivery Network (ODN), Education, HT Champions, Primary Care session (collaboration with adults epilepsy colleagues), Tees Valley Managed Clinical Network Study Day
- Working with scientific researcher who is looking at epilepsy and inequality across the country share our learning and collaborate on local projects
- Establishment of NEY HT Group for Epilepsy resources
- Sharing (and taking) learning through North East and Yorkshire Regional Epilepsy Leadership Group
- NENC are represented within the OPEN UK national forum which enables opportunity to share learning and participate and engage
- Clinical Lead is a member of the Epilepsy 12 National Audit Project Group and contributes to the building and content of the Audit project. LD metrics (ESN access) are currently being considered to be part of Epilepsy 12 outcomes and be included into the next cycle of the audit

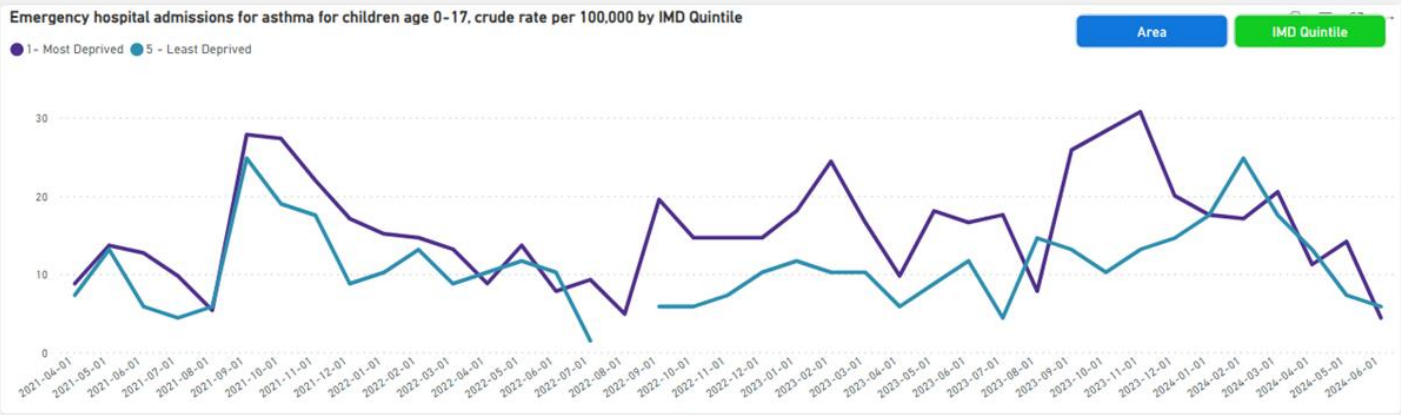
Plans for narrowing the gap

- Continue the roll out of the NECB
- Continue localised Service Improvement planning incorporated HI focus. This will provide opportunity to measure the impact of the interventions and how we are narrowing that gap
- Continue to develop accessible information and resources and improved VCSE offer to support families
- Continue to deliver education and signposting/top tips re paediatric epilepsy
- Work with services to ensure that CYP are seen by person with appropriate knowledge and skill to effectively manage their condition to reduce the potential for non elective admission, targeting resources where it is most needed.
- Establishment of ESN Community of Practice
- Strengths and Difficulties Questionnaire (SDQ) and Psychology Adding Value – Epilepsy Screening (PAVES) pilot being considered (funding dependent)
- Increase access to ESN for LD patient cohort (funding dependent)
- Considering the potential for Poverty Proofing for Epilepsy patients in collaboration with RCPCH, taking learning from Diabetes programme

Asthma:

ICB Overall Position	(range by geography)	486.6 – 564 per 100,000 pop

Data Source: NENC Healthier and Fairer Insight Dashboard
Reporting Period: April 2023 to March 2024 (12 month rolling period)



Clinical Conditions Strategic Plan measure

The CYP core20 plus 5 aim for Asthma is to address the over reliance on reliever medications and reduce the number of asthma attacked.

Within NENC, the inequalities in unplanned admissions for children with asthma follows a seasonal pattern. Between September and January each year, the gap between the most and least deprived populations increases, but at all other periods the rates remain similar (although the rate is generally higher in the most deprived population, potentially because the prevalence of the condition is greater for these children.

Because of this seasonality, it's difficult to set an annual trajectory or target which would fully reflect and reduction in inequality gap across the year.

In relation to the reliever medication, locally it has been difficult to access robust data which would provide the insight into the prescribing practices, particularly through an inequalities lens.

Recent data from NHSE provides some insight by ICB and Primary Care Network but the data is only up to and including January 2023. The insight from this data shows NENC reducing the rates of Salbutamol prescribing and increasing the rate of more preventative treatments.

Primary IBC Outcome	**Giving children and young people the best start in life**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Child Health and Wellbeing Network**

North East North Cumbria Health & Care Partnership

The causes for the inequality gap

- Asthma is the most common long-term medical condition in children in the UK, with around 1 in 11 children and young people living with asthma. The UK has one of the highest prevalence, emergency admission and death rates for childhood asthma in Europe. Outcomes are worse for children and young people living in the most deprived areas, this could be because of exposure to second hand smoke or environmental pollution, poor living environments, inequity of access to healthcare or poorer control and management of their condition. Research by Imperial College
- London suggests that being born into disadvantaged circumstances increased the likelihood of developing persistent asthma by as much as 70%.
- The causes of inequality gaps for 0-18yr olds in the North East and North Cumbria is multifaceted and not possible to summarise, some relevant (but not comprehensive) evidence has been highlighted.
- The NENC CHWN Facts of Life document (published Sept 21) confirms that broader environmental and socioeconomic factors shape health-seeking behaviours as well as admission behaviour which includes emergency admissions for children. The long term conditions asthma and epilepsy are disproportionately represented in young people in our most deprived areas.
- The NENC region as a whole has a higher proportion (29.4%) living in the 20% most deprived areas of England than the national average (20.2%), and all of our local authorities with the exception of Eden have a higher Index of Multiple Deprivation (IMD) 2019 deprivation score than the national average of 21.7.
- The COVID Inquiry report (Taylor-Robinson 23) highlighted that Emergency hospital admissions for asthma are largely preventable and that Inequalities in asthma and lifelong lung function are the result of the complex interplay of environmental conditions up to school age. It highlights that Maternal smoking, low birthweight, premature birth, not being breastfed, poor housing conditions, poor indoor and outdoor air quality, have all been found to predispose children to asthma, and are more commonly experienced by children growing up in disadvantaged socioeconomic circumstances He concludes the report that promotion of health equity in childhood is imperative not just for moral reasons but for the long-term good of society and for economic growth.

