NHS
North East and
North Cumbria

Integrated Delivery report

February 2024

(Reporting period December 2023/January 2024)

Better health and wellbeing for all...

Contents

Executive Summary

The NENC Integrated Delivery Report provides an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions. The report also provides an overview of the ICS position on the NHS Oversight Framework and CQC ratings of organisations.

The report focusses on the objectives specified within the 2023/24 operational planning requirements; this encompasses a wide range of recovery objectives as well as some NHS Long Term Plan (LTP) and NHS People Plan commitments. The report is discussed in detail at the Finance Performance and Investment Committee and the Quality and Safety Committee. The report is also received by the ICB Executive Committee and the NENC ICB Board.

Reporting period covered:
January 2023 – A&E metrics, bed occupancy, handover delays, ambulance response times, cancer 62 day backlog and metrics for learning disability and autism services.
December 2023 – all other standards unless otherwise specified.
Finance is at month 10 (January 23).

Key changes from previous report

Health Inequalities

Tackling inequalities in outcomes, experiences and access is one of the four key purposes of ICSs. Good quality robust data enables us to understand more about the populations we serve and identify groups at risk of poorer access to healthcare, poor experiences or outcomes, and deliver targeted action to reduce healthcare inequalities. This month's report includes a detailed update on progress against the health and healthcare inequality metrics outlined within the NENC ICB Joint Forward Plan 23-28, NENC Integrated Care Partnership (ICP) Better Health and Wellbeing for All Strategy and NHS England's statement on information on health inequalities.

NHSE published the statement on information on health inequalities on 27 November 2023 setting out a description of the powers available to relevant NHS bodies to collect, analyse and publish information in connection with health inequalities for the period 1 April 2023 to 31 March 2025, with a view to being reviewed initially every 2 years. This is intended to encourage better quality data, completeness and increased transparency and drive improvement in the provision of good quality services and in reducing inequalities across our system.

The first statement focuses on a small number of data indicators aligned to the 5 priority areas for addressing healthcare inequalities set out in the 2023/24 priorities and operational planning guidance and the CORE20PLUS5 approach for adults and children and young people and are to be disaggregated where available by age, sex deprivation and ethnicity. ICBs and NHS Trusts should use this statement to identify key information on health inequalities and set out how they have responded to the statement in annual reports.

Planning

In lieu of no national 24/25 operational planning guidance, a local high level interim submission has been requested by NHSE by 27 February 2024. The first full submission will be required on 21 March 2024.

CQC

The Newcastle upon Tyne Hospitals NHS FT - the CQC published their report in January which showed that the Trust's overall rating had deteriorated from `outstanding` to *'requires improvement'* following

inspection of the Trust's core services (July to September 2023). The well led domain was rated as inadequate, safe, effective and responsive domains assed as requires improvement and the caring domain was good. An unannounced focused responsive inspection of maternity services was also undertaken in response to whistleblowing concerns about safety and culture. A further targeted inspection into surgical cardiothoracic services was undertaken in response to increased whistleblowing concerns following the core inspection.

The CQC identified a number of 'must' and 'should' do actions both Trust wide and service specific. The Trust has commenced their improvement work, and updates will be provided via their Quality Review Group.

South Tees Hospital NHS FT – A maternity inspection was undertaken in January 2024. James Cook requires improvement overall, and for being safe and well-led. Friarage Hospital assessed as requires improvement overall and for being well-led, and good for being safe.

North Cumbria Integrated Care NHS FT:

CQC Requirement Notices -'Must do' actions have been approved by the Trust Executive Board, the action plan was shared with the CQC in December and the first progress against action plan meeting has been held. Monthly meetings with the collaboratives are now in place, with the aim of completing the majority of 'must do' actions within next 6 months with a focus on sustainable change.

CQC Ionising Radiation (Medical Exposure) Regulations inspection, September 2023. The report was issued in October 2023. The nuclear medicine department had some examples of good practice, for example quality assurance (QA) of policies and procedures and incident management. However, there were some areas that required improvements to maintain compliance with the regulations.

County Durham and Darlington NHS FT – The CQC undertook a follow up inspection of the Trust`s maternity services in January 2024. Feedback from the inspection is awaited. The Trust`s maternity service was placed in escalation with NHSE oversight following CQC`s inadequate rating of the services at both sites. The Trust continue work to implement required improvements.

Independent Providers: Barchester Billingham Grange Mental Health Act Monitoring visit for Grange Ward took place in November 2023. Some areas for improvement were highlighted within the report by the CQC to which Barchester has responded with an action statement highlighting areas which have been addressed. The report has been shared with the ICB.

Hospice - St Cuthberts. The CQC conducted an unannounced visit across two days 10th and 11th November 2023. The final report was published in January 2024 confirming the providers rating as "requires improvement". An action plan is being developed in response to areas highlighted within the report.

Priory, Darlington
The CQC conducted an unannounced inspection in December 2023. An update on the feedback from this was requested at the January Quality &

Contracting meeting with Priory on 29 January 2024, they advised an update should be available by end of February 2024.

Category 2 mean end of year forecast (NEAS)

The forecast for February shows a slight improvement for the 2023/24 average, moving to 34 minutes 36 seconds. This is due to better actual performance in January than was previously forecast. There is still some risk, the February and March forecast of just over 31 minutes would be the best monthly actual this financial year if achieved.

Elective long waits

NENC was the best performing ICS in December 23 for RTT performance with 68% on the waiting list for elective (non-urgent) treatment waiting less than 18 weeks.

NENC is ranked 2/42 ICBs for having the lowest proportion of 65+ and 52+ week waiters on their elective waiting list.

104+ week waiting time pressures remain at NUTH (adult spinal) but continue to reduce. A small number of independent sector patients were recorded in error in the latest published data. Unpublished data for week ending 11 February shows that there are no longer any patients in NENC that have been waiting over 104 weeks for elective treatment, this is a significant milestone.

78+ week waiting time pressures are growing particularly at NUTH and South Tees. NUTH remain in Tier 1 for Elective, and S Tees were recently escalated to Tier 2 for Elective.

There is a continued reduction in the number of 65+ week waiters across NENC, following a growing trend since April 23. Providers are to set a 24/25 trajectory in the planning round.

There have been two months reduction in 52+week waiters. Providers required to set a 24/25 monthly trajectory in the 24/25 planning round.

Elective recovery – mutual support

Mutual support between trusts is essential to elective recovery and reducing the variation in waiting times. A Provider Collaborative led Mutual Support Group is now in place that supports the identification of pressured specialities and related opportunities. Very positively trusts have offered capacity and this in turn resulted in some of the ICB's longest waiting patients being offered earlier access at an alternative provider. It is estimated that almost 600 requests have been made and around 340 patient transfers as a result.

Combined cancer 62-day referral to treatment standard

The Northern Cancer Alliance Board met on 19 January and discussed the importance of the 62 day standard to patient outcomes in certain pathways and asked that the ICB System Performance Group consider this as a priority and work with providers to develop improvement trajectories. The NENC System Performance Group has confirmed support for this and noted that the 2024/25 operational planning submission will include a monthly trajectory for the 62-day referral to treatment standard overall and in addition the ICB will look at pathways where timing has a significant impact on outcomes.

Other areas of note/risk

Mental health waiting times

Adult and older adult (AMD) MH Waiting Times: At the end of December 2023, 35,714 adults were waiting for a 1st MH direct contact, 32% have been waiting less than 18 weeks and 17.4% greater than 104 weeks.

Children and Young People (CYP) MH waiting times: At the end of December 2023, 25,340 CYP, (15,552 CYP autism and neurodevelopment patients) had been waiting for a 2nd contact, 33.6% CYP have been waiting less than 18 weeks and 10.1% CYP (7.7% CYP autism, neurodevelopmental) greater than 104 weeks. Further analysis in relation to <18 week, 18-26 week, 53-104 week and 104+ trends is available in the report appendices. The waiting time position continues to worsen.

A variety of transformation work is underway and reviewed by the NENC Mental Health and Learning Disability Sub-Committee. Further analysis of waiting time data will be coordinated through the NENC MHLDA Performance and Oversight Group. TEWV performance improvement continues to be monitored through the Care Group Board, CYP outcomes metrics continue to improve. CNTW redesigned pathway for CYPS neurodevelopmental has been presented to oversight group. CYP services diagnostic waiting times, rapid improvement work underway.

NB MHSDS data is subject to variable data quality between providers. All providers submitting to MHSDS are included. Definitions as below open to differences in interpretation, particularly as to what is defined as a contact. Reporting to move to new national standard once supported by MHSDS submissions.

Adult "*People with an accepted referral waiting for a 1st direct or indirect contact".*
Children *"Children and Young People (0-17) with an accepted referral waiting for a 1st or 2nd direct or indirect contact".*

Mental health services: Talking Therapies

The numbers of people accessing Talking Therapies for anxiety (TTAD) continues to be behind plan. The multi-disciplinary Transformation Team are undertaking a deep dive to agree credible options/recommendations for future commissioning of TTAD services. Currently there is significant variation of provision across NENC.

Mental health services: Out of Area Placements (bed days)

The number of Out of Area Placements (OAP) bed days reduced significantly in July following a peak in June. This reduction has been maintained in November, although this remains behind plan at 345 OAP Bed days compared to a November plan of 201 across NENC. As of beginning of December 23, CNTW have 0 inappropriate OOA placements and TEWV reporting an improved position at 5.

NENC ICB continue to explore the issues causing the underperformance and mitigating actions with all partners to recover the target. Actions include robust case management, embedding clinically ready for discharge reporting and discharge facilitation.

Learning Disabilities and Autism: IP Care

Reducing reliance on inpatient care (IP) – The quarter 3 trajectory 124 was not met. The actual position at the end of quarter 3 was 170 (46 over target). At the end of January there were 166 compared to a quarter 4 trajectory of 113 which remains a risk for year end.

Units of Dental Activity (UDA) compared to plan

Following a request from NENC Finance Performance and Investment Committee the metric within this report which measures UDA performance now measures actual units of dental activity contracted in comparison to planned levels of dental activity. Cumulative performance at Q3 year to date was 2.89m units of dental activity contracted compared to a Q3 cumulative plan of 3.19m. Following validation with the ICB dental team it should be noted that:

- The delivery profile typically fluctuates during the year depending on workforce availability, i.e. it is not unusual for delivery to be low in the first quarter; drops around the main holiday periods of summer and Christmas, with delivery increasing in Q4 as providers strive to hit their annual UDA delivery target (there is no contractual requirement to deliver activity evenly across the year). Future reporting is being developed to capture monitoring of trends and seasonality.
- The position shown excludes activity undertaken within the ICB's incentivised access scheme which is commissioned based on sessions rather than UDAs.
- Since the plan was set there has been a drop in the number of UDAs commissioned because of contracts that have been handed back, the activity for which has not yet been fully re-commissioned. However, a formal procurement process has commenced which if successful will see an increase in commissioned UDAs in 2024-25.
- In addition, for further context (not linked directly to UDA delivery), there has been a steady improvement in the number of unique patients treated since the ICB took over responsibility for commissioning, rising from 49.56% of the resident population in April 2023 to 50.3% in January 2024, however there is still some way to go to recover to pre-covid levels of 58.23% (April 2020).

Operational plan delivery - summary dashboard

A broad range of metrics are reviewed and monitored through strategic programmes and through ICB oversight and contracting arrangements. This supports the delivery of standards and improvement. Where appropriate this is underpinned using a Statistical Process Control (SPC) approach which is considered best practice to enable systems to understand where there is significant variation and most risk and therefore focus attention on those areas that require improvement support.

This report includes a sub-set of those metrics primarily focussed on the national objectives for 2023/24. The metrics are reported at ICB level, and the narrative refers to place or organisations by exception. Other metrics, not routinely included in this report, will be added by exception if there is significant improvement or deterioration or concern about progress. These will be escalated via programme or oversight routes.

The dashboard is in three parts:

Part 1 - Recovering core services and improving productivity – national objectives 2023/24
These are the key metrics specified in the 2023/24 priorities and operational planning guidance for the NHS to support recovery of core services and improve productivity. They predominantly link to access or responsiveness of services and patient experience but some link to effectiveness/outcomes e.g., cancers diagnosed at an earlier stage are more likely to result in a better outcome. Others have a link to safety e.g., the maternity metrics. Use of resources is also

included in this section given the importance of delivering a balanced net position to recovery and sustainability.

Part 2 - NHS Long Term Plan and transformation – national objectives 2023/24
These metrics are also specified in the 2023/24 priorities and operational planning guidance but link to commitments from the NHS Long Term Plan and service transformation. Many of these link to access to services, effectiveness, improving outcomes and personalisation.

Part 3 – National safety metrics
This includes important metrics/data linked to patient safety.

The dashboard Part 1 and 2 includes the metrics that are listed as objectives in the national planning guidance, however the delivery section later in the report also includes some additional metrics, either associated with the actions in the operational planning guidance or local priorities.

DASHBOARD KEY

National objective	This provides a brief description of the national objective and associated timeframe, most aim for achievement by end of March 2024 and have a local month by month trajectory. Some objectives have a longer time frame. A full description of the objectives is included in Appendix 1. The dashboard also includes 2022/23 objectives linked to elective care long waits that have not yet been achieved (104 and78 week waits).
Plan – March 2024	NENC's plan for end of March 2024 (From the final operational planning submission in May 2023 or the November 2023 H2 submission where relevant)
Plan – month	This specifies the NENC operational planning trajectory or national required standard for the month that is reported against in the report. The reporting period varies between metrics e.g., UEC metrics have more recently published data than other metrics.
Actual	This number represents the actual performance in the most recent reported month. This is primarily monthly published data, where more recent unpublished data is available the narrative later in the report often uses this to provide an indication of the direction of travel. The colour shading in the 'actual' column draws attention to those metrics that are well ahead or well behind plan in that month. Colour coding is not applied where the plan has been met or missed by a small margin. Met – well ahead of plan Not met – well behind plan
Trend	This indicates whether performance over time is **improving** or **worsening.** Where Statistical Process Control (SPC) is used, the trend category relates to the variation output generated by SPC and therefore indicates significant improvement or deterioration. Where SPC is not appropriate a number of data points are used to ensure it reflects a trend rather than normal variation.
Benchmark	Where possible the NENC performance is compared with the England or North East and Yorkshire (NEY) position as a benchmark. The number represents the England position unless otherwise stated and the colour shading indicates: NENC compares favourably NENC does not compare favourably No comparative data available For ambulance response times the bench mark is expressed as a ranking position out of the 11 ambulance providers.

Data flow is not yet established against some of the new objectives and will be included as soon as possible.

Please note - Reporting period covered in this month's dashboards:
January 2024 – A&E metrics, bed occupancy, handover delays, ambulance response times, cancer 62 day backlog and metrics for learning disability and autism IP services, Never events, Finance
December 2023 – all other standards unless otherwise specified. .

Part 1 Recovering core services and improving productivity – national objectives 2023/24

	National objective 2023/24	March 24 Plan	Plan (month)	Actual	Trend	Bench mark
Urgent and emergency care	A&E waiting times within 4 hours (76% by March 2024) *	79.2% (81%)	78.5%	74.1%		70.3% (8/42)
	Category 2 ambulance response times (average 30 mins)	30 m (avg)	33:42 m:s	35.:23m		4/11
	Adult general and acute bed occupancy 92% or less	92.1%	93.1%	92.3%	Worsening	94.2%
Community health services	2-hour urgent community response (standard 70%)	70%	70%	80.9%	Improving	84.2%
	Reduce unnecessary GP appointments: a) Direct referral from community optometrists and b) Self referral routes					
Primary care	a) GP practice appointments within two weeks and			84.4%		82.6%
	b) Urgent appointments the same or next day			68.7%		68%
	More appointments in general practice by Mar 24	1.6m	1.49m	1.44m		
	Additional Roles Reimbursement Scheme by Mar 24	1,526		1,682	Improving	
	Improving units dental activity (UDA) contracted (Q3)	5.315m	3.189m	2.890m		
Elective care	Eliminate waits of over 104 weeks (by July 2022) **ICB**	0		5		21/42
	Eliminate waits of over 104 weeks (by July 2022) **Provider aggregate** (No H2 submission)	0	2	6		
	Eliminate waits of over 78 weeks (by April 2023) ***ICB** plan* (No H2 submission)	0	5	344	Worsening	21/42
	*Eliminate waits of over 78 weeks (by April 2023) ***Provider Aggregate plan (Nov 23 H2 submission)***	167	293	377		
	Eliminate waits of over 65 weeks (by March 2024) **ICB** Plan (No H2 submission)	31	955	2030		2/42
	*Eliminate waits of over 65 weeks (by March 2024) **Provider aggregate plan (*Nov 23 H2 resubmission*)**	1145 (14)	2198	2148		
	Eliminate waits of over 52 weeks (by March 2025) **ICB** Plan (No H2 submission)	5142	6092	7624		2/42
	Eliminate waits of over 52 weeks (by March 2025) **Provider** aggregate (No H2 submission)	5135	6104	8096		
	Deliver 109% value weighted activity (amended to 105%) 28/1/24	105%		96%		
Cancer	*Reduce the number of patients waiting over 62 days w/e 28/1/23 (H2 resubmission)	817 (800)	903	987	Improving	
	Cancer faster diagnosis standard 75% by March 2024 ***ICB Plan (No H2 submission)***	77%		78.1%		71.1%
	*Cancer faster diagnosis standard 75% by March 24 ***Provider aggregate Plan (Nov23 resubmission) H2***	77.2% (77.6%)	77.3%	78.5%		
	Stage at diagnosis ambition 75% by 2028					
Diagnostics	Diagnostic test within six weeks 95% by March 2025	89.4%	89.2%	83.6%		72.5%
	Diagnostic activity levels to support recovery 28/1/24	109%	110%	113%		
Maternity	Maternal mortality rate per 1000					
	Still births per 1000 births (2021)			2.53		3.52
	Neonatal deaths per 1000 live births (2021)			1.86		1.6
	Increase fill rates for maternity staff					
Use of Resources	Deliver a balanced net system financial position for 2023/24	£49.87 m	£52.32 m	£32.37m		

***H2 Provider resubmission. March 24 plan as per H2; Monthly plan commenced from Nov 23 data. (denotes original plan).**

Part 2 NHS Long Term Plan and transformation – national objectives 2023/24

	National objective 2023/24	March 24 plan	Plan (Month)	Actual	Trend	Bench mark
Workforce	Improve retention (turnover)	12.1%		9.3%	Improving	11.3%
	Improve staff attendance (sickness)	5.6%		5.7%	Improving	5%
Mental health	*Improve access to mental health support for CYP	53,245	52,243	56,975	Improving	
	Increase the number of people accessing Talking Therapies for anxiety (TTAD)	22,540	7,424	4,575		
	*Community mental health services (5% increase) 2+ contacts	34,855	33,761	38,300	Improving	
	*Total number of inappropriate Out of Area Placements (OAP) Bed days (Nov 23)	162	201	345		
	Recover the dementia diagnosis rate to 66.7% Jan24	67%	67%	68.6%	Improving	63.8%
People with a learning disability and autistic people	Annual health check and plan for people on GP LD registers (75% March 2024) (Cumulative Nov23)	75%	43.2%	39.3%		
	*Reduce reliance on inpatient care -adults (ICB)	52	52	91		
	*Reduce reliance on inpatient care -adults (secure)	61	61	75		
	Reduce reliance on inpatient care – under 18s	8	8	5		
Prevention and health inequalities	Hypertension (77% by March 2024) Sept 23	77%	77%	71%		
	Use of lipid lowering therapies (60%) Sept 23	60%	60%	63%		
Adults	Increase uptake of COVID vaccines (highest priority group as@ 17/12/23)			63.8%		
	65+ receiving flu vaccination (as @17/12 23)	85%		76.8%		
	Increase uptake of pneumonia vaccines					
	Increase uptake of SMI health checks (Cumulative) December 23		16,325	16,002		
	% pregnant women from BAME groups on continuity of care pathway by 29 weeks Nov23		N/A	40%	Improving	
	75% Cancers Diagnosed at stage 1&2 by 2028					
Children & Young People (CYP)	CYP: Asthma: address over reliance of medications					
	CYP: Decrease the number of asthma attacks Proxy: Rate of unplanned admissions for asthma 0-17 yr olds, per 100,000		N/A	11		
	CYP: Increase access to glucose monitors and insulin pumps					
	CYP: Access to epilepsy specialist nurses					
	CYP: Rate tooth extractions due to decay children admitted as IP in hospital aged <10 per 100,000		N/A	22	Worsening	
	CYP: El. WL <10 awaiting IP tooth extraction Jan24			257	Worsening	
	CYP accessing mental health service for 0-17 years	53,245	52,243	56,975	Improving	

*NENC Plan does not meet or exceed the national objective

Reporting period covered:
January 2024 – A&E metrics, bed occupancy, handover delays, ambulance response times, cancer 62 day backlog and metrics for learning disability and autism IP services, Never events, Finance
December 2023 – all other standards unless otherwise specified.

Part 3 – Core safety metrics – December/January 23/24

	National objective	Mar 24 plan	Plan (YTD)	Actual Month	Actual YTD	Trend	Benchmark
Never events	Zero Jan 24	0	0	2	17		
Infection prevention control	MRSA	0	0	3	18		
	C Diff		420	54	500		
	E Coli		652	83	790		
Mortality		**Two trusts (CDDFT and STSFT) are showing higher than the expected range for SHMI.**					

NB The data on the number of serious incidents is no longer be reported. Providers are now underway with their transition to PSIRF and will cease the application of the former serious incident framework. Regular updates regarding PSIRF implementation, and any shared learning, will be received in the bimonthly PSIRF updates to the Quality and Safety Committee.

Mortality

CDDFT - early analysis shows the main underlying cause is a data quality issue associated with coding and the use of a new electronic patient record system. This will take time to address, and it may be many months before the impact is seen in SHMI data. Progress will be monitored through quality review mechanisms as well as seeking assurance on quality of clinical care through mortality reviews and any serious incidents.

STSFT - the overall trust figures include a hospice and the trust has requested the hospice data is extracted from the overall trust data. NHS Digital has confirmed the removal of the hospice data from the indicator although no date has been set. The ICB continue monitor through surveillance and attend the trust's mortality review meeting.

Reporting period covered:

January 2024 – A&E metrics, bed occupancy, handover delays, ambulance response times, cancer 62 day backlog and metrics for learning disability and autism IP services, Never events, Finance.
December 2023 – all other standards unless otherwise specified.

NHS
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Health and Healthcare Inequalities

**Better health
and wellbeing for all...**

Progress Update on Health and Healthcare Inequalities – February 2024

This section of the 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 Joint Forward Plan)
- NENC ICP Better Health and Wellbeing for All Strategy ("the strategy")
  (NENC ICP Strategy)
- NHS England's statement on information on health inequalities ("the statement")
  (NHSE Statement)

Join Forward Plan

The plan outlines the ICBs goals for improving all aspects of health and care focused on NHS delivered and commissioned services and is due for update in March 2024. The plan identified the following objectives:

- Longer and healthier lives
- Fairer outcomes for all
- Better health and care services
- Giving children and young people the best start in life

Better Health and Wellbeing for All Strategy

The strategy provides a strategic direction and agrees commitments to improve the health and care of people in the North East and North Cumbria, based on the understanding of health and care needs across the region and at the 13 local authority places. It is focused on what is required to achieve the plan, stated in the following goals:

- Reduce the gap between our ICP and the England average in life expectancy and health life expectancy at birth, by at least 10% by 2030.
- Reduce the inequality in life expectancy and healthy life expectancy at birth between people living in the most deprived 20% of neighbourhoods and least deprived 20%, by at least 10% by 2030.
- Increase the percentage of children with good school readiness at reception, especially for children from disadvantaged groups.
- To ensure that our Integrated Care System is rated as good or outstanding by the Care Quality Commission.
- To reduce smoking prevalence from 13% of people over 18 in 2020 to 5 % or below by 2030
- Reduce alcohol related admissions to hospital by 20% by 2030.
- Halve the difference in the suicide rate between our ICS and England in 2019/21 (three year rolling average) by 2029/31.
- Reduce drug related deaths by at least 15% by 2030.
- Increase the percentage of people diagnosed at the early stages of cancer (stage 1 & 2) to the national target of 75% by 2030.
- Increase the percentage of regulated services, across each of social care, primary care, and secondary care, that are rated as good or outstanding by the Care Quality Commission by 2030.

The NHS statement on health inequalities

The statement was published on 27th November 2023 and 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. By adhering to this statement, ICBs will strengthen their position in that annual assessment. It is the update provided here that will support this requirement through publication within the ICB annual report.

NENC Current position in relation to NENC Health and Healthcare Inequalities Goals

The 4 priority objectives within the Joint Forward Plan require the delivery of programmes of work across the ICB and ICS in partnership with our local authorities. Whilst mostly focused within the Healthy and Fairer Programme through the Prevention, Healthcare Inequalities, and NHS Contribution to Social and Economic Inequalities workstreams, addressing health and healthcare inequalities requires all ICB programmes and workstreams to focus on addressing health and health care inequalities should the inequality gap in life and healthy life expectancy is to be reduced.

Longer and Healthier Lives

Life expectancy figures have not been updated since baseline, with national publication updated on average every two years. The key contributing conditions to the inequality gap between the most and least deprived communities within the NENC are Cardiovascular disease, Cancer and 'External causes' which include suicide and accidental poisoning.

The CVD prevention workstream metrics show an increase in hypertension diagnosis and management since baseline, and although there is variation by Sub-ICB, overall, the inequality gap is reducing which will in time have an impact on the mortality gap.

Cancer detection at stage 1 or 2 is starting to increase again after a reduction during COVID period, and whilst the rate is still lower than the England if NENC continue to increase and the focus upon the most disadvantaged areas continues, the inequality gap will reduce, again impacting upon the longer term mortality outcomes.

The rate of suicide has reduced considerably compared to baseline, reducing the gap between NENC and England from 3.7 (per 100,000 population) in 2021 to 2.3 (per 100,000) in 2022.

