North East
North Cumbria
Health & Care
Partnership

Health and Healthcare Inequalities Report 2024-2025

March 2025

Purpose of report

- The following report provides an update on progress against the health and healthcare inequality metrics outlined within the following documents, and the requirements of the NENC ICB to report progress against these:

  - NENC ICB Joint Forward Plan 23-28 ("the plan“)
  - NENC Integrated Care Partnership (ICP) Better Health and Wellbeing for All Strategy ("the strategy")
  - NHS England’s statement on information on health inequalities ("the statement")
  - NENC ICB Integrated Delivery Report (“the IDR”)

- The aim is to provide an understanding of current outputs and outcomes specific to the Core20PLUS5 aims included within “the IDR” and to provide an update and assurance on the measures of inequality included within “the statement”. This includes an update on the work being undertaken to reduce the identified healthcare inequalities for each clinical area, and the setting of ambitions towards 2030
- The report also provides intelligence on the healthcare challenges for the population within the most deprived communities of NENC and potential future challenges to the system

National Healthcare Inequalities agenda

- There are three main national drivers of the healthcare inequality agenda.
  - Core20PLUS5 for adults
  - Core20PLUS5 for children and young people
  - NHS England Legal Statement

- The Core20PLUS5 frameworks for Adults and Children & Young People state aims for addressing performance across 10 clinical pathways, including the narrowing of the inequality gap associated with deprivation and ethnicity.
- The NHSE Legal statement that was published in November 2023 and updated in March 2024 provided information on how powers should be exercised in connection with health inequalities for the period 1 April 2023 – 31 March 2025. The statement was stated to 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.

Local Strategies, reporting requirements and progress

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

- **Clinical Conditions Strategic Plan**
  - Where clinical outcomes and aims are cross cutting with the ICB Clinical Conditions Strategic Plan, work on metric development has been undertaken in collaboration with the team working on the outcomes framework for the strategy, including meeting with NEQOS colleagues to ensure alignment and the avoidance of duplication.
  - Following the publication of the plan it is expected that the development of the outcomes framework will continue over the coming months as one piece of work informs the other, and vice versa.
  - Whilst the metrics within the Clinical Conditions Strategic Plan may report clinical and population outcomes, the Health and Healthcare Inequalities Report focuses primarily on inequalities evident due to deprivation and/or ethnicity, reported to monitor fairer outcomes for all.

Local Strategies, reporting requirements and progress

- **Integrated Delivery Report**

  - Within the ICB Integrated Delivery Report (IDR) the metrics aligned with the Core20PLUS5 clinical pathway ambitions have required updating. Whilst the Core20PLUS5 frameworks for Adults and Children & Young People stated aims in addressing performance across 10 clinical pathways, including the narrowing of the inequality gap associated with deprivation and ethnicity, no national direction or technical guidance was provided as to how these should be measured.

  - Extensive work with Programme leads has been undertaken to ensure that the aims within the framework are represented by smart, meaningful metrics within the IDR which reflect the ongoing work for each clinical pathway.

  - Following the work with the Programme leads on metric development, work has taken place between the ICB Insights Team and Healthier & Fairer Analytical support with ICB Managerial, Clinical and Director leads on ensuring that the reporting of these metrics is accurate, including reporting of the inequality gap for deprivation and ethnicity (where available)

Healthcare Inequalities Future Plans and Ambitions to 2030

- Inequalities in health and healthcare outcomes continue to be experienced by our communities across most aspects of consideration within this report. These inequalities can be demonstrated against both ethnicity and deprivation measures, and whilst progress within some of the metrics demonstrate improvement in the scale of the inequalities, there remain gaps within our understanding and robust plans to address these.
- Understanding of health inequalities associated with deprivation and ethnicity will improve as data flows become more robust and using alternative sources of intelligence where data flows cannot be established will support an understanding of the NENC position. Members of the ICB and NECS Analytical Teams continue to work with national partners in shaping how this can be achieved. However, coding within routine healthcare sets can be improved, particularly relating to the accurate capture of ethnicity.
- This edition of the report also starts a journey to articulate how identified inequalities will be reduced through the setting of ambitions to 2030. The expected relative impact of interventions on reducing the gap are described and shown in the form of waterfall charts. What is evident is that despite interventions being identified that will positively impact on inequalities, these persist.
- Local Delivery Team insight packs have been produced using the framework set out in this report to aid local prioritising of transformation activity.

Summary 1/2

Longer and Healthier Lives

Three key contributors to the inequality gap in life expectance within NENC are CVD, Cancer and ‘External causes’ (which includes Suicide).

- CVD prevention metrics continue to demonstrate an improvement at population level and in the inequality gap by deprivation.
- The early detection of cancer (at stage 1 or 2) is improving in NENC but remains lower than the England average. There is inequality gap in cancer screening but there are targets set and plans in place to reduce this.
- The Suicide rate in has reduced for both males and females. The gap between NENC and the England average is narrowing.

Fairer outcomes for all

The NHS contribution to reducing social and economic inequalities programme contributes to the delivery of fairer outcomes for all through the Healthy Communities and Social Prescribing, Health Literacy, Poverty Proofing and Digital Inclusion projects, working with providers to ensure access to services and patient experience is considered through a wider determinants of health lens.

- The proportion of individuals with Serious Mental Illness attending their 12-month physical health check is improving and is higher than the England average

Summary 2/2

Better Health and Care Services

As part of the NHSE legal Statement, inequalities within the elective waiting list, and Urgent Care utilisation for children and young people are considered

- The inequality gap by deprivation and ethnicity within the elective waiting list is small at less that 1%pt for 18 weeks, 52 weeks and 65-week waiters.

Giving Children and Young People the best start in life

The aim to increase the percentage of children with good school readiness at end of reception, especially for children from disadvantaged groups is supported by the work of the Children and Young Person Core20PLUS5 programme of work addressing access and outcomes relating to 5 clinical pathways affecting children (Asthma, Mental Health, Oral Health, Epilepsy, Diabetes) and the work of the Local Maternity and Neonatal System.

- Inequalities remain for babies born before 37-week gestation but the slope index of inequality for NENC has reduced in the latest reporting period.

Data Summary (1/2)

Area	Metric	Time Period	NENC	Inequality gap	Inequality Trend
Maternity	% of babies born before 37 weeks gestation	Year to July 2024	Lower % overall Wider Inequalities	SII = 3%	↓
Cardiovascular disease	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	Year to September 2024	Higher achievement overall Narrower inequalities	Deprivation = 2.2%pts Ethnicity = 15.3%pts	↓
	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	Year to September 2024	Higher achievement overall No apparent inequalities	Deprivation = -7.2%pts Ethnicity = -7.8%pts	↔
	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	Year to September 2024	Higher achievement overall Inequalities by ethnicity	Deprivation = 0.1% Ethnicity = 4.1%pts	↑
Cancer	Percentage of cancers diagnosed at stage 1 or 2	2022/23	Lower than England	SII = 7%pts	↔
	% of eligible population uptake in breast screening	3 years to March 2024	Higher achievement overall Narrower inequalities	SII = 13.3%	↓
	% of eligble population uptake in bowel screening	2.5 years to March 2024	Higher achievement overall Narrower inequalities	SII = 16.3%	↓
Respiratory	% of eligible population receiving COVID vaccination	Autumn/Winter 2024/25	Lower achievement overall Wide inequalities	Deprivation = 22.6%pts Ethnicity = 27.6%pts	↑

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Data Summary (2/2)

Area	Metric	Time Period	NENC	Inequality gap	Inequality Trend
Mental Health	% of SMI patients with a health check against trajectory	Q4 2023/24	Higher than England	-	↓
	Rate of deaths by suicide	2022	Higher than England	Compared with England 2.4 per 100,000 pop	↓
	Crude rate of Mental Health Act Detentions per 100,000 population	2023/24	Higher than England Wider inequalities	Deprivation = 160 per 100,000 pop	↑
	Recovery rate within Talking Therapies	2023/24	Higher than England Wide Inequalities	Deprivation = 16%pts	↓
	Crude rate of CYP supported through NHS funded mental health with at least one contact by IMD (per 1,000 population	2023/24	Increase in access Inequalities by deprivation	Deprivation = -45.6 per 1,000 pop	↑
Learning Disabilities	% if Learning Disability patient s with a health check in the last 12 months	Year to December 2024	Lower than last year Wider inequalities	Deprivation = 2.5%pts Ethnicity = 23.6%pts	↑
Diabetes	% of people with Type 1 diabetes receiving all 8 care processes (adults)	2023/24	Low achievements Wider inequalities	Deprivation = 22.6%	↑
	% of people with Type 2 diabetes receiving all 8 care processes (adults)	2023/24	Low achievements Wider inequalities	Deprivation = 27.6%pts	↑
	% of newly diagnosed Type 2 diabetics referred to Structured Education	Year to November 2024	Low achievements Narrow Inequalities	Deprivation = 5%pts	↑
	% of newly diagnosed Type 2 diabetics attending Structured Education	Year to November 2024	Low achievements Wide Inequalities	Deprivation = 3%pts	↑
	% CYP Type 1 receiving all 3 care processes	Q3 2024/25	High achievements Narrow inequalities	Deprivation = -0.5%pts Ethnicity = 2.5%pts	↔
	% of CYP type 1 diabetic children accessing Hybrid closed loop Technology	Q3 2024/25	High achievements Some inequalities	Deprivation = 9.7%pts Ethnicity = 8.2%pts	↑
Prevention	Rate of Alcohol admissions per 100,000 population	2023/24	High rates Wide Inequalities	Deprivation = 725 per 100,000 pop	↓
	Prevalence of smoking	2023	Similar to England Wide Inequalities	Deprivation = 6.9%pts	↓
	Prevalence of Class III obesity	December 2024	High rates Wide Inequalities	Deprivation = 2.8%pts	↔

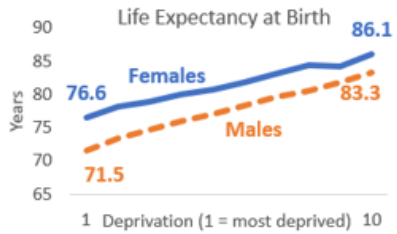
Population Overview

- 33% of the population within NENC reside within the 20% most deprived areas nationally. This is equal to approximately **1,000,000 people**. This population is what we define as the ‘Core20’ population.
- The Core20 population has a younger age profile compared with the overall ICB, much of this is driven by the lower life expectancy within the population.
- They are less likely to have a diagnosed long-term condition, but those who do tend to have more than 2, leading to complex multimorbidity and increased need.
- The Core20 population have a greater prevalence of modifiable risk factors such as smoking, alcohol use and drug misuse. Estimates also suggest the prevalence of obesity is also greater although the information held within GP records doesn’t reflect this low-income.
- NENC have a relatively small proportion of the population with an ethnicity documented as ‘non-white’ (8%), however, within the Core20 population, 12% are of non-white ethnicity. This highlights that there is a higher representation of ethnic minority groups residing within the most deprived areas.
- 35% of children in NENC are living within low-income families, this has increased significantly since 2014/15 and has a direct impact on the healthy life expectancy and best start in life.
- Individuals within the Core20 population die at an earlier age but also spend a longer time in poor health, be that self-reported poor health or diagnosed illness. The national evidence suggests there is a 12-year gap between the point in which ill health becomes apparent and when major illness is diagnosed.
- The self-reported poor health (healthy life expectancy) is often influenced by boarder economic and social factors such as employment and income.
- By 2040, the number of people experiencing major illness is expected to grow, mostly driven by population growth. However, the inequalities in major illness is going to be unevenly distributed, particularly within the working age population. 80% in major illness for working age population is going to occur within the 50% most deprived communities.
- The conditions expected to contribute to the increasing health inequalities are Chronic Pain, Type 2 diabetes, Anxiety and Depression, Heart Failure and COPD. The prevalence of all these conditions may not increase but the variation in the number of people affected in the Core20 population compared with the least deprived will.

Health of the NENC Population

Whole Population

Inequalities



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

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

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

Most Prevalent Long Term Conditions (All Ages)

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

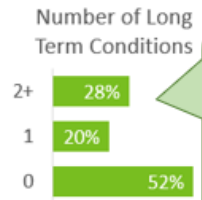
530,900 (17%) Have **Hypertension**

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

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

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

Multi Morbidity



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

Proportion of people with 2+ LTCs is **higher** in more deprived communities
Most Deprived **29%**
Least Deprived **25%**

Risk Factors

16% Are Smokers (Where Smoking Status Recorded)

38% Are Obese (Where BMI Recorded)

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

Children and Young People

Most Prevalent Long Term Conditions (Aged Under 18)

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

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

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

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

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

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

Obesity

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

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

(Highest Rate in England)

Year 6 obesity rates are **higher** in more deprived communities
Most Deprived **40%** Least Deprived **15%**

Mental Health

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

Adults (figures for all ages)

Lung Cancer

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

Incidence of Lung Cancer is **higher** in more deprived communities
Most Deprived **142.3**
Least Deprived **51.8**

Respiratory

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

Back Pain

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

Of these:
37% have anxiety
31% have depression

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

Anxiety and Depression (Age 18+)

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

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

Cardiovascular

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

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Core20 NENC Population

North East North Cumbria (NENC)
Population Profile for IMD Levels 1&2

Data Sources:
RAIDR Primary Care Data (June 2024)
Indices of Multiple Deprivation (IMD) 2019

33% (981,613) of the NENC population live in the 20% most deprived areas (IMD Level 1 & 2)

Gender

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

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

Age Breakdown

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

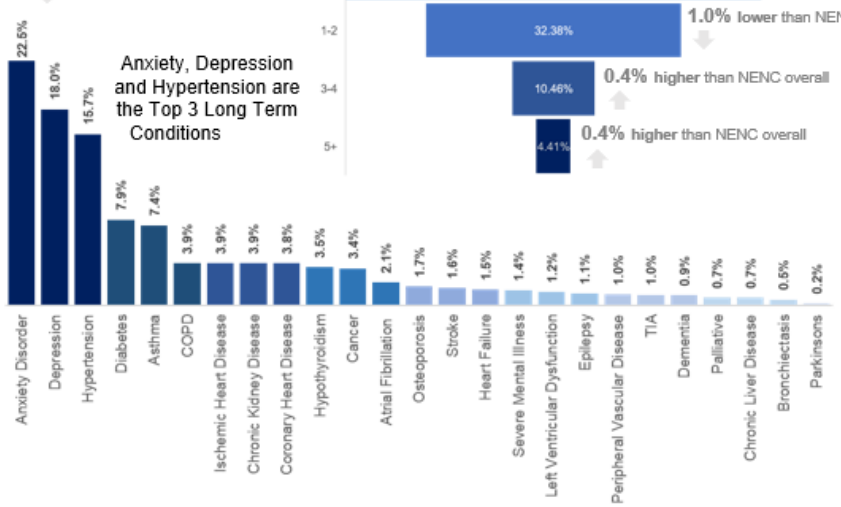
Aged 20-64 **59.7%** (585,838) — 1.2% higher than NENC overall