The work currently being undertaken to address the gap

- The following has been undertaken to improve the community offer to improve asthma management in the community, reduce the reliance on reliever inhalers and reduce risk of asthma exacerbation and therefore avoidable admission
- Roll out of National Asthma Care Bundle (NACB) and continued systemwide education and signposting to Beat Asthma and NENC HT resources (including localised education sessions, HT Champions lunch and Learn, Health protection forums, heads and senco forums, primary care time in time out and other various forums as well as multi agency North East and Cumbria Paediatric Asthma and Allergy Conference (NECPAAC) Summer 23
- Supported the development of Tackling Respiratory Illness Together (TRIPT) website which was very focused on dealing with respiratory illness in the context of poverty.
- Beat Asthma Friendly Schools (BAFS) work (and pilot programme work) has been targeted to the deprived localities (we published selection criteria for settings) with the intention to support improved asthma management in the community to reduce the risk of asthma exacerbation and therefore avoidable admission.
- Melissa Bus education and engagement activity for CYP in Durham
- Beat Asthma Friendly Clubs (BAFC) scheme launched Feb 24 for sports, clubs and community groups
- Community/professional resources developed (role of community pharmacist and referral pathways, how to use your inhaler)
- General Primary Care education – interactive webinars (x3 – 'A Question of Paediatric Asthma', 'Asthma in Practice' and 'Hot Topics in Paediatric Asthma') hosted Feb 23 and Jan 24
- Primary care targeted intervention has been into practices with high admission numbers – we targeted Primary Care Networks (PCNs) whose patients had contributed most to the admissions. 3 PCNS identified (17 practice) with 30+ surrounding community pharmacies. Further to these an additional 12 practices have received targeted intervention following identification of practices that are outliers since Jan 24.
- Secondary Care Nurses Community of Practice has been established and is progressing the development/implementation of a standardised checklist
- Work is progressing as part of the North East Housing Partnership and North East Housing Consortium to develop and implement a Beat Asthma Friendly Housing (BAFH) pledge and NENC regional approach to requests for rehousing, highlighting challenges and risks associated with deprivation and socioeconomic factors
- Links are being explored with the Smoking Cessation and Fresh Balance work programme

Plans for narrowing the gap

- To continue BAFS/BAFC roll out and ensure that we are capturing and monitoring HI and demographic data re school/community group populations – we have a record and spreadsheet to capture local demography
- To continue BAFH development work in collaboration with the North East Housing Partnership and Making Every Contact Count (MECC)
- To continue targeted intervention into practices based on relatively higher rates of admission in relation to population of CYP with asthma as primary diagnosis. (outlying practices have been identified)
- Work with partners to establish primary care RAIDR dataflow regarding Personalised Asthma Action Plan (PAAP) / PAAP Review and 2 day review
- Digitise referral pathway between primary and secondary care services
- Sunderland pilot proposal, bid though Healthy City grant being explored in collaboration with Sunderland Public Health Teams and Sunderland West PCN (funding dependent)

Diabetes : Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes

ICB Overall Position (2022/23) **15.2%pt difference between Type 1 and 2**

Figure 1 – % Type 1 receiving all 8 care processes

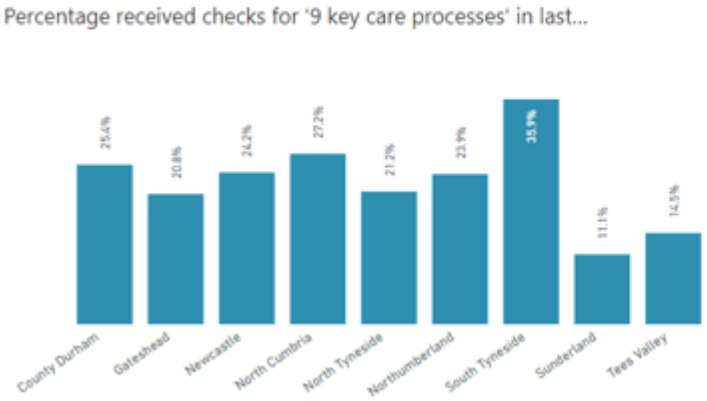
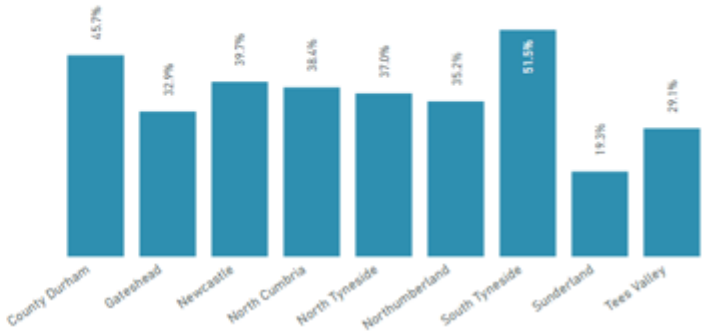


Figure 2 – % Type 2 receiving all 8 care processes



Data Source: National Diabetes Audit Annual Report
Reporting Period: 2022/23

Diabetes : Variation between % of referrals for structured education from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile

ICB Overall Position	**-8%pts**
Most deprived quintile %	**31%**
Least deprived quintile	**23%**

Data Source: NENC Diabetes Dashboard, NECS
Reporting Period: June 2023 – May 2024

North East North Cumbria Health & Care Partnership

The data above is taken from the National Diabetes audit annual report for 2022/23 and is supplemented with more recent data from the NENC Diabetes dashboard.

In 2022/23 there was a 15.2% point difference between the proportion of Type 1 and Type 2 diabetics receiving all 8 care processes, with type 2 reporting the greatest percentage (56.9% verse 41.7%).

Both Type 1 and Type 2 have seen an increase in the proportion of patients receiving all 8 care processes. This information is not available at deprivation or ethnicity at local level within the annual audit at present.

There is local variation with NENC in the delivery of the 8 care processes (or the 9 processes as shown above). Based upon the latest reporting period (June 2023 – May 2024) there has been 6,073 individuals from the most deprived communities newly diagnosed with type 2 diabetes. Of those, 2,680 (31%) were referred for Structured Education but only 612 (3%) attended. Fewer people from the least deprived communities were newly diagnosed (1,858) and a smaller proportion referred for structured education (23%). However, a slightly greater proportion of individuals attended and received structured education (4%).

Primary IBC Outcome	**Longer and Healthier Lives**
National guidance	**NHSE Legal Statement**
Lead Programme	**Long Term Conditions**

The causes for the inequality gap

- The region continues to face unique health challenges due to its mix of urban and rural populations. While rural areas generally have lower deprivation than urban, pockets of poverty exist, particularly in ex-mining villages and among older residents. Low population density and limited public transport in rural areas create access barriers to healthcare, especially for those on low incomes. Despite good broadband access, digital literacy remains a hurdle for optimal use of digital healthcare solutions. The region's economic history of manual labour leaves many lacking the digital skills needed in today's economy, further impacting health outcomes.

The work currently being undertaken to address the gap:

- We are establishing an ICB approach to long term conditions including diabetes prompted partly by the changes to the Clinical Networks. Workplans under development will be required to have a focused offer that aims to reduce the inequalities gap, these will be reviewed as part of the programme progression. We anticipate there will be learning that straddles conditions and communities and that we will be able to identify approaches that can be implemented swiftly with best outcomes for our most deprived communities. We will build on the fact that many people have more than one long term condition to deliver a more concise approach broadening the opportunity to really focus on narrowing the inequalities gap.
- Utilising data to undertake targeted work. Development of diabetes dashboard to better identify localities and practices that are not achieving expected targets for 8 care processes. Work in other clinical areas will enhance this approach so we are exploring ways of doing things once to improve our position.
- Building on stakeholder engagement with place based teams to present data, understand local challenges and work collectively to improve the position relating to the 8 treatment targets via deprivation for both T1D and T2D.
- Collaboration with obesity and wider system partners to deliver a unified approach and patient choice especially linking to the Health Weight and Treating Obesity strategy.
- Working collaboratively with Diabetes Prevention providers to target low referring practices to continue to increase referrals from Primary Care and the wider system i.e. Maternity Units, to the Programme.