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.

This includes ensuring access to healthcare is equitable for those from the most disadvantaged communities as well as the least disadvantaged, ensuring information provided to patients in support of support of making healthcare decisions is appropriate for all reading ages, and that access to digital developments in the provision of healthcare does not disadvantage those from lower socioeconomic communities.

The most recently published data indicates the percentage of children with good school readiness at reception, especially for children from disadvantaged groups has increased compared with last reporting period. There remain inequalities by gender, with a lower proportion of males with good school readiness.

Better health and care services

The better health and care services metric is currently measure using the latest CQC ratings across the ICB. There is currently variation in CQC ratings by setting with Health Care Organisations and Ambulance Trusts lower then Primary Medical Services, Social Care and Independent Sector providers.

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 support 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.

The continuity of care standard set out within the CORE20PLUS5 framework has been stood down, with NHS England writing to Regional NHSE, ICBs, Trusts and LMNSs on the 21 September 2022 advising them of that there would no longer be a target date for services to delivery Midwifery Continuity of Carer and local services would be supported to develop local plans that work for them. The letter advised that local midwifery and obstetric leaders should focus on retention and growth of the workforce and safe staffing. As a result of this letter, the NENC Local Maternity & Neonatal System decided to change the LMNS Continuity of Carer Sub Group to the LMNS Workforce Mult-Disciplinary Steering Group. The focus of this new group is to address system wide workforce issues.

The majority of metrics relating to best start in life have demonstrated an improvement within the last 12 months, with the exception of babies born at less than 37 weeks gestation.

Summary Health and Healthcare Inequalities Metrics position

The tables in this section provide a summary position of all metrics identified within the plan, the strategy, and the statement. A detailed narrative to explain the data source, the inequality gap, the actions currently underway to address this, and plans for further activity to reduce the gap are included in detail within ***Appendix 2*** of this report.

The data collection and position was undertaken by NECS Business Intelligence, with the narrative on the inequality gaps provided by ICB and NECS programme leads working within the Healthy and Fairer Programme and ICB workstreams.

Key for inequalities metrics tables

	Indicator trend	Inequality gap
⇔	No Change	No change
⇧	Positive Increase	-
⇩	Positive Reduction	Narrowing of inequalities
⇧	Negative Increase	Broadening of inequalities
⇩	Negative Reduction	-
N/A	No Trend data available	Data not stratified by Inequalities

	Existing inequalities
	No apparent inequalities
	No available data

Summary health and healthcare inequalities metrics - inequality by deprivation and ethnicity

Metrics included in the table below reflect those driven by national policy to be measured by ethnicity and deprivation.

Summary health and healthcare inequalities metrics			Indicator Trend	Inequality by Deprivation	Trend in Inequalities by deprivation	Inequality by ethnicity	Trend in Inequalities by ethnicity
NHSE Legal Statement	Elective recovery	Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks	⇔		⇔		⇔
		Elective activity vs pre-pandemic levels for under 18s and over 18s	⇧		⇔		⇔
	Urgent and emergency care	Emergency admissions for under 18s	⇩		⇩		N/A
	Respiratory	Uptake of COVID and flu by socio-demographic group			⇩		⇩
	Mental health	Rates of total Mental Health Act detentions	⇩		N/A		N/A
		Rates of restrictive interventions	⇩	N/A	N/A		⇩
		NHS Talking Therapies (formerly IAPT) recovery	⇧		⇔		⇩
		Children and young people's mental health access	⇧		⇩	N/A	N/A
	Cancer	Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	⇧		⇔	N/A	N/A
	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, by data	⇧		⇧		⇔
		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	⇧		⇔		⇔
		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	⇧		⇔		⇩
		Stroke rate of non-elective admissions (per 100,000 age-sex standardised)					
		Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)					
	Diabetes	Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile	N/A		⇔	N/A	N/A
	Oral health	3.7.ii Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted)	⇧		⇔	N/A	N/A
	Learning disability and autistic people	Learning Disability Annual Health Checks	⇔		N/A		N/A
		Adult mental health inpatient rates for people with a learning disability and autistic people	⇔		⇔	N/A	N/A
	Maternity and neonatal	Preterm births under 37 weeks	⇧		⇧	N/A	N/A
Better health and Wellbeing for all Strategy	Tobacco	Reduce smoking from 13% of adults in 2020 to 5% or below	⇩		⇩	N/A	N/A
	Alcohol	Reduce alcohol related admissions to hospital by 20%	⇩		⇩	N/A	N/A
	Healthy Weight and Treating obesity	Increase the number of people with a healthy weight.	⇧		⇧		N/A
Core20plus5 adults	Respiratory	Reduce the rate of emergency admissions due to acute COPD exacerbations	⇔		⇔	N/A	N/A
	Maternity	% of women on continuity of carer pathway	⇧		⇩		⇔

Summary Health and Healthcare inequalities Metrics position continued – whole system performance

The table below captures metrics which are presented at a whole system level of performance as outcomes which specifically reflect reducing health inequalities in themselves. The Children and Young people metrics are also provided at system level due to small numbers, however operationally deprivation and ethnicity is considered.

			Indicator trend
Core20plus5 CYP	CYP core20plus 5	Rate of unplanned admissions for asthma for children aged 0-17	⇩
		% of Diabetes patients aged 0-17 who have received all 8 care processes	⇧
		Epilepsy: Increasing access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism	⇧
		Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes	⇩
Better health and Wellbeing for all Strategy	Smoking cessation	Proportion of adult acute inpatient settings offering smoking cessation services	⇧
		Proportion of maternity inpatient settings offering smoking cessation services	⇧
	Mental health	Halve the difference in the suicide rate in our region compared to England	⇩
		Overall number of severe mental illness (SMI) physical health checks	⇩
	Substance Misuse	Reduce drug related deaths by at least 15% by 2030	⇩
	Social isolation and Vulnerability	Reduce social isolation, especially for older and vulnerable people	
	Best Start in Life	Increase the percentage of children with good school readiness at reception, especially for children from disadvantaged group	⇧

Many of the metrics have demonstrated over improvement compared with the baseline position and although inequalities remain, a reduction has been reported. The top three metrics to highlight as demonstrating improvement are:

- Halve the difference in the suicide rate in our region compared to England
- 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
- Reduce smoking from 13% of adults in 2020 to 5% or below

Other metrics have not demonstrated a positive change compared with the baseline position, in both overarching figures and inequalities. The three areas of concern are:

- Increase the number of people with a healthy weight.
- Preterm births under 37 weeks
- Overall number of severe mental illness (SMI) physical health checks

Overall Summary

Inequalities in health and healthcare outcomes continue to be experienced by our communities across all aspects of consideration within this report. These inequalities can be demonstrated against both ethnicity and deprivation measures, and whilst the variance in the scale of the inequalities demonstrates that actions can be undertaken to narrow these, inequality gaps remain.

Access to data to support our understanding of these inequalities has improved over recent months, however this remains in its relative infancy at individual project and programme level. It is the actions within

each of these projects and programmes that will ultimately impact on the attainment of the objects set out within the Joint Forward Plan and Better Health and Wellbeing for All Strategy.
This report and the detailed appendices in *appendix 2* have been approved at the Healthier and Fairer Advisory group on 16th February 2024.

NHS
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System Oversight

**Better health
and wellbeing for all...**

NHS Oversight Framework (NHS OF) Summary

This section of the report provides an overview of the current oversight segmentation and support arrangements and the ICB position against the NHS Oversight Framework metrics.

NHS Oversight Framework Segmentation and CQC ratings

ICSs and trusts were allocated to one of four 'segments' in 2021/22. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4) and influences the oversight arrangements that are established. NHS England holds the responsibility to review and change segmentation, this is undertaken regularly by the North East and Yorkshire Regional Support Group. Oversight of trusts in segment 1 and 2 is led by the ICB and oversight of trusts in segment 3 or 4 is undertaken by NHS England in partnership with the ICB.

NENC ICB is in segment 2, the table below shows the trust level overview of segmentation, CQC rating and any other support/escalation in place.

Provider	NHS OF segment	Oversight arrangements	Additional escalation/support	CQC overall rating/recent warning notices. Other external reviews of significance.
Cumbria, Northumberland, Tyne and Wear NHSFT	**1**	ICB led	*Action plan monitored via the Quality Review Group.	Outstanding (2022) (Learning disability and autism services - requires improvement Aug 2022*)
Northumbria Healthcare NHSFT	**1**	ICB led		Outstanding (2019) Maternity services – good overall (safe domain also good)
North Tees and Hartlepool NHSFT	**2**	ICB led	National maternity Safety Support Programme.	Requires improvement (2022) Maternity services – Requires Improvement (2022)
Sunderland and South Tyneside NHSFT	**2**	ICB led	Progress against CQC action plan provided through the Quality Review Group. National maternity Safety Support Programme.	Requires Improvement (2023) Maternity services – Requires Improvement (2023)
County Durham and Darlington NHSFT	**3**	NHS E/ICB led	Removed from Tier 2 Elective (12.4.23).	Good (2019) Maternity services at UHND and DMH rated as inadequate (Sept 23). Warning notice issued re improvements to managing each maternity service.
Newcastle Upon Tyne Hospital NHSFT	**3**	ICB led	Tier 1 – Elective & Cancer Northern Cancer Alliance and GIRFT support in place.	Requires Improvement overall – caring good, well-led inadequate) (Jan 2024) (Warning notice Dec 22 re healthcare provided to patients with a mental health need, learning disability or autism). Maternity services rated as requires improvement (May 23).
Gateshead Health NHSFT	**3**	ICB led	Enhanced finance oversight/ support led by NHS E.	Good (2019) Maternity services – Good overall (2023)
North Cumbria Integrated Care NHSFT	**3**	ICB led from Nov 23	Removed from Tier 2 Cancer to ICB/NCA monitoring and support (May 23). Enhanced finance oversight.	Requires Improvement (2020) Maternity services – good overall (Safe domain – requires improvement)
North East Ambulance Service NHSFT	**3**	NHSE Quality Improvement Board	Range of support including NECS support for incident reporting.	Requires improvement (2023) Awaiting outcome of independent review
South Tees NHSFT	**3**	NHSE/ICB oversight of finance	Quality - supported by ICB/NHSE. Enhanced finance oversight. Tier 2 – elective.	Good overall (May 2023) Maternity (Jan 24): James Cook requires improvement overall, and for being safe and well-led; Friarage Hospital requires improvement overall and for being well-led, and good for being safe (Jan 24)
Tees, Esk and Wear Valleys NHSFT	**3**	NHSE Quality Board	Support and additional capacity from the wider NHS to progress programme of improvement work across services.	Requires Improvement (2021)

CQC Inspections for Adult Social Care, Primary Medical Care and Hospitals Services
The Care Quality Commission publishes a weekly report on services which have been inspected by specialist teams of inspectors. The report lists those inspections by CQC sector, i.e. Adult Social Care, Hospitals, and Primary Medical Care and include any additional detail in relation to enforcement. An overview of CQC ratings for General Practice, residential and community social care is given below.

General Practice CQC ratings overview - February 2024
The table below shows the current range of CQC ratings for general practice by area. The picture is generally very positive with 37 practices rated as Outstanding, 303 as Good, 1 rated as Inadequate and 4 as Requires Improvement. Support arrangements are in place for those rated as Inadequate or Requires Improvement.

	Outstanding	Good	Requires improvement	Inadequate
Cumbria	8	26		
Darlington	1	10		
Durham	7	52	2	
Gateshead	1	23	1	
Hartlepool	1	10		
Middlesbrough		19		
Newcastle	3	25	1	
North Tyneside	4	20		
Northumberland	4	32		
Redcar and Cleveland		15		
South Tyneside	1	20		
Stockton	4	17		
Sunderland	3	34		1
ICB total	**37**	**303**	**4**	**1**

Residential Social Care Provider Overall Rating by Local Authority - February 2024
The table below shows the current range of CQC ratings for residential social care provider by Local Authority. Residential care providers include care home services with nursing (CHN), care home services without nursing (CHS), and Specialist college service (SPC). Examples of providers which fit under the residential social care provider category are Nursing home, Residential home, rest home, convalescent home with or without nursing, respite care with or without nursing, mental health crisis house with or without nursing. The picture is generally positive with 44 providers rated as Outstanding, 644 as Good and 4 rated as Inadequate and 79 Requires Improvement.

	Outstanding	Good	Requires improvement	Inadequate
Cumbria	4	77	6	0
Northumberland	4	72	15	0
North Tyneside	1	36	4	0
Newcastle upon Tyne	6	48	9	1
Gateshead	4	35	8	0
South Tyneside	1	29	1	1
Sunderland	6	77	0	0
County Durham	11	112	14	0
Stockton-on-Tees	3	39	8	1
Hartlepool	0	22	3	0
Darlington	2	23	3	1
Middlesbrough	2	39	2	0
Redcar and Cleveland	0	35	6	0
Total	**44**	**644**	**79**	**4**

Community Social Care Provider Overall Rating by Local Authority - February 2024
The table below shows the current range of CQC ratings for residential social care provider by Local Authority. Community Social care category includes Domiciliary care services including those provided for children (DCC), Extra house services (ECX), Supported living services (SLS), and Shared Lives (formerly known as Adult Placement) (SHL).

The picture is generally very positive with 30 providers rated as Outstanding, 354 as Good, 25 rated as Requires Improvement and 1 rated as Inadequate.

	Outstanding	Good	Requires improvement	Inadequate
Cumbria	0	37	5	1
Northumberland	7	39	2	0
North Tyneside	4	23	1	0
Newcastle upon Tyne	5	38	2	0
Gateshead	0	36	3	0
South Tyneside	2	14	1	0
Sunderland	2	37	0	0
County Durham	5	47	4	0
Stockton-on-Tees	1	25	3	0
Hartlepool	0	11	0	0
Darlington	2	14	1	0
Middlesbrough	1	18	3	0
Redcar and Cleveland	1	15	0	0
Total	**30**	**354**	**25**	**1**

ICB position on oversight framework metrics

The NHS Oversight Framework (NHS OF) includes a number of metrics across the domains of preventing ill health and inequalities; people; and quality, access and outcomes. In August 2023 the number of metrics within the NHS OF was reduced from 89 to 65. ICBs continue to be ranked according to their performance on 39 of these individual metrics and reported as being in the highest quartile, interquartile or lowest quartile range for each indicator. There is a large cross over between the oversight framework metrics and the objectives in the executive summary dashboards so individual metrics are not repeated here but the high-level summary in the table below outlines the distribution across the quartiles by domain and notes how many standards were met in this latest data period.

Domain (Total number of indicators)	Number of indicators in highest quartile	Number of indicators in Interquartile range	Number of indicators in lowest quartile	Number met against those with identified standard
Preventing ill health & reducing inequalities (11 down to 5)	4	1	0	1 of 5
People (9)	5	3	1	0 of 0
Quality, access and outcomes (50 down to 27)	10	16	7	3 of 20
Leadership (2 down 0)	0	1	0	0 of 0
TOTAL	**19**	**21**	**8**	**4 of 39**

Actions
Trust oversight meetings provide an important mechanism to discuss and understand challenges associated with delivery of oversight framework metrics as well as identify any common themes and actions. Recent meetings are noted in the section below.

South Tyneside and Sunderland NHS FT Oversight meeting – 24th January 2024

A positive conversation noted improvements which have been made in the Trust position for the maternity Clinical Negligence Scheme for Trusts (CNST) and compliance is likely to be signed off this month. A Director of Midwifery has been appointed and takes up the role on 4 March. Although delivery of long waiter trajectories was behind plan it was acknowledged that there had been a higher number of referrals and that industrial action had impacted on elective work. The trauma and orthopaedic plan was on track with some smaller risks which should be mitigated by the end of March. It was noted that CQC improvement measures had progressed well and that the outstanding actions would be closed by the end of March. The Deloitte well led review which had commenced a year ago had confirmed that actions had been taken in relation to risk and the review is expected to conclude in March/April 2024.

Strategic Programme Oversight Meeting Urgent and Emergency Care – 25th January 2024

The first of the ICB strategic programme oversight meetings enabled a positive conversation with the Urgent and Emergency Care (UEC) network, noting good progress in delivery of the UEC Joint Forward plan. It was agreed that the programme has matured over time with effective prioritisation of the main delivery plans for the upcoming surge period. The network is seen as bringing together strategic planning with delivery through Local Area Delivery Boards (LADBs). The programme agreed to develop a framework around peer review to capture outcomes for discharge, transfers of care and front door which is currently being co-designed with our places. It was observed that there was an overlap between other workstreams such as frailty, ageing well, mental health and primary care, and that cross workstream, working needs to ensure that the right people are included at an operational level, noting that one programme director for primary community and UEC within the new ICB structures will help facilitate this collaboration.

Tees Valley Place Oversight meeting – 26th January 2024

A helpful discussion took place with the opportunity to reflect on the progress of the Tees Valley place based plans as well as understand key challenges and support which could be offered. Extensive work has been undertaken to get to the current collaborative working arrangements with partners in Tees Valley, especially with Local Authorities to understand key opportunities and pressures, noting how the local HWB strategies across Tees Valley had similar themes. From a Tees Valley point of view it was important not to lose sight of place however and it was suggested that specific actions could be reviewed from a Tees Valley perspective and then specifically for each place. Particular challenges were noted regarding the volume of children and young people with complex needs who needed case management as well as the ongoing work with the two Foundation Trusts around Clinical Services Strategy.

ICB Complaints and Healthwatch Themes

Complaints

The NECS Complaints Team handled a total of 173 new complaints/concerns and 9 compliments during October – December 2023 on behalf of the ICB:

Number of complaints /concerns	Action/outcome
117	complaints were referred to other organisations for investigation and response.
56	complaints/concerns were managed as NENC ICB cases
21	formal complaints led by the ICB were responded to during the quarter. Of these, 12 were upheld/partially upheld and 6 were not upheld. 3 further complaints were withdrawn.

The main category of ICB complaints/concerns which were upheld/partially upheld following investigation was Continuing Healthcare (CHC) with 6 upheld/partially upheld cases, and Commissioning of Dental care, also with 6 upheld/[partially upheld cases.

It was noted that during Q3, the Complaints Team also managed approximately 300 contacts from the public and staff relating to primary care complaints. This included emails and telephone calls which were triaged and redirected accordingly.

Learning from complaints
Examples of learning and service improvements identified from ICB complaints which were upheld/partially upheld in the quarter are noted below:

- **Commissioning of NHS dental care**

The ICB's Dental Commissioning Team is working closely with local dental networks and dental services to make improvements. Examples include:

- Dental practices who are able to offer extra hours of service have been given more funding to provide extra clinical sessions outside of their normal opening. This is to provide treatment for patients with urgent dental care needs and some specific groups of patients.
- Funding has been made available to improve the clinical triage of dental problems via the NHS 111 service and to increase the availability of out of hours dental treatment services.
- Incentives have been offered to try to retain dentists, particularly in areas where there are problems with the availability of NHS dentists.
- A training grant to support the employment of overseas dentists is available to local dental practices.
- £7.5m has been earmarked to secure a new NHS dental contract to address gaps in provision.

- **Continuing Healthcare**

- Support plan documentation relating to clients on a Personal Health Budget is being changed to a new format which will have clear information on training needs for carers; carer pay rates are to be reviewed on an annual basis.
- CHC staff have been reminded of the importance of professional communication with families and to be mindful of their perceptions.
- CHC nurse coordinators are encouraged to ensure clear explanations are provided when discussing CHC eligibility with patients and their families.
- A dedicated brokerage officer has been appointed within the CHC service who will develop a portfolio of available services within the North East and North Cumbria.

- In addition, specific service improvements were identified regarding the care packages of clients at the centre of individual complaints.

Performance against key performance indicators
All new ICB cases received during the quarter were acknowledged within the 3 working day target.

The ICB aims to respond to single-agency complaints within 30 working days of receipt (or of receipt of consent or agreement of the complaint plan, where applicable). Where this cannot be met, a revised date is agreed with the complainant. This KPI was met for ICB complaints closed during the quarter.

Healthwatch themes and engagement work across NENC

The NENC Healthwatch Network includes the fourteen Healthwatch organisations from each local authority area. Each Healthwatch is independent and local Boards set priorities based on feedback from residents.

The Network provides an invaluable service throughout the Integrated Care Service in the collation of their priorities by independently representing the voices of those living and working in our communities, whether it be locally, sub-regionally or regionally. A whole range of robust and comprehensive methods of information gathering have been applied, with particular reference to those who are seldom heard and disadvantaged, when determining our areas of work. This will enable meaningful intelligence to be fed into discussions, at all levels, to help shape and develop service provision for all people in our region.

Social Care themes:

- Nursing/Care Home settings - it is sometimes felt the care sector and the dignity that needs to be afforded to patients/residents is not given the priority required compared to the Health sector. 3 of our Healthwatch organisations (North Tyneside, Northumberland, and Hartlepool) are looking at the provision & quality of care with Nursing/Care Home settings.
- Domiciliary care - North Tyneside, South Tyneside and Sunderland
- Provision of day care - Newcastle, Gateshead and Stockton
- Assessment of care – Gateshead,
- Experiences of carers – Middlesborough, Redcar & Cleveland and Westmorland & Furness
- Adult Social Care Lived Experience Evaluation - Darlington

Health Sector themes:

- GP access – the majority of Healthwatch have raised concerns relating to GP access. Healthwatch Hartlepool focusing on letters re CVD for the >40's
- Dentistry Access – this is still one of the highest reasons residents are contacting Healthwatch for help & guidance.
- Pharmacy is beginning to feature more in the concerns by Healthwatch given many pharmacies are removing their supplementary hours. Healthwatch Northumberland has published a report on the closure of a major provider in the Cramlington locality. As part of the H&WB and the Northumberland County Pharmacy Needs Assessment, HWN has been part of the decision to declare a formal 'gap' in services in the Blyth area due to community pharmacy closures and reducing hours.
- Hospital discharge - identified by 7 of the Healthwatch and 2 have already published their findings this year based on consultation and research (Hartlepool & Sunderland). Hartlepool is currently reviewing the implementation of their previously published recommendations to North Tees & Hartlepool FT.
- Maternity – Healthwatch Northumberland is engaging with parents of young children to find out their experience of using the Health Visiting services. The provider in Northumberland changed in the last two years on top of changes during the pandemic and on-going workforce issues. Their report is due to be published in early Spring.

- Community mental health services – 7 Healthwatch continue to look at this area.
- Learning Disability & Autism - there is a great deal of work happening across the Network looking at the provision of services. In some areas this will examine performance in Primary Care of ensuring Annual Health checks are carried out in a timely manner. Plus diabetes awareness for learning disabilities/mental health
- Access for those with a sensory disability - continues to be an area of concern as does the wider concern in ensuring all Health & Care services adhere to the Accessibility Standards Framework.
- Emotional support to crisis - work continues to engage with Children & Young People given concerns raised.

Healthwatch Northumberland is chairing the Northumberland Adult Social Care Peoples Advisory Panel. They have brought together a group of service users and carers to work with senior managers ensuring lived experience is taken into account in plans and strategies. The panel will also be involved in training for frontline staff.

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Delivery of 2023/24 Objectives

Better health and wellbeing for all...

Urgent and Emergency Care - January 24 (except *data)

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Benchmark
A&E waiting times < 4hrs (76% by March 24)	79.2%* (81%)	78.5%	74.1%		70.3% 8/42
Category 2 ambulance response (NEAS)	30 min av	33:42	35:23		4/11
Adult G&A bed occupancy	92.1%	93.1%	92.3%		95.4%
Patients not meeting the criteria to reside (CtR)		9.6%	9.2%		
Ambulance handovers >59mins:59s*w/e 29/1/24	0	0	202		
111 Call Abandonment (NEAS plan)	3%	16%	9.2%	Improving	
Mean 999 call answering time	<10s	9s	2.8s	Improving	5.5s

*H2 Provider resubmission. March 24 plan as per H2; Monthly plan commenced from Nov 23 data. (denotes original plan).

Observations

- **A&E performance** at 74.1% remains above the national average although is short of the NENC January plan (78.5%). In addition, NENC remain in the top 25% of performing ICS`s ranking 8th out of 42 ICS`s in January.
- **Ambulance response times** ranking 1/11 of ambulance providers for Cat1 response. Cat 2 mean response has improved in January 24 to 35:23 compared to 42:29 in Dec 23, and NEAS is ranked 4/11 of all ambulance providers.
- **Ambulance handover delays** - reducing percentage over 60 minutes but deterioration in average under 60 minutes to 48 hours per day.
- **Bed occupancy** compares favourably to the national/ regional position but deterioration in Dec which was at 90.6%.