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

Long-Term Conditions

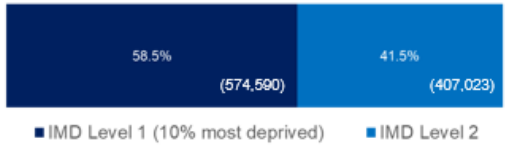
47.3% (463,920) have at least **1 Long Term Condition**
0.2% lower than NENC overall

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

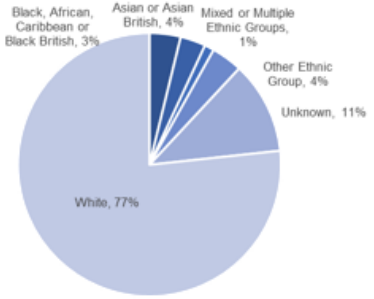


Number of Long-Term Conditions

IMD Deciles (Deprivation Levels)



Ethnicity



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

Vulnerable Characteristics

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

Drug/ Alcohol Misuse

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

Smoking Status

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

Weight Management

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

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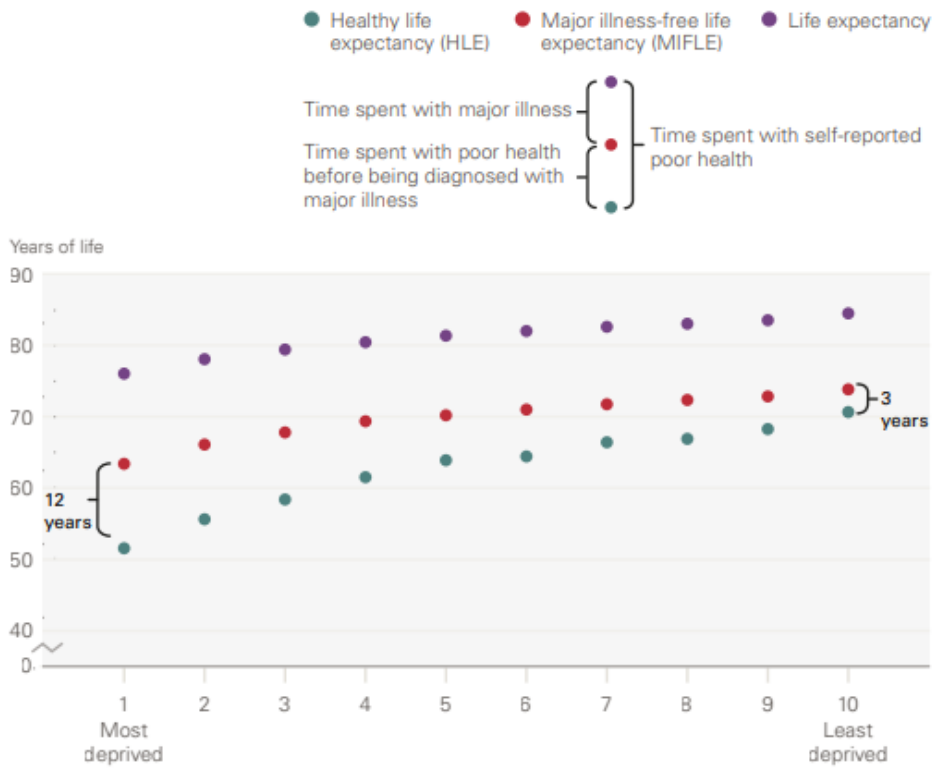
Inequalities in disease identification

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



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

The chart (left) shows the relationship between Major illness free life expectancy, healthy life expectancy and life expectancy by index of multiple deprivation in **England**. At present, the information is not available at ICB level.

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

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

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

Data Source: The Health Foundation – Health Inequalities in 2040

Health Inequalities in 2040

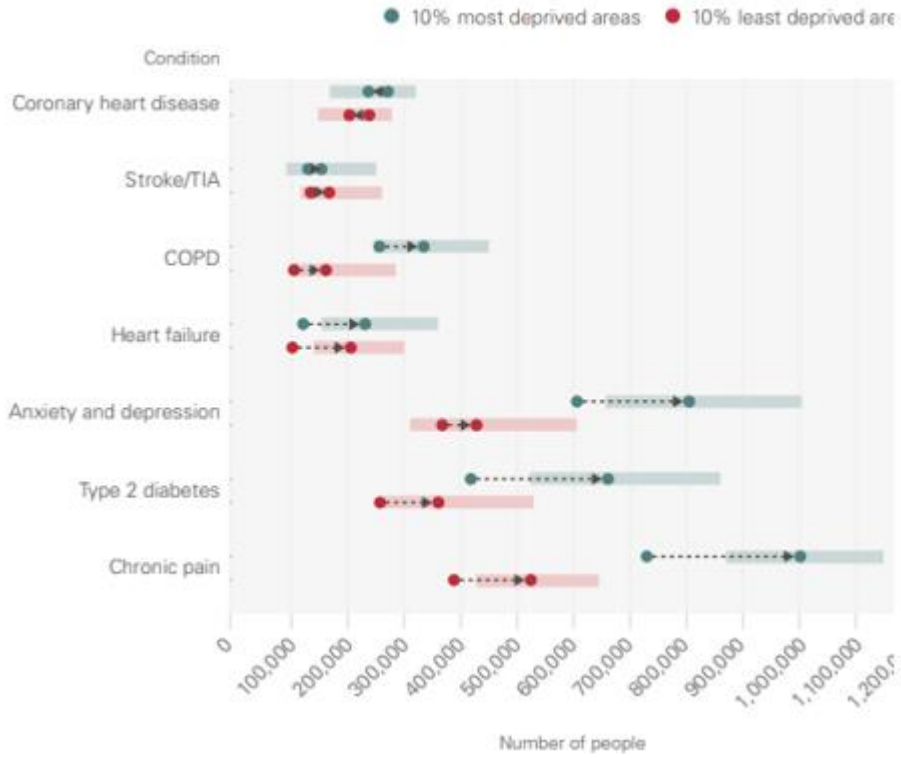
Nationally, people within the most deprived communities are reported as having a major illness free life expectancy of 63.7 years. Within the least deprived communities this is 74.1 years.

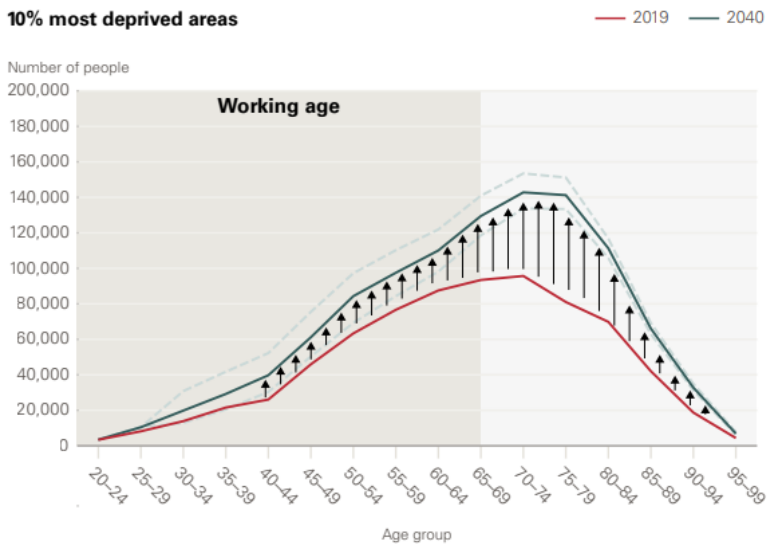
By 2040, the major illness free life expectancy age is not expected to change significantly. However, with population growth, it is expected that many more individuals will be affected by major illness.

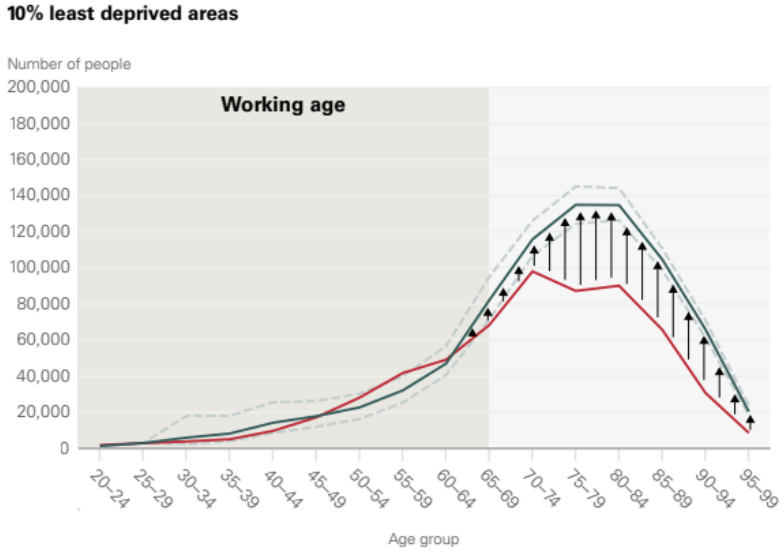
For individuals over the age of 70, there is no apparent social gradient. However, for working age population (20 – 69), 80% of the increase will be for those residing IMD 1 to 5 (those most deprived)

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

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







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Data Source: The Health Foundation – Health Inequalities in 2040

Social and Economic Factors impacting Healthy Life Expectancy

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

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

Economic inactivity due to sickness and disability

The average rate in NENC is **8.9%** ranging from **6.2%** in Darlington to **12.4%** in Hartlepool. Hartlepool has the second highest rate within England but has seen a reduction compared with last report. Darlington has seen a 2%pt increase

Employment Rate

The rate of employment in NENC ranges between **62.6%** in Middlesbrough and **79.3%** in Cumberland. **11** of the Local Authorities have a lower-than-average rate and **Middlesbrough has seen an increase since last report and no longer has the lowest rate in England**

Children living in poverty

35% of children in NENC are living in poverty. This ranges from **24.5**% (North Tyneside) to **38.7**% (Middlesbrough). There is variation by ethnicity with 67% of children from none white ethnicity in NENC reported as living in poverty

Income

The median monthly pay in NENC is approximately **£2,272**, ranging from **£2,156** in Middlesbrough and **£2,393** in Cumberland

Out of Work benefits

The out of work benefit rate for NENC ranges between **6.1%** in Westmorland and Furness and **15.1%** in Hartlepool. **Hartlepool has the second highest rate within England**

Active Travel

There has been an increase in active travel since the last report. Between **62.3%** (Middlesbrough) and **75.5%** (Newcastle) of people in NENC walk or cycle at least once per week. **6** Local Authorities in NENC still have a lower-than-average rate of active travel but this is an improvement

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Data Source: Social and Economic impact on HLE – NECS February 2024

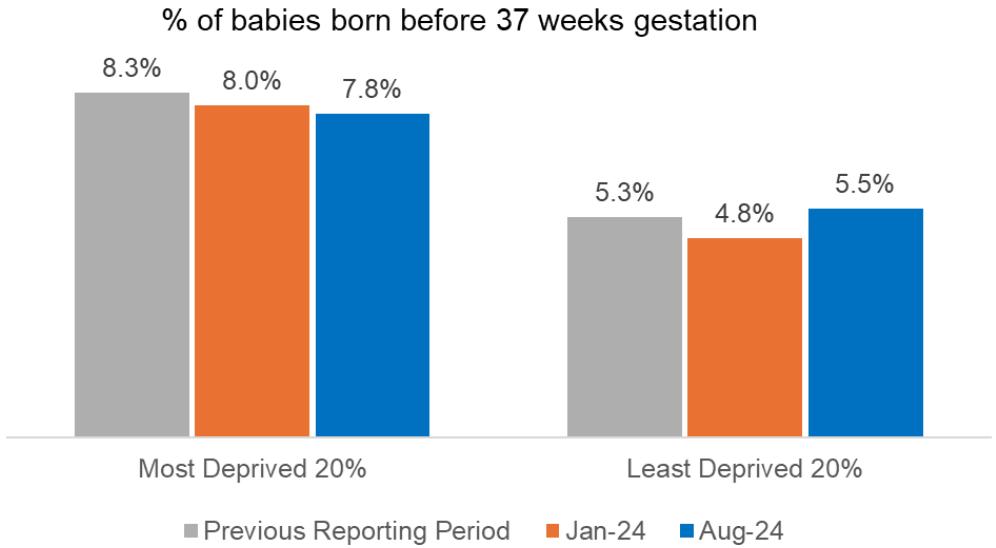
Maternal and Neonatal – Inequalities in pre-term births (under 37 weeks)

The data included in this report has been taken from the most recent NHSE Health inequalities report and relates to the position in September 2023 to August 2024 (12 month rolling period).
6.98% of babies in NENC were born at less than 37 weeks gestation, a reduction compared with the previous report. The rate in NENC is slightly lower than the England position of 7.2%.

For women from the most disadvantaged communities, 7.8% have babies born before 37 weeks gestation, compared with 5.5% in the least disadvantaged. The most disadvantaged communities have reported a reduction in rate consistently over the last and the least disadvantaged have experienced fluctuations.

Using the slope of inequality index, NENC currently has greater inequalities for this indicator than the England average (3 compared with 2.8). The Slope index in NENC has reduced inline with the reduction for the most disadvantaged rate but also because the rate for the least disadvantaged has increased, reducing the overall gap.

This data is currently not reported by Ethnicity



	January 2024	August 2024	Trend (last 3 periods)
NENC ICB overall position	6.9%	6.8%	↓
England overall Position	7.2%	7.1%	↓
NENC ICB Slope Index of inequality	3.4	3.0	↓
England Slope Index of inequality	3.1	2.8	↓

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

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Primary ICB Outcome	Giving children and Young People the best start in life
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	LMNS

The causes for the inequality gap

- Level of patient data at time of booking and during the antenatal period, specifically IMD and ethnicity
- Tobacco and substance use in pregnancy
- Language and communication barriers
- Poverty
- Maternal physical health, including nutrition, physical activity, BMI, age,
- Other pregnancy risks (not exhaustive), pre eclampsia, diabetes, IVF, multiple birth…
- Provision to, and access of, healthcare
- Maternal working and environmental conditions

The work being undertaken to address the gap

- Re-establishment of the Pre-Term Birth Clinical Expert and Advisory Group, including review of patient and public voice representation to hear from the most disadvantage communities.
- Embedding, promotion and assurance of NENC Smoking at time of Delivery pathway, incentive scheme and training.
- Embedding, promotion and assurance of NENC Alcohol in pregnancy pathway, tool and training.
- Collaboratively action planning the findings of Maternity Booking Project.
- NENC Maternity core competency training for maternal healthy weight.
- Implementation of the Pregnancy Anticipatory Care (PAC) Model which provides enhanced targeted support to reduce inequalities.
- Establishment of the Maternal Healthy Weight research evaluation to inform NENC practice plans.
- Translation of Patient Information.