Plans for narrowing the gap

- Review data sources as part of the newly established Diabetes Workstream using a deep dive approach to identify issues of variance in relation to the 8 Care Processes across the NENC Primary Care practices.
- Identify a work programme across NENC that will include a requirement to include approaches to address unwarranted variation from prevention to treatment and management of complications.
- Increase awareness of the services and support for patients in relation to Diabetes in collaboration with system partners and look for opportunities to capitalise on partner projects and programmes.
- Increasing awareness of nationally commissioned programmes, promotion of referral processes and understanding or attendance patterns.
- Collaborate with the Deep End practices to support the promotion of prevention and delivery of educational programmes for patients.

Urgent Care : Emergency admissions for under 18s – 12 month period 2023/24

ICB Overall Position	**83.8 per 1,000 population (under 18)**
Rate in most deprived quintile	**86.5 per 1,000 population**
Rate in the least deprived quintile	**59.9 per 1,000 population**
Inequality Gap by deprivation	**26.6 per 1,000 population**
Rate in ethnic minority communities	**92 per 1,000 population**
Inequality Gap by Ethnicity	**18.4 per 1,000 population**

Figure 1 – Emergency admissions for under 18's per 1,000 population by deprivation

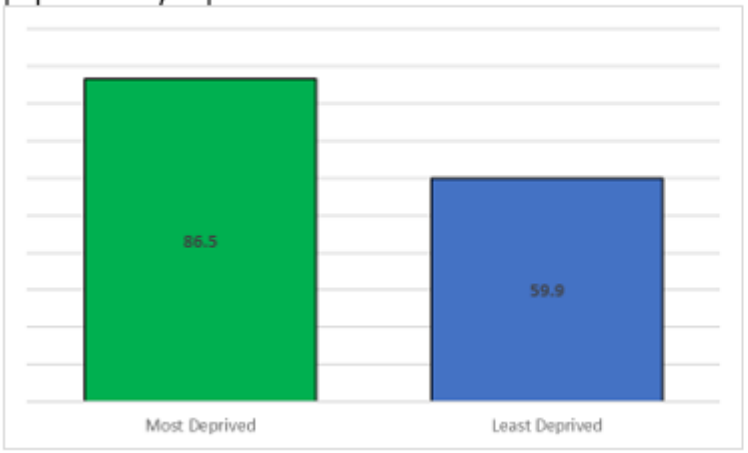
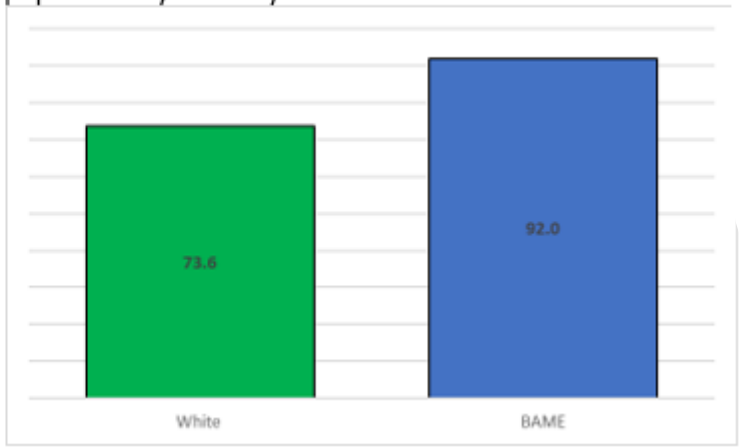


Figure 2 – Emergency admissions for under 18's per 1,000 population by ethnicity



Data Source: RAIDR Patient Activity Dashboard
Reporting Period: April 2023 – March 2024

Data included in the figures above are taken from RAIDR Patient Activity dashboard and relate to Financial year 2023/24. All emergency admission data for children and young people under the age of 18 have been included. Population data by IMD and Ethnicity sourced from NHSE.

For every 1,000 child/young person residing within NENC, there were 83.8 admissions during 2023/24.
There is variation by Index of multiple deprivation score, with those in the most disadvantaged communities admitted more frequently than those in the least disadvantaged. This in total equates to an inequality gap of 26.6 admissions per 1,000 population or 27 more admissions from the most disadvantaged than the least.

For every child/young person from an ethnic minority community, there were 90.2 admissions during the reporting period. This is greater than the rate for CYP coded as white/British. In addition to this, 10% of emergency care admissions for children has not valid ethnicity recorded, therefore the full scare of variation is unknown. The rates included within this iteration of the report are greater than the previous iteration. The reason for this is mostly due to the time period included. The previous iteration included April – November only, which clearly excluded the winter period. While inequalities were reported in the previous version, the gap was not as great as when we look at the full financial year. This may indicate that inequalities may increase during the winter pressure period.

Primary IBC Outcome	**Better health and care services**
National guidance	**NHSE Legal Statement**
Lead Programme	**UEC/Child Health and Wellbeing Network**

North East North Cumbria Health & Care Partnership

The causes for the inequality gap

- The causes of inequality gaps for 0-18yr olds in the North East and North Cumbria is multifaceted and not possible to summarise in full here, relevant (but not comprehensive) evidence has been highlighted.
- The NENC CHWN Facts of Life document confirms that broader environmental and socioeconomic factors shape health-seeking behaviours as well as admission behaviour which includes emergency admissions for children. It is also evidenced that the rate of emergency hospital admissions for type 1 diabetes is significantly higher for older children and young people, and that children and young people from deprived or black and minority ethnicity backgrounds are more likely to experience diabetic ketoacidosis at diagnosis and poorer diabetes control that could lead to emergency admission. The long-term conditions asthma and epilepsy are disproportionately represented in young people in our most deprived areas.
- The COVID Inquiry report (Taylor-Robinson 23) highlighted that emergency hospital admissions for asthma are largely preventable and that Inequalities in asthma and lifelong lung function are the result of the complex interplay of environmental conditions up to school age. It highlights that maternal smoking, low birthweight, premature birth, not being breastfed, poor housing conditions, poor indoor and outdoor air quality, have all been found to predispose children to asthma, and are more commonly experienced by children growing up in disadvantaged socioeconomic circumstances He concludes the report that Promotion of health equity in childhood is imperative not just for moral reasons but for the long-term good of society and for economic growth.

The work currently being undertaken to address the gap – (Examples of)

- Accessible and trusted NHS health education resources - Healthier Together Champions (reaching over 50,000 families) and our 16 Beat Asthma Friendly Schools and 1 club and targeted primary care intervention have worked directly into communities with higher levels of deprivations for avoidable admissions and education
- CHWN-produced CYP Core20PLUS5 framework for NENC with the development of a toolkit and resources enable the identification and consideration of wider determinants impacting those experiencing health inequalities and thus target work to narrow the gap utilising the Health Inequalities learning platform. This has progressed to include 8 funded case study projects to demonstrate the approach.
- Youth Mental Health First Aid training and epilepsy mapping to improve resilience and early support for young people in communities.
- Across system training in asthma and school accreditation to broaden workforce capacity
- Access to diabetes technology – c.300 families provided with a repurposed NHS Trust mobile phone, laptop and/or donated sim card to facilitate access to diabetes technologies which are proven to improve outcomes, c.60% in lower three deprivation deciles.