Actions/interventions/learning

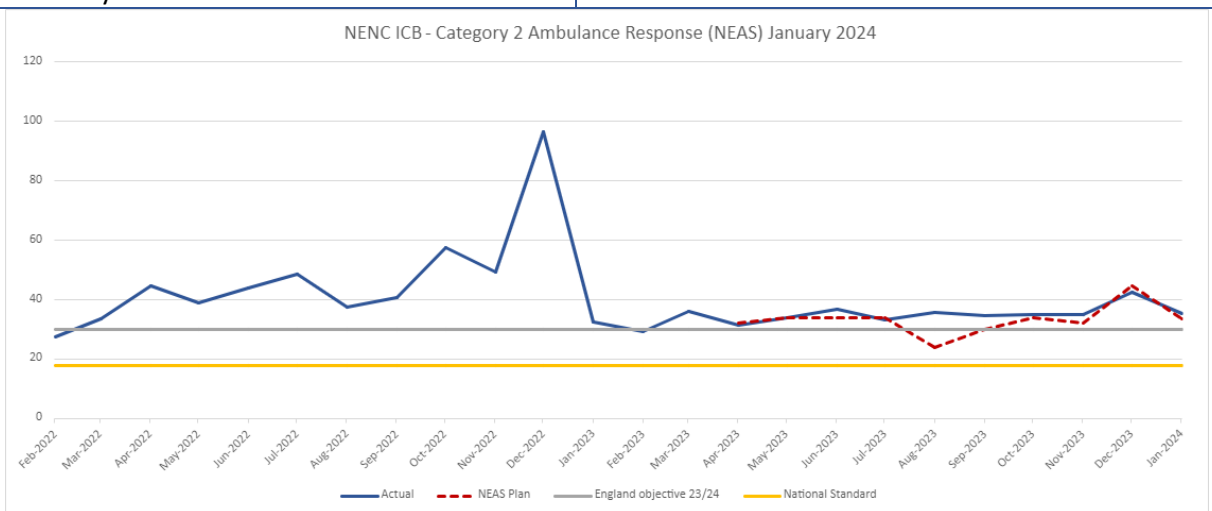
- National focus on all A&Es meeting 76% waiting time target by March 2024 – at organisational level and not just ICB aggregate position.
- Escalation process for ambulance handover delays - whole system focus on managing undifferentiated risk and trigger now in place (Dec to March) to Silver/ Gold & Strategic Command for handovers over 2 and 3 hours
- Front Door navigation and MDT working in A&E – variation of paramedic and senior nurse resources across 11 sites – evaluation now underway.
- Acute Respiratory Hubs across system - now 42 hubs offering over 30,000 appts – evaluation underway
- Increase in utilisation of Virtual Wards across system and plan for integrated models with Urgent Community Response services for 2024/25 - model in development

Quality implications/risks

- Sustained focus on reducing ambulance delays and getting vehicles back on the road including immediate release policy development & sign off.
- Risk of harm and death for patients with long waits – whole system focus on reducing long waits in all parts of the system.

Recovery/ delivery

- **Variation -** main work area for whole of UEC is to understand and then reduce inappropriate variation through a learning and improvement approach.
- Peer review process planned for Discharge and Transfers of Care across the NENC system.



Primary and Community Care – December 23(except *data)

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Benchmark
2-hour urgent community response (UCR) *Nov23	70%	70%	80.9%	Improving	84.2%
Reduce unnecessary GP appts: direct referral community optometrists/self-referral					
Proportion of GP practice appointments within two weeks (where appt been requested within 2 weeks)			84.4%		82.6%
More appointments in general practice by March 24	1.6m	1.49m	1.44m		
Additional Roles Reimbursement Scheme (ARRS)	1526		1,682	Improving	
Improving units of contracted dental activity (UDA) Q3	5.315m	3.189m	2.890m		
Proportion of appointments the same or next day			68.7%		68%
2-hour UCR first care contacts attended*Nov23			5025	Improving	

Observations

- Decrease in appointments across primary care in the corresponding months of Dec 22 and Dec 23. This may be attributable to sickness / annual leave or focus on vaccinations.
- ICB working with General Practice on predictive modelling and by Nov 24 will be able assess plans for routine and urgent appointments to prepare UEC system accordingly.
- ICB led a programme of workshops supporting General Practice with workforce recruitment, reducing the predicted ARRS underspend outturn pro-rata for the year 23/24.
- To increase access to UDA activity the ICB is funding schemes in areas with access issues.
- UCR exceeding 70% threshold – all Trusts are now publishing data via the National UCR Dashboard.
- Continued upward trend in UCR referrals.

Actions/interventions/learning/risks

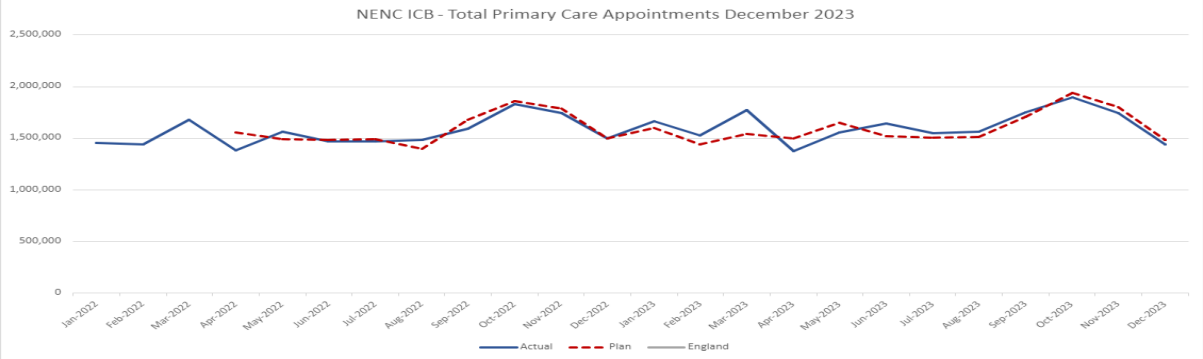
- NENC ICB Primary Care Access Recovery plan – practices, PCNs reviewing access models and digital tools to support patients accessing services and tackling "8am rush"
- New digital framework will be published March and NENC ICB are working with Practices to understand requirements.
- ARRS workshops continue supporting maximising spend.
- Primary Care Dental Team structure developed, briefing documents for enquiries and patient interface, Local Authorities and MPs. ICB working with all local Healthwatch`s to better understand people`s experiences to help inform the region`s NHS dental recovery plan.
- Risk remains of dental contracts being given up where contractual obligations cannot be fulfilled. Any financial resource associated with this will be quickly made available to other providers where capacity to deliver. National dental recovery plan incentivises new dental registrations from March and the increase in the baseline UDA rates.
- Ambulance referrals for UCR lower than expected, work ongoing to improve data collection and increase activity.

Quality implications

- Quality & Primary care stakeholder group undertaken assessment of legacy Primary Care quality reporting systems.
- ICB wide Primary Care quality reporting system now agreed. Places determining arrangements for actioning. Extracts to feed into IDR report.

Recovery/delivery

Primary Care access recovery plan actions include:
a) practices underway with improvement programme
b) first cohort of analogue practices converting to digital
c) launch of the pharmacy first scheme
d) development of the Primary to secondary care interface groups to look at reducing bureaucracy.



Elective care – December 23 Actual data displayed at provider aggregate level.

Objective	Plan Mar24	Plan (Month)	Actual	Trend	Bench mark
52 week waits (eliminate by Mar 25) (No H2)	5135	6104	8096		
65 week waits (0 by end of Mar24) *	1145 (14)	2198	2148		
Value weighted Activity levels (105%) 28/1/24	105%		96%		
78 week waits (0 by end Mar 23) *	167	293	377		
104 week waits (0 by end of Mar 22)	0	2	6		
Reduce outpatient follow ups by 25%					
FFT – outpatients (trust range)			94.7% - 100%		
FFT – inpatient care (trust range)			89.8% - 99%		

*H2 Provider resubmission. March 24 plan as per H2; Monthly plan commenced from Nov 23 data. (denotes original plan).

Observations

- Long standing upward trend in waiting list size reversed, decreasing Aug23 – Dec 23.
- NENC best performing ICS in Dec 23 for RTT performance with 68% on the waiting list for elective (non-urgent) treatment waiting less than 18 weeks.
- NENC ranked 2/42 for 65+ and 52+ww.
- 104+ week pressures remain at NUTH (adult spinal) but continue to reduce. A small number of independent sector patients recorded in error in the latest published data.
- 78+ww growing particularly at NUTH and S Tees. NUTH remain in Tier 1 for Elective, and S Tees recently escalated to Tier 2 for Elective.
- Decrease in 65+ww following growing trend since April 23. Providers to set a 24/25 trajectory.
- Decreasing volume of 52+ww continues. Providers required to set a 24/25 monthly trajectory.

Actions/interventions/learning

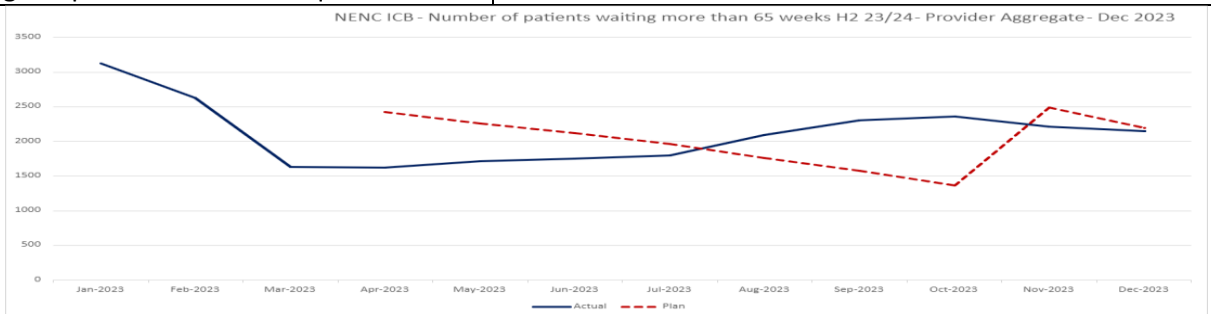
- **Mutual Support**: co-ordination group established for mutual aid requests, theatre utilisation and capacity across NENC.
- **Validation – WL size:** Trusts actively monitoring against 90% target for RTT validation, administrative, technical and clinical validation initiatives underway across NENC.
- **Outpatient transformation:** Relaunch of OP leads group underway. Action plan for April 24 - Mar 25 will be formed feeding into the SECB delivery plan.
- **GIRFT:** provider collaborative took over the support of the GIRFT programme in Dec 23 and a GIRFT delivery plan is being drafted focusing on the rollout of the Further Faster Programme alongside Elective hubs, Day Case and theatre utilisation.
- **Alliances – Clinical Specialities – Pathways:** Work is underway across the various High Volume Low Complexity (HVLC) Alliances to develop work programmes, engage with Clinical Leads and speciality data packs.
- Progress has been made with regards to the implementation of the National Back Pain pathway. Stakeholders from the ICB, Spinal Network and Provider Collaborative have formed a 'NENC Back Pain Delivery Group' which will meet regularly to progress key actions and deliverables.

Quality implications/risks

- Patient choice may result in treatment being deferred and impact on the ability to improve the overall waiting list position.
- Patient access policies to be agreed across the system which are inclusive and recognise potential Health Inequalities.

Recovery/delivery

- Recovery impacted by several periods of Industrial action.
- Work on validation continues across trusts.
- Tier 2 elective meetings with S Tees to monitor progress.
- Work continues through the Tier 1 elective meetings with NUTH.



Cancer and Diagnostics - December 23 (except *data)

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Bench mark
Reducing 62 Day Backlog *28/1/24 ***H2	817 (800)	861	987	Improving	
Faster Diagnosis Standard (FDS) ***	77.2% (77.6%)	77.3%	78.5%		71.1%
Stage at diagnosis ambition 75% by 2028					
Monthly Cancer 62 Day Performance**			63%		62.8%
% Receiving diagnostic test < 6 weeks (by Mar25)	89.4%	89.2%	83.6%		72.5%
Diagnostic activity against plan *28/1/24	109%	110%	113%		

**Interim national ambition from October 23 is to achieve 70% (national standard 85%) for 62 day monthly cancer performance by March 24.

NB: FDS Actual and data displayed at Provider aggregate level.

***H2 operational plans at provider aggregate level for Mar24 and monthly plans monitored from Nov23 data onwards () denotes original plan.

Observations

- The ICB continues behind plan for backlog reduction although this has been a slowly improving position since October. Greatest challenge in urology, skin, upper & lower gastrointestinal. Skin referrals dropped since October and urology remains the biggest ICB pressure.
- NENC ICB Faster Diagnosis Standard demonstrates continued high performance at aggregate level, with 2 providers in the ICB below the standard in the reporting period.

Diagnostics

- There has been a slight deterioration in overall performance following 3 months of improvement, due to reduced activity associated with holiday period.
- Colonoscopy performance continues to improve.
- MRI and Audiology remain a focus for the ICS.

Actions/interventions/learning

- Significant effort in backlog recovery sustained into 23/24 with support from NCA, ICB and NHS England.
- From Jan 24, the NHSE Tier 1 elective escalation meeting for NuTH will include cancer with continued support from the ICB.
- NCIC not within escalation with NHS England but they continue to have regular support from the ICB, due to their position against yearend backlog reduction.
- FDS – National focus on all FDS performance and cancers diagnosed via FDS and reducing the gap.
- Work continues ensuring high levels of data completeness for Cancer Outcomes and Services Dataset (COSD) data at Trust level, focused on stage at diagnosis and recording of stratified follow up.

Diagnostics

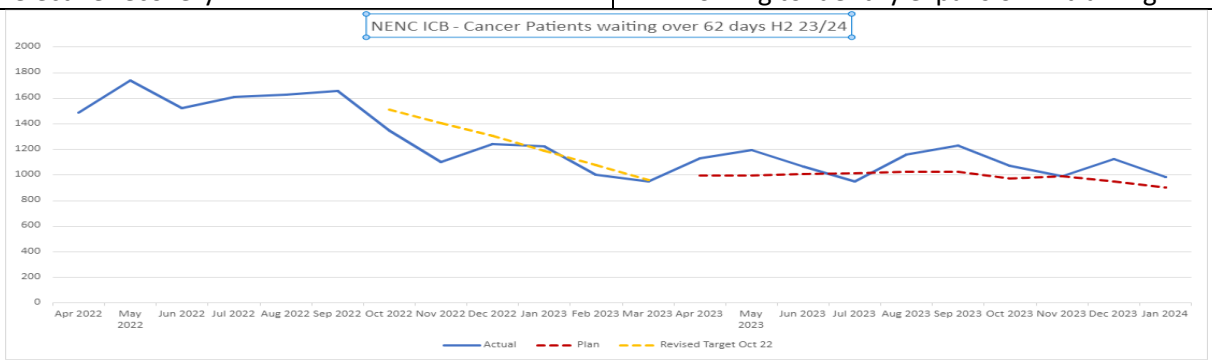
- Continuing facilitation of mutual aid discussions.
- MRI deep dive to understand increasing backlog.
- Imaging demand and capacity review.
- ICS Diagnostic team working with Audiology leads through newly established NENC Audiology Group.

Quality implications/risks

- Reducing long waits and cancer backlog improves quality of life.
- FDS provides a timely diagnosis and improves opportunity for treatments.
- Improved equity in access to diagnostic services.
- Availability of diagnostics impacts on cancer waits and elective recovery.

Recovery/delivery

- 2022/23 cancer backlog trajectory challenged, work on specific pathways via the pathway boards and with Trust with biggest backlogs ongoing.
- FDS strong performance expected to continue.
- Recovery expected Mar 25 for diagnostics standard.
- Implementation of diagnostic workforce strategies, working to identify expansion in training.



Maternity – March 2023

Objective	Plan Mar24	Plan (month)	Actual	Trend	Benchmark
Maternal mortality					
Still births per 1000 births			3.39		3.52
Neonatal deaths per 1000 live births			1.86		1.6
Increase fill rates for maternity staff					
Proportion of maternity settings offering tobacco dependence services			50%	Improving	
FFT: Maternity services	Range from 63.6% to 96.6% who would recommend the service across our providers.				

Observations

Still births and neo-natal deaths demonstrate a worsening position across NENC. Data at provider level is published through the National Maternity Dashboard on an annual basis and through the NHS Oversight Framework.

- Maternity and Neonatal Engagement Group meeting Jan 24. Outcomes to be finalised.
- Learning and Improvement Event held Feb 24. The event showcased outstanding practice from the 8 Ockendon visits and the resulting quality improvement programme. Speakers included NENC ICB CEO and Steve Cram.
- 'Project PROMISE' (Promoting a Multidisciplinary and Inclusive Staff Experience) launched and Trusts invited to submit an Expression of Interest for funding to support in improved staff wellbeing.
- Perinatal Pelvic Health Services group in place with midwifery, physiotherapy and urogynaecology representatives from our 8 NENC Provider Trusts.
- 4 Digital Midwifery Leads appointed to workstreams: Induction of Labour, Perinatal Pelvic Health, Pre-Term Birth and Equality and Inclusion.

Actions/interventions/learning

- North Tees and Sunderland & South Tyneside FTs remain under the national Maternity Safety Support Programme. Both units received positive progress reports from NHSE, but no immediate plans to remove from the programme.
- South Tees maternity unit CQC inspection report published Jan 24 with the service Requiring Improvement. The Trust is being supported by the ICB and LMNS to improve service provision as outlined in the CQC report.
- Funding streams for 24/25 to be confirmed by NHSE for the LMNS, which poses a risk in relation to financial planning.
- Recruitment and retention of multi-disciplinary team (MDT) staffing across our providers is a pressure – collaboration across NENC in workforce capacity underway.
- Awaiting confirmation from NHSE that the Independent Senior Advocate role can commence.
- Implementation of Saving Babies Lives Care Bundle v3, assurance gathering was successful to enable all 8 provider Trusts to meet Feb24 submission deadline.
- LMNS hosting an event March 24 to look at how Personalised Care and Support Planning, including informed consent can be better embedded with maternity and neonatal services.

Quality implications

- Continued focus on the quality and safety of maternity and neonatal services to provide safe and compassionate care.
- Listening to women and their families, continues to address inequalities.
- NENC continues to utilise evidence from national reviews to improve services and support staff for continual improvement.

Recovery/delivery

- Continue to the use the learning health system model to combine data, collaboration and quality improvement techniques towards collective improvement.
- Work closely with other LMNSs across the country.
- Task and finish group to understand health and wellbeing of maternity and neonatal staff in development.

Use of resources Data period M10 (January 24)

	Month 10 YTD plan	Month 10 YTD actual	2023/24 Annual plan	2023/24 Forecast Outturn
ICS financial position (surplus)/deficit	£52.32m	£32.37m	£49.87m	£35.00m
ICB financial position (surplus)/deficit	(£27.00m)	(£28.03m)	(£32.40m)	(£32.41m)
Running cost position	£52.21m	£50.97m	£62.37	£60.85m
Capital funding	£161.30m	£126.83m	£217.08m	£250.06m
QIPP/Efficiency savings	£317.93m	£317.70m	£408.36m	£409.55m
Mental health investment standard	6.73%	6.73%	6.73%	6.73%

Observations

- The ICS is reporting a year to date (YTD) deficit of £32.37m compared to a planned deficit of £52.32m, a favourable variance of £19.95m.
- The forecast position remains a deficit of £35.0m, reflecting the revised plan approved by board in November 2023. This is an improvement of £15m compared to the original planned deficit.
- This includes the impact of additional non-recurring support funding and other financial flexibilities agreed by NHSE in November 2023.
- The ICB is reporting a YTD surplus of £28.0m, an improvement to plan of £1.0m, with a forecast surplus for the year of £32.4m in line with plan.
- Running costs - the ICB continues to report a small underspend (forecast £1.5m underspend) against running cost budgets.
- Capital spending forecasts now include the impact of IFRS16 (lease accounting) resulting in a forecast overspend of £33m. The overspend relates purely to IFRS16. Some additional funding is expected to help mitigate this pressure and work continues via the Provider Collaborative to manage capital spending plans over the rest of the year.
- The ICS is reporting efficiency savings slightly in excess of plan, however this includes significant non-recurring efficiency savings.
  The ICB is expecting to achieve the MHIS target for 2023/24 (growth in spend of 6.73%).

Actions/risk

- Due to the time lag of certain cost and activity information, and historical volatility in areas such as prescribing, there is still a level of uncertainty in the forecast outturn position.
- Total unmitigated risks increased slightly at month 10 to £12.2m (£8.7m at month 9) reflecting a risk that the system may not be able to retain certain PDC benefits linked to IFRS16, which are currently included in the forecast position. This is awaiting confirmation from NHSE.
- Unmitigated risks remain considerably lower than earlier in the year.
- Across the system, spending controls have been reviewed in line with NHSE requirements following submission of a deficit plan.
- Additional controls have been implemented by ICB Executive Committee including a pause on discretionary non-staff spend (alongside vacancy controls already in place) and identification of additional risk mitigations.
- Work continues on the development of 'ICB 2.0' in response to the forthcoming 30% real terms reduction in running cost allowances.
- Recurring efficiency plans are currently forecast to under-deliver by almost £68m. This is offset by additional non-recurring savings in the current year but will increase the challenge for 2024/25.

Quality impact

Good financial management supports delivery of high quality services and reduction of health inequalities. All programme areas have a named finance to support programme delivery.

Recovery/delivery

Financial controls are being reviewed across the system, with additional controls implemented where necessary to manage potential financial risks.
Work continues across the system on the development of the medium term financial strategy and appropriate financial recovery plans.

Workforce – Staff Sickness September 2023/ Turnover October 23

Objective	Plan Mar 24	Plan (Month)	Actual	Trend	Benchmark
Improve staff retention (turnover systemwide NENC Providers)	12.1%		9.3%	Improving	11.3%
Improve staff attendance (sickness systemwide NENC Providers)	5.6%		5.7%	Improving	5%

Observations

Sickness

- The nationally reported in-month ESR recorded sickness rate for M5 has remained stable at 5.6%, which is in line with target.

Turnover

- National methodology has changed. Definition of turnover is leavers, plus other staff who remain in the NHS but who have changed profession or employer in the last 12 months.
- NENC continues to improve showing a 9.3% turnover rate against a plan of 12.1%.

Data

- Work underway to understand the different data sources to ensure consistency of reporting and monitoring across the ICB.
- Data included in this report is based on the nationally available data through NHSE (NHS Digital).

Actions/interventions/learning

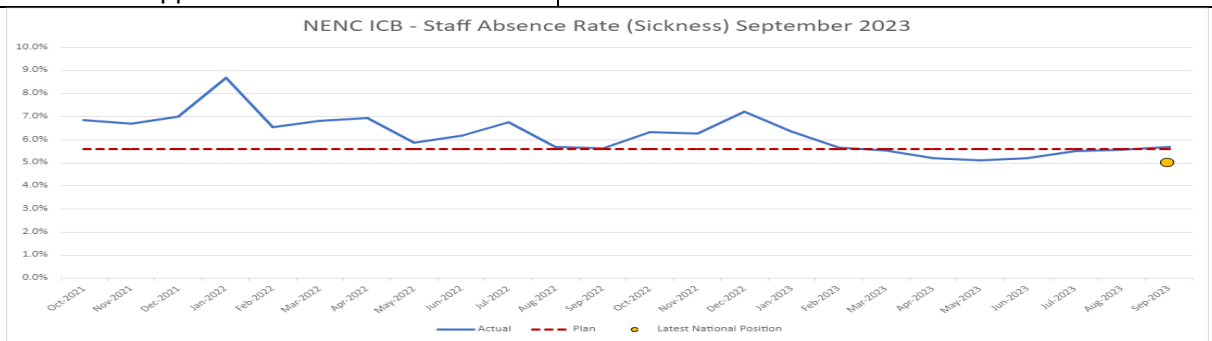
- Both sickness and turnover continue to be trust priorities for action and captured as within the operational planning.
- Work ongoing to review approach to operational planning ensuring ongoing dialog between the ICB and providers, linked to budgets and activity. An operational planning workshop developed several agreed actions and principles.
- Bespoke narrative template to be used in 2024/25 planning round to supply information relating to the main KPIs.
- Risk linked to pressure on remaining staff due to sickness and turnover having a detrimental impact on their health and wellbeing. This will be mitigated as staff health and wellbeing has been identified as a key priority within the ICB People & Culture Plan and the agreed extension of the Health and Wellbeing Hub to the end of March 24 to support staff across health and social care.
- The NENC People and Culture Plan is now in the final stages of development with three of the six priorities being supply, retention and health and wellbeing.

Quality implications/risks

- Higher levels of sickness affect patient safety & quality as there are less staff available for duty.
- Staff turnover will impact on quality due to: Lack of continuity of care, staff shortages through vacancies putting pressure on remaining staff, time and effort involved in recruiting, training and inducting new staff members.
- To mitigate the above risks and issues, provider trusts have all articulated they have plans in place to reduce sickness absence, improve retention and reduce turnover and have also agreed to provide mutual support

Recovery/delivery

- The operational planning round has indicated that overall, the Trusts are aiming from March 23 to March 24
  - to reduce sickness absence by 0.33%
  - to reduce turnover by 0.38%
- Looking at the current reporting period it would appear that trusts have already achieved the targets set and work will continue to maintain or surpass those levels for the remainder of the year.



Mental Health: Adults – December 23 (*except)

Objective	Plan Mar 24	Plan (month)	Actual	Trend	Benchmark
TTAD access	22,540	7424	4575		
Community mental health (CMH) 2+ contacts 5% increase	34,855	33,761	38,300	Improving	
No. inappropriate out of area (OOA) bed days *Nov 23	162	201	345		
Dementia diagnosis rate *Jan 24	66.7%	67%	68.6%	Improving	
People with SMI receiving physical health check *Sept 23		16325	145		
MH Adults waiting >104 weeks for 1st Direct appt**			6227		
MH Adults waiting >52 weeks for 1st Direct appt**			14,619		

***MHSDS data subject to variable data quality between providers. All providers submitting to MHSDS included. Definition **Adult** "People with an accepted referral waiting for a 1st direct or indirect contact" open to difference in interpretation. Reporting to move to new national standard once supported by MHSDS.*

Observations

- **TTAD** - NHS Talking Therapies for Anxiety and Depression (TTAD) access remains below plan and target, which reflects national position. Challenges relating to workforce, increased acuity, inappropriate referrals. Recovery targets are consistently met, and most providers are meeting 6 and 18 weeks and recovery targets, however none meeting 1st to 2nd appointment wait target signifying waiting pressures routinely manifest downstream.
- **Community Mental Health –** Since April 23 across NENC performance against 2+ contacts remains significantly above plan.
- **OOA Placements:** reducing from peak in June 2023. Since Dec23, CNTW have 0 inappropriate OOA placements and TEWV improving, currently 5.
- **Dementia:** diagnosis rate remains in excess of NENC target, a continuing positive trend since May 2023.
- **SMI Physical Health checks:** Significant improvement against target.
- **Adult and older adult (AMD) MH Waiting Times**: Dec 23, 35,714 adults waiting for a 1st MH Direct contact, 32% have been waiting <18 wks; 17.4% 104+ wks. Further analysis available in appendices.