Plans for narrowing the gap

- Continued focus on the reduction of tobacco use in pregnancy, including the development of data sets by postcode to inform partnership working to target additional biopsychosocial interventions.
- Using findings of the South Tees booking project (Poverty Proofing©, Health Literacy, Creative Health & Digital), to tackle disparities in access to early pregnancy booking and care across NENC Maternity Services.
- Address and learn from the findings of the Maternity Migrant Pathway evaluation.
- Development of NENC cannabis and cocaine pathway.
- Specific communication and engagement across the system and with women and families at risk of pre-term birth, including safe pregnancy spacing.
- Develop ethnicity and complex social factors data reporting in relation to preterm birth.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Giving children and Young People the best start in life
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	LMNS

Cardiovascular Disease

September 2024, 71.1% of patients (aged 18 and over) with hypertension in NENC had a blood pressure reading below the age-appropriate threshold, a slight increase compared with the previous reporting period. Despite remaining below the ambition of 77%, NENC have a rate higher than the England average.

The proportion is lower for those from the most deprived communities and those of black ethnicity (56.4%) and the inequality gap compared with those of white ethnicity (71.7%) has increased.

65% of patients (aged 18 and over) with no GP recorded CVD diagnosis and a QRISK score of 20% or more were receiving lipid lowering therapy. This is in line with the ambition of 60% and is higher than the England average.

The proportion of patients on lipid lowering therapy is lower for those within the **most** affluent communities, however, this does not suggest that those within the most deprived communities are necessarily receiving optimal levels of treatment.

92.2% 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.

There is now an extremely small inequality gap by deprivation (0.1%pts) but the gap between those of white ethnicity (92.2%) and those of ethnic minority groups continues to increase, particularly those from Asian communities (81.1%).

Data Source: CVD Prevent
Reporting Period: Snapshot September 2024

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

	September 2023	September 2024	Change
NENC ICB overall position	71.1%	71.2%	↑
England overall position	66.6%	66.8%	↑
NENC Inequality gap by deprivation	3.2%pts	2.2%pts	↓
NENC inequality gap by ethnicity	14.5%pts	15.3%pts	↑

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

	September 2023	September 2024	Change
NENC ICB overall position	62.6%	65.3%	↑
England overall position	59.7%	62.4%	↑
NENC Inequality gap by deprivation	-7.5%pts	-7.1%pts	↔
NENC inequality gap by ethnicity	-7.8%pts	-7.9%pts	↔

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

	December 2023	September 2024	Change
NENC ICB overall position	91.7%	92.2%	↑
England overall position	90.6%	91.3%	↑
NENC Inequality gap by deprivation	-0.6%pts	0.1%	↑
NENC inequality gap by ethnicity	2.9%pts	4.1%pts	↑

Clinical Conditions Strategic Plan measure

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

North East North Cumbria Health & Care Partnership

The causes for the inequality gap

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

The work being undertaken to address the gap

- Community blood pressure kiosk project – this project aims to improve access to blood pressure checks, and subsequently hypertension case finding and management, in deprived and ethnic minority populations.
- Healthy heart checks project – working in collaboration with Health Innovation NENC, the project aims to deliver health checks in most deprived areas and Core20PLUS5 communities across NENC.
- Targeted improvement work with Primary Care – we have utilised data to identify poorer performing practices in relation to the diagnosis and management of the ABC conditions. These GP Practices have been offered support and education via our CVD Prevention Clinical Leadership team. A number of the GP Practices were within the lowest IMD deciles.
- Education and training – the ICB learning academy now hosts a CVD section to support learning across the system. A CVD tile on the MECC gateway has also been developed to support CVD information and signposting. Blood pressure champion training is also offered a delivered to our voluntary sector colleagues.
- Regional Lipid Clinic Survey – intelligence gathered to understand the variation in services delivered within NENC lipid clinics. Regional Lipid Clinic Survey – intelligence gathered to understand the variation in services delivered within NENC lipid clinics.

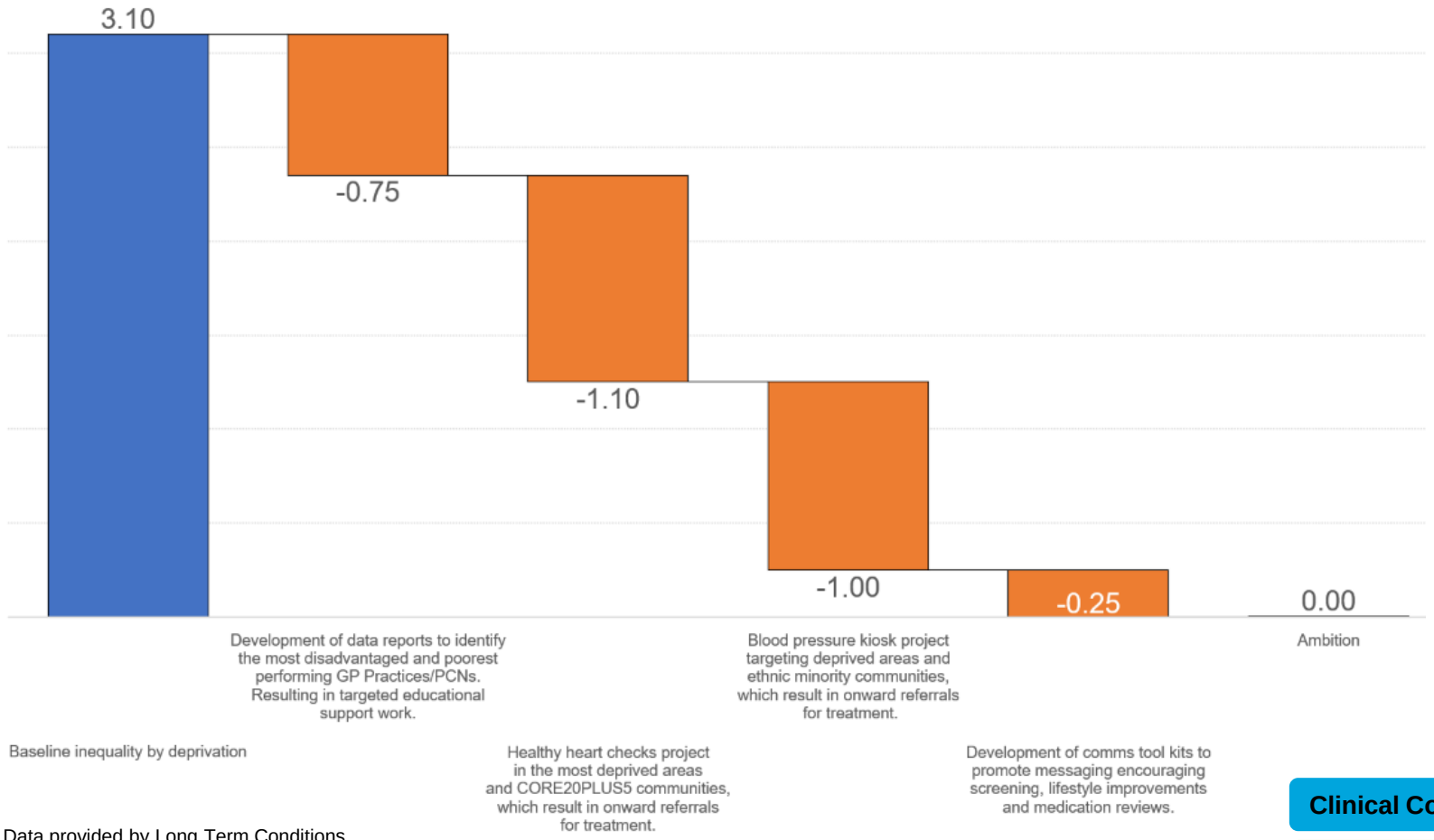
Plans for narrowing the gap

- Development of a CVD work plan under the LTC group which will support the ICB Clinical Strategy and will include deliverables related to addressing health inequalities.
- Targeted public communications aimed at the relevant demographics and areas informed by data. Communications to be tailored to audience, I.e., having a key message video a from south Asian clinician aimed at south Asian populations.
- Exploring the development of CVD risk factor optimisation services to support the secondary prevention of CVD.
- Utilisation of learning from previous projects to prioritise the work which addresses the variation within our services and tackles health inequalities.

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

Reduce Inequalities in Hypertension Management (Deprivation)



Data provided by Long Term Conditions

The waterfall chart shown to the left shows the inequality gap between the most and least deprived communities, in hypertension management in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The metric included here is **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.**

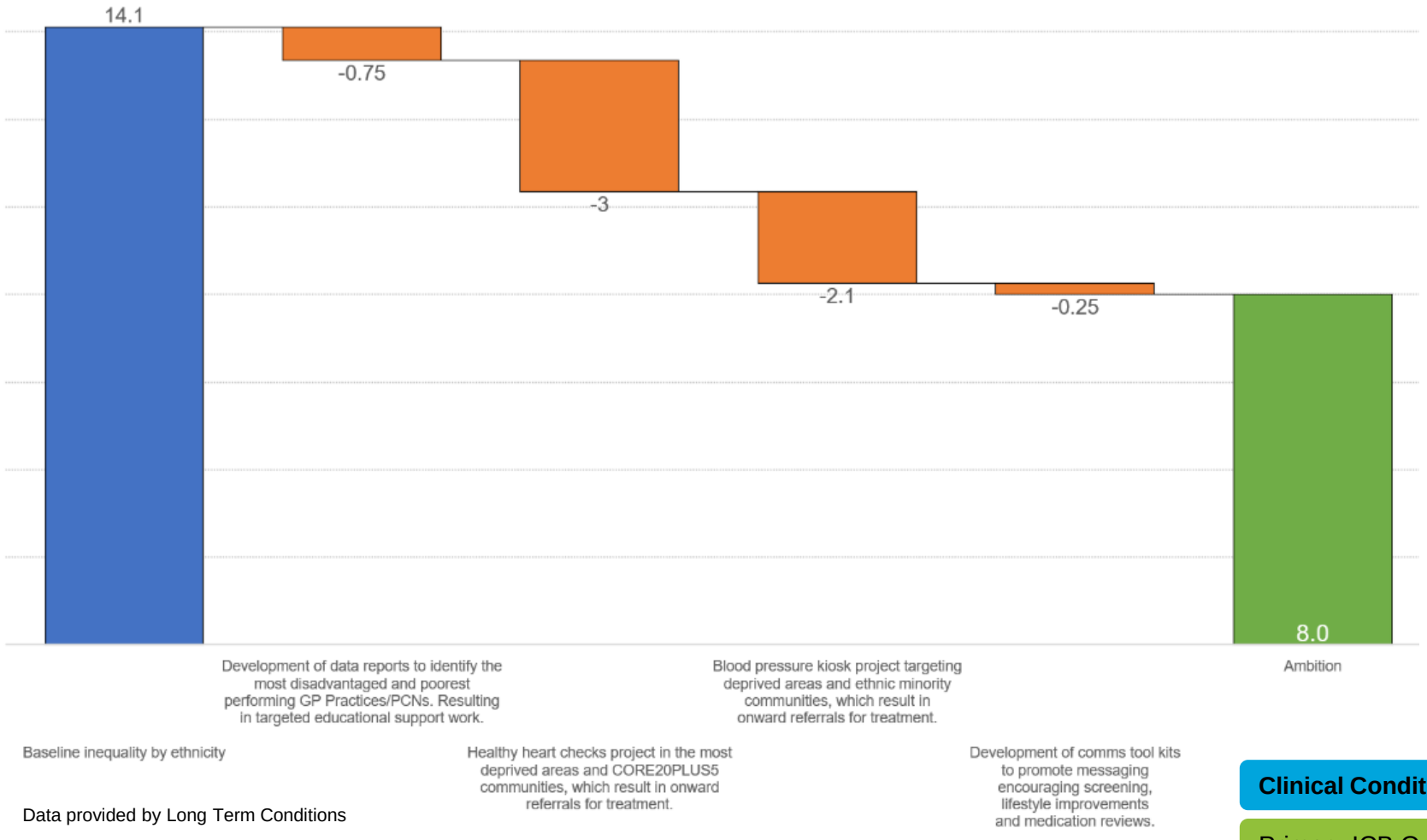
The ambition of the workstream is to reduce the inequality gap by deprivation from 3.1%pts to 0. To do so, the following interventions will be delivered with the **estimated** following impact;

- Development of data reports to identify the most disadvantaged and poorest performing GP Practices/PCNs. Resulting in targeted educational support work. (-0.75%pts)
- Healthy heart checks project in the most deprived areas and Core20PLUS5 communities, which result in onward referrals for treatment. (-1.1%pts)
- Blood pressure kiosk project targeting deprived areas and ethnic minority communities, which result in onward referrals for treatment. (-1%pt)
- Development of comms tool kits to promote messaging encouraging screening, lifestyle improvements and medication reviews. (-0.25%pt)

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

North East North Cumbria Health & Care Partnership

Reduce Inequalities in Hypertension Management (Ethnicity)



Data provided by Long Term Conditions

The waterfall chart shown to the left shows the inequality gap between individuals of white ethnicity and ethnic communities, in hypertension management in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The metric included here is **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.**

The ambition of the workstream is to reduce the inequality gap by ethnicity from 14.1%pts to 8%ptd. In order to do so, the following interventions will be delivered with the **estimated** following impact;