Plans for narrowing the gap

- Data workstreams to improve data gaps so they can support analysis for improvement and impact in this area (including plus groups)
- CYP Transformation Service Improvement looking to address the lack of admissions data that triangulates HI or BME data for epilepsy cohort.
- Healthier Together partnering with VCSE and schools to ensure reach into communities of high levels of deprivation and non-white ethnicity to support their families with healthcare guidance and access.
- Beat Asthma Friendly school roll out and primary care interventions will capture and monitor Health Inequalities and demographic data re school/community population and explore data improvement opportunities.
- Work to promote health equity in childhood across the NENC – eg following the EQUIPC Report focusing on surgical access for children in areas of deprivation, the Paediatric ODN will make recommendations for improvement.
- Joint initiatives for maximise success i.e. Healthier Together, poverty proofing & Deep End practices.
- ICB CYP Clinical Strategic plan– Ensure the long-term conditions focus adopts its key principles - health inequalities and inclusion group approach – work ongoing.
- Include a ‘narrow the gap’ approach to CYP Transformation deliverables.
- Localised Epilepsy Service Improvement planning incorporating a Health Inequalities focus.
- Improve access to planned care especially in our marginalised communities.
- HCL TA implementation for all young people will improve diabetes control (inc. ethnic minorities)

Elective Recovery : Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks

18 week waits

ICB Overall Position	33.1%	↓
Inequality Gap by deprivation	0.7%pt	↓
Inequality Gap by Ethnicity	-0.5%pt	↓
Variation by Trust	20.4% - 42.8%	

33% of patients on the current waiting list have waited 18 weeks of more. A slightly greater proportion of individuals from the most deprived communities have waited 18 weeks. A smaller proportion of patients from ethnic minority groups have waited 18 weeks but when interrogating the specific ethnic groups, a greater proportion of Asian patients are waiting. There is significant variation by Trust.

52 week waits

ICB Overall Position	2.6%	↑
Inequality Gap by deprivation	0.1%pt	
Inequality Gap by Ethnicity	-0.1%pt	
Variation by Trust	0.3% - 3.9%	

2.6% of patients on the current waiting list have waited 52 weeks of more, a slight increase compared with last reporting period. There is a tiny variation by deprivation and ethnicity but significant variation by Trust.

65 week waits

ICB Overall Position	0.3%	↓
Inequality Gap by deprivation	-0.1%pt	
Inequality Gap by Ethnicity	0	
Variation by Trust	0-0.8%	↓

0.3% of patients on the current waiting list have waited 65 weeks of more, a reduction compared with last reporting period. There is little to no variation by deprivation or ethnicity but there is variation by Trust. The Trust variation has reduced compared with last reporting period.

Data Source: RAIDR waiting well dashboard
Reporting Period: July 2024

North East North Cumbria Health & Care Partnership

The data included above has been taken from the 'Waiting Well dashboard', July 2024 and RAIDR Patient Activity Dashboard (April to November 2022 compared with April to November 2023).

33% of patients awaiting an elective procedure within the ICB have waited 18 weeks or more, a slight reduction since the last reporting period. The current position shows a small but insignificant inequality gap for both deprivation and Ethnicity. However, when looking at specific ethnic groupings, a greater proportion of patients with Asian ethnicity seem to be waiting 18 weeks of more compared with the other ethnic groupings.

A smaller percentage of those from Ethnic minority communities are shown to be waiting 18 weeks but if they do, a greater proportion wait over 52 and 65 weeks.
Those from the most deprived communities are shown to have a greater proportion waiting longer than 18 weeks but not 52 and 65 weeks.

There is significant variation in waits by Provider, potentially highlighting geographic inequalities.

Primary IBC Outcome	**Better Health and Care Services**
National guidance	**NHSE Legal Statement**
Lead Programme	**Long Term Conditions**

The causes for the inequality gap

- Health literacy levels across the population
- Digital accessibility and use differing between organisations.
- Children and Young People (CYP) - limited ability for parents and carers to take time off work to attend elective appointments, in addition to the impact on CYP in taking time out of education.
- CYP prioritisation uses a process created for adults, resulting in slower recovery of CYP Elective wait times in comparison to adults.
- Differences in organisational service provision / capacity for particular specialities
- Rurality in parts of the system and ability of patients to travel to access care

The work currently being undertaken to address the gap

- Working with digital leads both at a system and regional level to look where opportunity there is to develop consistency across digital capability and accessibility for patients.
- Working with Waiting Well colleagues to ensure patients are optimised for surgery and procedures whilst on the waiting list.
- Mutual Support Co-ordination Group (MSCG) established and meets weekly to ensure system working and collective management of long waiters, maximising capacity, and resource.
- CYP Steering Group established to address the gap in elective recovery. The CYP checklist and data will be reviewed in order to develop a workplan to look at key areas of priority and pressure (spanning across Outpatients, Theatres, Pre-Assessment), utilising GIRFT guidance and evidence-based interventions. This is to ensure parity across the system for CYP.
- Progress made in understanding key cohorts of patients and updates on emerging work to link with NHSE regional and national teams. Further data through an inequality lens to be brought to the Strategic Elective Care Board to inform next steps and focus for providers, including non RTT pathways as well.
- Clinical Alliances established across pressured specialities, bringing together providers across the system to look at where pathways can be standardised, and access improved across the system for patients. These include MSK, Eye Care, ENT, CYP, General Surgery, Gynaecology, Spinal
- Elective Care governance refreshed to align to key sub-groups and develop / identify key priorities; tackling Health inequalities will be a thread through all these groups in improving outcomes for patients.
- Supporting trusts to work with their peer groups (alongside system peers) who support similar patient demographics to share and learn good practice in terms of patient support.

Plans for narrowing the gap

- Further work with Waiting Well to link information into providers for effective scheduling, booking and validating patients on Elective waiting lists
- Further work with Clinical Alliances and Elective Care Sub-groups, will focus on delivery of equitable care across the system collectively, for example:
- reviewing access policies across the system
- developing early risk assessments to support patients for planned surgery.
- implementing single points of access across the system for specialties such as Spinal and Eye Care.
- Work with analysts to identify at a more granular level differentials related to ethnicity or other protected characteristics.
- MSCG to continue to review longest waiters and particular cohorts of patients under significant pressure. Regular monitoring of provider Waiting Lists and tracking of patient movement across the system as a whole.
- Different models of delivery evening and weekend appointments to help make service more accessible and specialist CYP days such as 'Operation Tooth Fairy'.
- Communication campaigns for patients to promote support available for patients to access care.

Mental health : Rate of suicide in North East per 100,000 age standardised population (2022)

		Male	Female
ICB Overall Position	13.7	21.4	6.4
England Position	11.3	17	5.9
Inequality Gap 2022	2.4	4.4	0.5
Inequality Gap 2021	3.9	6.7	1.3
Change	-1.5	-2.3	-0.8

The suicide rate in NENC varies by gender with the rate in males significantly higher than the rate in females. However there is gap between NENC and England rates for both.