Actions/interventions/learning

- **TTAD** - Transformation Team undertaking deep dive to agree credible options/recommendations for future commissioning of TTAD services. Currently significant variation of provision across NENC.
- Report progressing through Mental Health, LD and Autism subcommittee governance process and work programme designed to implement its findings.
- **Access to community mental health services (CMH)** – Increasing referrals and growing caseloads.
- Data and digital workstream progressing the capturing of VCSE activity to include into the Mental Health Services Data Set (MHSDS), making significant progress on data processing and cleansing.
- Significant progress in PCN data flow compliancy.
- Strong focus on Alternative to Crisis provision, moving toward personalised care, and Right Care Right Person.

Out of Area Placements (bed days). Actions include robust case management, embedding clinically ready for discharge reporting and discharge facilitation.

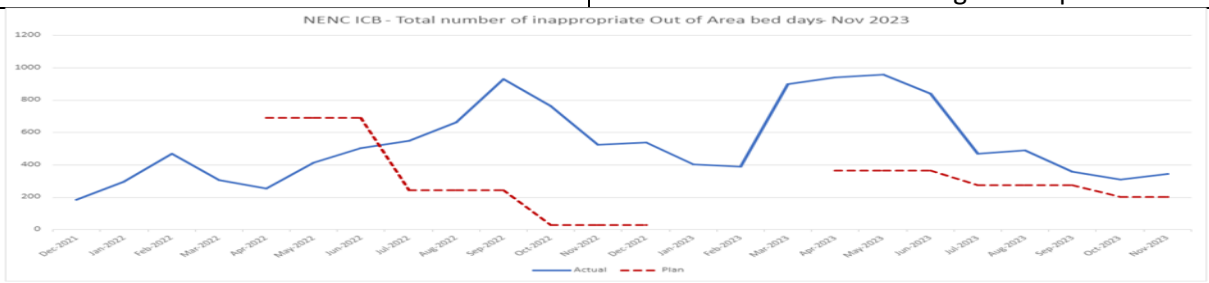
AMH waiting times: NENC IP Quality transformation programme to tackle such challenges underway.

Quality implications

- Negative impact on mental health whilst waiting.
- Patients awaiting repatriation to their home area have poorer outcomes and less likely to receive frequent family visits due to distance.
- Resettlement/rehabilitation may not be as timely as when placed in home area.
- SMI health checks are important to identify physical health needs and support access to services.

Recovery/delivery

- **TTAD** – Overview and Delivery group and TT Transformation Team working to identify options and recommendations by Jan 24 for consideration by the ICB.
- **CMH:** VCSE Financial pressures impacting community transformation plans 23/24 limiting capacity in community to prevent admissions and facilitate discharge.
- Further analysis of **waiting list** pressures through NENC MHLDA Performance Oversight Group.



Mental health: Children & Young People (CYP) -June/August/Oct 23

Objective	Plan 24	Plan (month)	Actual	Trend	Bench mark
Improve access to mental health support for CYP - December	53,245	52,243	56,975	Improving	
CYP Eating disorders (ED) - urgent within 1 week – Sept	95%	95%	62%		
CYP Eating disorders (ED) – routine within 4 weeks - Sept	95%	95%	79%		
MH CYP waiting time (WT) for 2nd contact >104 weeks**			2565		
MH CYP waiting time (WT) for 2nd contact >52 weeks**			8516		
MH CYP WT Autism & Neurodevelopmental >104 weeks **			1199		
MH CYP WT Autism & Neurodevelopmental >52 weeks**			6321		

***MHSDS data subject to variable data quality between providers. All providers submitting to MHSDS included. Definition "Children and Young People (0-17) with an accepted referral waiting for1st or 2nd direct or indirect appointment" open to differences in interpretation. Reporting to move to new national standard.*

Observations

- Access remains above operational plan trajectory showing significant improvement, however, remains below LTP target.
- Demand has increased beyond LTP projections combined with an inability to recruit and retain staff. Recovery plan is submitted and live for this area.
- Challenges in reporting accurate data with transformation work developing to improve this position.
- Pressure remains in **CYP eating disorder** services not meeting the 95% standard (12 month rolling), exacerbation developed in the pandemic and continues. New ways of working and successful recruitment are showing some improvement which is expected to continue.
- **CYP Waiting Times**: At the end of Dec 23, 25,340 CYP (15,552 CYP autism and neurodevelopment patients) had been waiting for a 2nd contact, 33.6% CYP waiting <18 wks, 10.1% CYP (7.7% CYP autism, neurodevelopmental) 104+ wks. Further analysis in relation to <18 wk, 18-26 wk, 53-104 wk and 104+ trends is available in the report appendices. Waiting time position has worsened.

Actions/interventions/learning

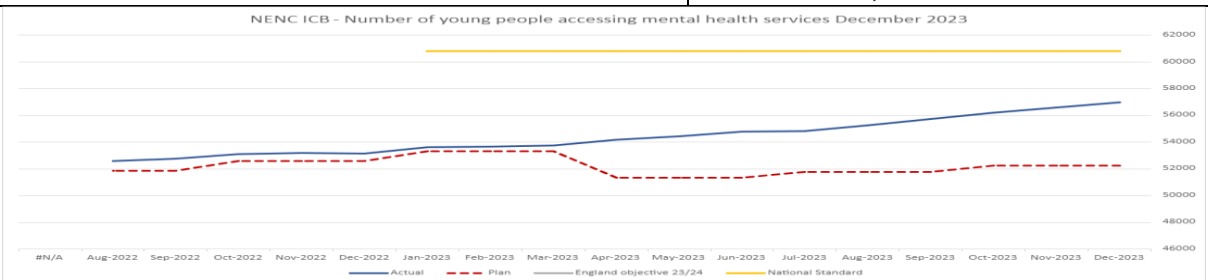
- Place based reviews underway to improve CYP access: waiting list initiative, evaluation, pathway redesign.
- Recruitment and retention pilots underway including continued commitment to improving access to psychological therapies for CYP.
- ICB wide evaluation developed key areas for consideration in the CYP eating disorders services considering ways to improve waiting times and access. Paper due to Feb MHLDA sub-committee.
- **CYP waiting times:** Range of transformation work underway. TEWV Performance Improvement continue to be monitored through the Care Group Board, CYP outcomes metrics continue to improve. CNTW redesigned pathway for CYPS neurodevelopmental presented to oversight group. CYP services diagnostic waiting times, rapid improvement work underway.

Quality implications

- Children, young people and families may experience exacerbation of difficulties as they wait to be assessed or start treatment.

Recovery/delivery

- CYP access operational plan trajectory is currently being exceeded, however the LTP trajectory will not be achieved.
- The ICB is investing in extra support, where available, to improve CYP access. The ICB is working in partnership at place to ensure a graduated response is available to support children, young people and families with her emotional, mental health and wellbeing needs.



People with a learning disability and autistic people – Dec/Jan 23/24

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Bench mark
Annual health check and plan for people on GP LD registers (Cumulative 75% March 24) **Nov 23**	75%	43.2%	39.3%		
Reduce reliance on inpatient care adults (ICB) **Jan**	52	52 (Q4)	91		
Reduce reliance on inpatient care -adults (Secure)	61	61 (Q4)	75		
Reduce reliance on inpatient care <18s Jan 23	8	8	5		
Care and Treatment Reviews (adults)	Compliant			**Worsening**	
Care Education and Treatment Reviews (CYP) Dec	Compliant			**Worsening**	
Learning from death review (LeDeR) compliance	Compliant		91% completed		
Eligible reviews completed within 6 months of notification	Compliant		21% (6 month rolling)		

Observations

IP beds Adults only - Q3 trajectory 124 (ICB 60; Secure 64) was not achieved. Actual: 170 (46 over target).

Jan 24 - Adults only, as reported via the AT database

- 10 discharges (ICB), includes 1 LOS > 13 yrs, 4 LOS < 6 months.
- 6 admissions including 1 readmission.

CTR Compliance (December 2023 metric)

- Worsening trend Adult Repeat CTRs, issues continue Durham and Tees Valley (31 of 68) and no Assuring Transformation (AT) updates for Newcastle Gateshead Q3 (member of staff left).
- Worsening trend Adult pre/post CTRs (7 of 15).
- Worsening trend Children, non-compliance for pre/ post admission CETRs and non-compliance for repeat CETRs.
- Pre-admission metric based on CTRs / CETRs, Local Area Emergency Protocol (LAEP) reviews do not contribute.

Actions/interventions/learning

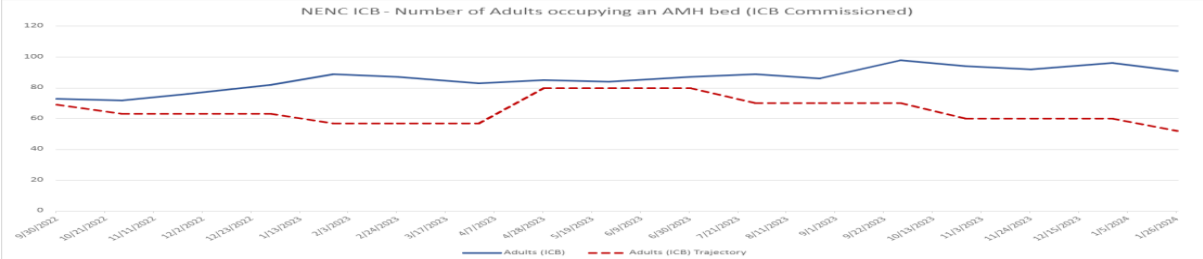
- NEY Region hosted LeDeR Listening Event 1st February 2024 and NENC presented examples of best practice.
- Reasonable Adjustments Digital Flag event held Patients, Voluntary Sector & Community Group Dec 23.
- Stakeholder awareness raising webinar held Jan 24 and a Digital Champions masterclass planned for Feb 24.
- ICB Transformation Team, Programme Management Approach development sessions being held.
- NEY NHSE C(E)TR DSR Policy Workshops for Experts by Experience and Clinical Experts planned for Feb/Mar24.
- NEY NHSE Risk Stratification for CYP Workshop planned for 20th March 2024.
- NEY NHSE Regional offer of CTR / DSR bespoke awareness-raising sessions under development – community and in-patient autism services.

Quality implications

- ***MH and LDA In-patient Quality Transformation Programme:*** Bed and "out of area" patient censuses completed. Weekly meetings continue, ICB team visits to independent sector and acute MH wards underway.
- ***CTR oversight panels:*** Establishment of Complex Care Directorate will be key.
- ***LeDeR:*** Q3 Report submitted and assurance panel scheduled Feb24. LeDeR dashboard is now 'live'.
- Workforce to complete LeDeR reviews remains an issue. Durham and Tees Valley CTR team workforce issues will not be resolved until implementation of ICB 2.0.

Recovery/delivery

- ***Senior Intervenor*** executive group outcome report drafted, discussions underway to take forward the recommendations.
- ***In-patient data and Care Education and Treatment Reviews:*** Durham and Tees Valley teams continue to be supported by transformation team, allowing CTRs and oversight visits to continue.



Prevention and Health Inequalities including Core20+5: Adults

Objective	Plan Mar 24	Plan (Month)	Actual	Trend	Bench mark
Hypertension (77% by March 2024) Sept 23	77%	77%	71%		
Use of lipid lowering therapies (60%) Sept 23	60%	60%	63%		
People with SMI receiving a Health check 23		16,325	16,002		
Increase uptake of COVID vaccines (Highest priority group as @17/12/23)			63.8%		
Increase uptake of flu vaccines 65+ as@17/12/23	85%		76.8%		
Increase uptake of pneumonia vaccines					
% pregnant BAME women on continuity of care pathway by 29 weeks Sept23		N/A	40%	Improving	
75% cancers diagnosed stage 1 or 2 by 2028					

Observations

- NENC continue to improve performance in relation to hypertension case finding and the effective treatment. Currently above England average for both and on target.
- Lipid lowering therapies – positive trend continues with a high proportion of at risk patients on lipids across NENC and CVD prevent national audit data saw a slight increase between March and June 23.
- **SMI Physical Health checks** represents 60% of NENC total, ranging from 51% to 79% across localities.
- % Pregnant BAME and CORE20 women on Continuity of Carer pathway continues to increase, however this standard has been removed by the LMNS.

Actions/interventions/learning

- Detailed understanding across all metrics where inequalities against deprivation and ethnicity are known is included in the additional health inequalities report.
- A clinically led **NENC Lipids whole pathway network** has been established. GP clinical leadership and project support in place to link with underperforming PCNs through clinical leads and agree action plans to improve diagnosis and management of **Hypertension**/Atrial Fibrillation/lipid profile. Pharmacy recruitment underway.
- **COPD/CVD -**ICB multi-media communications has been specifically directed towards people with COPD and chronic respiratory diseases among the many clinical at risk groups for the flu campaign.
- **SMI Physical Health checks** are being supported through direct funding to GP federations, enhanced approaches to engagement with harder to reach patients, and using AARS roles to support delivery.
- **Maternity** - LMNS Personalised Care and Support Planning met December 2023 with a focus on the implementation of Personalised Care across NENC.

Quality implications

- Implications for not addressing known inequality gaps remain a quality issue in terms of patient access, experience, and outcome. Actions plans to address these can be found in the additional health inequalities report.

Recovery/delivery

- Action plans against each metric where inequalities against deprivation and ethnicity are known is included in the additional health inequalities report.

Prevention and Health Inequalities including Core20+5: Children

Objective	Plan Mar 24	Plan Month	Actual	Trend	Benchmark
Asthma – address over reliance of medications					
CYP: Decrease the number of asthma attacks Proxy: Rate of unplanned admissions for asthma 0-17 yr olds, per 100k		N/A	11		
Increase access to glucose monitors and insulin pumps					
Proportion of diabetes patients (type 2) receiving 8 NICE care processes Mar 23			46.5%		46.7%
Access to epilepsy specialist nurses					
CYP: Rate tooth extractions due to decay children admitted as IP in hospital aged <10 per 100,000		N/A	22	Worsening	
CYP: Elective WL <10 awaiting IP tooth extraction. Jan 24			257	Worsening	
Improve access rates CYP people`s mental health service for: 0-17 yr olds, certain ethnic groups, age, gender and deprivation. Oct 23	53,245	52,243	56,975	Improving	

Observations

- Using a proxy measure, we know there are inequalities in access to a specialist epilepsy nurse across NENC with 10.1 WTE across the ICB, 2 trusts reporting 0.
- Proportion of **diabetes** patients (type 2) receiving 8 NICE care processes is at 46.5% almost in line with the national at 46.7%
- The **tooth extraction** rate - The number of children age <10 awaiting a tooth extractions continues to increase.
- There are currently 22 times more children receiving IP tooth extraction from the most disadvantaged communities than the least disadvantaged.
- Rate of **Asthma** attacks in CYP demonstrate variation by area with the North of the ICB reporting a slight reducing trend (from April 2023) and the other three areas are reporting a consistent trend.
- **CYP MH** access remains above operational plan trajectory but below Long Term Plan (LTP) target. The majority of contacts are those from the most deprived communities (rate increasing at a greater rate than from the most affluent communities.

Actions/interventions/learning

- Work continues to develop and enhance the Alliance for children`s epilepsy across primary and secondary care.
- NHSE funded inequalities project underway to provide reconditioned NHS mobile phones and laptops to children with **T2 Diabetes** living in income deprived families
- The Community Health Worker (CHW) Network are liaising with **paediatric dentistry** about the work that they are involved in and any potential pieces of work that could be supported re: oral health and health inequalities over and above the extraction backlog.
- **Asthma** - Additional capacity has been recruited to the asthma workstream to support with targeted intervention into primary care, data received from Healthier and Fairer Colleagues which has enabled the identification of 42 practices for further local intervention now taking place before end March 24
- The development work done by the CHW Network Health Inequalities Advisors in support of **CYP with mental health** concerns will help inform approaches that organisations can take to target specific groups who may not currently be accessing services.

Quality implications

- 5/8 acute trusts have referral criteria from epilepsy clinics for children with 'intellectual disabilities' and 4 /8 for those with developmental concerns.
- Almost half of the children on the elective waiting list for a tooth extraction are from those most deprived communities, and there remain challenges to obtaining and collating accurate data and some development work needs to be carried out to rectify this.

Recovery/delivery

- Action plans against each metric where inequalities against deprivation and ethnicity are known is included in the additional health inequalities report.

Safety – October/November 2023

Objective	Plan Mar 24	Plan YTD	Actual (month)	Actual YTD	Trend	Benchmark
Never events Nov23	0	0	2	17		
MRSA Dec23	0	0	3	18		
C diff Dec23		420	54	500		
E coli Dec23		652	83	790		
Mortality	**Two Trusts (CDD FT & STSFT) are showing higher than the expected range for SHMI**					

Observations

- NENC is over trajectory for key HCAI infections and infection control management progress continues as a challenge with a deteriorating national picture.
- Increased demand on Trust estate and daily challenge to ensure patient flow through the hospitals adding to current pressures for infection control management
- Two Trusts (CDDFT & STSFT) are showing higher than expected for the Summary Hospital Mortality Indicator (SHMI) for up to August 2023 data. This will be closely monitored. All other Trusts are in the expected range.
- 17 Never Events have been reported since April 2023 by 6 Trusts.

Actions/interventions/learning

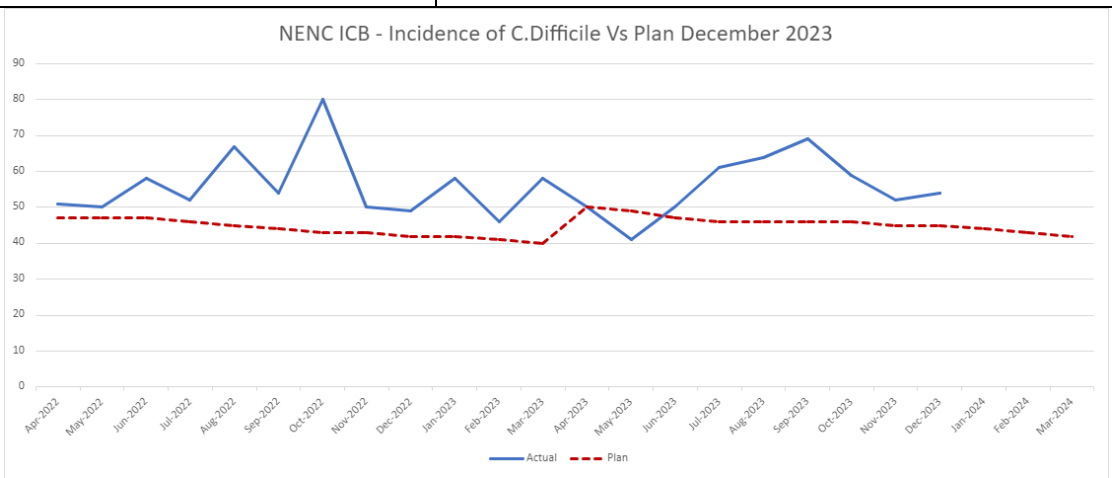
- Oversight across NENC through the AMR/HCAI subcommittee where learning and good practice shared at place and local QRGs.
- Northumbria HC IPC team successfully secured funding from NHSE to further the hydration project for acute and community settings
- The first meeting of community IPCN nurses held October, ongoing work streams to be determined.
- Workbook for care champions underway.
- Joint working with Drug and alcohol team to look at hygiene for Intravenous drug abusers (IVDA) in light of 2 recent MRSA Bacteraemia cases in the community.
- Allocated funding for CDDFT admission testing for Carbapenemase Producing Enterobacteriaceae (CPE) in designated patient groups.
- Quality & Safety Committee monitor data relating to mortality, regional mortality network to support quality improvements.
- Themes for Never Events are monitored to gain appropriate assurances to ensure learning has been identified and shared.

Quality implications

- MRSA cases have been subject to post infection review to explore any lapses in care and learning.
- Impact of increased infection risk on patient safety and length of stay in hospital.
- Never event learning shared through established forums and clinical networks.
- Mortality reviews undertaken, with increased scrutiny through the medical examiner process.

Recovery/delivery

- The ICB is looking to establish as a learning platform to support learning across the region.
- Sound risk assessments have been developed by our Trusts for management of HCAI.
- IPC Patient Safety Incident response (PSIRF) matrix and framework developed. Regular updates to the Quality and Safety Committee.
- ICB wide plan on a page developed and agreed for universal precautions, Clostridium Difficile and Gram Negative Bacterial Infections.



Appendix 1 – 2023/24 National objectives description

	Recovering core services and improving productivity
Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals: Expand direct access and self-referral where GP involvement is not clinically necessary. By September 2023, systems are asked to put in place: • direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations • self-referral routes to falls response services, musculoskeletal services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.
Primary care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of Resources	Deliver a balanced net system financial position for 2023/24

	NHS Long Term Plan and transformation
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults are cared for in an inpatient unit
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	CORE 20PLUS5: Increase uptake of COIVD, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions
	Hypertension case finding and optimal management and lipid optimal management
	Asthma – address over reliance of medications
	Decrease the number of asthma attacks
	Increase access to real time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic backgrounds
	Increase proportion of those with type 2 diabetes receiving recommended NICE care processes
	Epilepsy – increase access to epilepsy specialist nurses and ensure access in the first year of care for those with LDA
	Reduce tooth extractions due to decay for children admitted as IP in hospital aged <+10
	Improve access rates to children and young people`s mental health service for 0-17 year olds, certain ethnic groups, age, gender and deprivation.

NHS
North East and
North Cumbria

Appendix 2
Health and healthcare inequalities metrics and narrative

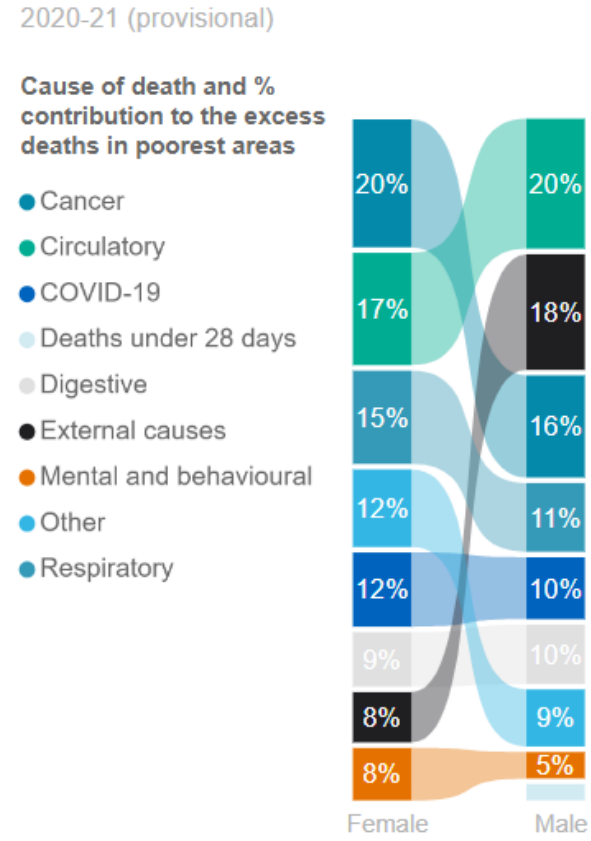
Better health
and wellbeing for all...

Longer and Healthier lives and fairer outcomes

<u>Longer and Healthier lives:</u> 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.
<u>Fairer Outcomes:</u> 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.

Figure 2 – Life expectancy at birth - NENC

Figure 3 – Diseases that contribute to the life expectancy gap



Data Position
The data above is taken from OHID - Picture of Health showing the current NENC life expectancy for males and females compared with England average and an overview of the diseases which contribute to the inequalities in life expectancy within our ICB.
Key disease groups driving inequalities within NENC are Cancer and Circulatory disease for women and Circulatory and External causes for men.
The current inequality gap between NENC and England is 1.5 years for females and 1.5 years for males. (2021).
The inequality between the most and least deprived is 9.4 years for females and 11.5 years for males (2018-20).

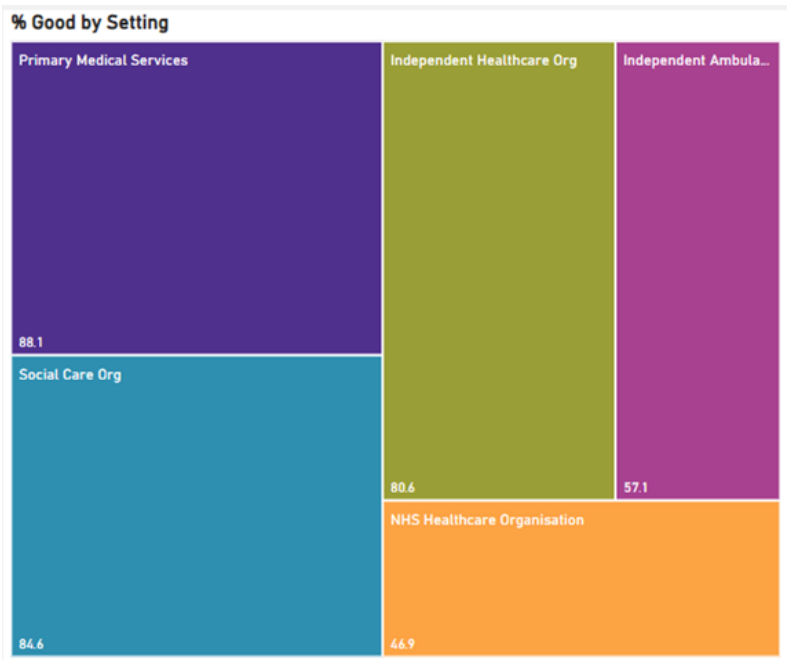
Better health and care services

<u>Better health and care services</u>: To ensure not just high-quality services, but the same quality no-matter where you live and who you are.