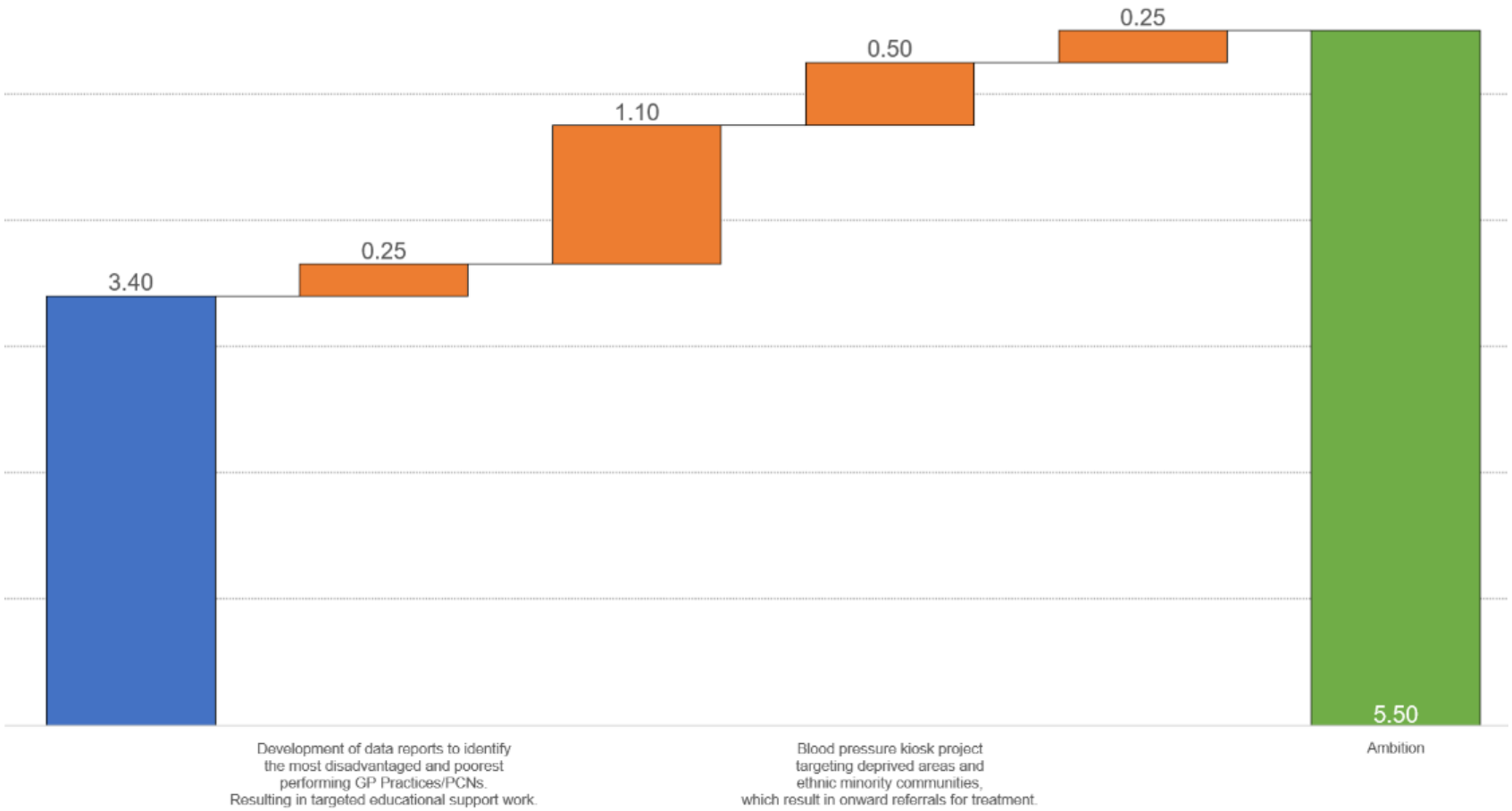
- Development of data reports to identify the most disadvantaged and poorest performing GP Practices/PCNs. Resulting in targeted educational support work. (-0.75%pts)
- Healthy heart checks project in the most deprived areas and Core20PLUS5 communities, which result in onward referrals for treatment. (-3%pts)
- Blood pressure kiosk project targeting deprived areas and ethnic minority communities, which result in onward referrals for treatment. (-2.1%pt)
- Development of comms tool kits to promote messaging encouraging screening, lifestyle improvements and medication reviews. (-0.25%pt)

Clinical Conditions Strategic Plan measure

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

North East North Cumbria Health & Care Partnership

Increase incidence of hypertension within Core20 Population



Data provided by Long Term Conditions

The waterfall chart shown to the left shows the rate of hypertension detection in the last 12 months (incidence rate) in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

One of the clinical aims of Core20PLUS5 is to increase hypertension case finding.

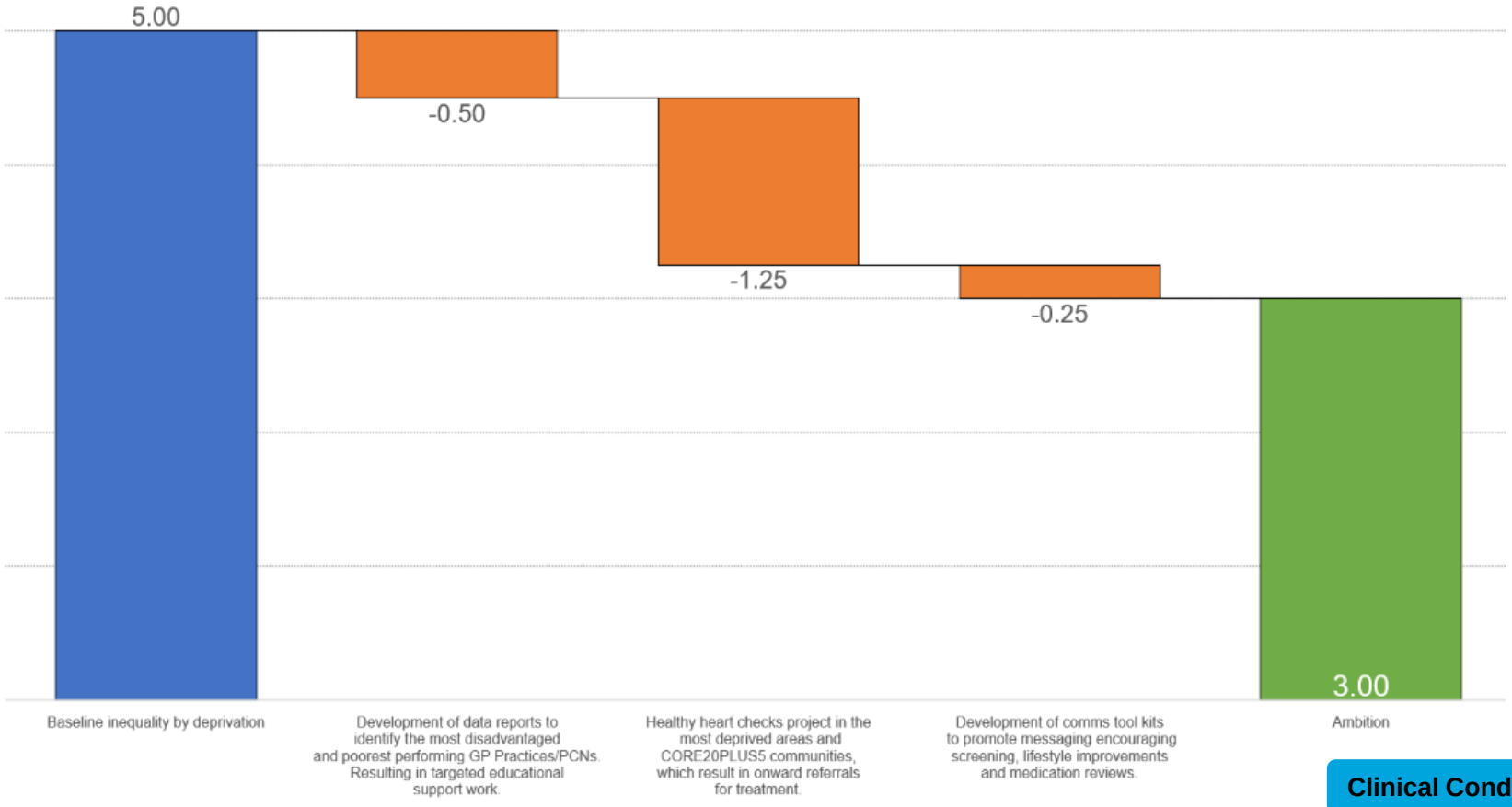
The ambition of the workstream is to increase the annual incidence rate in the most deprived communities from 3.4% to 4.5%. In order to do so, the following interventions will be delivered with the **estimated** following impact;

- Development of data reports to identify the most disadvantaged and poorest performing GP Practices/PCNs. Resulting in targeted educational support work. (+0.25)
- Healthy heart checks project in the most deprived areas and Core20PLUS5 communities, which result in onward referrals for treatment. (+1.1%)
- Blood pressure kiosk project targeting deprived areas and ethnic minority communities, which result in onward referrals for treatment. (+0.50)
- Development of comms tool kits to promote messaging encouraging screening, lifestyle improvements and medication reviews. (-0.25)

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

Reduce Inequalities in patients with CVD who have non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l



Data provided by Long Term Conditions

The waterfall chart shown to the left shows the inequality gap between the most and least deprived communities, in cholesterol management in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The metric included here is **Percentage of patients aged 18 and over, with GP recorded CVD (narrow definition), in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l**

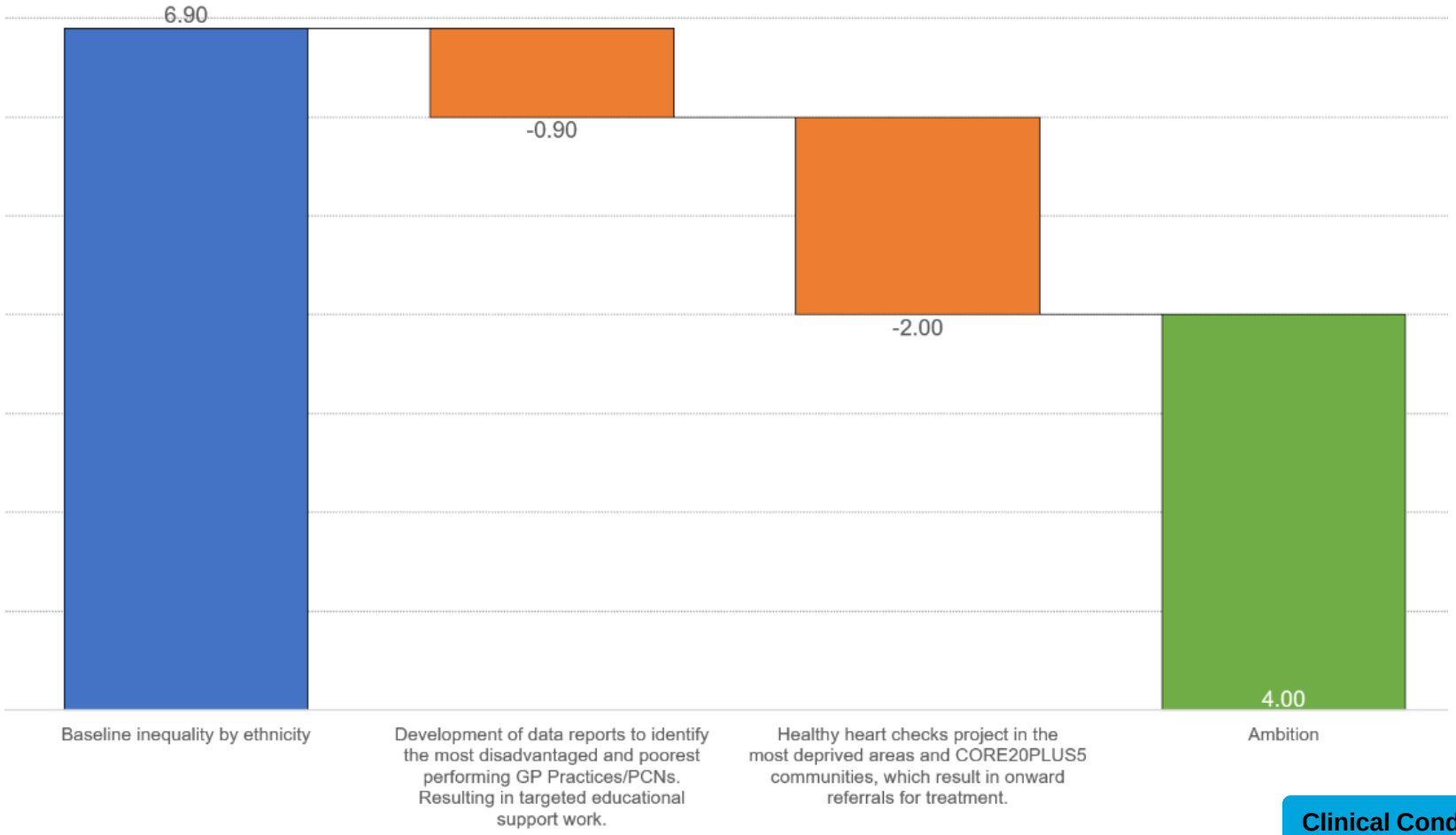
The ambition of the workstream is to reduce the inequality gap by deprivation from 5%pts to 3%pts. In order to do so, the following interventions will be delivered with the **estimated** following impact;

- Development of data reports to identify the most disadvantaged and poorest performing GP Practices/PCNs. Resulting in targeted educational support work. (-0.5%pts)
- Healthy heart checks project in the most deprived areas and Core20PLUS5 communities, which result in onward referrals for treatment. (-1.25%pts)
- Development of comms tool kits to promote messaging encouraging screening, lifestyle improvements and

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

North East North Cumbria Health & Care Partnership

Reduce Inequalities in AF treatment (by Ethnicity)



Data provided by Long Term Conditions

The waterfall chart shown to the left shows the inequality gap between individuals of white ethnicity and ethnic communities, in Atrial Fibrillation management in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The metric included here is **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**

The ambition of the workstream is to reduce the inequality gap by ethnicity from 6.9%pts to 4%pts. In order to do so, the following interventions will be delivered with the **estimated** following impact;

- Development of data reports to identify the most disadvantaged and poorest performing GP Practices/PCNs. Resulting in targeted educational support work. (-0.9%pts)
- Healthy heart checks project in the most deprived areas and Core20PLUS5 communities, which result in onward referrals for treatment. (-2%pts)

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

Cancer - Diagnosis at Stage 1 and 2

Percentage of cancers diagnosed at Stage 1 or 2

	2022/23
NENC ICB position	55%
England Position	58%
NENC most deprived position	52%
NENC least deprived position	59%

Data Source: Rapid Cancer Registration Data
Reporting Period: 2022/23

Uptake of Cancer Screening (Breast and Bowel)

		March 2023	March 2024	Trend
Breast screening	NENC ICB position	69.0%	73.1%	↑
	England position	65.1%	70.4%	↑
	NENC Slope Index of inequality	16.1	13.3	↓
	England Slope index of inequality	17.1	15.6	↓
Bowel screening	NENC ICB position	72.9%	74.0%	↑
	England position	70.2%	71.0%	↑
	Slope Index of inequality	15.3	16.3	↓
	England Slope index of inequality	17.1	17.2	↓

Data Source: NHS Futures – Health inequalities reporting
Reporting Period: 2023/24

There are two output measures for Cancer; % of cancer diagnoses detected at stage 1 or 2 and Cancer Screening rates. The first measure is suggested by NHSE within the Core20plus5 framework but measurement of this is difficult due to the capture of staging within the available dataset. It is hoped that this will become available and will be included when it does. The second measure has been included as a local proxy measure for staging, due to more robust data quality.

Based upon available, unvalidated data, the estimate proportion of cancers identified at stage 1 or 2 in NENC is 55%, a slight increase compared with the previous reporting period. This proportion is lower than the England average of 58%. In NENC the rate for the most deprived population is 52% and for the least deprived it is 59%, resulting in a 7%pt inequality gap for NENC.

An alternative, more timely measure introduced by NHSE is cancer screening rates. For NENC ICB, there are inequalities in both breast and bowel cancer screening, but the calculated gap is less than the England average.

The most recent slope index of inequality for screening of these cancers are 13.3 (breast) and 16.3 (bowel). The slope index of inequality for both these measures has reduced over the last 12 months at the same time the overall achievement has increased. This highlights that not only are more people receiving screening, but more people from the most disadvantaged communities are accessing.