Compared with 2021, the rate of suicide in males has reduced at a greater rate than the England average, closing the gap from 6.7 per 100,000 population to 4.4. The rate in females has also reduced and more than halved the gap between NENC and the England average

Figure 2 – Age standardised Suicide rate per 100,000 population 2021 and 2022 by gender

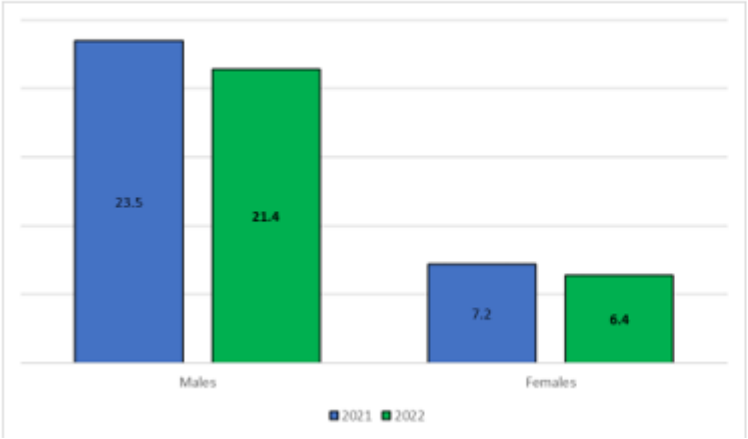
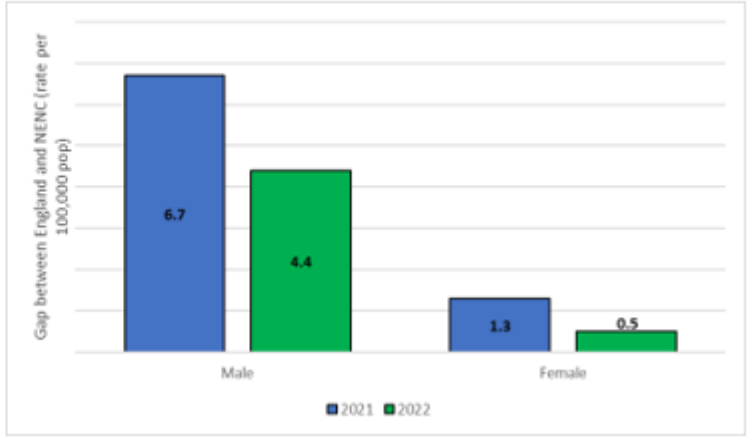


Figure 3 – Age standardised Gap in Suicide rate per 100,000 population England verse NENC



Data Source: Office of National Statistics – Deaths from Suicide data tables
Reporting Period: 2022/23

North East North Cumbria Health & Care Partnership

Primary IBC Outcome	**Longer and healthier lives**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Mental Health**

Mental health: Mental Health Act detentions crude rate per 100,000 population – 2022/23

ICB Overall Position	100 per 100,000 population
Trend	Reducing
Inequality Gap by deprivation	128 per 100,000 population ↓
Inequality Gap by Ethnicity	143.8 per 100,000 population ↓

Figure 1 – Mental Health Act detentions crude rate per 100,000 population by Deprivation

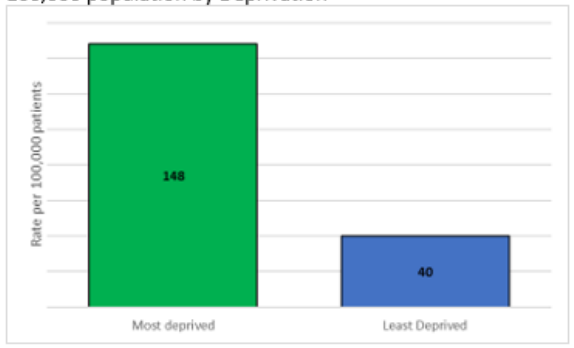
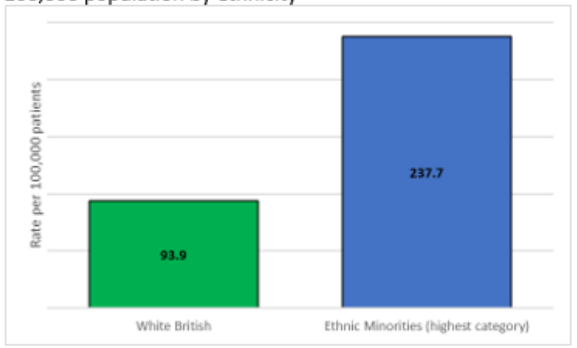


Figure 2 – Mental Health Act detentions crude rate per 100,000 population by ethnicity

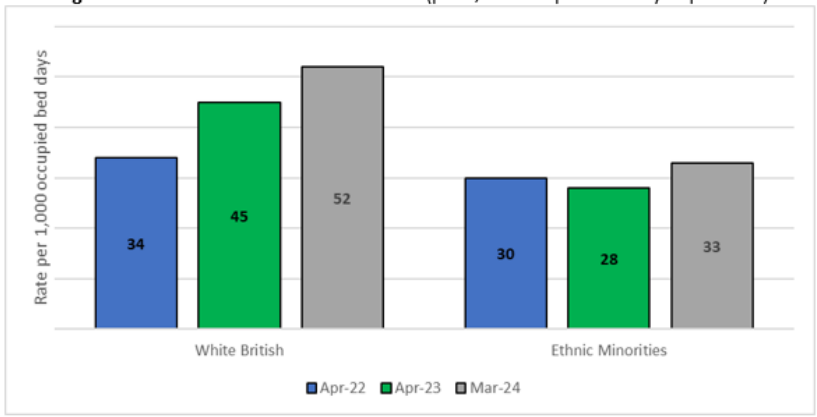


Data Source: NHS Digital, Mental Health Dashboards
Reporting Period: 2022/23

Mental health : Rates of restrictive interventions (per 1,000 occupied bed day - April 2023)

ICB Overall Position (April 2023)	43 per 1,000 occupied bed days
ICB Overall Position (March 2024)	49 per 1,000 occupied bed days
Inequality Gap by deprivation	Not reported
Inequality Gap by Ethnicity	19 fewer per 1,000 occupied bed days

Figure 3 – Rates of restrictive interventions (per 1,000 occupied bed day - April 2023)



Data Source: NHS Digital, Mental Health Dashboards
Reporting Period: April 2023

During 2022/23 there were 2,099 reported mental health act detentions within NENC. Equating to a rate of 100 per 100,000 population. This is a reduction compared with the last 2 years. The rate for those residing within the most deprived communities is significantly greater than the rate in the least deprived with an inequality gap of approximately 128 per 100,000 population, highlighting a greater need in the most disadvantaged communities.

The rate for those within ethnic minority communities is significantly greater than the rate for those of white ethnicity. This equates to an inequality gap of approximately of 143 per 100,000 population, the gap has reduced compared with 2021/22.

For every 1,000 occupied bed days, 49 patients were reported as receiving restrictive interventions. Compared with the April 2023, there has been an increase.
Within the national dashboard, the information is not segmented by IMD (Indices of Multiple deprivation) so we are unable to identify any potential inequalities by deprivation.
The rate of restrictive intervention for those from ethnic minority communities is lower than the rate for those of white ethnicity. Compared within April 2023, there has been an increase for both white and non-white ethnic communities.

Causes for the inequality gap – Mental Act detentions

- We know at a national level that people from minoritised groups have poorer mental health and access to mental healthcare, including increased use of crisis pathways, leading to more negative experiences and outcomes compared to the majority white British groups.

The causes for the inequality gap – Restrictive interventions

- A significant cause of restraint inequality is unconscious bias. This can happen because of people's natural tendency for organising their social worlds into categories (eg age, gender, cultural background, body size). All humans tend to identify with certain categories, depending on the life experiences that have shaped their ideas, attitudes, beliefs, and language.