Figure 2 – CQC ratings by Sub ICB

Organisation Name	% Inadequate	% Requires Improvement	% Good	% Outstanding
NHS County Durham Sub ICB	1.1	8.0	82.2	8.7
NHS Newcastle Gateshead Sub ICB	0.7	8.9	82.9	7.5
NHS North Cumbria Sub ICB	0.5	9.2	82.1	8.2
NHS North Tyneside Sub ICB	1.0	5.7	84.8	8.6
NHS Northumberland Sub ICB	0.0	8.7	80.6	10.7
NHS South Tyneside Sub ICB	1.3	5.3	88.2	5.3
NHS Sunderland Sub ICB	0.6	0.6	92.1	6.7
NHS Tees Valley Sub ICB	1.2	8.3	84.9	5.7
Total	**0.8**	**7.4**	**84.2**	**7.6**

Figure 3 – CQC ratings - % Good by setting



Data Position

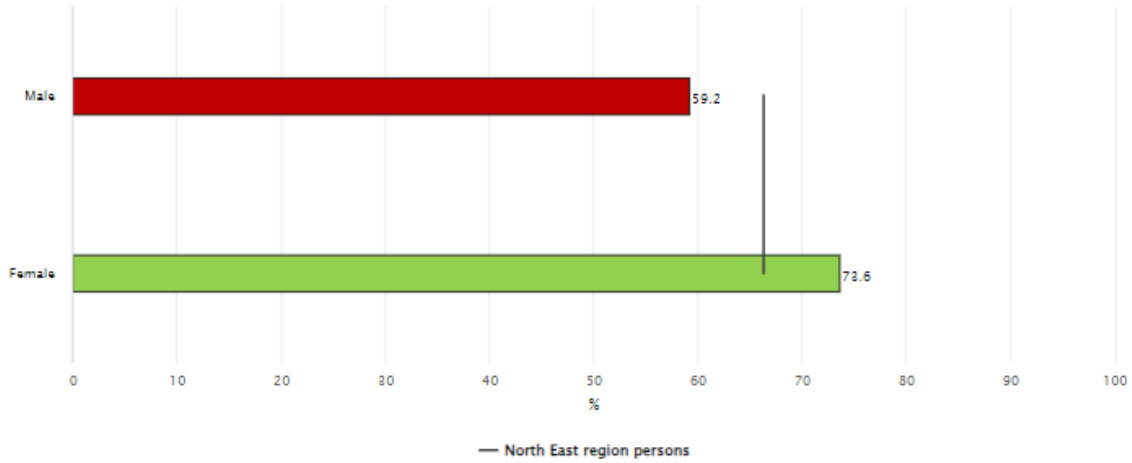
The data above is taken from Healthier and Fairer insight dashboard and highlights the current CQC ratings by Sub ICB as well as variation by setting across NENC.
84.2% of organisations across NENC were rated Good by CQC. This varied significantly by setting with Primary Medical Services reporting 88.1% and Healthcare Organisations 46.9%.

Best Start in Life

<u>Best Start in Life:</u> Increase the percentage of children with good school readiness at reception, especially for children from disadvantaged groups.

ICB Overall Position	66.3%
England Position	67.2%
Reported Inequalities	by Gender
Inequality Gap	14.4pts between males and females

Figure 1 – % of children with good school readiness at reception by gender



Data Position

The data above is taken from PHE Fingertips – Child and Maternal health dashboard and shows the proportion of children with good school readiness at reception by region, compared with the England average. This indicator is included within the Better health and wellbeing for all, Joint strategy for North East and North Cumbria, and requires the indicator to reported by inequalities. At present, the only inequality breakdown available is by gender.

The trend for the North East region is shown to be increasing with a rate of 66.3% in 2022/23 compared with 64.1% in 2021/22. The proportion of male children with a good school readiness in the north east is significantly lower than the proportion of females, with an inequality gap of approximately 14.4%pts.

There is no trend data available for North Cumbria but the current position is slightly lower than the North East region with 65%, although the inequality gap by gender is not as wide.

Elective Recovery

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	34%
Inequality Gap by deprivation	1%pt
Inequality Gap by Ethnicity	-1%pt
Variation by Trust	23% - 42%

34% of patients on the current waiting list have waited 18 weeks of more. A 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. There is significant variation by Trust.

52 week waits

ICB Overall Position	2%
Inequality Gap by deprivation	0
Inequality Gap by Ethnicity	1%pt
Variation by Trust	0% - 4%

2% of patients on the current waiting list have waited 52 weeks of more. There is no variation by deprivation. A greater proportion of patients from ethnic minority groups have waited 52 weeks. There is significant variation by Trust.

65 week waits

ICB Overall Position	0.8%
Inequality Gap by deprivation	-0.1%pt
Inequality Gap by Ethnicity	0.2%pt
Variation by Trust	0-1.8%

0.8% of patients on the current waiting list have waited 65 weeks of more. A smaller proportion of patients from the most deprived communities have waited 65 weeks. A greater proportion of patients from ethnic minority groups have waited 65 weeks. There is significant variation by Trust

Figure 1 – 18 week Waits by IMD, January 2024 by deprivation

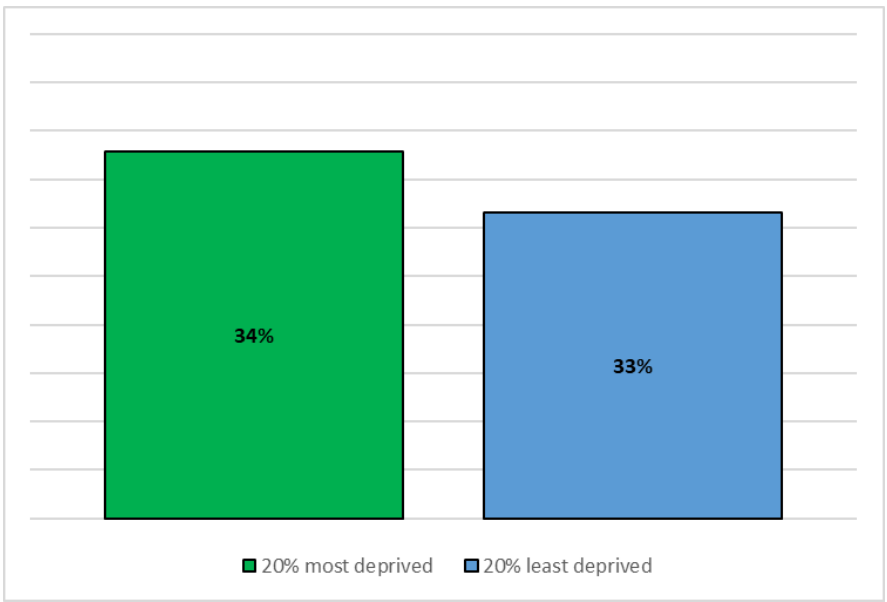
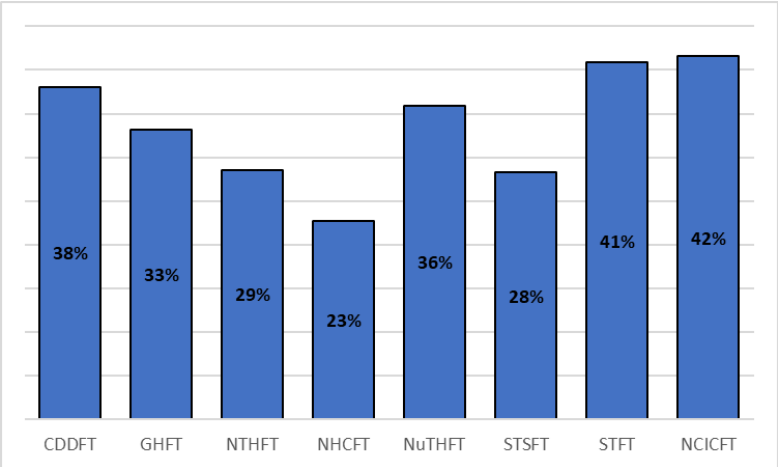


Figure 2 – 18 week Waits by Provider, January 2024 by Trust



Elective Recovery: Elective activity vs pre-pandemic levels for under 18s and over 18s

ICB Position	10% increase in activity in 2023/24 compared with 2022/23	
Inequality Gap by deprivation	0	No apparent inequality gap by deprivation and there has been a greater increase for Ethnic minority communities compared with White communities.
Inequality Gap by Ethnicity	-2%pt	

Data Position

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

- 34% of patients awaiting an elective procedure within the ICB have waited 18 weeks or more. The current position shows a small but insignificant inequality gap for both deprivation and Ethnicity.
- 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.
- There has been a 10% increase in Elective activity for adults in 2023/24 when compared with the same period 2022/23. There are no reported inequalities. Need to source 2018/19 Elective activity numbers to enable comparison with pre pandemic levels as this was not available. Analysis but Trust was undertaken but due to previous coding issues by one of the trusts, the data quality did not meet the threshold for inclusion.

The causes for the inequality gap

- Potential differences in format for patient communication
- Health literacy levels across the population

- Accessibility to transport in order to attend appointments and hospital within a considerable distance
- Digital accessibility and use
- CYP – limited ability to take time additional time off work in order to bring children to elective appointments, in addition to the impact on CYP in taking time out of education.

The work currently being undertaken to address the gap

- Working with Waiting Well colleagues to ensure patients are optimised for surgery / procedures whilst on the waiting list.
- Mutual Support Co-ordination Group (MSCG) has been established to ensure system working and collective management of long waiters, maximising system capacity and resource.
- Children and Young People (CYP); identification of the gap in recovery between CYP and adults. Data has also highlighted some differences in area of deprivation, ethnicity, and age ranges. This has been shared at the Strategic Elective Care Board with identification of a CYP Checklist in order to close the gap in recovery.
- Progress had been made in understanding key cohorts of patients and update on emerging work to link with across NHSE regional and national. Further data from an inequality lens will be brought to the Strategic Elective Care Board to inform next steps and focus for providers, including non RTT pathways as well.

Plans for narrowing the gap

- Further plans to work with Waiting Well to link information into providers for effective scheduling, booking and validating patients due to attend for elective care. MSCG to continue to review longest waiters and particular cohorts of patients under significant pressure. Regular monitoring of providers laiting lists and tracking of patient movement across the system as a whole.
- CYP Steering Group has been established in order 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 the CYP.
- Outpatients leads have health inequalities as one of their main deliverables on the 24/25 Outpatient Improvement Plan this will include focus on
    - Support to reduce DNA
    - Patient Choice and Patient Support
    - Communication with patient (Contact centre, Patient Engagement Portals, text messaging and use of navigators)

Urgent Care

Urgent Care: Emergency admissions for under 18s

ICB Overall Position	56.4 per 1,000 population (under 18)
Trend	Reducing
Rate in most deprived quintile	58.8 per 1,000 population
Inequality Gap by deprivation	18.4 per 1,000 population
Rate in ethnic minority communities	57.2 per 1,000 population
Inequality Gap by Ethnicity	7.2 per 1,000 population

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

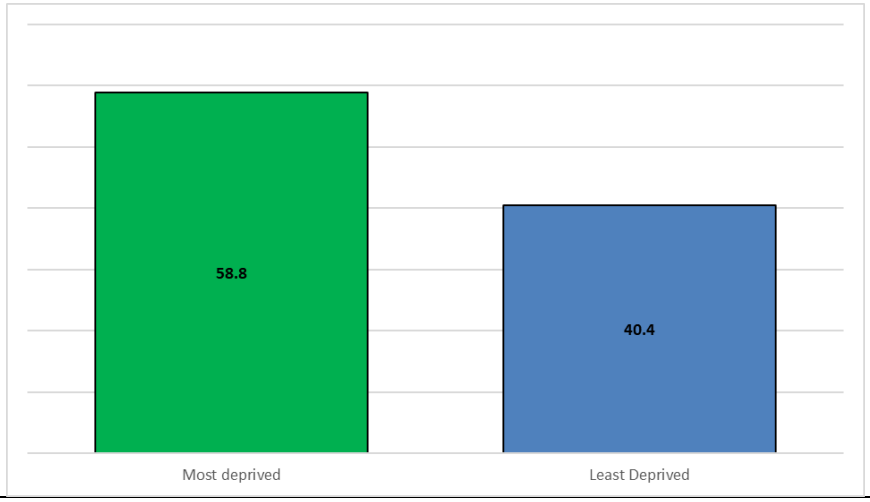
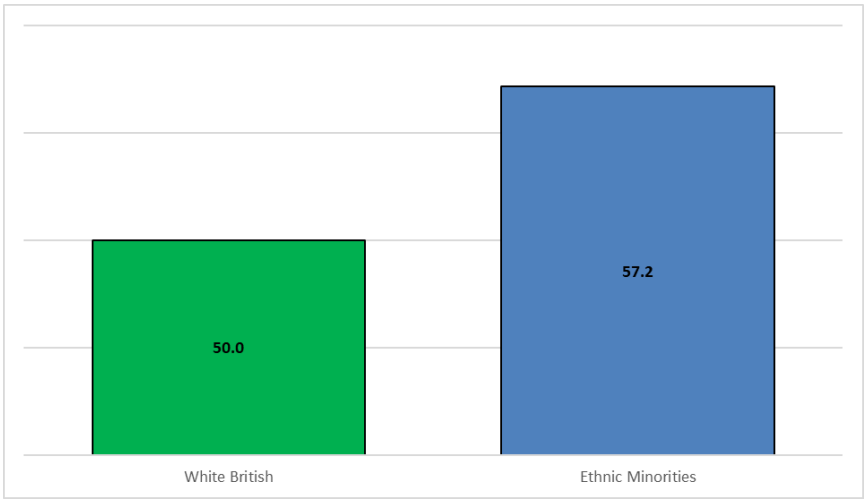


Figure 2 – Emergency admissions for under 18's per 1,000 population by ethnicity



Data Position

Data included in the figures above are taken from RAIDR Patient Activity dashboard and relate to April to November 2023 (Financial year 2023/24). Population data by IMD and Ethnicity sourced from NHSE.

- The rate of emergency admissions for Children and Young people (aged 18 and under) is shown to be reducing when comparing the time period with the previous two years (April to November).

- For every 1,000 child/young person residing within NENC, there were 56.4 admissions during that period compared with 62.7 in 2021/22.

- 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 18.4 admissions per 1,000 population or 18 more admissions from the most disadvantaged than the least.

- The inequality gap has reduced between 2021/22 and 2023/24 by 1 admission per 1,000 population, highlighting the reducing trend in emergency admissions is greater for the most disadvantaged areas. For every child/young person from an ethnic minority community, there were 57.2 admission during the reporting period.

- It is not possible to accurately compare with 2021/22 as data suggests there has been an increase in more accurate coding of ethnicity since that period. There is variation by ethnicity group which highlights a greater rate of emergency admissions for children from Ethnic minority communities compared with White communities.

The causes for the inequality gap

Multiple factors contribute to unequal healthcare access and outcomes for young people (0-18) in North East England and North Cumbria. Broader social and economic conditions, like poverty and ethnicity, influence children's health behaviours and hospital admissions.

Children with long-term conditions like asthma and diabetes are more likely to be from disadvantaged backgrounds. These conditions are often linked to environmental factors like poor air quality and housing, which disproportionately affect low-income families.

The COVID Inquiry emphasizes the largely preventable nature of asthma admissions and the complex interplay of early childhood experiences that contribute to lifelong lung health. Maternal health, air quality, and socioeconomic circumstances all play a role.

Investing in childhood health equity is crucial for not only moral reasons but also for society's long-term well-being and economic growth. Local data shows that accessible community health hubs can significantly reduce unnecessary emergency department visits for respiratory issues.

While this summary highlights key points, the full picture is more nuanced. Further research and action are needed to address the multifaceted causes of healthcare inequality for young people in the NENC.

The work currently being undertaken to address the gap

- Accessible and trusted NHS health education resources - Healthier Together Champions (reaching over 10,000 families) and our 13 Beat Asthma Friendly Schools and targeted primary care intervention have worked directly into communities with higher levels of deprivations for avoidable admissions and education.
- 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.250 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, 60% in lower three deprivation deciles.
- Established over thirty all-age ARI hubs across the region during the seasonal period. Each based in areas of low socioeconomic deprivation (ARI hub post codes located in Indices of Deprivation deciles of 5 or less.

Plans for narrowing the gap

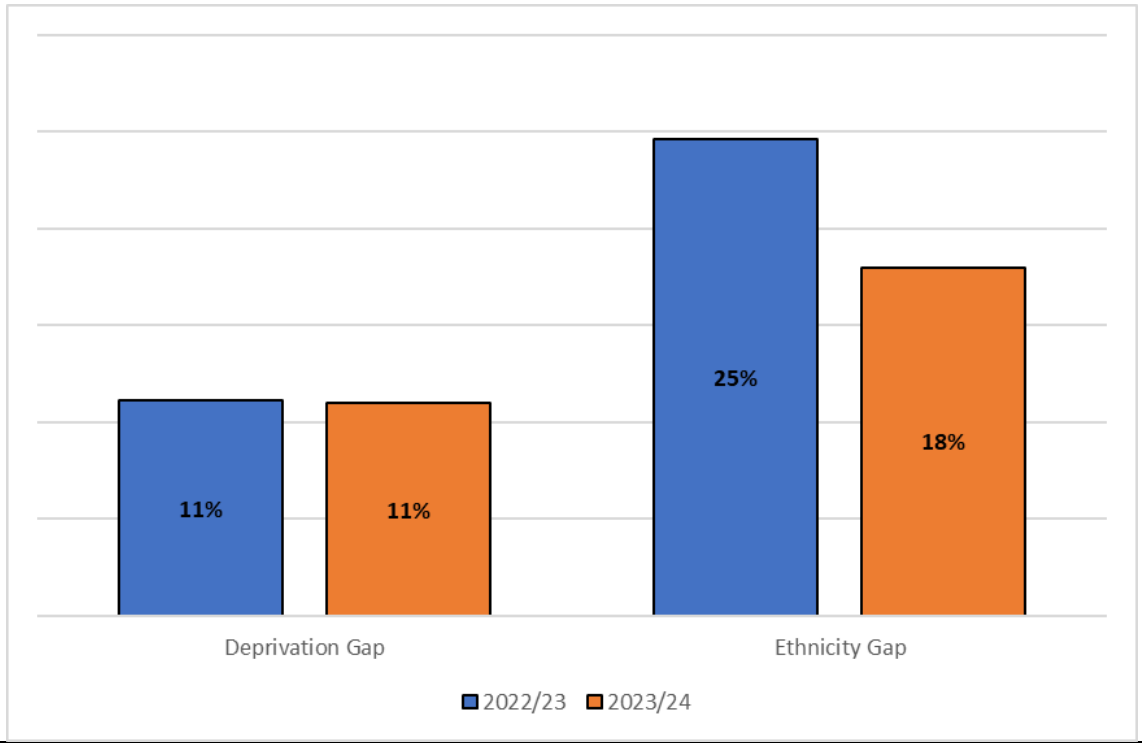
- Data workstreams to improve data gaps so they can support analysis for improvement and impact in this area (including plus groups), including CYP Transformation Service Improvement looking to address the lack of admissions data that triangulates HI or BME data for epilepsy cohort.
- Healthier Together partnering with schools in high levels of deprivation and non-white ethnicity to support their families with healthcare guidance.
- 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
- Apply NENC CYP Core20PLUS5 - focused application of toolkit and plans to work with Vanguard Emergency Admissions services to collect case studies that reduce the gap
- ICB CYP Clinical Strategy Prioritisation launch – Ensure the long-term conditions focus adopts its key principles - health inequalities and inclusion group approach
- 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.

Respiratory

Respiratory: Uptake of flu vaccination by socio-demographic group

Inequality Gap by deprivation	11%pt
Change in inequality gap compared with 2022/23	-0.1%pt
Inequality Gap by Ethnicity	18%pt
Change in inequality gap compared with 2022/23	-6.6%pt

Figure 1 – Changes to inequality gap for Flu Vaccinations



Data Position

The data included above has been taken from the Healthier and Fairer dashboard which uses Primary Care Vaccination data as it's source. We were unable to access data relating to COVID vaccinations, therefore this analysis relates to Flu only.

At the point of analysis, the Vaccination programme for 2023/24 is not yet complete, therefore comparing ICB overall position for this year with previous is not appropriate. However, given the late stage of the season at which the data was extracted it is not expected to materially change. The analysis has focused upon the proportional variation between the suggested inequality groups and is reported as percentage point differences.

The inequality gap in flu vaccine uptake between the most disadvantaged communities and the least disadvantaged communities is 11%pts for this year, highlighting the fact that proportionately, fewer people from the most disadvantaged areas have received their flu vaccination.

When comparing the reported gap with the previous year, there has been a slight reduction of 0.1%pt.

The inequality gap in flu vaccination uptake between those from Ethnic Minority communities and white ethnic communities is currently 18%pts, highlighting fewer people from ethnic minority communities received their flu vaccinations this year.

When comparing this gap with the previous year, there has been a reduction, a narrowing of the gap equating to 6.6%pts.
Caveat: The ethnicity reporting excludes any individuals where ethnicity status is 'not recorded' or 'not known'. Some of the increase in uptake for ethnic minority communities compared with previous year may be as a result of improved capture of status.

The causes for the inequality gap
At the moment we do not have an explanation for the change in gap for ethnicity from 22/23 to 23/24. It is an interesting finding which we will look in to.
The overall gaps for both deprivation and ethnicity are seen across most reporting sources and we are aware of these.

The work currently being undertaken to address the gap
In 23/24 we undertook a range of work to address inequalities in flu uptake which included:

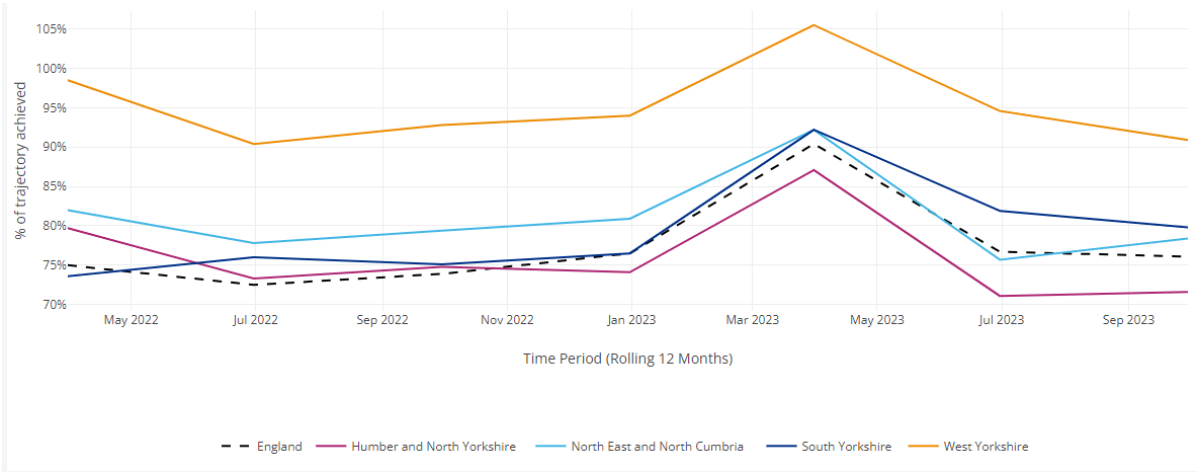
- Established a previously unavailable flu and COVID Inequalities data set which allowed detailed analysis of the different sub-populations and their uptake.
- Provided detailed Ward level uptake data for the previous 22/23 season and then through the 23/24 season to ICB Place Leads so that localised action could be taken for low uptake communities.
- Commissioned our school age immunisation services to deliver initiatives aimed to address inequalities.
- As we are not shifting the gap on these inequalities, we are undertaken a Season review and initiating some specific work, including Deep Dive work to understand better the Under 65s At Risk Cohort.

Mental Health

<u>Mental Health</u>: Overall number of severe mental illness (SMI) receiving physical health checks

ICB Overall Position	**78.4%**
Change since 2022	**-1%pt**
England Position	**76.1%**

Figure 1 – SMI annual health checks in last 12 months



<u>Mental Health:</u> Halve the difference in the suicide rate in our region compared to England (2022)

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

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

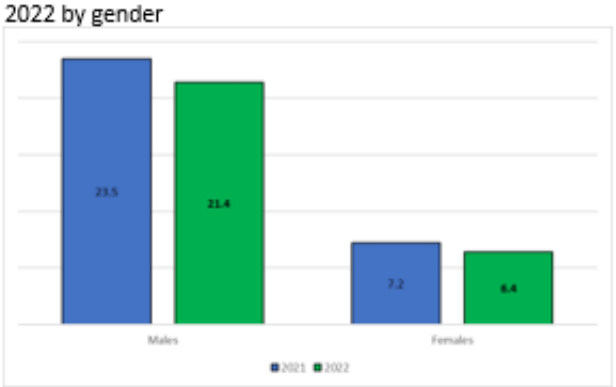
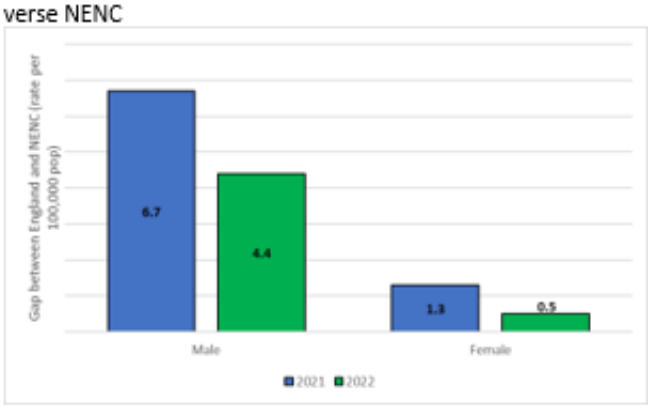


Figure 3 – Gap in Suicide rate per 100,000 population England verse NENC



Data Position

The data above is taken from NHSE health inequality analysis report and the Office for national statistics publication on Suicides, released December 2023. The data relates to 2022.