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Cancer Network

The causes for the inequality gap

- In NENC there is a higher burden of disease in all tumour sites, particularly in Lung Cancer, and cancer is diagnosed later in our communities of health inequality due to health literacy and health behaviours, and poorer access to primary and other care services (profile of deep end practices).

The work being undertaken to address the gap

- NCA has a comprehensive early diagnosis workplan focusing 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.
- The Cancer Programme is nationally funded and assured, and locally we use a proportional universalist approach to allocating cancer transformation funding to projects and organisations that can target the most support where it is most needed to narrow the inequality gap. Early diagnosis projects are targeted at communities and PCN's by triangulating health inequality indicators (such as Core20/IMD scores) cancer incidence (including rates of emergency presentation which usually map to both later presentation and health inequalities) and uptake rates for screening and case finding initiatives.
- We are aware that even high performing programmes that exceed the national standard for uptake (e.g. bowel cancer screening) will mask poorer uptake in communities of health inequality and seek to address this by cohorting and targeting our engagement efforts at those who will experience the most barriers to uptake of screening (examples include the siting of mobile cervical sampling, targeting of behavioural science projects and geospatial mapping to utilise PCN engagement and cancer awareness staff capacity).

Plans for narrowing the gap

- NCA have ambitious plans to narrow the gap, and in 25/26 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.
- Specifically on screening there are a number of targeted projects aimed at reducing inequalities in access and uptake of screening in for example: for 'first time' screeners, for populations with poorer outcomes and a history of later diagnosis, improving access to breast screening and self-examination for South Asian women, mobile cervical screening targeting populations living in areas of high deprivation and lung cancer screening with a focus on areas of high deprivation, SMI populations and other health inclusion groups.
- Using Lung cancer as an exemplar: NCA have developed a 5-year Lung cancer strategy to address the work, and health inequalities in that tumour site. As part of that work we need to ensure that all patients experience equitable access to services, have high quality care and get fair outcomes. This begins by understanding the different needs of our patient populations in need of a health care service. Until we robustly gather the complete data set about the factors that contribute to patients facing challenges to accessing care, we will not fully understand how we can completely mitigate health care inequalities. This data collection challenge is not included in our 'waterfall' of projects but is a crucial first step in informing how we narrow the gap.
- There are particular challenges seen in our most time sensitive, poor outcome cancers e.g. Lung Cancer. We know this is a disease linked to deprivation, predominantly linked to tobacco use. Referrals into a lung pathway have a high prevalence of multi-morbidity, Serious Mental Illness, drug and alcohol dependency and a social context of adverse life experiences. Referrals via an emergency route highlight those that did not or could not access standard referral pathways (about a third of cases.)

North East North Cumbria Health & Care Partnership

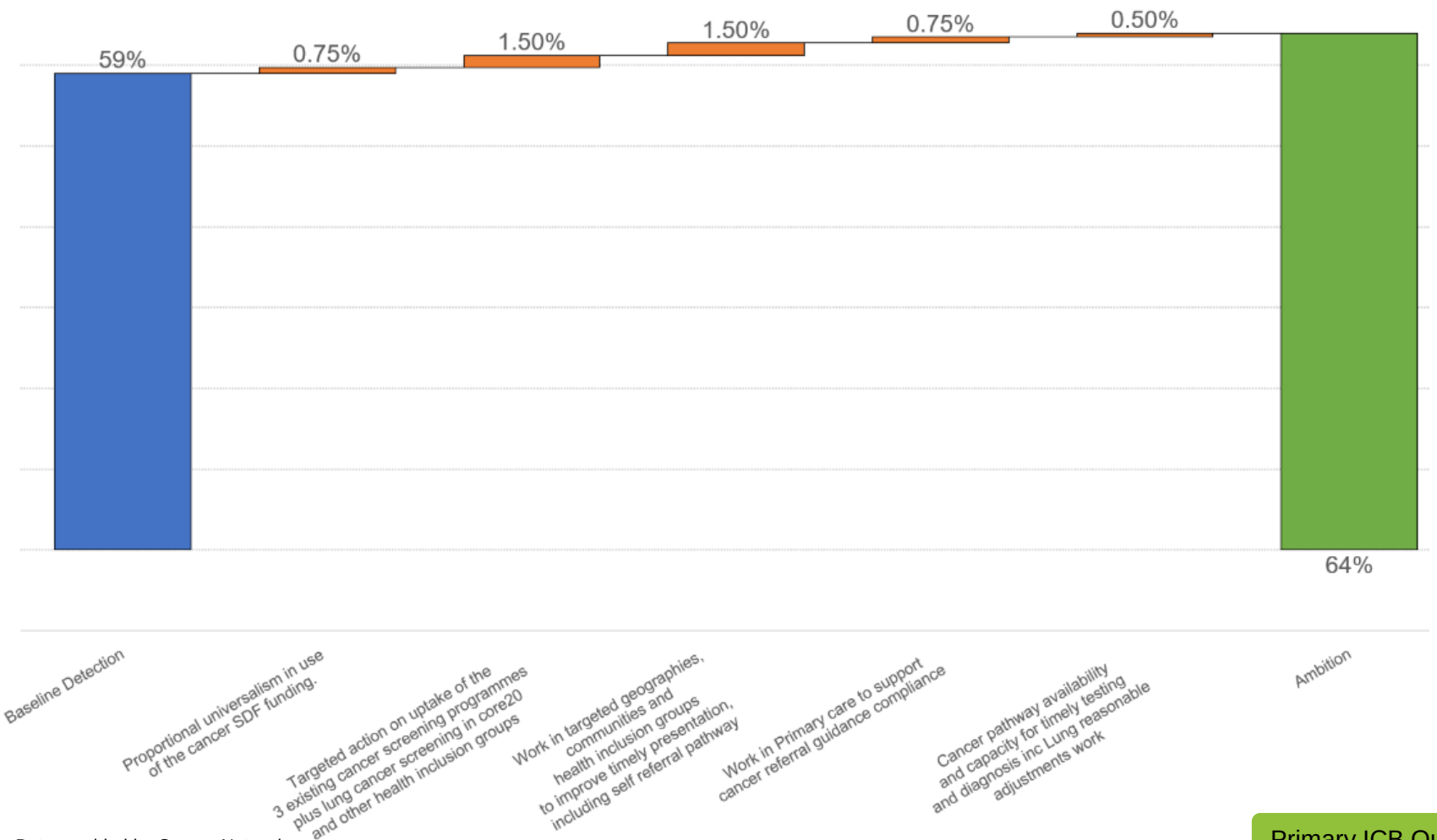
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Cancer Network

Plans for narrowing the gap (cont.)

- If we set our overall aim to pilot equalising the experience in the Lung Cancer pathway, we need to think afresh, at system level about how we reduce the barriers to accessing care for those with the highest prevalence of disease eg rather than making it easier for the whole population to access diagnostics. This should consider whole system self-referral hotlines for patients with red flag symptoms for lung cancer, that could be accessed by patients, their care givers, link workers, housing officers – eg barrier free access to a high risk cohort.
- Then, once all-source referrals are received by a trust there should be a standard process for incorporating provided information regarding additional need/ necessary reasonable adjustments. At present, a bookings clerk might not upload this information as it is felt to be for clinical interpretation only (current position at one trust). But if there is a straight to test pathway and missed appointments are recorded as DNAs then a patient may never get to see a clinician. Eg: Patient M was referred on SNSS Pathway and CT requested. The appointment details were only posted to her, no other attempt at reasonable adjustments. She is a carer and had had to move in with her recently bereaved daughter with SMI so hadn't picked up the post. She missed x2 scans and was discharged. She eventually went back to see her GP and was referred to lung as she had respiratory symptoms then and was found to have a lung cancer.
- Although piloting this approach to reducing healthcare inequalities would start in the Lung Cancer pathway, if successful we would aim to spread this across the other cancer pathways and indeed offer it as an example of practice to other ICB workstreams.
- Confounding factors working against our ability to narrow the gap 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 (eg mobile cervical screening provision versus cost of provision in primary care). Also, it must be recognised that some of the health inclusion groups being rightly targeted by this work can only contribute a tiny percentage point of improvement towards an overall NENC target.
- Nationally we are on trajectory with the best performing areas (those starting with less burden of disease and a less stark health inequality profile) in achieving a 1-2% improvement in early diagnosis rates; however, proceeding at that trajectory would only take NENC to 68% early diagnosis by 2030. In narrowing the gap between the most and least deprived we are already bucking the national trend where the gap is widening.
- It is accepted that further improvement on the early diagnosis standard would be dependent on innovative filter tests (such as MCED tests) becoming available, the longer term resourcing/targeting of early diagnosis projects such as the lung screening programme, and a comprehensive costed workforce plan included within the NHS 10 year plan (currently being consulted upon.)

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Cancer Network

% cancer detected at Stage 1 or 2 in the Core20 population



The waterfall chart shown to the left shows the inequality gap between the most and least deprived communities, in the proportion of cancers which are detected at stage 1 or 2 in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to increase the stage 1 and 2 detection rate in the Core20 population from 59% to 64%. In order to do so, the following interventions will be delivered with the **estimated** following impact;

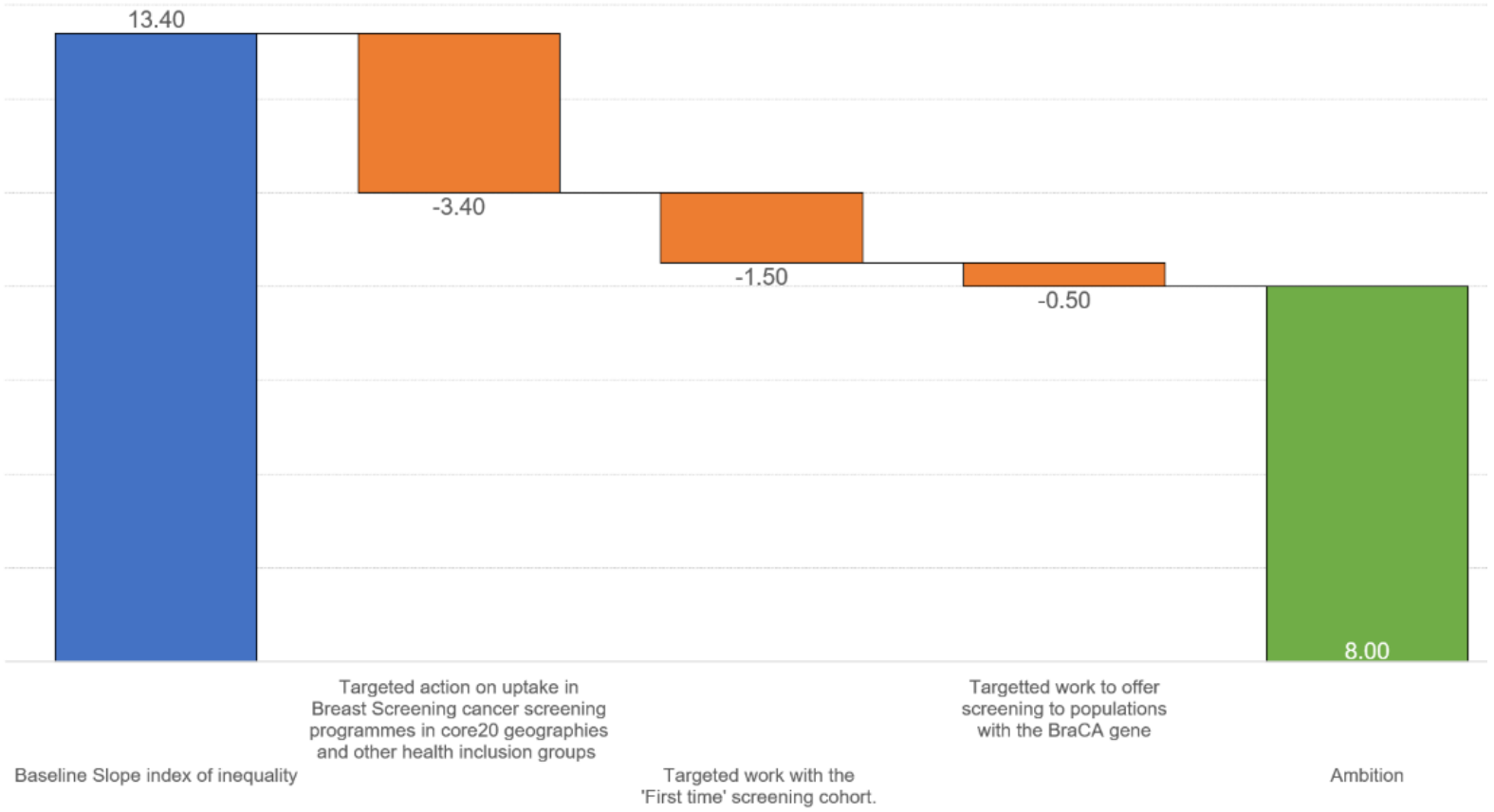
- Proportional universalism in use of the cancer SDF funding. (+0.75%pts)
- Targeted action on uptake of the 3 existing cancer screening programmes plus lung cancer screening in core20 and other health inclusion groups (+1.5%pts)
- Work in targeted geographies, communities and health inclusion groups to improve timely presentation, including self referral pathway (+1.5%pts)
- Work in Primary care to support cancer referral guidance compliance (+0.75%pts)
- Cancer pathway availability and capacity for timely testing and diagnosis inc Lung reasonable adjustments work (+0.5%pts)

Data provided by Cancer Network

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Cancer Network

% of eligible population receiving breast screening – slope index of inequality



The waterfall chart shown to the left shows the slope index of inequality between the most and least deprived communities, in the eligible population receiving breast screening in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to reduce the inequality gap by deprivation from 13.4 to 8. In order to do so, the following interventions will be delivered with the **estimated** following impact;