Mental health : NHS Talking Therapies (formerly IAPT) Recovery rate –2022/23

ICB Overall Position	**50%**
Inequality Gap by deprivation	**18%pts**
Inequality Gap by Ethnicity	**5%pts**

Figure 1 – NHS Talking Therapies (formerly IAPT) Recovery rate –2023/24 by deprivation

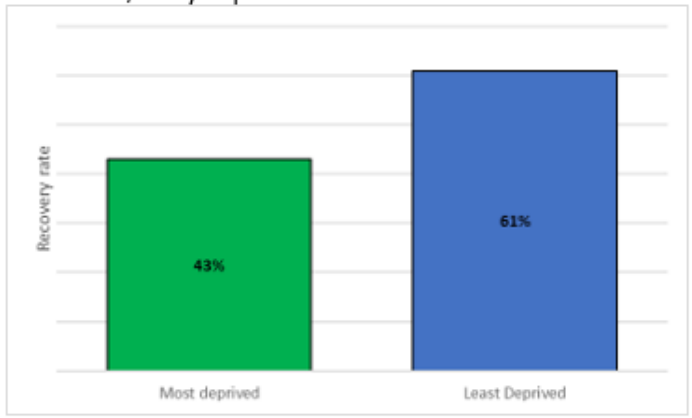
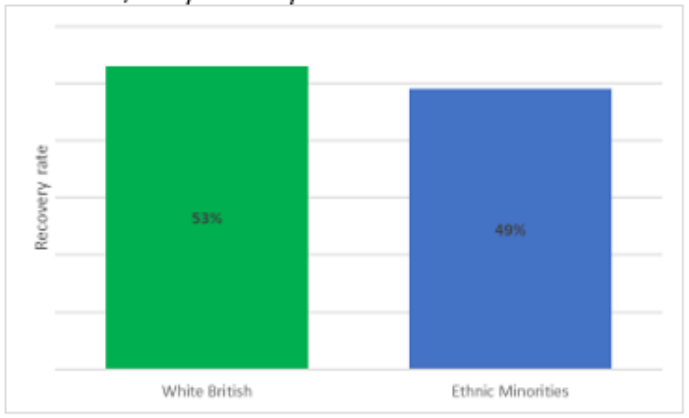


Figure 2 – NHS Talking Therapies (formerly IAPT) Recovery rate –2023/24 by ethnicity



Data Source: NHS Digital, Mental Health Dashboards
Reporting Period: 2022/23

Clinical Conditions Strategic Plan measure

The data included above is taken from the most recently available Talking therapies data from NHS Digital. The data relates to the most recent annual statistics but has been supplemented within this narrative to provide a more contemporary position from the quarterly statistics from the same source. Please note, the quarterly data does not segment by IMD, therefore we are unable to provide an update on the inequality gap by deprivation beyond the annual figures.

In 2022/23 50% of patients within NENC who started treatment with a high score were discharged with a score lower than the clinical threshold. This is defined as 'recovery'. The national recovery rate target is 50%.

The recovery rate for patients from the most deprived communities is lower at 43%. Compared with patients from the least deprived communities, there is an 18%pt inequality gap in recovery.
The recovery rate for patients from ethnic minority communities is also lower at 48%. Compared with patients of white ethnicity, there is an inequality gap by ethnicity of 5%pts.

The 2023/24 data for quarter 4 shows a slight increase in the ICB recovery rate to 51%. The ethnicity inequality gap also seems to have reduced to 3%pts following an increase in rate for patients from ethnic minority communities but also a reduction in recovery rate for those of white ethnicity.

Primary IBC Outcome	**Longer and healthier lived**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Mental Health**

North East North Cumbria Health & Care Partnership

The causes for the inequality gap

- Across NENC there are significant differences in recovery rates between deprivation levels. In January 2023, 55% of people who completed a course of treatment from the least deprived decile recovered, compared to 42% from the most deprived decile.
- In January 2023 there were 11,892 more people who completed a course of treatment from the 3 most deprived deciles when compared to the 3 least deprived ones. Even though a larger number of people from the most deprived deciles complete treatment, they are less likely to reach movement to recovery thresholds than their least deprived counterparts. Deprivation and mental health are inextricably linked. Poor housing conditions, unemployment and income insecurity are all factors for poor mental health.
- NENC are in line with national trends with a clear link between prevalence of anxiety disorder and depression with deprivation and other social factors.

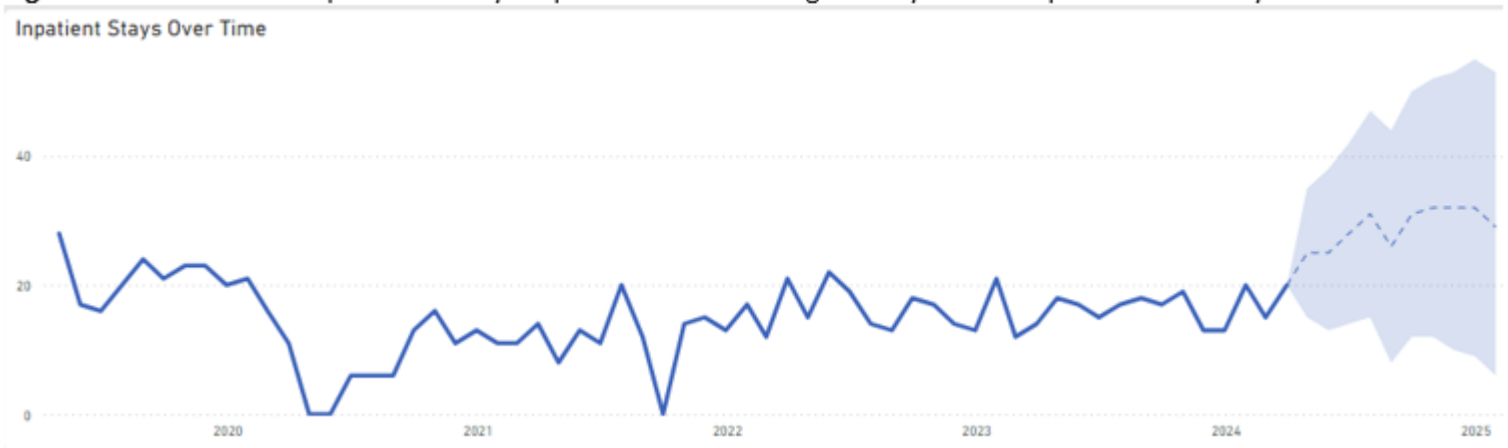
The work currently being undertaken to address the gap

- The head of programme transformation for Mental Health within the ICB's transformation team will
- · Seek to develop a standard service specification.
- · Review pathways for psychological support, to ensure people get to the right services when they need them.
- · Develop a contracting and procurement plan.
- · Develop an interlinked commissioning and workforce transformation plan for 25/26 moving forwards, inclusive of identified SDF spend in 25/26
- Consideration to understand experiences across our communities and how we may reduce inequalities will be given within this programme of work. However, plans for future work are being finalised at present therefore unable to provide any further update.

Mental health : Adult mental health inpatient rates for people with a learning disability and autistic people

ICB Overall Position	**12% of all inpatient activity**
Most deprived position	**8.6% of inpatient activity**
Least deprived position	**3.3% of inpatient activity**

Figure 1 – Mental health inpatient activity for patients with Learning diability – Most deprived community



Data Source: NENC Mental Health Dashboard, NECS
Reporting Period: 2023/24

The data above has been taken from the NENC mental health dashboard and shows the proportion of inpatient admissions for individuals from the most deprived communities which are aligned to Learning Disabilities.

The current data suggests that 8.6% of inpatient stays for the most deprived communities are aligned with learning disabilities. This is lower than the overall proportion of 12%. This is likely to be as a result of more varied reasons for admissions for individuals within these communities rather than a lower need for the learning disability population.

In 2023/24 there were a total of 2,346 mental health admissions recorded for individuals from the most deprived communities. 202 of those were for individuals with a learning disability diagnosis.