- The proportion of patients with a diagnosis of Serious mental illness who have received their annual health check within the last 12 months is currently 78.4%, a reduction of 1%pt compared with the same period last year.
- The latest figures are higher than England average.
- 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.

The causes for the inequality gap

- Patients with an SMI in NENC are more likely to live with food, fuel, travel and digital poverty.
- Patients need reasonable adjustments but may not be aware.
- Patients have co-morbidity related to their illness e.g. substance misuse, obesity, smoking related diseases, medication side effects and be more likely to struggle to make the changes needed.
- Patients have more difficulties accessing health and social care because of the above, e.g. screening.
- Carers may need extra support to manage the mental and physical conditions of their loved one / client.
- Parity of esteem for mental health.
- Average reading age of patients in NENC is 8, so information may not be readily accessible and is not translated on the whole.

The work currently being undertaken to address the gap

- Across NENC SMI physical health checks in both primary and secondary care, and we are nearly at or > 60 % of the population of SMI seen at the end of Q3.
- We are rolling out Prevention of Adult Not Brought Strategy « Learning Disability Network (necldnetwork.co.uk) Reasonable Adjustment Campaign « Learning Disability Network (necldnetwork.co.uk).
- Primary care social prescribing support for patients.
- Patients have SMI specific smoking cessation in some areas.
- SMI outreach workers in some areas to support those who do not or cannot attend.
- Patients have some specific support around substance misuse in some areas.
- VCSE involvement in recovery colleges to support patients and carers.
- Some areas have maternity specific mental health support.
- We are all working towards community mental health transformation.

- Health literacy workstream.

Plans for narrowing the gap

- Roll out of these campaigns across NENC:
    - Reasonable Adjustment Campaign « Learning Disability Network (necldnetwork.co.uk)
    - Prevention of Adult Not Brought Strategy « Learning Disability Network (necldnetwork.co.uk)
- Continued support for primary care SMI checks.
- Consideration of further roll out of SMI specific support.

Healthier and fairer workstream working on Core20PLUS5 and inclusion.

- Health literacy workstream.
- Consideration of work to join up health checks with more comprehensive information about related support e.g. physical health toolkit for SMI.

<u>Mental health</u>: Mental Health Act detentions crude rate per 100,000 population – 2021/22

ICB Overall Position	100 per 100,000 population
Trend	Reducing
Inequality Gap by deprivation	128 per 100,000 population
Inequality Gap by Ethnicity	171 per 100,000 population

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

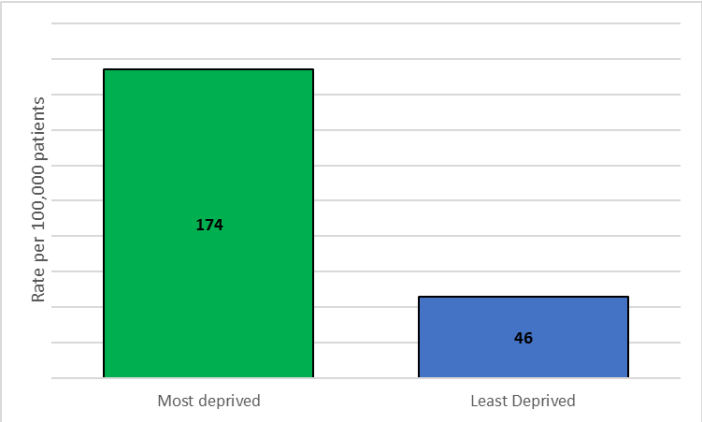
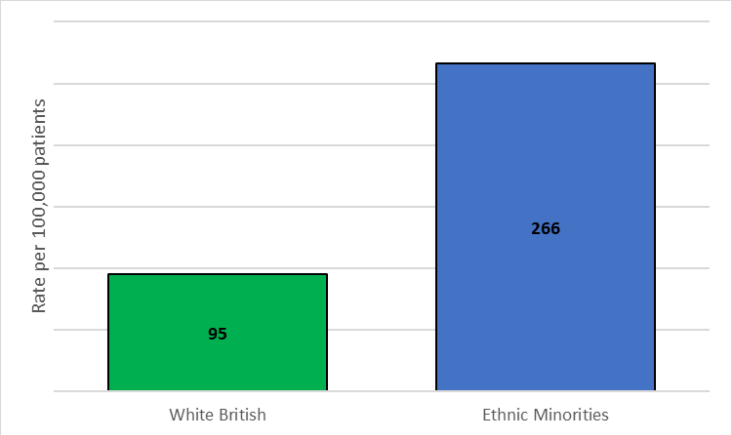


Figure 2 – Mental Health Act detentions crude rate per 100,000 population by ethnicity



Data Position

The data included above is taken from the most recently available Mental Health Act statistics from NHS Digital. The 2022/23 data is due to be published late January 2024.

- During 2021/22 there were 3,015 reported mental health act detentions within NENC. Equating to a rate of 100 per 100,000 population. This is a reduction compared within 2020/21.

- 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 123 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 171 per 100,000 population.

The causes for the inequality gap

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 work currently being undertaken to address the gap

Tracked though TEWV FT integrated information system; work to commence following the introduction of new incident reporting system to explore the ability to segment this data by protected characteristic and deprivation.

Currently, people from minority backgrounds are underrepresented on the manager panels and overrepresented in using our services. CNTW FT has embarked on a project, working with CNTW Mental Health Act Office, to increase the representation of people from minority groups on the managers panel for reviewing the detention of our patients.

Implementation the new Patient Safety Incident Response Framework, focusses on the compassionate engagement with everyone affected by incidents, including our staff, our service users, families, and carers. The aim is to understand how incidents happen and the system and process issues that contribute to them, rather than apportioning blame, allowing for more effective learning which improves the safety of care.

Work to address the Patient Carer Race Equality Framework forms a key part of our medium term objectives for Equality Diversity and Inclusion and discussions around this have taken place with the Executive Management Group and Trust Board.

We are also repositioning our Equality Diversity and Inclusion Steering Group through looking at its Terms of Reference and Membership from a group that has predominantly considered Workforce Inequality issues to one that also addresses health inequalities. In anticipation of this a mapping exercise has taken place against the Health Inequalities Leadership Framework Key Lines of Enquiry.

CNTW is actively investigating the link between ethnicity, deprivation, and detention rates. They'll track trends, analyse specific groups, and compare data with other areas like closed culture and EDI. Education is a key focus, overseen by the Trust Mental Health Steering Group with regular reports to the board.

Plans for narrowing the gap

A patient safety summit on inequalities is planned for March 2024. The event will showcase national data, local experiences, and community perspectives on the intersection of patient safety and inequalities. Educational materials for staff are also being developed to highlight the importance of addressing inequalities for optimal patient safety.

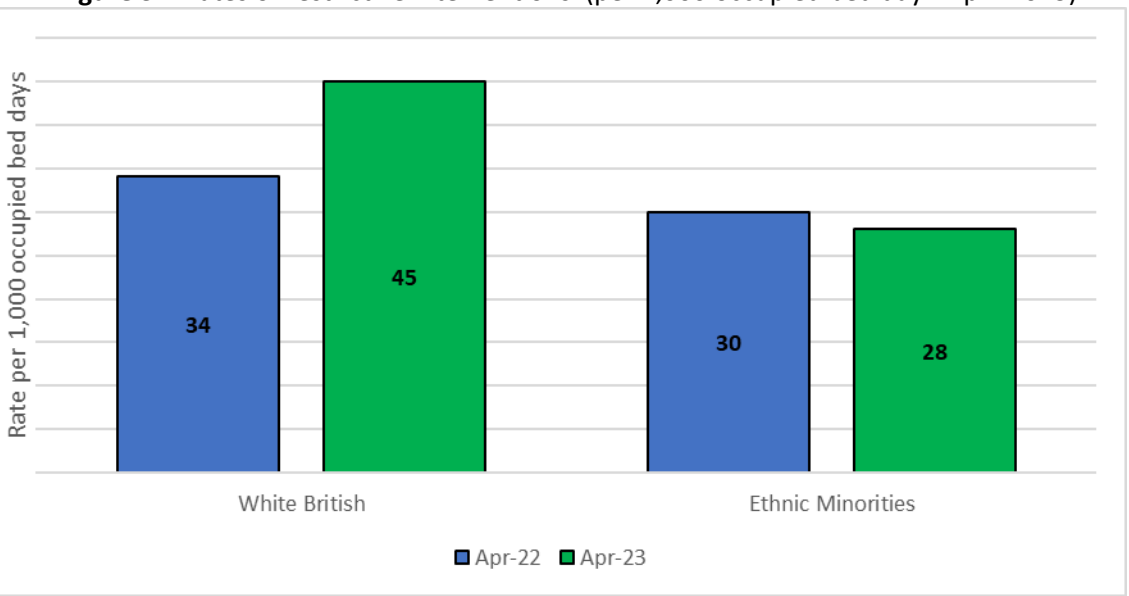
Rates of total mental health act detention by ethnicity will also be reported through PCREF from 2025 and by all protected characteristics in response to the Use of Force Act. This will form part of routine board reporting and actions developed in response

The Patient Carer Race Equality Framework requires FTs to prioritize areas for improvement regarding equality legislation, regularly monitor progress, and engage with diverse communities. Co-developed actions within local plans will utilize patient experience data for service improvement. Outcome measures will be similarly employed, and feedback systems for ethnic communities will be established.

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

ICB Overall Position	43 per 1,000 occupied bed days
Inequality Gap by deprivation	Not reported
Inequality Gap by Ethnicity	17 fewer per 1,000 occupied bed days

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



Data Position

The data included above is taken from the most recently available restrictive interventions dashboard from NHS Digital. The source data is reported as Mental Health minimum dataset. The information reflects the latest reported position (April 2023) and has been compared with April 2022 for context.

- For every 1,000 occupied bed days, 43 patients were reported as receiving restrictive interventions. Compared with the same period the previous year, there has been a reduction.

- 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 2022, there has been a reduction in the rate for patients from ethnic minorities but an increase from white ethnic communities.

- 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.

The causes for the inequality gap

- 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.

The work currently being undertaken to address the gap

- Tracked though TEWV FT positive and safe dashboard which can be analysed at team level. Work to commence following the introduction of new incident reporting system to explore the ability to segment this data by protected characteristic and deprivation.
- A programme of work on positive and safe has commenced which monitors the positive and safe dashboard this includes consideration of the characteristics of those most often restrained including autistic people
- TEWV FT is working to make our clinical environments more accessible to autistic people including initial environmental audits in adult mental health wards and are rolling out mandatory Autism training and online Oliver McGowan training.
- Human Rights Training is in place. Talk First Initiative has interventions and training in place designed to reduce the rates of restrictive interventions. Training for all staff on awareness of Learning Disability and Autism, meeting the Oliver McGowan mandatory requirements.
- Implementation the new Patient Safety Incident Response Framework, focusses on the compassionate engagement with everyone affected by incidents, this includes our staff as well as our service users, families, and carers. The aim is to understand how incidents happen and the system and process issues that contribute to them, rather than apportioning blame, allowing for more effective learning which improves the safety of care.

Plans for narrowing the gap

- Rates of physical mechanical and chemical restraint seclusion and segregation by ethnicity will also be reported through PCREF from 2025 and by all protected characteristics in response to the Use of Force Act. This will form part of routine board reporting and actions developed in response
- BIHR training has been provided to clinicals leaders and ethics committee members including a module on restrictive interventions and human rights. A further cohort will be trained in 2024. BIHR also offer a number of supervision sessions for complex cases.
- Rates of physical, mechanical and chemical restraint will be reported by the Patient Carer Race Equality Framework and for all protected characteristics through the Use of Force Act 2018. The Equality Diversity and Inclusion Team are working with the Organisational Development Team, the International Recruitment Team and Staff Networks to develop and deliver training and initiatives for staff that increase cultural competency across all protected characteristics and therefore help address unconscious bias as identified in Restraint Reduction Network Training Standards 2020 report as a key factor in explaining restraint inequalities.

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 4 – NHS Talking Therapies (formerly IAPT) Recovery rate –2022/23 by deprivation

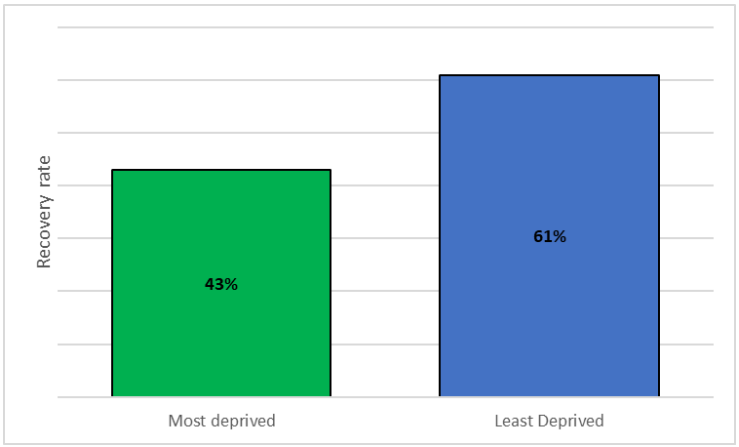
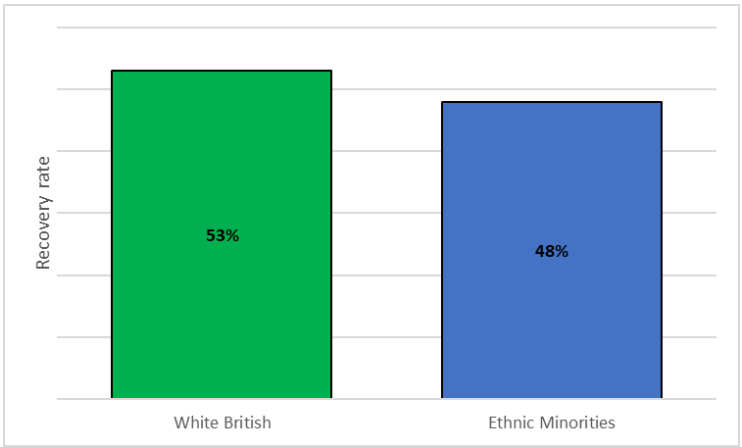


Figure 5 – NS Talking Therapies (formerly IAPT) Recovery rate –2022/23 by ethnicity



Data Position

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 a 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 2 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.

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

NENC ICB have conducted a ‘deep dive’ into NHS Talking Therapies and inequalities during 23/24. Key points from the NENC data:

Prevalence of anxiety and depression markedly higher in females compared to males and in both the female white British and some minority ethnic groups.

There is a clear link between anxiety and depression and deprivation.

Referral rates into Talking Therapies follow the demographic profile with higher rates for females and people living in the most deprived areas.

Referrals typically concentrated in the 20-to-50-year age band despite high prevalence rates across all ages.

Recovery rates are typically better for older populations.

Recovery rates typically lower for people resident in the more deprived areas.

High rates of referral for military veterans and people with substance misuse (drugs and alcohol) issues who also suffer from anxiety disorder or depression.

Drop our rate amongst people with substance misuse are higher than for the general population.

Recovery and reliable improvement rates for vulnerable groups are typically lower than those reported for the general population.

Men tend to be underrepresented with 37.6% of females and 23.8% of males aged 16 and over on a depression or anxiety disorder register in primary care. Although the overall prevalence of mental disorders is lower in men than in women, men are less likely to access psychological support

This deep dive also highlighted place-based variance in investment which does not correlate with better access rate or clinical outcomes for deprived communities. But there are difficulties in comparing like for like.

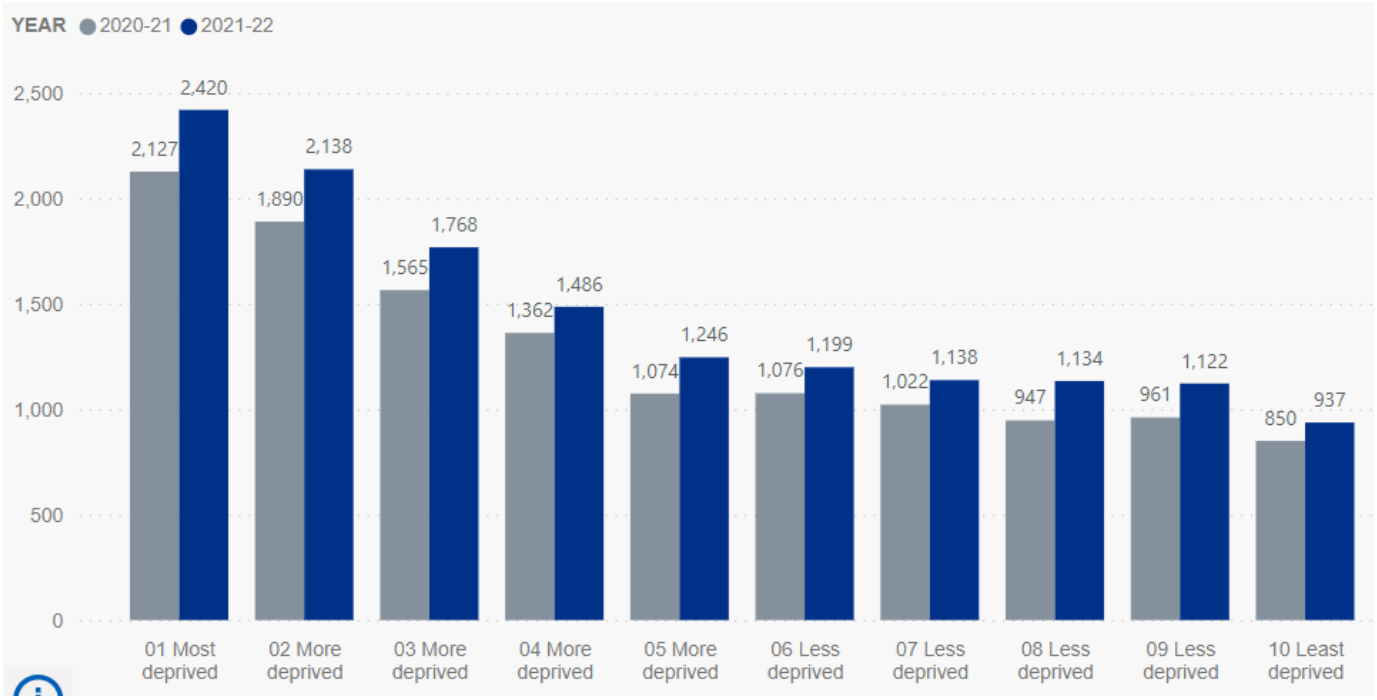
Plans for narrowing the gap

A full review of NHS Talking Therapies has taken place through 23/24 and an options appraisal has been submitted to our Mental Health, Learning Disabilities and Autism Sub-committee in January 2024. NENC also has a well-established Talking Therapies Delivery and Oversight Group, consisting of ICB, Providers and People with lived experience that is focussed on sharing good practise and iterative improvements.

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

ICB Overall Position	8,862 per 100,000 population (51,545)
Most deprived communities %	42.7% (22,000)
Least deprived communities %	8.5% (4,400)
Trend	Increasing

Figure 1 – Crude rate of CYP supported through NHS funded mental health with at least one contact by IMD (per 100,000 population)



Data Position

The data included above has been taken from NHS Digital Mental health bulletin dashboard. The data relates to 2021/22 activity and reports the crude rate of access at ICB level and how that is reflected in the most and least deprived communities.

- In 2021/22 there were 51,545 children and young people referred to mental health services who had at least 1 contact. Local data from the NENC mental health dashboard indicates that this continues to increase with a cumulative report of 53,000 in April 2023 (12 month rolling period).
- At present, the local mental health dashboard does not segment by deprivation. The Mental health bulletin highlights great levels of variation by deprivation in 2021/22 with 45% of contacts aligned to children from the most deprived communities (deciles 1 and 2) compared with 8.5% from.
- The rate of children accessing from the most deprived communities appears to be increasing at a great rate than those from the least deprived.

The causes for the inequality gap

It is recognised nationally that more children and young people aged 0-25 need to be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams.

This includes readily accessible crisis care, seamless transition programs to adult services, and integrated efforts across sectors. These needs arise from several factors, including high poverty rates, low educational attainment, and the pandemic's impact. The prevalence of social, emotional, and mental health needs, bullying, substance and alcohol misuse amongst NENC school pupils are significantly higher than national averages.

The work currently being undertaken to address the gap

- CHWN-produced CYP Core20PLUS5 framework for NENC, with development of toolkit and resources which enables identification and consideration of wider determinants impacting those affected by health inequalities. The framework highlights 'Positive Mental Wellbeing' as one of five priority areas to address, thus supporting the delivery of targeted work to narrow the gap

- Youth Mental Health First Aid training and epilepsy mental health mapping to improve resilience and early support for young people in communities

- The CNTW FT Children's Transformation programme is one of 3 major programmes looking at the Trust wide transformation of services. The transformation covers children's community, inpatient and specialist services. We have several groups looking at addressing priorities from a national, regional and Trust perspective. We are also supporting locality developments with the sharing of knowledge and practice. CNTW Child and Adolescent Programme Priorities include reducing access time to children's services, improving experience of children's services, and CYP eating disorders.

- TEWV FT has developed an equality and diversity dashboard which shows significant differentials in engagement and higher levels of was not brought and cancellation from our most deprived communities.

- A programme of Poverty Proofing has been undertaken in partnership with Children North East. Building on this in the coming year, specific projects will be developed to close the gap in DNA/WNB between our most and least deprived communities.

Plans for narrowing the gap

- NENC CYP Core20PLUS5 - HI Advisors can offer focused application of toolkit and plans to work with MH Vanguard services to collect case studies to share

- ICB CYP Clinical Strategy – mental health & anxiety

- CNTW and TEWV FT's will continue work towards transformation programme. In TEWV, a focus group with care experienced young people on barriers and access to services is scheduled for February and will inform the development of educational material for staff on inequalities and its impact.

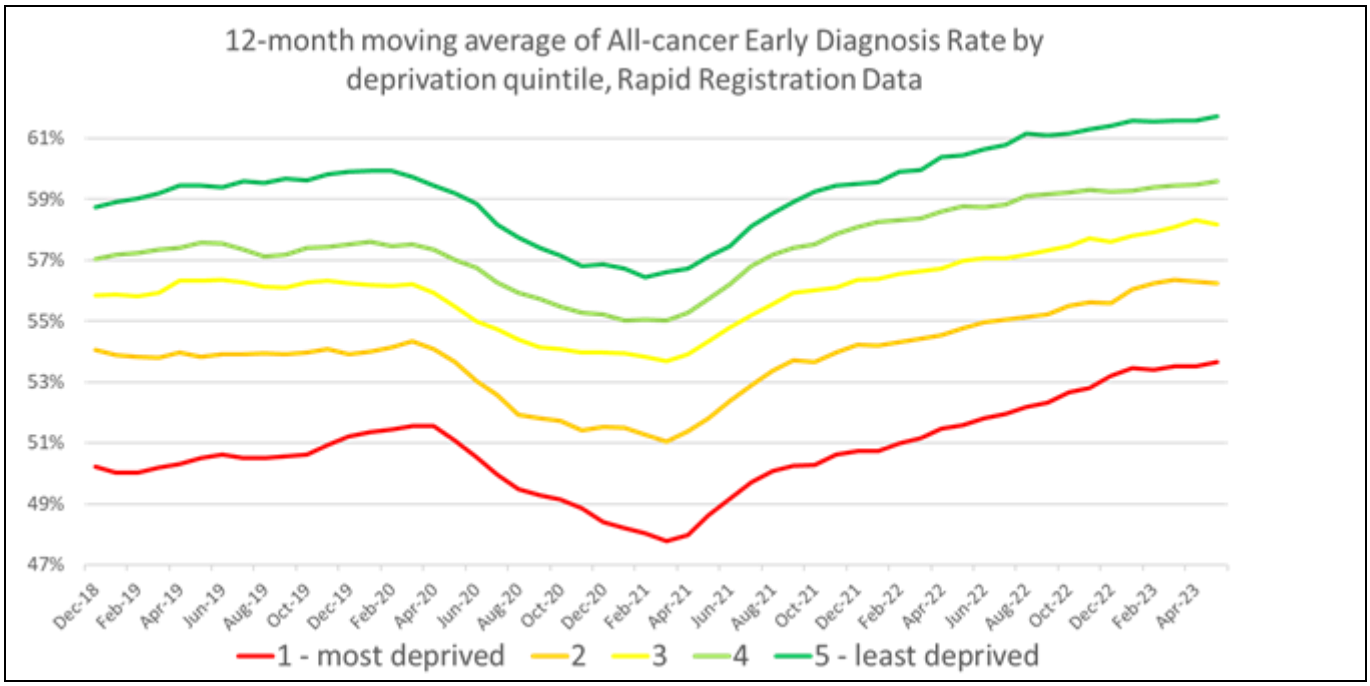
- Social prescribing for children, exploring possibility of expanding this across PCNs in NENC Clinical Strategy – mental health & anxiety

- CNTW and TEWV FT's will continue work towards transformation programme. In TEWV, a focus group with care experienced young people on barriers and access to services is scheduled for February and will inform the development of educational material for staff on inequalities and its impact.

Cancer

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	54.2%
England Position	57.7%
Inequality Gap by deprivation (England)	7%pts



Data Position

The metric for cancer is that 75% of cancers will be diagnosed at an early stage by 2030.

- Pre covid (2019/20) NENC early diagnosis rate was 54.2% with the national average being 56.1% (NDRS: Cancer Data - Cancer Analysis System CAS2109 data. https://www.cancerdata.nhs.uk/stage_at_diagnosis)
- After a reduction during covid, the rate for NENC in 22/23 has only recovered back to the pre-pandemic level of 54.2% with the national average being 57.7% (NCRAS – Rapid Cancer Registration Data (RCRD) https://cancerstats.ndrs.nhs.uk/RCRD/COVIDDashboard NB: this data is unpublished).
  So, although the NENC rate is improving, the gap between local and England rates is growing, and the trajectory towards 75% is not being achieved (NENC modelling in 2018 was 62% by 2028).