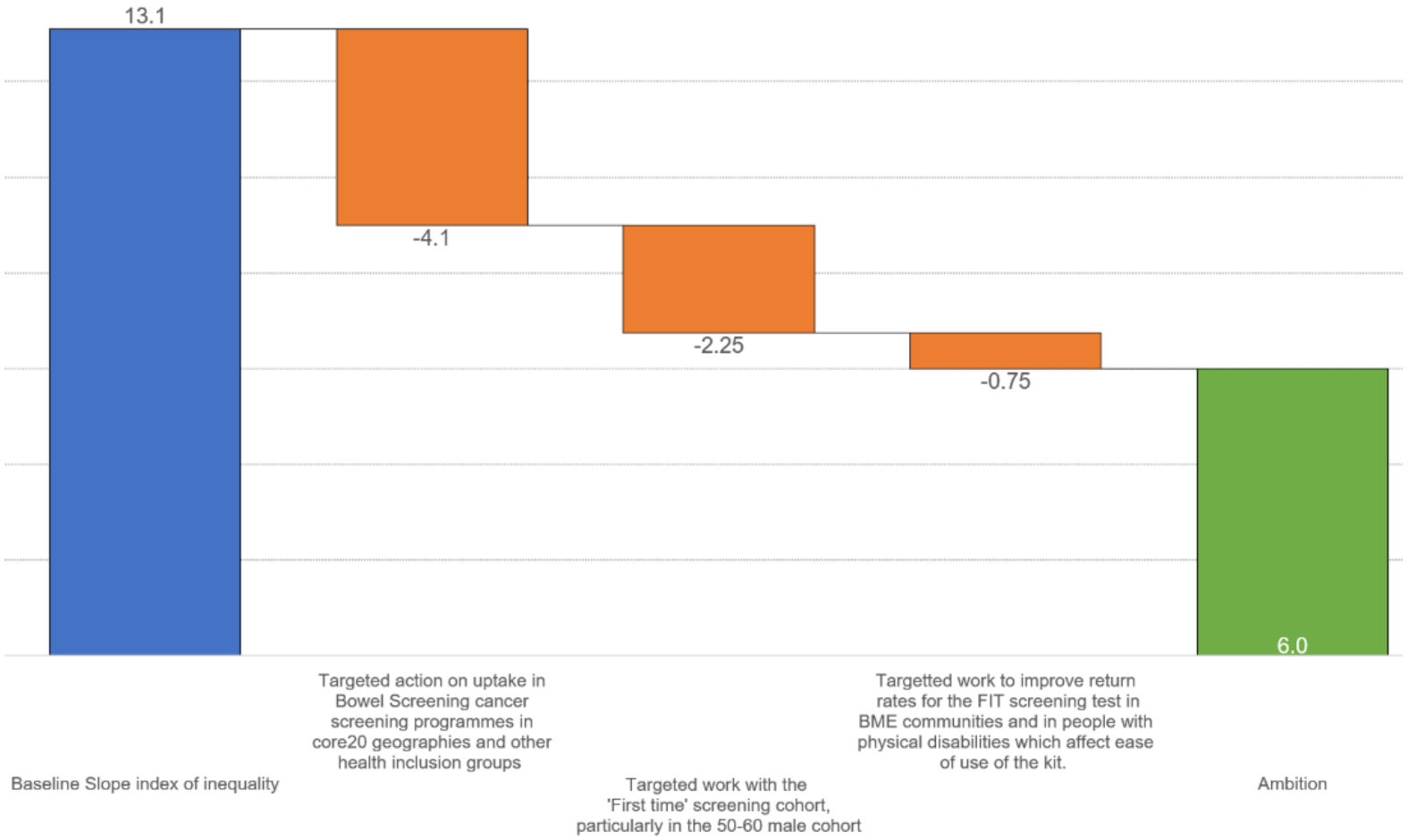
- Targeted action on uptake in Breast Screening cancer screening programmes in core20 geographies and other health inclusion groups (-3.4)
- Targeted work with the 'First time' screening cohort. (-1.5)
- Targeted work to offer screening to populations with the BraCA gene (0.5)

Data provided by Cancer Network

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Cancer Network

% of eligible population receiving bowel screening – slope index of inequality



The waterfall chart shown to the left shows the slope index of inequality between the most and least deprived communities, in the eligible population receiving bowel screening in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to reduce the inequality gap by deprivation from 13.1 to 6. In order to do so, the following interventions will be delivered with the **estimated** following impact;

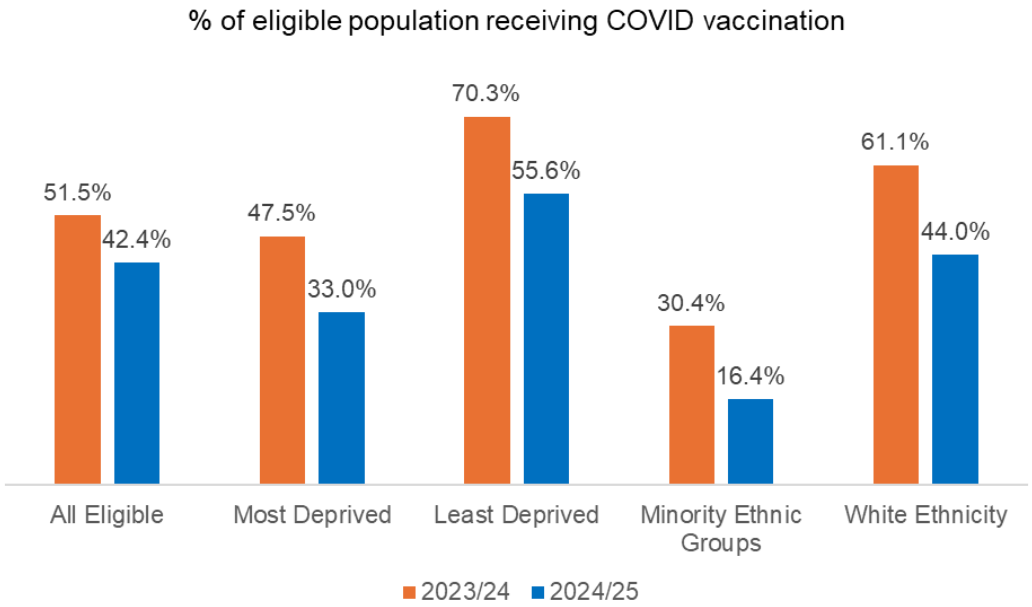
- Targeted action on uptake in Bowel Screening cancer screening programmes in core20 geographies and other health inclusion groups (-4.1)
- Targeted work with the 'First time' screening cohort. Particularly in the 50-60 male cohort (-2.25
- Targeted work to improve return rates for the FIT screening test in BME communities and in people with physical disabilities which affect ease of use of the kit. (-0.75)

Data provided by Cancer Network

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Cancer Network

Respiratory – COVID Vaccination Uptake



Percentage of eligible population receiving COVID vaccination

	2023/24	2024/25	Trend
NENC ICB overall position	51.5%	42.4%	↓
NENC most deprived position	47.5%	33.0%	↓
NENC least deprived position	70.3%	55.6%	↓
NENC white ethnicity position	61.1%	44.0%	↓
NENC non-white ethnicity position	30.4%	16.4%	↓

Data Source: COVID vaccination data -Foundry and NENC Primary Care Data
Reporting Period: Autumn/Winter 2024/25

The data shown in the table reflects the proportion of eligible individuals across NENC ICB who have received their COVID vaccination. At overall ICB level, there has been a reduction in the proportion in 2024/25 compared within the previous reporting period.

When looking at the data by socio-economic status (defined using Index of multiple deprivation of residence in this instance), there is an inequality gap in receiving the vaccination between the most and least deprived communities. In 2023/24 the inequality gap by deprivation was calculated as 22.8%pts, this has reduced slightly in 2024/25 to 22.6%pts.

There is also an inequality gap by ethnicity, with a greater proportion of people of white ethnicity receiving the vaccination compared with ethnic minority communities. The inequality gap has reduced slightly in 2024/25 compared with the previous reporting period, but this is because the uptake within the white communities has reduced at a greater rate than within the ethnic minority communities.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Screening and Immunisations

The causes for the inequality gap

The evidence for the causes for the inequalities gap vary between population and geography. The main themes are:

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

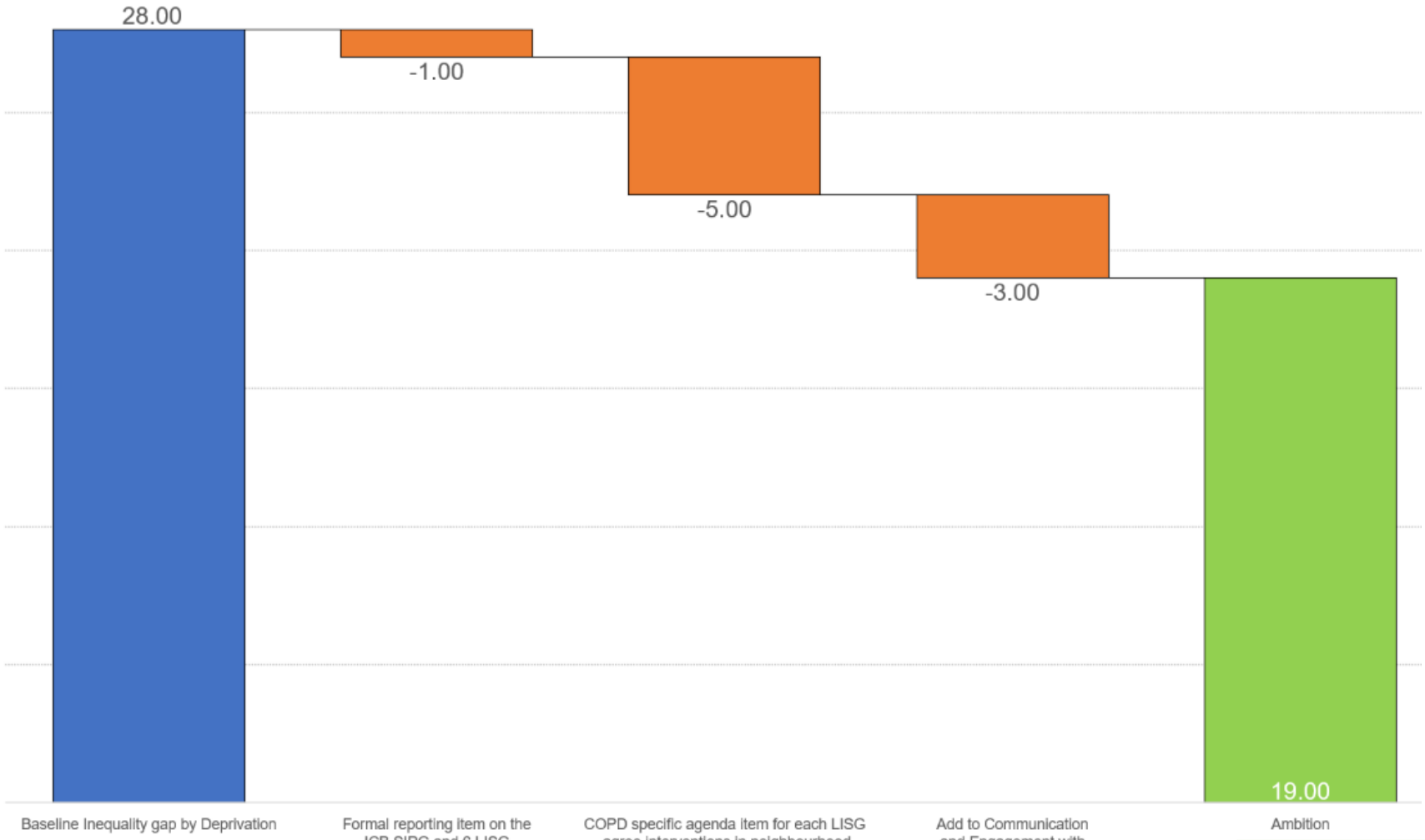
The work being undertaken to address the gap

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

Plans for narrowing the gap

- The first key deliverable in 2025 is to provide actionable data derived insights to COVID vaccination uptake in COPD patients down to a sub ICB level. Together with the NEY respiratory network and the ICBs LTC working group, advice and guidance can be given to the 6 LISGs to develop localised interventions and performance monitoring with providers, supported by LA and PH teams.
- The second key deliverable is to develop, in partnership with clinicians and patients with COPD, a communication toolkit focused on the importance of COVID vaccination. The communication toolkit will also promote the importance of Flu and RSV vaccinations. This will be shared with all patient facing services and networks including Detained Estates, Asylum and Migrant communities.

Inequality gap in COVID vaccination for eligible population



The waterfall chart shown to the left shows the inequality gap between the most and least deprived communities, in the proportion receiving a COVID vaccination in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to reduced the inequality gap between the most and least deprived from 28%pts to 19%pts. In order to do so, the following interventions will be delivered with the **estimated** following impact;

- Formal reporting item on the ICB SIPG and 6 LISG (-1%pt)
- COPD specific agenda item for each LISG agree interventions in neighbourhood teams (-5%pts)
- Add to Communication and Engagement with a specific COPD toolkit " (-3%pts)

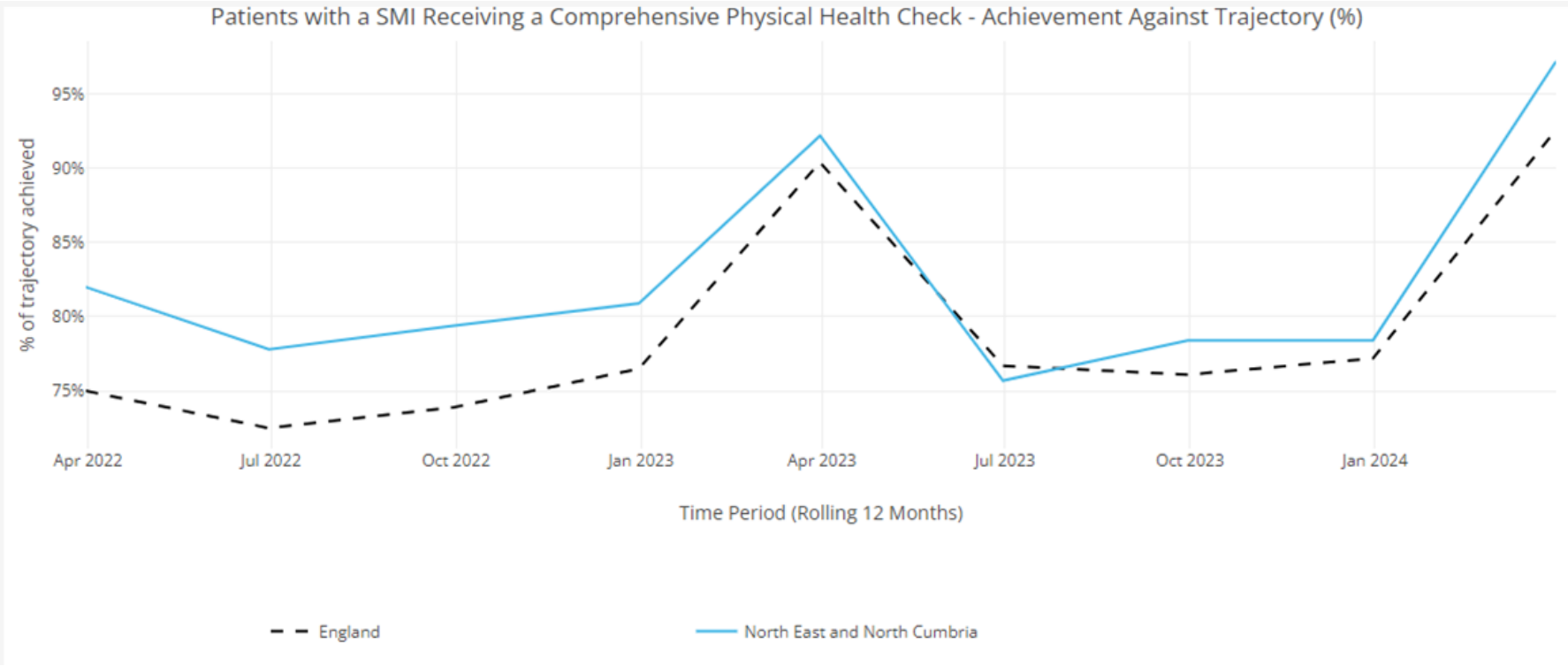
Data provided by Screening and Immunisations

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Screening and Immunisations

Serious Mental Illness Health Checks

Proportion of SMI patients receiving a health check in the last 12-months against trajectory



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

	2022/23	2023/24	Trend
NENC ICB position	92.2%	97.2%	↑
England position	90.4%	92.6%	↑

The data is taken from NHSE health inequality analysis report released May 2024, which is the latest available published data.