The overall number of inpatient stays for patients with learning disabilities is following an increasing trend but the trend for those individuals from the most deprived communities is less.

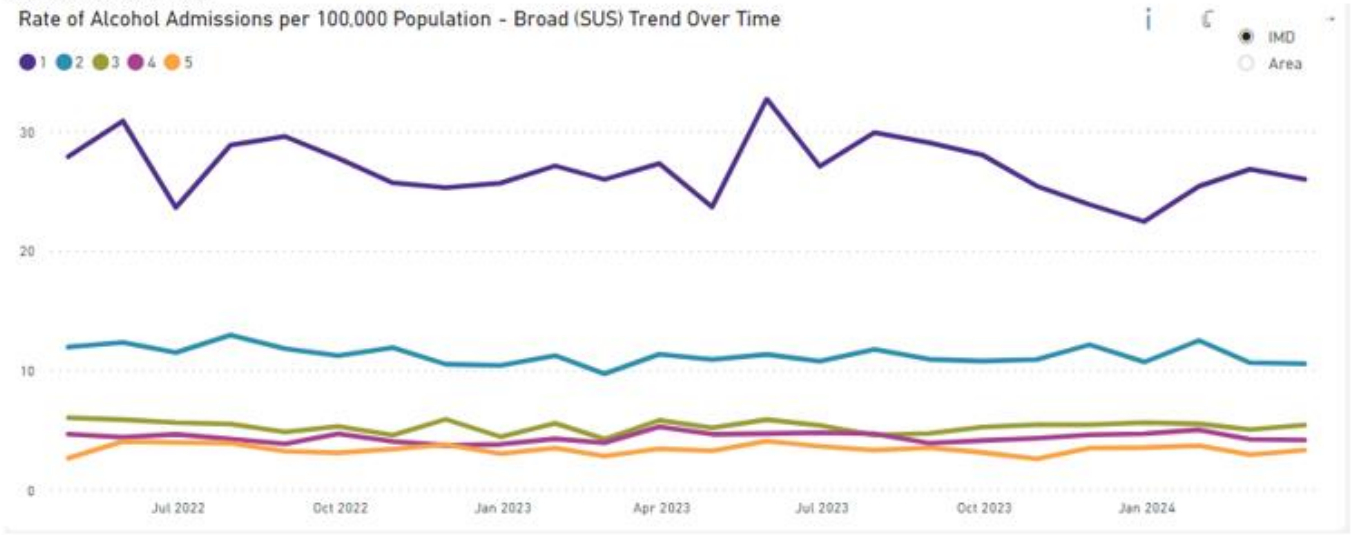
North East North Cumbria Health & Care Partnership

Primary IBC Outcome	**Fairer outcomes for all**
National guidance	**CYP Core 20 plus 5**
Lead Programme	**Mental Health**

Alcohol: Reduce alcohol related admissions to hospital by 20% (2021/22)

ICB Overall Position 2023/24	800.5 per 100,000 population
ICB Overall Position 2022/23	826.3 per 100,000 population
ICB Overall Position 2021/22	883.0 per 100,000 population
% change for ICB since 2021/22	-9.3% in rate per 100,000 population
Change for most deprived IMDs	-9.5% in rate per 100,000 population
Change for the least deprived IMDs	0.5 per 100,000 population
Inequality Gap by deprivation	8.3 times more admissions

Figure 1 – Admission episodes for Alcohol related conditions (broad) by IMD and month April 2022 – March 2023 – NENC Alcohol dashboard



The data above is taken from NENC Alcohol insight dashboard and it is based upon local hospital data to measure Alcohol admissions, taking into account alcohol as a primary and contributing factor.

The latest full financial year (April 2023 – March 2024) reports a rate of 800.5 per 100,000 population which is a reduction compared with the previous period (826.3). Although the rate of admission for individuals from the most deprived part of the ICB remains more than 8 times higher than for those from the least deprived, the most recent ICB reduction rate is predominantly driven by a reduction for those within the most deprived communities (a reduction of 9.5%.

The current rate of alcohol admissions for those within the most deprived communities (20% most deprived) is 402.7 per 100,000 population, compared with 48.5 per 100,000 population from the least deprived.

North East North Cumbria Health & Care Partnership

Primary IBC Outcome	**Fairer outcomes for all**
National guidance	**NHSE Long Term Plan**
Lead Team	**Healthier and Fairer**

The causes for the inequality gap

- It is well recognised that similar levels of alcohol consumption in deprived communities (vs. more affluent) result in higher levels of alcohol-related ill health, despite the fact that average consumption is usually lower in these areas. This is due to the harmful effects of alcohol being linked to a range of social determinants of heath such as diet, smoking, access to healthcare and stress.
- The above average levels of deprivation within the North East & North Cumbria are therefore reflected in the levels of alcohol related hospital admissions in this region.

The work currently being undertaken to address the gap

- Since 2020 NENC ICS has prioritised the prevention of alcohol harm and developed a comprehensive strategy to facilitate greater NHS engagement and collaboration in the prevention of alcohol harm and the associated health inequalities.
- The strategy, which covers the breadth of prevention – including 'upstream' primary prevention; identifying those at risk and ensuring they can access support (secondary prevention); and reducing the harm experienced by those with problematic alcohol use (tertiary prevention) - relies on partnership working across multiple agencies to drive this preventative approach forward. Key elements of the programme include:
- Clinical leadership and management at regional level Eg. We have established an Alcohol Clinical Network for the ICS, enabling a whole system approach to improve pathways and collaboration between partners
- Using data and intelligence to understand and respond to the needs of the population Eg. We have developed local intelligence tools to support partners such as PCNs to use a population health management approach to identifying people at risk of alcohol related harm/associated health inequalities. This has led to targeted clinical interventions to those with the greatest need.
- Promoting, implementing and contributing to the existing research and evidence base on alcohol risk, harm and treatment Eg. We have developed (in collaboration with NHSE Health Education) a regional workforce training programme 'The NENC Programme for Alcohol Studies' to equip the system-wide workforce with the skills and knowledge to prevent and manage alcohol.
- Creating and supporting improved pathways within and between NHS and public health commissioned/other community services Eg. We have provided additional funding to Alcohol Care Teams in NENC to ensure comprehensive provision of these teams in all NENC Acute Trusts, and we have funded Recovery Navigators in all Acute Trusts to provide additional support into the journey to recovery for those with complex needs.

Plans for narrowing the gap

- We will continue to build on this strategic approach to reduce alcohol harm and ensure that all projects in the alcohol programme workplan address health/healthcare inequalities. Anticipated projects for 25/26 include the development of a NENC strategic plan to support the prevention of alcohol harm in primary care, building on existing work that has already been successfully adopted by other partner organisations in our region, such as the Programme for Alcohol Studies, Alcohol Let's Talk initiative and Stigma Kills campaign, in addition to scaling up population health management projects that have been evaluated as pilots.
- The ability to improve longer term on reducing alcohol related health inequalities in NENC is dependent on the long term resourcing of the Alcohol Programme and associated workforce such as Alcohol Care Teams in acute trusts.