The causes for the inequality gap

In NENC there is a higher burden of disease and cancer is diagnosed later in communities of health inequality

The work currently being undertaken to address the gap

NCA 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 programme is nationally funded and uses proportional universalist approach to allocating cancer transformation funding to projects and organisations that can target the most support where it is most needed.

Early diagnosis projects are targeted at communities and PCN's by triangulating health inequality indicators (such as CORE20) cancer incidence (including emergency presentation) and uptake rates for screening and case finding initiatives.

We are aware that even high performing programmes that exceed the national standard for uptake 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 the Grail sampling vans and the development of mobile cervical sampling).

Plans for narrowing the gap

NCA have ambitious plans to narrow the gap, and as we move into planning the 24/25 cancer delivery plan we will continue to target our work as outlined above and ensure that all projects in the cancer workplan address health and healthcare inequalities.

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 the best performing areas (starting with less burden of disease and a less stark health inequality profile) are achieving a 3% improvement in early diagnosis rates; proceeding at that trajectory would take NENC to 72% early diagnosis by 2030.

Further improvement on that standard would be dependent on innovative filter tests (such as the Grail test) becoming available, the longer term resourcing/targeting of early diagnosis projects such as the lung health checks programme, and a comprehensive costed workforce plan.

Cardiovascular Disease

<u>Cardiovascular Disease</u>: 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	71.1%
England Position	67%
Inequality Gap by deprivation	3.2%pts
Inequality Gap by Ethnicity	14.4%pts

Figure 1 – Inequality gap by Deprivation for indicator CVDP007HYP

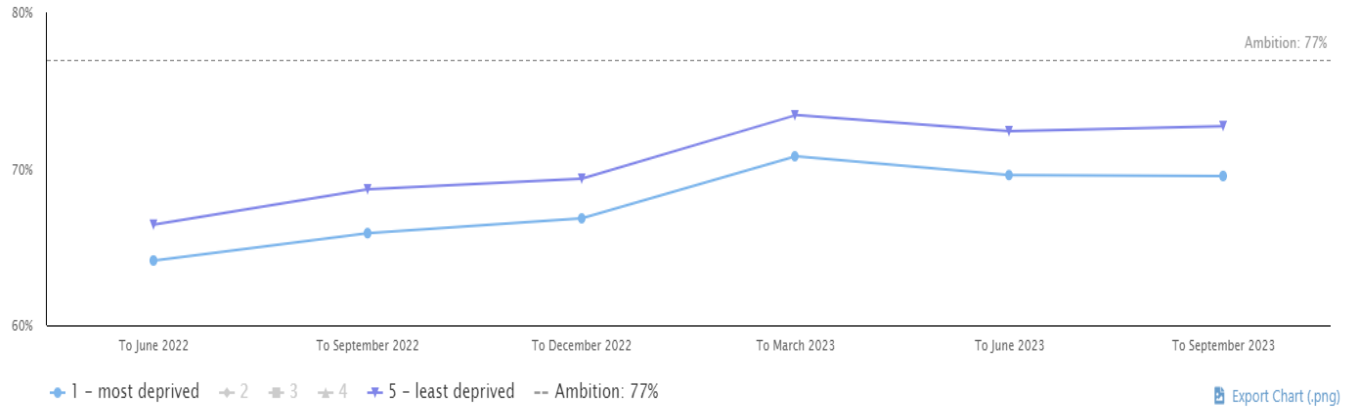
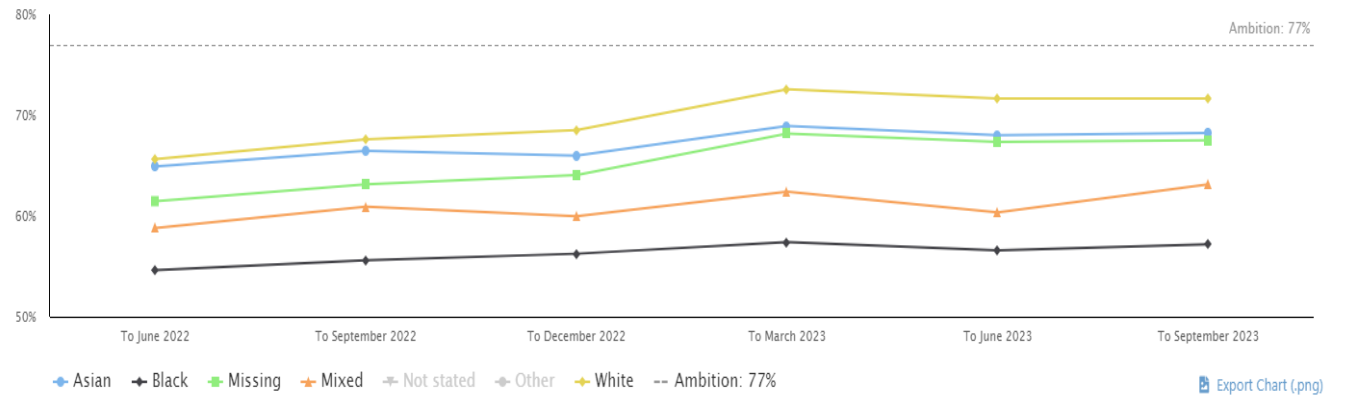


Figure 1 – Inequality gap by ethnicity for indicator CVDP007HYP



<u>Data Position</u>

The data included above is taken from the National CVD Prevent data, covering a 12-month rolling period for each data point.

- Up to September 2023, 71.1% of patients (aged 18 and over) with hypertension in NENC had a bloody pressure reading below the age-appropriate threshold. 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 when compared with the those from the least deprived, there is an inequality gap of 3.2%pts. This gap is shown to have increase slightly over the last year.
- The proportion for those from ethnic minority communities varies by ethnicity, with those recorded as Black reporting the lowest. When comparing the achievement for Black patients and patients of white ethnicity, there is a 14.4%pt inequality gap.

<u>Cardiovascular Disease</u>: 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%
England Position	60%
Inequality Gap by deprivation	-7.5%pts
Inequality Gap by Ethnicity	-8.6%pts

Figure 1 – Inequality gap by Deprivation for indicator CVDP003CHOL

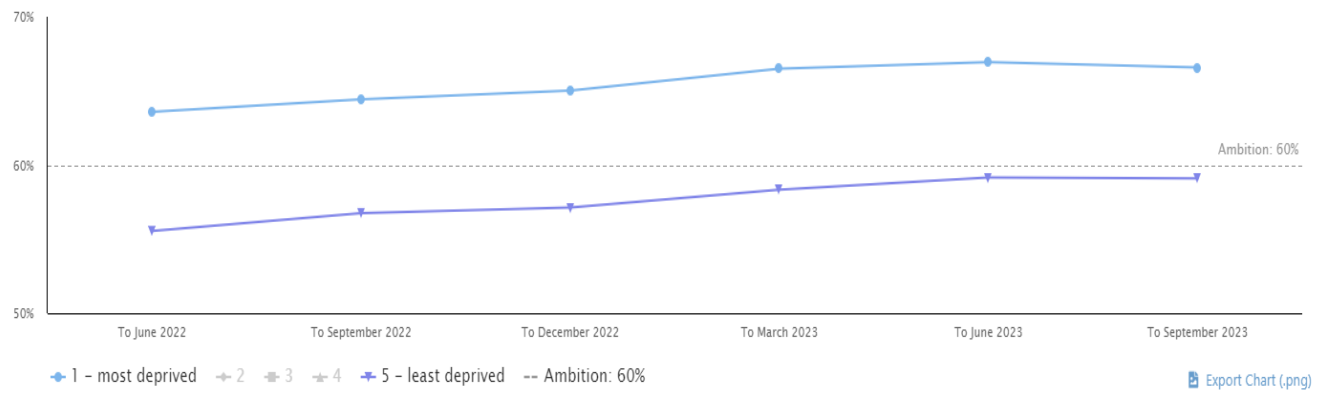
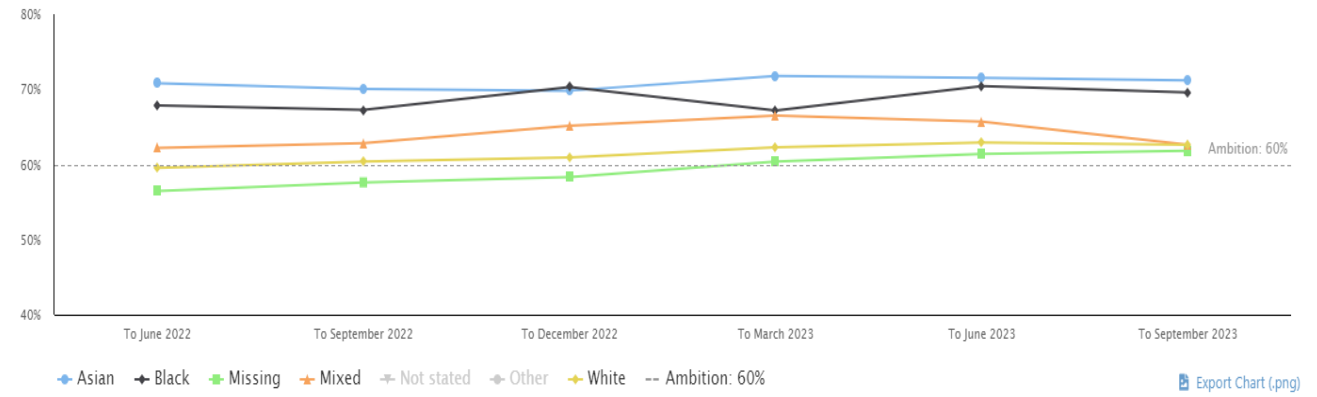


Figure 1 – Inequality gap by ethnicity for indicator CVDP003CHOL



<u>Data Position</u>

The data included above is taken from the National CVD Prevent data, covering a 12-month rolling period for each data point.

- Up to September 2023, 63% 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 is greater for those from the most deprived communities and for those from ethnic minority communities, particularly black and Asian patients. This has remained consistent for the last 18 months. This highlights no apparently inequality gap at present.

<u>Cardiovascular Disease</u>: 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	91.5%
England Position	90.5%
Inequality Gap by deprivation	-0.3%pts
Inequality Gap by Ethnicity	5.4%pts

Figure 1 – Inequality gap by Deprivation for indicator CVDP002AF

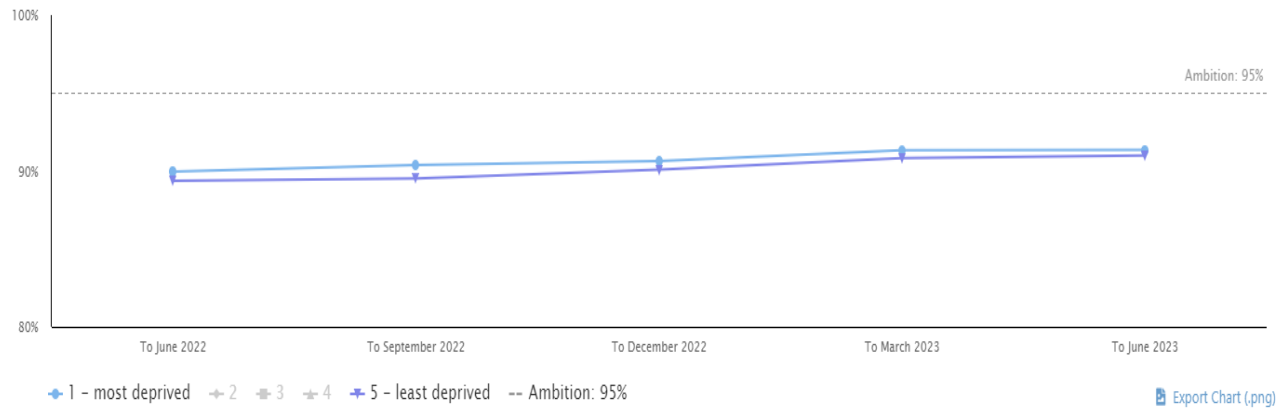
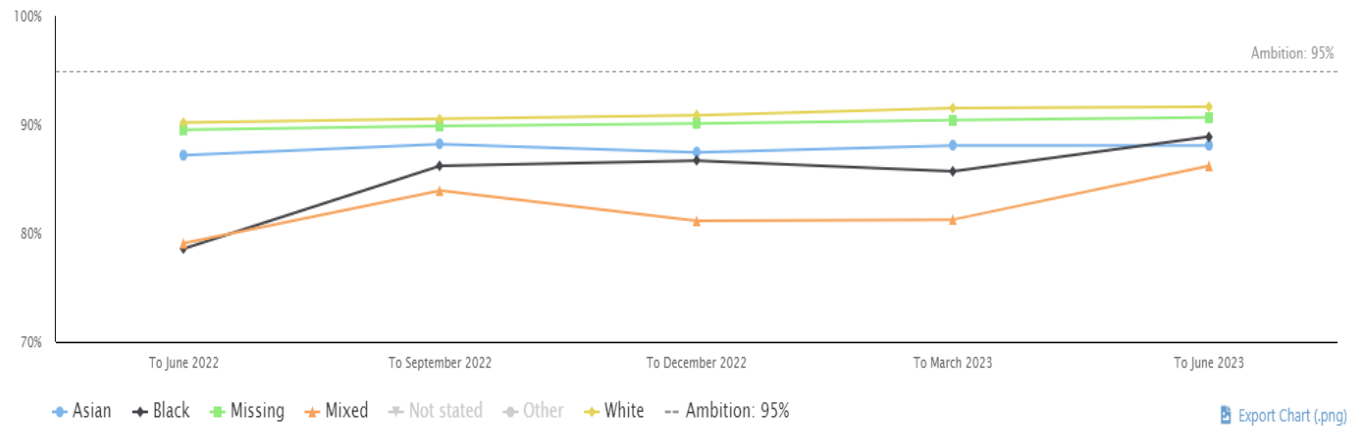


Figure 1 – Inequality gap by ethnicity for indicator CVDP002AF



<u>Data Position</u>

The data included above is taken from the National CVD Prevent data, covering a 12-month rolling period for each data point.

- Up to September 2023, 91.5% 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 highlighting no apparently inequality gap by deprivation.
- The proportion for those from ethnic minority communities varies by ethnicity, with those recorded as 'Mixed' reporting the lowest. When comparing the achievement for 'Mixed' ethnicity patients and patients of white ethnicity, there is a 5.4%pt inequality gap.

The causes for the inequality gap

Patient engagement with health services is key to facilitate the detection and management of the ABC conditions for CVD Prevention. Engagement within deprived communities and ethnic minorities groups is a contributor to the inequality gap. Typically, these groups do not engage with health services, which can be due to a number of factors. Barriers to accessing health services might include affordability (to travel) and capacity to attend appointments, health literacy related factors, and knowledge and understanding of CVD and its associated risks. Health beliefs may also negatively influence health-seeking behaviours in these groups. Additionally, those communities impacted the most by the inequality gap generally have the most associated CVD risk factors, which may also contribute to widening the inequality gap.

The work currently being undertaken to address the gap

Work has been undertaken on developing data reports to better understand health inequalities across the system relevant to CVD Prevention. Utilising this intelligence, targeted improvement work with identified GP Practices and PCNs is on-going utilising a CVD Prevention Clinical Leadership team.

A project improving access to blood pressure checks is in its early stages of implementation. The project aims to improve access to blood pressure checks for deprived and ethnic minority communities through placement of blood pressure kiosks in community centres.

Collaborative working is on-going to develop CVD community champions to promote CVD Prevention awareness, signposting, and education in seldom heard communities.

The coordination of the CVD Prevention network and its meetings and events continues to bring together key stakeholders from across the system, facilitating learning and collaborative working opportunities. Furthermore, the more recently established lipids network achieves similar outcomes, and plans to conduct a regional survey to understand where efforts should be targeted.

Plans for narrowing the gap

Longer term strategies plan to look at sustaining successful projects that contribute to narrowing the health inequalities gap, these may include the targeted improvement work and the community based projects. Business intelligence will be utilised to understand the impact on the health inequalities gap.

A piece of insight work is currently being planned to gather intelligence on the enablers and barriers experienced in deprived communities in relation to accessing healthcare for CVD related checks and knowledge and understanding on the topic.

Utilising the intelligence gathered from the regional lipids survey will be used to address variation across the system.

Diabetes

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

ICB Overall Position(2021/22) 10.9%pt difference between Type 1 and 2

Figure 1 – % Type 1 receiving all 8 care processes

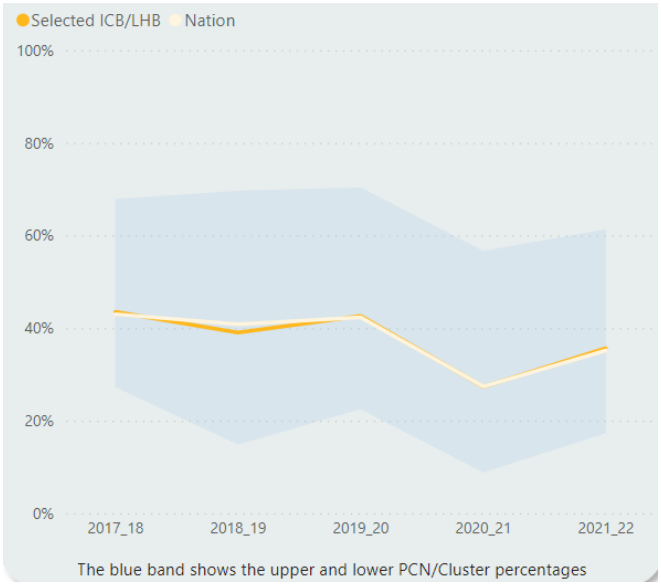
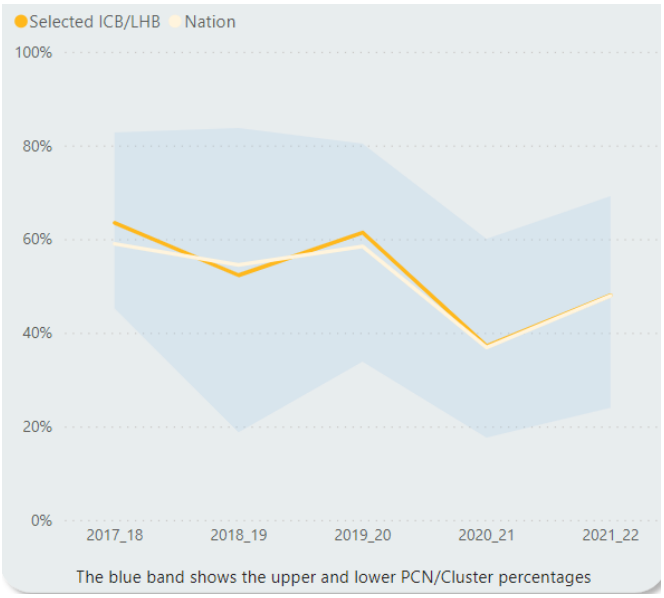


Figure 1 – % Type 2 receiving all 8 care processes



<u>Diabetes</u>: Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile (Latest month)

ICB Overall Position	-27%pts
Most deprived quintile %	33%
Least deprived quintile	6%

Data Position

The data above is taken from the National Diabetes audit annual report for 2021/22 and is supplemented with more recent data from the NENC Diabetes dashboard, providing a snapshot of the current position as of November 2023.

- In 2021/22 there was a 10.9% point difference between the proportion of Type 1 and Type 2 diabetics receiving all 8 care processes, with type 2 reporting the greatest percentage (50.8 verse 39.9). This information is not available at deprivation or ethnicity at local level within the annual audit at present.

- The latest snapshot data (November 2023) from the NENC Diabetes dashboard segments the monthly data by inequality areas. The data suggests less variation between type 1 and 2 for those from the least deprived communities and for those of white ethnicity.

- A greater proportion of type 2 diabetics from the most deprived communities are referred into structured education compared with those from the least deprived communities.

The causes for the inequality gap

The region faces 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

- **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.
- **Presentations of data** to local stakeholders relating to the latest quarterly 8 treatment targets via deprivation for both T1D and T2D and which **challenges ICB leads** on ways to address under performance.
- **Equity in provision and access to diabetes technology** across the diabetes patient pathway.
- **Collaboration with obesity and wider system partners** to deliver a unified approach and patient choice
- 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.
- **Implementation of Type 2 Diabetes in Young** Programme targeting people living with early onset of type 2 diabetes who will benefit from more intensive and targeted care.
- **Expanding access to the Diabetes Remission** programme
- Working with Maternity services to ensure a consistent approach to implementation of NICE guidelines related to Diabetes & Pregnancy including supporting good glucose management throughout pregnancy to improve outcomes.

Plans for narrowing the gap

- **Review data sources** using deep dive approach to identify issues of variance in relation to the 8 Care Processes across the NENC Primary Care practices.
- Support a range of **facilitated targeted work** with providers across the NENC localities to address unwarranted variation in prevention services with the aim reducing inequalities in referral, uptake and health outcomes.
- **Increase Treatment Targets and Care Processes trajectory** across NENC.
- **Increase awareness of the services** and support for patients in relation to Diabetes in collaboration with system partners.
- Undertake a **time limited piece of work** to map out the range of education provision across the NENC and make recommendations for improvement if appropriate.
- Increasing awareness of nationally commissioned programmes
- Collaborate with the Deep End practices to support the delivery of educational programmes for patients.
- Deliver **preventative approach to mental health** for people living with diabetes.
- Collaborate with **third sector organisations** such as Diabetes UK
- Develop **ICB led communications strategy** for Diabetes including Weight Management services aimed at raising awareness of menu of available options, eligibility and access to the wide range of services available for these health conditions.

Smoking Cessation and Tobacco Control

<u>Smoking cessation and Tobacco Control</u>: Proportion of adult acute inpatient settings offering tobacco dependency treatment services

ICB Overall Position- 100%- All NENC trusts offer adult Acute & Mental Health inpatient tobacco dependency treatment services [10 Trusts {8 Acute, 2 MH}, 10 clinical pathways]

<u>Smoking cessation and Tobacco Control</u>: Proportion of maternity settings offering tobacco dependency treatment services

ICB Overall Position: 100% all NENC maternity settings offer tobacco dependency treatment services (inpatient & community [8 Acute Trusts, 8clinical pathways] ***** Please note that LA's also commission community stop smoking services, an important element of NHS LTP delivery and smoking cessation landscape in NENC

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

ICB Overall Position (OHID)	13% (2022)
ICB Overall Position (Primary Care)	15.9% (May 2023)
Most Deprived (Primary Care)	24.2% (May 2023)
Least Deprived (Primary Care)	6.6% (May 2023)
Inequality gap by Deprivation	17.6%pts

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

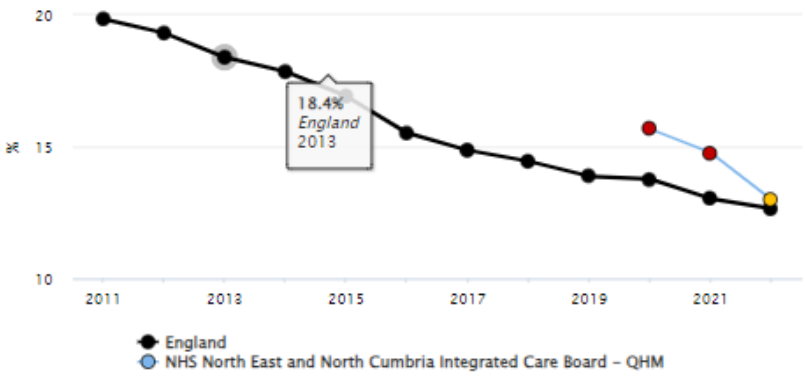
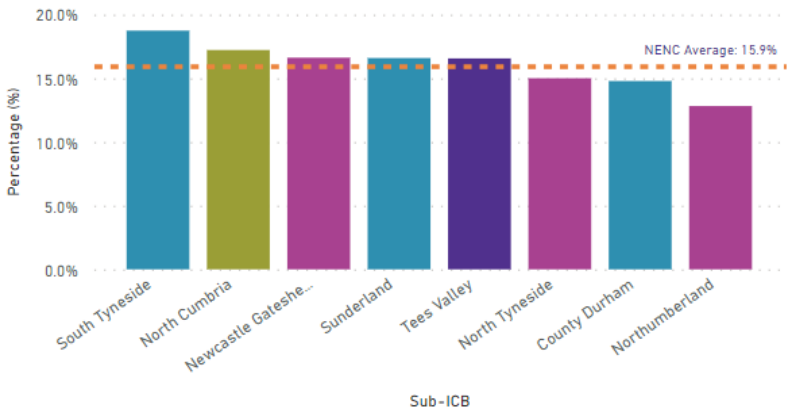


Figure 2 – Smoking Prevelance of people with smoking status updated in the last 12 months – Primary Care



Data Position

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.
- Using local data, the prevalence of smoking is reported as 15.9% (aged 16 and over). The rate is higher for individuals from the most disadvantaged areas (24.2%). When compared with the rate for the least disadvantaged communities, the inequality gap is reported as 17.6%pts. The NE has seen one of the largest declines in adult smoking rates in England since 2010 although the fall is not universal particularly with CORE20PLUS groups.

The causes for the inequality gap

The cause of inequality gap is largely from tobacco use which is the biggest driver of health inequalities. The higher level of deprivation and disadvantage in the North East and North Cumbria (37% of urban areas in NENC are in the most deprived quintile), and 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

- NHS Contribution to tobacco dependency treatment (TDT) within acute and mental health inpatient settings and maternity. 15/18 clinical pathways fully established.
- Targeted work in primary care (4 pilot sites) focused on Severe Mental illness population for enhanced smoking cessation with expansion to Community Mental Health Settings.
- Innovative regional NHS Staff Tobacco Dependency Offer in NHS Foundation Trusts (now completed).
- LA's already commission Stop Smoking Services in Community and OHID is providing support to LA's in implementing the North East Position statement on "Helping Smokers to Quit" (August 2023).
- The ICB also jointly fund Fresh alongside 12 NE LA to provide regional footprint included targeted work on de-normalisation of tobacco, advocacy and mass media campaigns as part of a comprehensive region wide tobacco control approach.