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

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

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

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Fairer Outcomes for all
National guidance	Core20PLUS5
Lead Team	Mental Health

Learning Disability Health Checks

Proportion of Learning Disability patients receiving a health check in the last 12 months

	July 2024	December 2024	Trend
NENC ICB position	63%	61%	↓
Most deprived communities	64.3%	60.5%	↓
Least deprived communities	66.2%	58%	↓
White communities	65.3%	61.6%	↓
Non-white communities	44.2%	38%	↓

Figure 1 – Learning disability annual health checks by Ethnicity

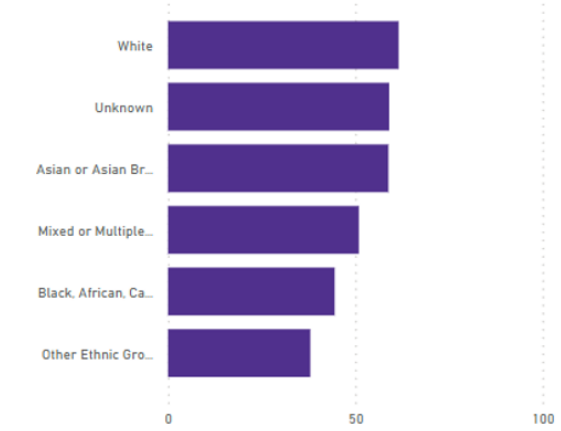
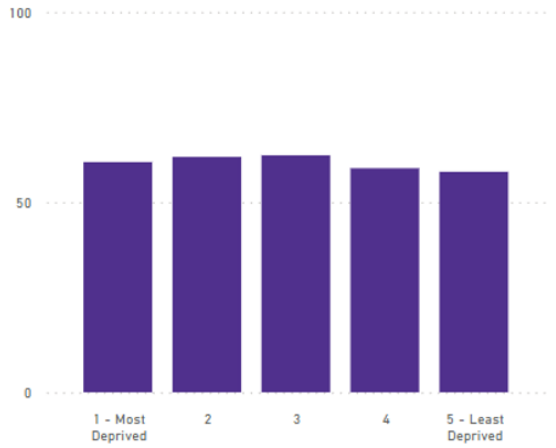


Figure 2 – Learning disability annual health checks by deprivation



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

The data has been taken from NENC Healthier and Fairer dashboard, derived from NENC Primary Care data. It reflects the proportion of people with a diagnosis of Learning disability who have a recorded health check in the previous 12-month period.

A greater proportion of individuals from the 20% most deprived communities (60.5%) are shown as having received their health check in the last 12 months compared with the least deprived (58%), although both have experienced a reduction compared with the previous reporting period. The reduction may be aligned to the change in method for identifying when health checks are due, changing the due date to the month of an individual's birthday. If this is the case, the percentage will increase again in the next two reporting periods.

There is an inequality gap by ethnicity with a smaller proportion of those from ethnic communities with a learning disability, in particular those of mixed or multiple ethnic groups, receiving their annual health check compared with those of white ethnicity.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Fairer Outcomes for all
National guidance	Core20PLUS5
Lead Team	Learning Disability Network

The causes for the inequality gap

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

The work being undertaken to address the gap

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

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Fairer Outcomes for all
National guidance	Core20PLUS5
Lead Team	Learning Disability Network

Plans for narrowing the gap

- Full implementation of the Reasonable Adjustment Digital Flag across NENC, health and social care Reasonable Adjustment Flag « Learning Disability Network (necldnetwork.co.uk)
- Moving AHC delivery from 'within QoF' year to 'birthday month' of the person with learning disability
- Fully refresh the 'Learning Disability Population Health Management Profiles' to enable targeted improvement work on importance of AHCs and quality of AHCs in most disadvantaged places
- Improving 'learning disability GP registers' working with national team on standardising how to identify a cyp with learning disability.
- Reviewing how patients are invited in for healthcheck to identify any barriers to uptake and also focusing on education as to the benefits of the check.
- The development of post cards and posters to raise awareness of health checks and encourage people to attend for their checks. The work was co-produced with children from a Northumberland school who created the design and involved ICB comms team regarding fine tuning and arrangement of printing. The materials will be distributed across Northumberland early in 20205 with the hope that this can be rolled out further across the region.
- Working with third sector providers, to extend the support for accessing to health checks for people who do not necessarily have a diagnosis of a learning disability, but who present with significant needs and are likely to benefit from support It I expected that this will target people with a higher level of deprivation, who are more likely to present with significant health needs, and less likely to have a formal diagnosis.
- A digital post has been embedded within South Tyneside (and potentially wider), with an aim to improve data on local registers.
- A national NHSE indicator is expected to be released in the future which focuses on increasing the quality of health checks to ensure a robust and meaningful process, which we anticipate will further help us locally to reduce health inequalities.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Fairer Outcomes for all
National guidance	Core20PLUS5
Lead Team	Learning Disability Network

CYP Diabetes

Percentage of Type 1 receiving all 6 care processes

		Quarter 3 2024/25
Type 1 Diabetes	NENC ICB position	78.7%
	England Position	80.0%
	NENC most deprived position	78.7%
	NENC least deprived position	78.2%
	NENC white ethnicity position	78.4%
	NENC non-white ethnicity	75.9%

The information included in this report is taken from the National Paediatric diabetes audit dashboard and reflects the outputs for 2024/25. There is currently little to no variation in the proportion receiving the 6 care processes by deprivation. There is a reported inequality gap of 2.5%pts by ethnicity.

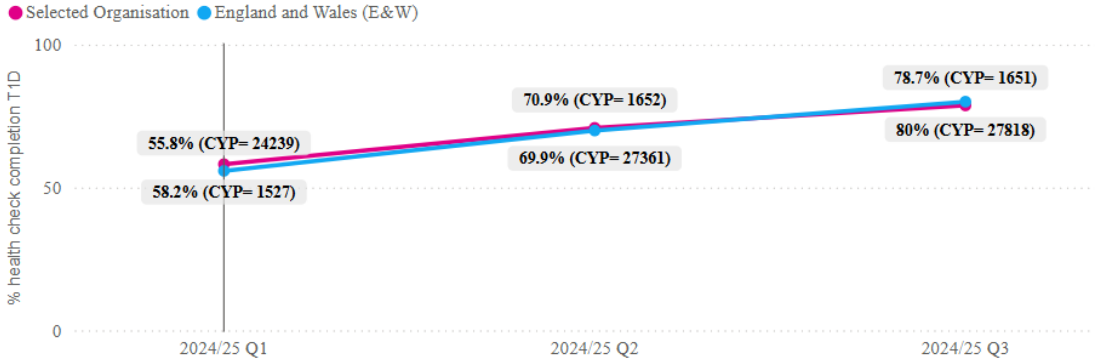
Percentage of type 1 diabetic children accessing Hybrid closed loop

		Quarter 4 2023/24	Quarter 3 2024/25	Trend
Type 1 Diabetes	NENC ICB position	41.5%	63.2%	↑
	England Position	28.3%	54.4%	↑
	NENC most deprived position	38.6%	60.2%	↑
	NENC least deprived position	46.9%	69.9%	↑
	NENC White ethnicity position	42.1%	64.3%	↑
	NENC Non-white ethnicity position	49.0%	56.1%	↑

The proportion of children accessing Hybrid Closed loop has increased both locally and nationally. The increase has been seen across all groups but there remains inequalities by both deprivation and ethnicity. The gap by deprivation is currently 9.7%pts and by ethnicity 8.2%pts, a slight reduction compared with baseline.

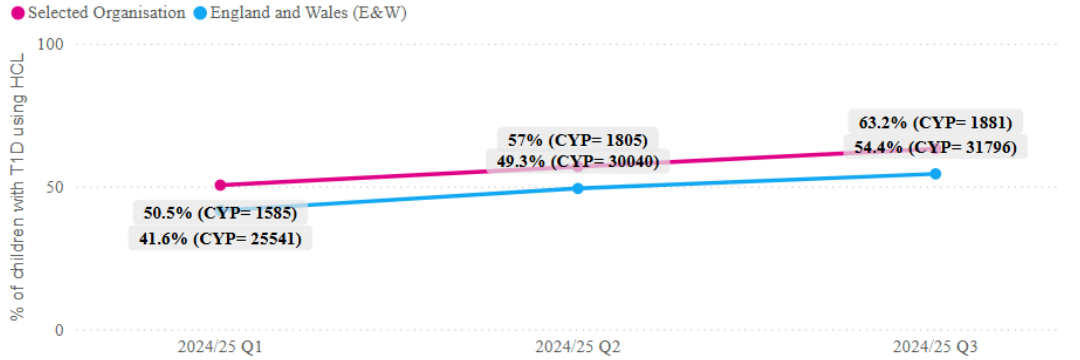
North East North Cumbria Health & Care Partnership

Percentage of Type 1 receiving all 6 care processes



Data Source: National Paediatrics Diabetes Audit Dashboard
Reporting Period: 2024/25

Percentage of type 1 diabetic children accessing Hybrid closed loop



Data Source: National Paediatrics Diabetes Audit Dashboard
Reporting Period: 2024/25

Clinical Conditions Strategic Plan measure

Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

The causes for the inequality gap

- CYP with Type 2 Diabetes receiving key health checks – The incidence of CYP with type 2 diabetes is rising, however we still have a very small number of patients (50 patients reported in 22/23 NPDA) therefore only 1 or 2 patients that miss their key checks will have an impact on the data. In terms of inequalities in accessing key health checks, there is a small gap (3.5%) between white and non-white ethnicity and no gap between the most and least deprived. Ethnicity should not be a barrier to accessing key health checks however -

1. some families who don't speak English as a first language find accessing healthcare more difficult than English speaking families
2. T2 patients often have more complex social needs and therefore data may be missing due to patient moving in and out of area
3. accuracy of the ethnicity coding

- CYP with type 1 diabetes accessing Hybrid Closed Loop technology – Access to HCL technology has recently (late 2023) been made mandatory for anyone living with type 1 diabetes via a NICE Technology Appraisal (TA943), the data therefore reflects a very current change in diabetes care.
- Prior to this, the two component parts of HCL, insulin pumps and continuous glucose monitors (CGMS) were accessed under different NICE guidelines, in the case of insulin pumps the access was limited to children and young people under 12 years. Following all available guidance, MDTs across NENC have always strived to achieve equitable access to all diabetes technologies and we have consistently led the way when compared with other areas of England and Wales. Since the publication of TA943, MDTs offer HCL to ALL families (no age limiting criteria) and we do expect to see a sharp increase in overall access to HCL in the next quarterly report (30.08.2024).
- However, we know that 49% of our population live in the most and second most deprived quintiles and this is creating a barrier for those looking to access diabetes technology -
- 1) as the diabetes technology advances, the requirement to have access to a compatible mobile phone and laptop is essential to access the full functionality of the technology.
- 2) diabetes technology is complex to manage, and we know there is a connection between levels of literacy and deprivation.
- 3) accessing the required healthcare to manage diabetes, including additional hospital appointments needed to commence diabetes technology can present a challenge for some families.
- The data shown above does however represent a reduction in the deprivation gap since the 21/22 NPDA report which showed a 11.1% gap between most and least deprived accessing insulin pumps and 13.8% gap between the most and least deprived accessing CGMs.

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

The work being undertaken to address the gap

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

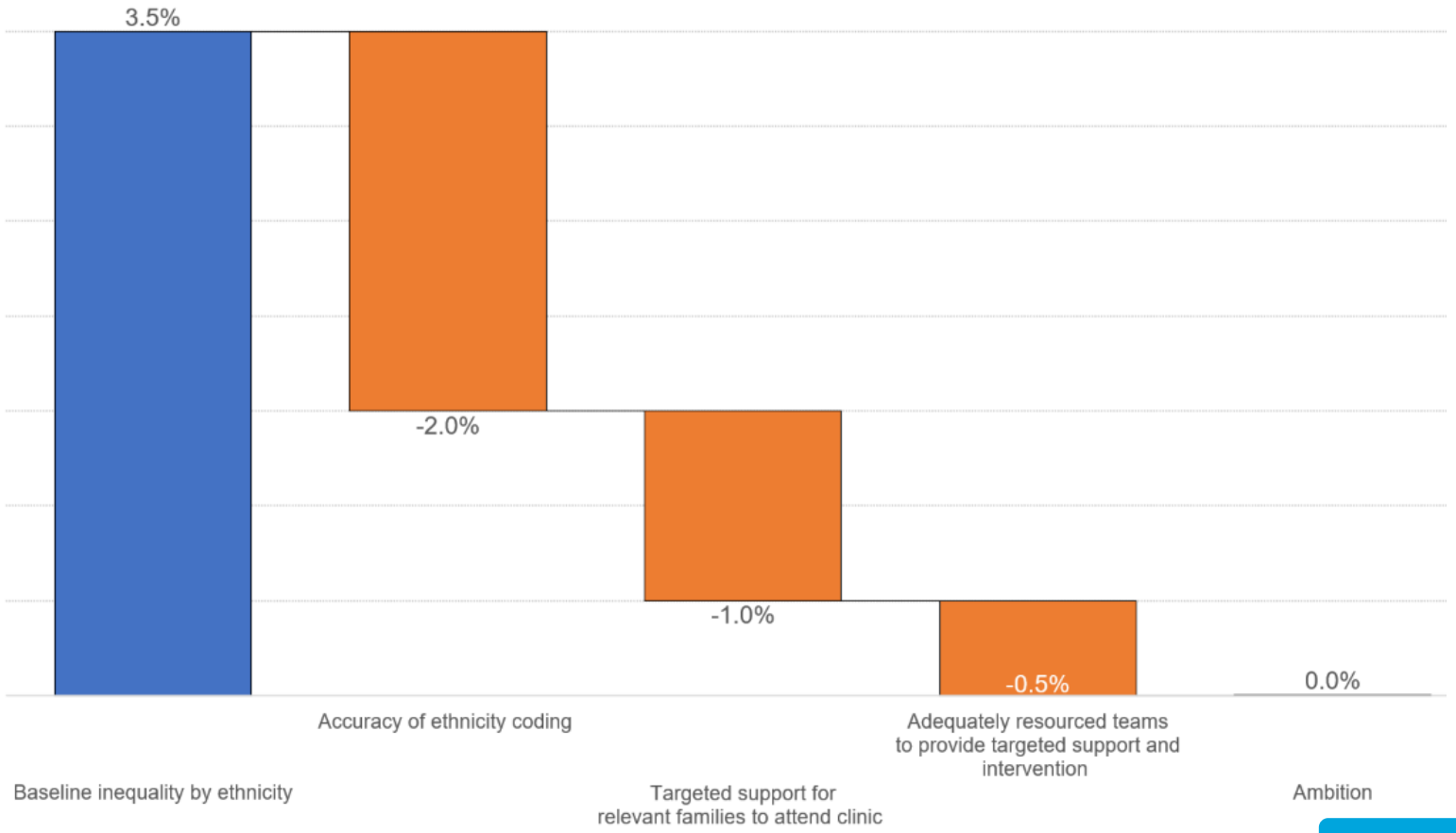
Plans for narrowing the gap

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

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

% of children and young people with diabetes receiving all six care processes – Inequality gap by Ethnicity