Smoking cessation and Tobacco Control: Reduce smoking from 13% of adults in 2020 to 5% or below

ICB Overall Position (OHID)	13% (2022)	↓
ICB Overall Position (Primary Care)	15.1% (February 2024)	↓
Most Deprived (Primary Care)	23.1% (February 2024)	↓
Least Deprived (Primary Care)	6.2% (May 2023)	↓
Inequality gap by Deprivation	16.9%pts	↓

Figure 1 – Smoking prevalence in adults (18+) – APS 2022

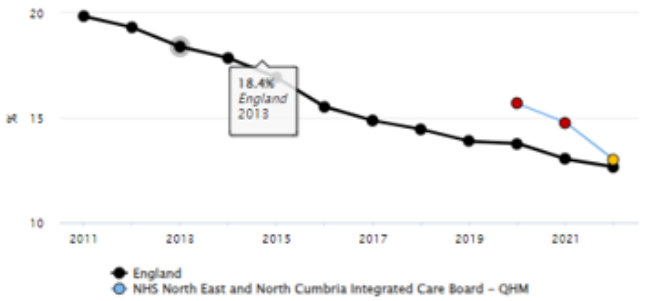
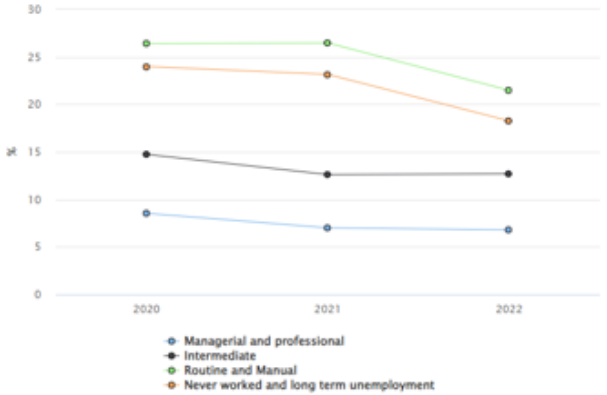


Figure 2 – Smoking prevalence in adults by socioeconomic group



North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure

The data included above is taken from two sources, the official prevalence on smoking figures published within PHE Fingertip. The data source is the Annual Population Survey. The NENC Tobacco dashboard, data source Primary Care data with a smoking status in the last 12 months.

The official trend in smoking prevalence for NENC is significantly reducing from 15.7% in 2020 to 13% in 2022. This means NENC is no longer significantly higher than the England average in relation to smoking prevalence. The official data is not segmented by deprivation at local level but it is segmented by socio-economic group and sex. By socioeconomic grouping, there is a 14.7%pt inequality gap between routine and manual workers, and people within managerial and professional employment. Over the last 2 years, the rate for routine and manual workers has reduced considerably but there has been little to no change for those in the managerial and professional category.

Using local data from patient GP records, the prevalence of smoking is reported as 15.1% (aged 16 and over), a reduction of 0.8%pts in the last 6 months. The rate is higher for individuals from the most disadvantaged areas (23.1%). This cohort of individuals have experienced the greatest reduction in the last 6 months, reducing from 24.2%. When compared with the rate for the least disadvantaged communities, the inequality gap is reported as 16.9%pts (down from 17.6%pts).

Primary IBC Outcome	**Longer and healthier lives**
National guidance	**Legal Statement**
Lead Programme	**Healthier and Fairer**

The causes for the inequality gap

- Smoking remains the larger driver for health inequalities and there are higher rates in people with lower income. It is transmitted across generations in cycle underpinned by social norms. The converse relationship between deprivation and smoking rates result in higher rates of smoking attributable ill health and premature mortality in NENC.

The work currently being undertaken to address the gap

- Reducing health inequalities through measures that have greater effect on smokers in higher prevalence groups through both population interventions and targeted interventions is key.
- Fresh is jointly funded by the ICB and 12 NE LA public health to provide a world leading and award winning tobacco control program covering the 8 key strands of activity.
- NHS Contribution to tobacco dependency treatment (TDT) within acute and mental health inpatient settings and maternity services. 17/18 NHS LTP clinical pathways fully established.
- Expanding targeted work in primary care focused on Severe Mental illness population for enhanced smoking cessation, continuation Community Mental Health Settings smoking cessation alongside two trusts.
- LA's already commission Stop Smoking Services in Community and Fresh , Taskforce & OHID are providing support to LA's to implement the North East Position statement on "Helping Smokers to Quit" (August 2023) and utilising the additional funding from Govt' to increase numbers of smokers who quit in NENC.
- Emerging work with Targeted Lung Heath Check (TLHC) to incorporate rapid identification and support for smokers in NENC and continuation of NENC maternity incentives scheme.

Plans for narrowing the gap

- The TDTS services funding mainstreamed and secured through existing contracts. Treating tobacco dependency embedded as routine clinical care led by Smokefree NHS Taskforce.
- Use data driven insights to improve quality and outcomes.
- Whole system approach (as per regional vision)- region wide tobacco control programme an approach through Fresh needs long term funding as this will have population wide impact on reducing adult smoking rates.

Healthy Weight and Treating Obesity: Increase the number of people with a healthy weight. – (Rate of Obesity per 1,000 population)

ICB Overall Position	295 per 1,000 population
Most deprived communities	390 per 1,000 population
Least Deprived communities	226 per 1,000 population
Inequality gap by deprivation	164 per 1,000 population

Figure 1 – Rate of obese patients per 1,000 population

The data above is taken from the NENC weight modelling undertaken in 2023. Source data is health survey for England and Primary care data. The data refers to patients with a BMI equal to or greater than 30.

Just under a third of the adult population within NENC are estimated to be obese. The rate is greater within the most deprived communities with a rate of 390 per 1,000 population. The inequality gap is currently 164 per 1,000 population.

There has been an increase in the rate of obesity in NENC compared with the modelling which was undertaken in 2021. The greatest increase has been for those within the most deprived communities, increasing from 380 per 1,000 population to 390. The inequality gap has increased from 155 per 1,000 population to 164 per 1,000 population.

Data on recorded prevalence is available using Primary Care data. When comparing the rate for those with a recorded BMI with the modelled estimates, there is a gap, particularly for certain age groups (those less likely to be frequenting Primary care). For this reason, the modelled estimate has been used.

The causes for the inequality gap

- Several key socio-economic factors that include income, housing, education, access to space, exposure to advertising and sale of unhealthy foods have a significant impact upon whether people can be active or eat healthily and thus ultimately the risk of developing obesity. The major driver of all these factors is what we eat, which in turn is shaped by our food environment, and we need to understand how this plays a key role in driving health inequalities between people living in advantaged and disadvantaged circumstances. The data above highlights the number of people who are living in poverty, thus eating healthy food can be secondary to eating at all.
- There is variation and inequalities in support service provision across the ICB. The patient experience key areas of concern were aligned to access in terms of availability of services and the ease of accessing them with the reliance upon healthcare professionals to sign post them.

The work currently being undertaken to address the gap

- HWTO workplan that has key actions to support primary, secondary and tertiary prevention for obesity and promotion of healthier weight
- Investment in specialist weight management services that meet policy minimum standards targeted at patients living in the 20% most deprived wards.
- Behavioural insights project to understand the enablers and barriers experienced by adults in relation to increasing uptake of digital weight management services (DWMP) within the most deprived communities in NENC.
- Pilot using behavioural insights to support self-referral to DWMP pilot targeting Men aged 30 -55 in the most deprived areas of the NENC.
- Working closely with PCN's across NENC to increase referrals to DWMP and weight management support services particularly in areas of deprivation
- Healthy Weight and Treating Obesity Healthcare Needs Assessments (Adult and Children and Young People) to inform and support the ICS Healthy Weight and Treating Obesity Programme and strategic plans

Plans for narrowing the gap

- Develop a NENC Whole Systems Approach for Healthy Weight and Treating Obesity across the ICB
- Development of NENC Healthy Weight and Treating Obesity Strategy