Plans for narrowing the gap

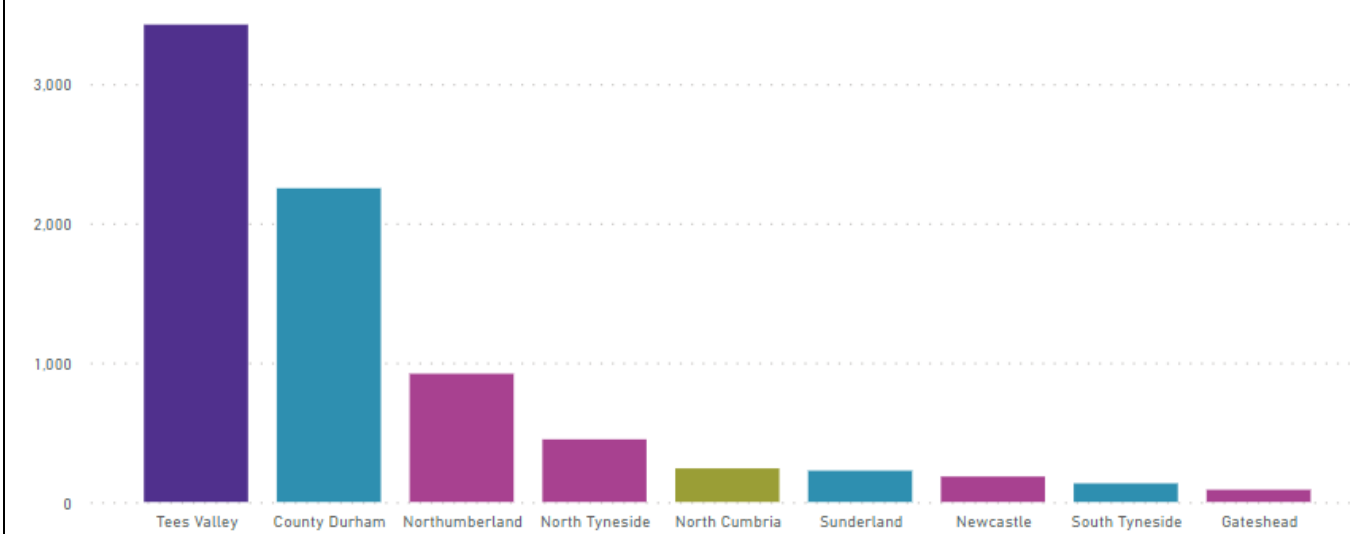
- The TDTS services need to be fully established and embedded as routine clinical care led through Smokefree NHS Taskforce.
- Focused work in primary care with opportunity to work with Deep End practices and through Targeted Lung Health Checks and targeted work with priority groups e.g. SMI.
- Use data to engage with key stakeholders including LA Tobacco commissioners to inform commissioning and service delivery for community smoking cessation services.
- 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

Oral Health

Oral Health: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted) (rate per 1,000 pop)

ICB Overall Position	(range by geography)	0.9 to 34.3 per 1,000 pop
Inequality Gap by deprivation	22 times more from IMD 1 or 2	

Figure 1 – Hospital Inpatient tooth extractions for under 10 years per 100,000 population by Sub ICB



Data Position

The data above has been taken from the ICB Healthier and Fairer dashboard, source data from Secondary Uses Service (SUS) data. It excludes any procedures which may have occurred within a community setting.

There is significant variation in the rate of Tooth extraction for children aged under ten across the ICB and by deprivation. There is currently 22 times more children receiving inpatient tooth extraction from the most disadvantage communities than the least disadvantaged.

For context, the Elective waiting list for tooth extraction for the same age group reports a similar demographic profile with almost 20 times more from the most disadvantages areas than the least deprived awaiting the procedure. This suggests the demographic profile of the activity reflects the demand.

Geographically, Northumberland, North Cumbria and North Tyneside have the greatest number of children waiting.

It has been flagged by Dr Greig Taylor and Dr Oliver Sumner (paediatric dentistry, Newcastle Dental Hospital) that there remain challenges to obtaining and collating accurate data and some development work needs to be carried out to rectify this

The causes for the inequality gap

There is longstanding evidence of oral health inequalities in children by family socioeconomic status, area-based deprivation measures, and geography. The NENC CHWN Facts of Life document identified 'Poverty' and 'Health promotion' as priority areas for children and young people across the NENC region. The NENC has significantly high rates of poor health related to poor diet, with 12/13 NENC LAs having significantly higher rates of tooth decay than the England average.

Food-insecure children have poorer physical health across a wide range of indicators, including higher levels of dental problems. The consequences of food insecurity are severe with a complex mix of both physical and mental health consequences which are felt by families who are living in food insecure environments. This issue is a key area of concern. Disruption to dental services, education and children's diets due to the COVID-19 pandemic have also primarily impacted the more socially disadvantaged groups, further widening inequalities.

The work currently being undertaken to address the gap

- CHWN-produced CYP Core20PLUS5 framework for NENC, with the development of a toolkit and resources which enables identification and consideration of wider determinants impacting those affected by health inequalities, and highlights Food Insecurity as one of five priority areas to address, thus supporting the delivery of targeted work to narrow the gap, with oral health being a national and regional priority area
- The Child Health and Wellbeing Network are liaising with colleagues in paediatric dentistry – Dr Oliver Sumner, Consultant in Paediatric Dentistry at Newcastle Dental Hospital, and Dr Greig Taylor, NIHR Clinical Lecturer and Specialist/Post-CCST in Paediatric Dentistry at Newcastle University School of Dental Sciences – about the work that they are involved in and any potential pieces of work we could support re oral health and health inequalities.
- Dr Greig Taylor is co-leading a project with Dr Emma Lim, Dr Ryc Aquino and Dr Luisa Wakeling entitled 'Taking healthcare where it is needed the most', utilising the West End Food Bank in Newcastle as a pilot site for feasibility. This does have a dental focus but incorporates a whole manner of health care professionals.
- Through the Dental Managed Clinical Network, we are looking to share learning about improving theatre efficiency, understand regional referral patterns and develop pathways - including some early work on mutual aid between regional services/trusts, improving access to specialist paediatric dental care across the region so that patients are seen closer to home

Plans for narrowing the gap

- ICB CYP Clinical Strategy – oral health is a priority area.
- NENC CYP Core20PLUS5 - HI Advisors can offer focused application of toolkit and plans to work with Vanguard services to collect case studies to share.
- Dental Managed Clinical Network exploring collation of demographics of dental waiting lists to get better understanding of characteristics of those waiting for tooth extraction.
- Dr Greig Taylor and Dr Luisa Wakeling are taking a 'Dental Bus' to the West End Food Bank in April for a week to provide care for children and adults, who currently are struggling to access a dental practitioner or have sufficient funds to attend the dental hospital. These are all in their infancy but have great potential to inform local policy.
- There are some oral health promotion teams across the region who run a range of schemes mainly in schools such as education sessions and some targeted toothbrushing schemes (but these could be expanded with more resource).
- The real key is to stop children having as much decay and remove/reduce the need for teeth to be extracted. This would be through preventative programmes such as supervised toothbrushing (perhaps targeted to certain schools/areas and thus reducing inequalities); ensuring availability of toothbrushes and fluoridated toothpaste; water fluoridation schemes; ensuring access to regular dental check-ups in primary dental care with professional-led preventative packages; education around basic oral health and dietary messages.
- In the short term, increasing access to theatre lists would help as well as increasing workforce, but dental decay is essentially (for most) a preventable disease.

Learning Disability and Autistic People

Learning disability and autistic people: Learning Disability Annual Health Checks

Most deprived communities	58.9%
Least deprived communities	59.1%
White Ethnicity	60.7%
Ethnic Minorities	40.7%

Figure 1 – Learning disability annual health checks by Ethnicity

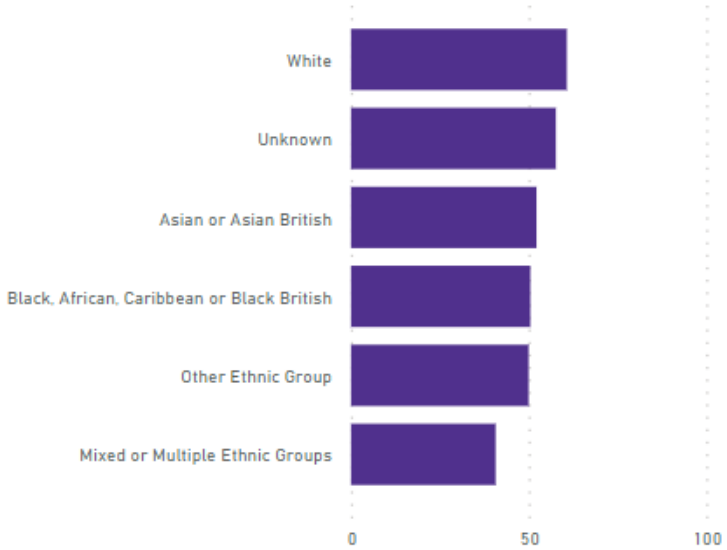
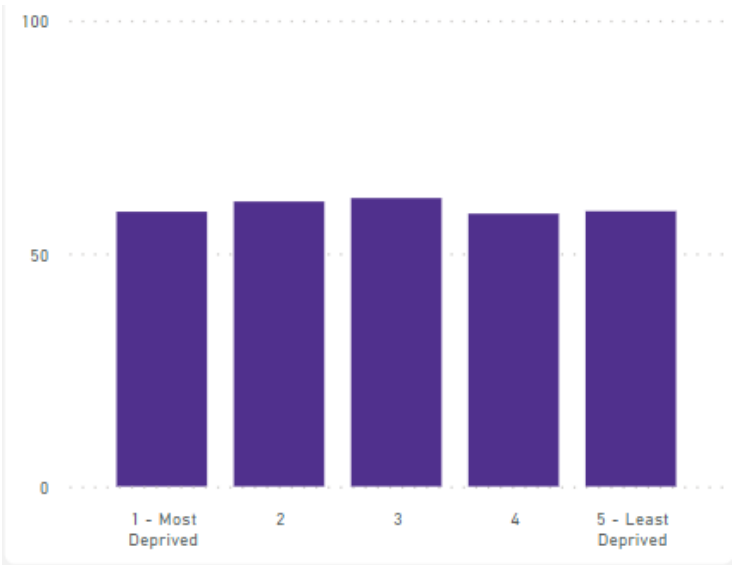


Figure 2 – Learning disability annual health checks by deprivation



Data Position

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

- There is a small 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.

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

- The healthier and fairer workstream is undertaking evaluations of existing system wide work on this along Core20plus principles.
- The learning disability network Learning Disability Network (necldnetwork.co.uk) actively involved in reducing healthcare inequalities Tackling Health Inequalities « Learning Disability Network (necldnetwork.co.uk) across a number of health and care areas e.g. respiratory clinics
- Learning from NENC Leder reviews, incorporating this and national findings into education, policy and implementation.
- STOMP clinic pilot in Sunderland addressing the need for drug reduction in a safe environment.
- A pilot in North Cumbria bringing stakeholders together to improve recognition in young people-this pilot will explore possibility of multiagency assessment for learning disability for those children with an EHCP involving paediatrician, Educational psychology / education and CNTW psychologist around the time of the year 9 annual review. This would coincide with the child being around age 14 which is when the learning disability register / annual health checks happen in primary care.
- Work in Gateshead promoting annual health checks to patients and families from special school placements [14-18], roll out in Northumberland awaited – this work is also being considered with special schools and PCNs in North Cumbria.
- An action plan on all TEWV FT inpatient wards to ensure that autistic people have appropriate reasonable adjustments to their care and treatment. Themes for the action plan include: communication, environment, ward processes, training and supervision, service user and carer involvement, care planning and risk assessment, weekly drop in supervision session, inpatient reasonable adjustment questionnaire.

Plans for narrowing the gap

- There is no current real time system to flag when an individual with a learning disability is admitted though the reasonable adjustment flag should support this going forward in TEWV FT.
- NENC is a fast follower to adopt this work to increase documentation/recognition/sharing of reasonable adjustment for patients across health and care Reasonable Adjustment Flag - NHS Digital, Reasonable Adjustment Flag « Learning Disability Network (necldnetwork.co.uk).
- Work on labelling and recognising patients who may need to be added to the learning disability register in practices, following on from awaited national work.
- Rolling out STOMP work further.
- Continuing involvement in the national NHSE work on the quality and promotion of annual health checks.

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

ICB Overall Position	8% of all inpatient activity
Most deprived position	6% of inpatient activity
Least deprived position	11% of inpatient activity

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

Data Position

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 6% of inpatient stays for the most deprived communities are aligned with learning disabilities. This is lower than the overall proportion of 8%. 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.

The overall numbers for the most deprived communities in the last year range between 10 and 15 admissions per month compared with 0-6 for the least deprived communities.

The causes for the inequality gap

Autistic individuals or those with a learning disability often face unique health challenges, however these are further complicated by a higher likelihood of adverse experiences. This underscores the importance of addressing barriers to accessing tailored health services and ensuring consistent, community-based crisis support. By recognising and addressing these factors we can work towards fostering healthier and more equitable outcomes for all members of our community.

The work currently being undertaken to address the gap

- Introduction of and ICB assurance panel to oversee dynamic support registers and care (education) and treatment review processes across the region
- Creation of lived experience groups with a wide representation from across the region to understand challenges and pressures in different parts of the region
- Work to develop systems and processes to improve our understanding of the population and local, sub-regional, and regional level
- Proposals for a new approach to commissioning complex support for people being discharged from hospital are being considered
- Rolling out of the "select Mental Health" option within our 111 service to widen access to community based mental health support
- Finalisation of the findings from the Senior Intervenor system programme work, which has set out recommendations and actions to improve practice, culture, and address strategic issues

Plans for narrowing the gap

- Delivery of the inpatient quality transformation programme, aimed at improving the services we provide in our mental health hospital settings, and reducing our reliance on out of area and / or independent sector hospitals
- Delivery of the complex needs workstream within the Housing, Health, and Care programme, aimed at ensuring that there is good quality housing with the right wraparound care and support in the right places across the region, to ensure people are able to live in their own communities
- Setting up structures to ensure the oversight and assurance of community enhanced models of care, ensuring equity of access across the region
- Incorporating and taking forward recommendations and actions resulting from the Senior Intervenor system programme work

Maternal and Neonatal

Maternal and Neonatal: Preterm births under 37 weeks

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

Figure 1 – Slope of inequality index for pre term births (under 37 weeks) NENC and England

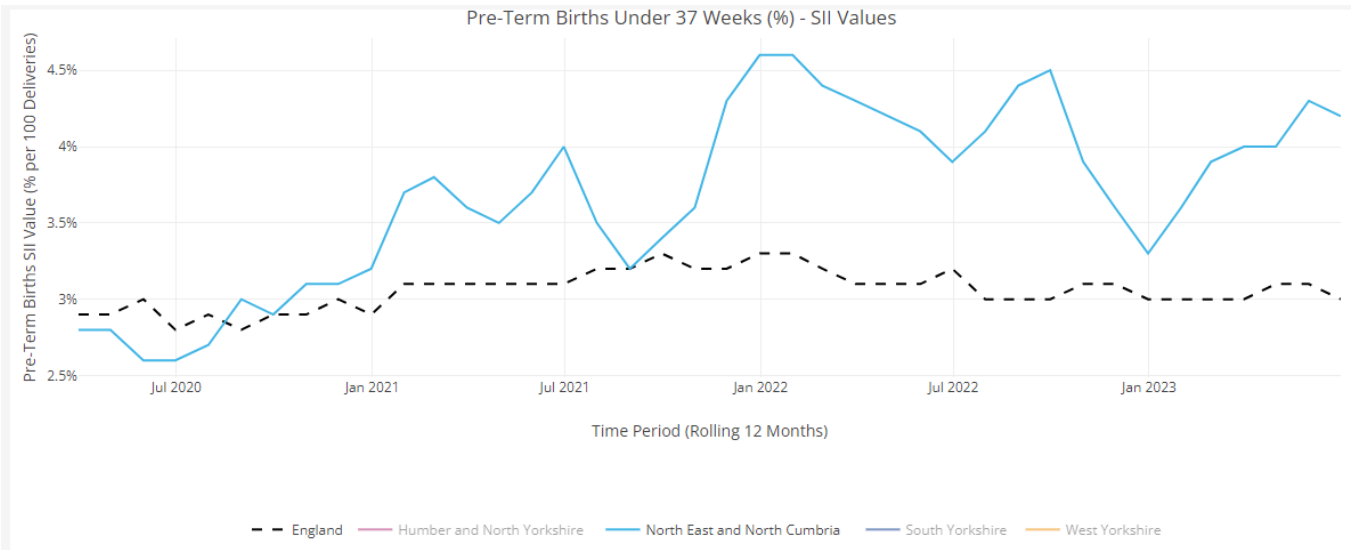
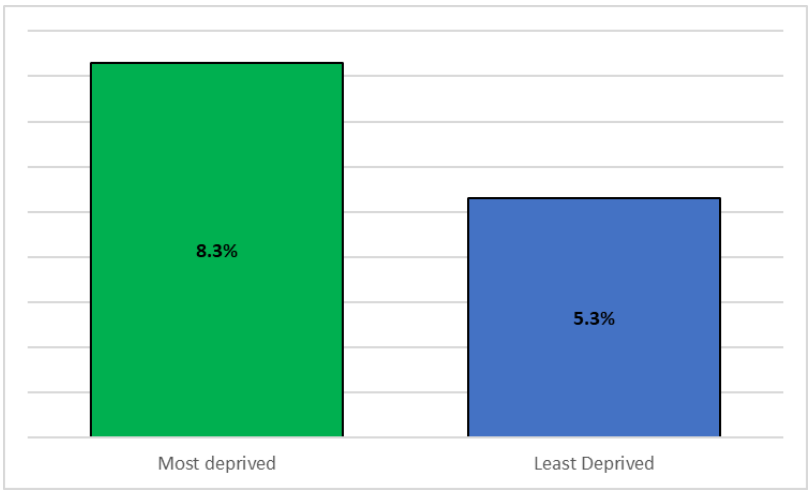


Figure 2 – Pre term births (under 37 weeks) by most and least deprived IMDs



Data Position

The data included above has been taken from the most recent NHSE Health inequalities report and relates to the position in May 2022 to May 2023 (12 month rolling period).

7.2% of babies in NENC were born at less than 37 weeks gestation. This is slightly higher than the England position of 7.1%.

For women from the most disadvantaged communities, 8.3% have babies born before 37 weeks gestation, compared with 5.3% in the least disadvantaged, this equates to an inequality gap of 3%pts.

Using the slope of inequality index, NENC currently has greater inequalities for this indicator than the England average and it continues to increase.

The causes for the inequality gap

- Smoking rates at booking and time of delivery higher than national rates
- Language and communication barriers
- High Index of Multiple Deprivation imposes restrictions on the ability to attend appointments and care

A recent systematic review identified possible mediators of PTB including 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 PTB, 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

- NENC ICS Financial Incentive Scheme – all 8 FTs are now onboard with the scheme and offer follow up tobacco treatment support up until 4 weeks postpartum. Latest data showing that 52.9% of people who take part in the scheme are from the 2 most deprived deciles:
    - 469 people from decile 1 (32.6%)
    - 291 people from decile 2 (20.2%)
- Trusts have been looking to adapt models to improve pregnant people engaging with services.
- All patient information leaflets are being translated in to the top 5 languages and easy read versions.
- Most of the women who were smoking at the time of attending the PTB clinic were referred to smoking cessation.

Plans for narrowing the gap

- Postcode data is collected for women who attend the PTB clinics or deliver a preterm baby before 34 weeks. This will be analysed at the end of 2023/24 to look for any trends or common themes.
- Consider how to monitor and tackle disparities and inequalities within Units and across the Region. Record postcodes, data on ethnicity and smoking at delivery.
- Need to tighten up all data collection, ensuring all variables recorded accurately, including extra variables that have been added.
- Work collaboratively with the PTB patient public voice representative to gather the views and feedback from service users in the most disadvantaged communities.

Alcohol

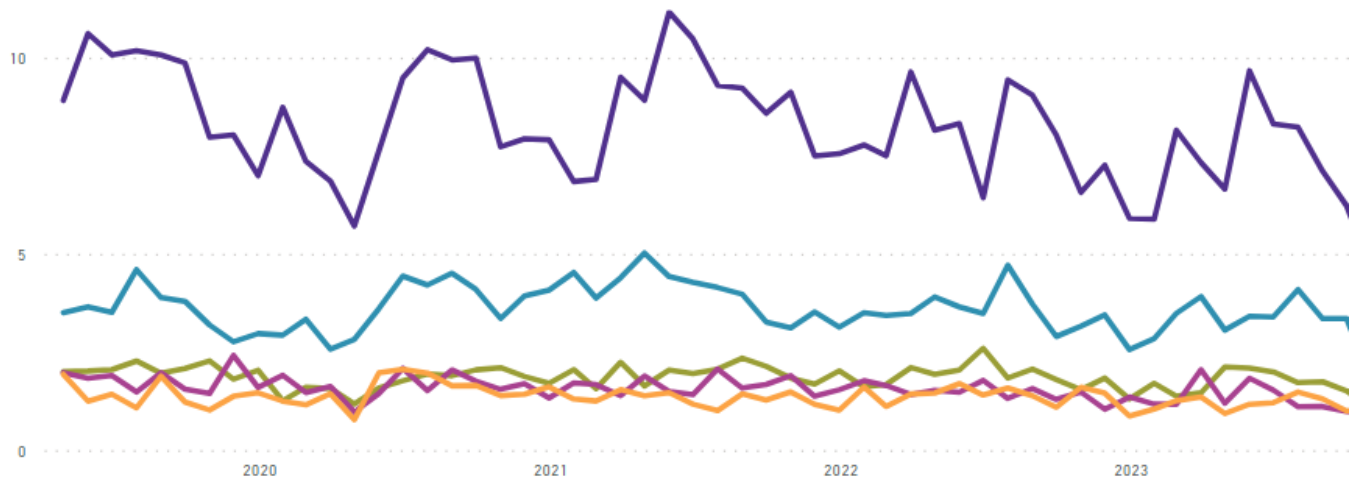
Alcohol: Reduce alcohol related admissions to hospital by 20% (2021/22)

ICB Overall Position	721 per 100,000 (DSR) population
England Position	494 per 100,000 (DSR) population
Inequality Gap by deprivation	14 times more admissions

Figure 1 – Admission episodes for Alcohol related conditions 2021/22 -LAPE

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	270,774	494	492	496
North East region	–	19,089	721	711	732
Sunderland	–	2,325	840	806	875
Gateshead	–	1,627	827	787	868
North Tyneside	–	1,740	819	781	859
South Tyneside	–	1,174	783	738	829
Darlington	–	833	774	722	828
Northumberland	–	2,600	768	738	799
Hartlepool	–	650	709	655	767
Stockton-on-Tees	–	1,349	689	653	727
County Durham	–	3,465	653	631	675
Middlesbrough	–	843	638	595	683
Redcar and Cleveland	–	885	627	586	671
Newcastle upon Tyne	–	1,597	609	579	640

Figure 2 – Admission episodes for Alcohol related conditions by IMD and month – NENC Alcohol dashboard



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**; we have established the 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**; 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**; 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 harm.

- **Creating and supporting improved pathways within and between NHS and public health commissioned/other community services**; 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 funding 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 24/25 include the development of a NENC pathway for the early identification of alcohol related liver disease to fibroscan. This project will focus on the accessibility of the pathway to the cohort of men aged 45-59 in areas of higher deprivation shown through the NENC Alcohol Dashboard to experience the greatest alcohol related harms.

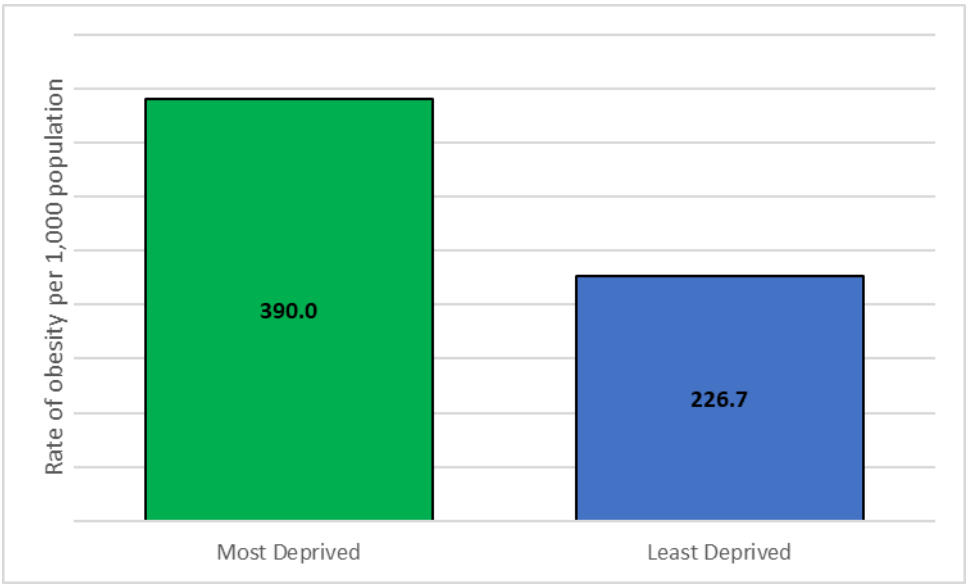
The ability to improve longer term on reducing alcohol related health inequalities in NENC is dependent on the long term resourcing of the Alcohol Programme and associated workforce such as Alcohol Care Teams in acute trusts.

Healthy Weight and Treating Obesity

<u>Healthy Weight and Treating Obesity</u>: 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



Data Position

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.

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 Assessment 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