The waterfall chart shown to the left shows the inequality gap between children of white ethnicity and children of other ethnic communities receiving all six care processes for Type 1 Diabetes in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to reduce the inequality gap by ethnicity from 3.5%pts to zero. In order to do so, the following interventions will be delivered with the **estimated** following impact;

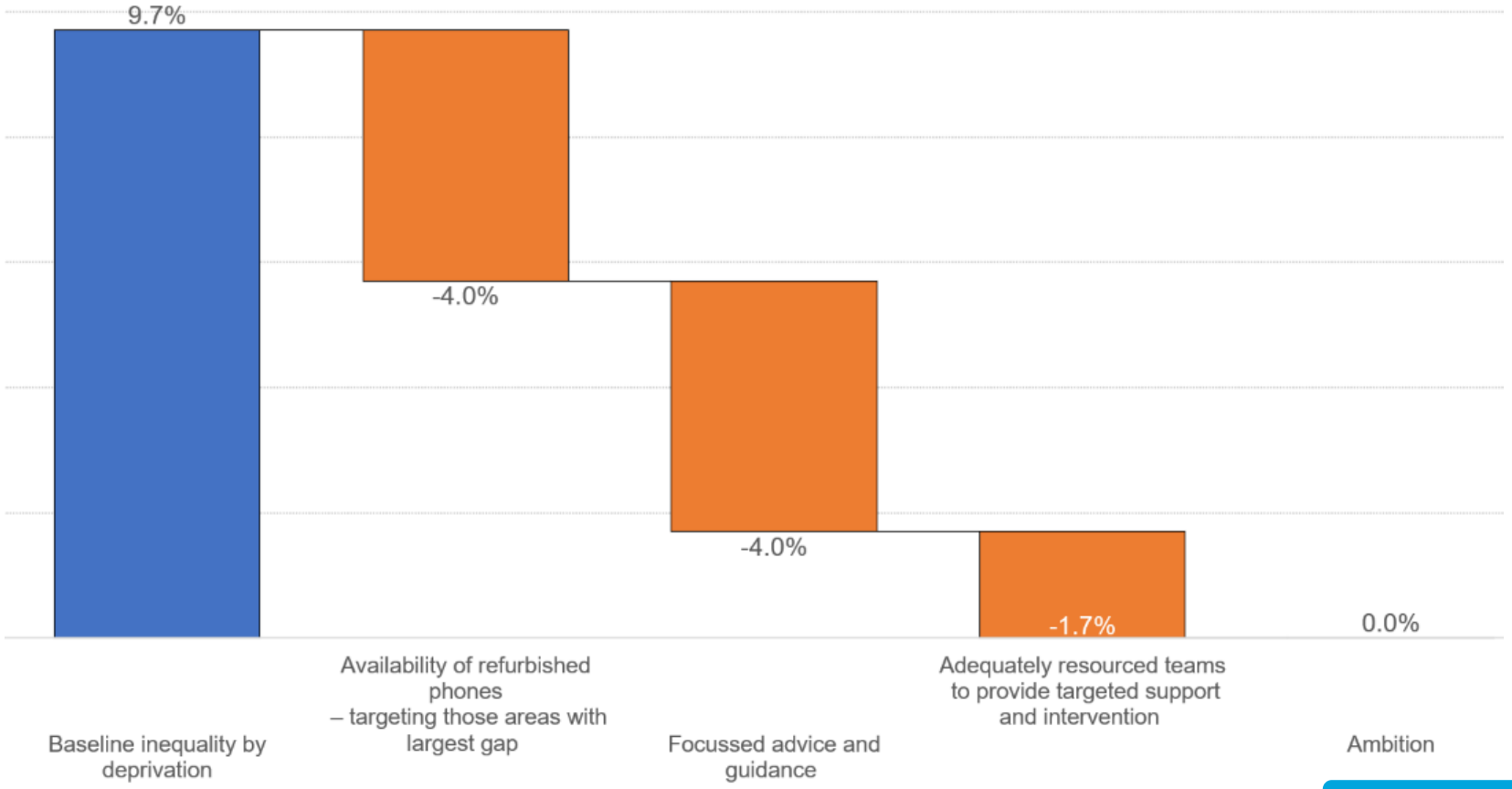
- Accuracy of ethnicity coding (-2%pts)
- Targeted support for relevant families to attend clinic (-1%pt)
- Adequately resourced teams to provide targeted support and intervention (-0.5pt)

Data provided by Data provided by the Children and Young People's NENC Diabetes Network

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

% of children and young people with diabetes accessing hybrid loop technology – Inequality gap by Deprivation



The waterfall chart shown to the left shows the inequality gap between children of white ethnicity and children of other ethnic communities receiving all six care processes for Type 1 Diabetes in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to reduce the inequality gap by ethnicity from 3.5%pts to zero. In order to do so, the following interventions will be delivered with the **estimated** following impact;

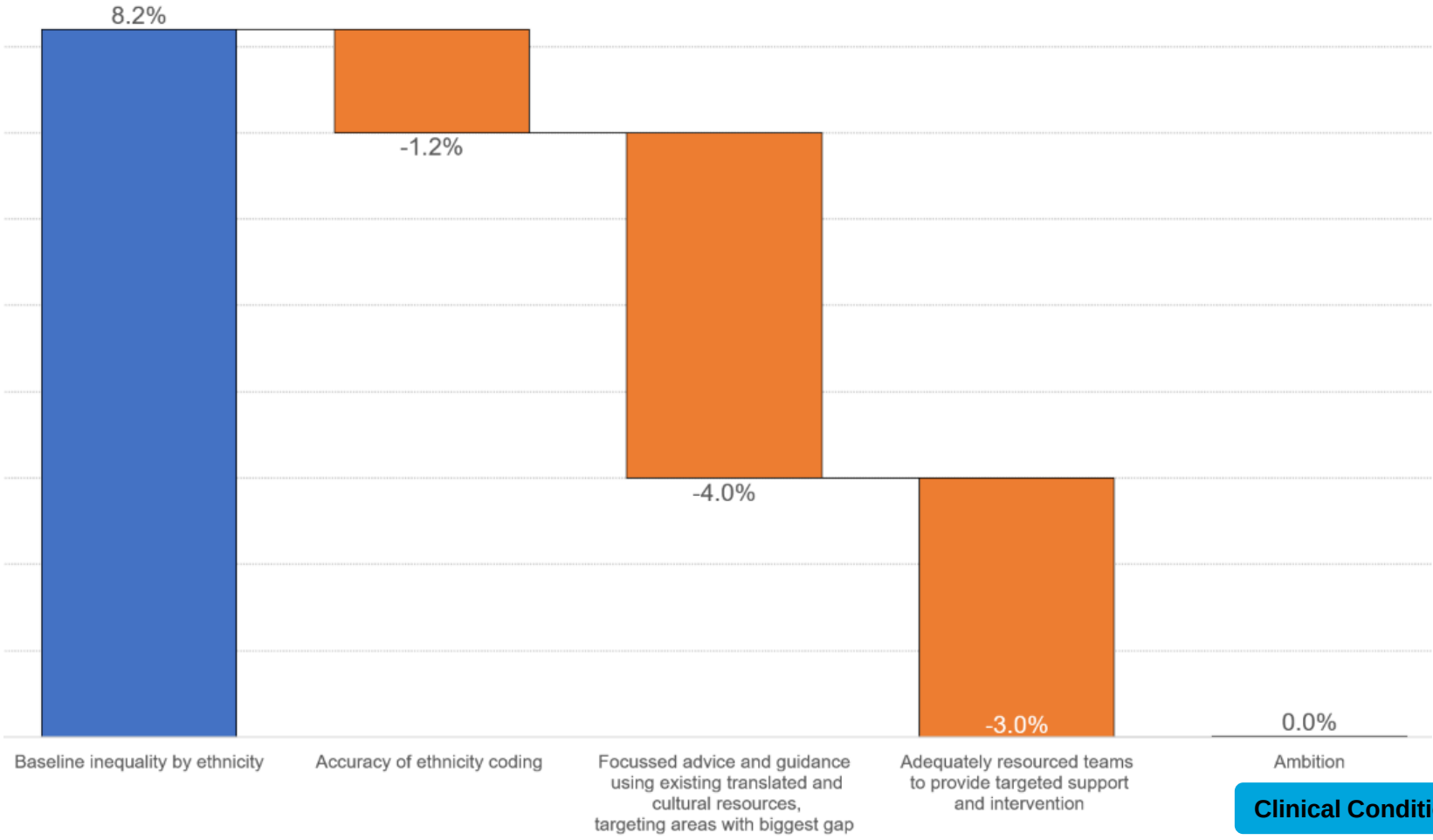
- Accuracy of ethnicity coding (-4%pts)
- Targeted support for relevant families to attend clinic (-4%pts)
- Adequately resourced teams to provide targeted support and intervention (-1.7%pts)

Data provided by Data provided by the Children and Young People's NENC Diabetes Network

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

% of children and young people with diabetes accessing hybrid loop technology – Inequality gap by Ethnicity



The waterfall chart shown to the left shows the inequality gap between children of white ethnicity and children of other ethnic communities for access to hybrid closed loop technology in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to reduce the inequality gap by ethnicity from 8.2%pts to zero. In order to do so, the following interventions will be delivered with the **estimated** following impact;

- Accuracy of ethnicity coding (-1.2%pts)
- Focussed advice and guidance using existing translated and cultural resources, targeting areas with biggest gap (-4%pts)
- Adequately resourced teams to provide targeted support and intervention (-3%pts)

Data provided by Data provided by the Children and Young People's NENC Diabetes Network

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

CYP Oral Health

Data Position

The Core20PLUS5 framework for children and young people includes a specific aim to reduce the back log for tooth extractions in hospital. This indicator was previously being reported using hospital admission data (SUS), specific to a procedures coded as ‘Tooth extraction’. Upon further consultation with the Executive and colleagues who are leading on the Oral health agenda, we have been advised that this data is not fully inclusive of all activity, therefore not providing a true representation of the position in NENC.

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

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

The causes for the inequality gap

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

The work being undertaken to address the gap

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

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

Plans for narrowing the gap

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

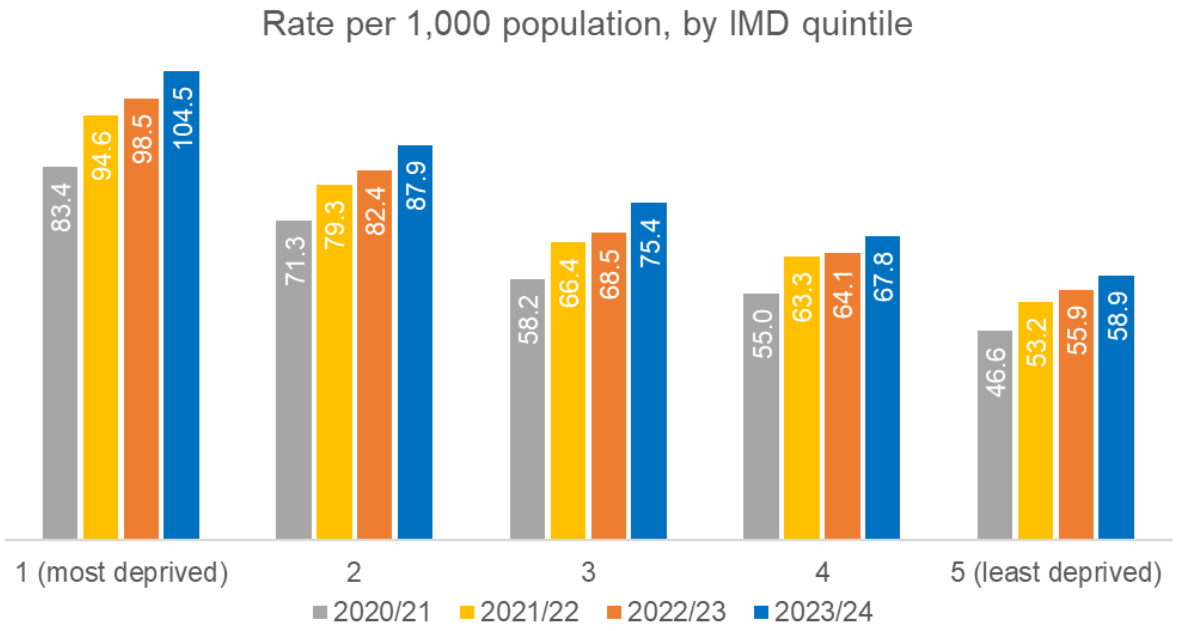
Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

CYP access to Mental Health Services

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

	2022/23	2023/24	Trend (last 3 reporting periods)
NENC ICB position	92	99	↑
Most deprived 20% position	98.5	104.5	↑
Least Deprived 20% position	55.9	58.9	↑

Data Source: Mental Health Bulletin - NHS Digital [accessed February 2025]
Reporting Period: 2024/25



North East North Cumbria Health & Care Partnership

The data included in this report has been taken from published NHS Digital Mental health bulletin dashboard. The data relates to 2022/23 and 2023/24 activity, reporting the crude rate of access at ICB level and how that is reflected in the most and least deprived communities.

In 2023/24 there were 53,740 children and young people referred to mental health services who had at least 1 contact, an increase compared with previous years.

The rate within the most deprived communities (IMD 1&2) is shown to be higher than the rate within the least deprived and both continue to show a year-on-year increase in line with national expectations. However, access within the least deprived communities was shown to have increased at twice the rate of the most deprived communities in 2022/23 and 2023/24.

The rate of access for non-white ethnic children continues to increase at a greater rate than that of children of white ethnicity.

Without understanding the prevalence of need within each of the communities, it is difficult to determine if the rate of access is reflective of the needs within the population. We can determine that children from all communities continue to access CYP mental health services and there does not appear to be any stark inequalities based upon this data.

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Mental Health

The causes for the inequality gap

- The ICB over position for the 2021/22 period was 89 per 1,000 population, equating to 51,545 individuals. This increased to 92 per 1,000 population (53,570 individuals) in 2022/23. For the 2024/25 operational plan, the NENC baseline was set at 57,205, with a target to reach 59,632. This target represents the NENC ICB's share of the national goal, which is set at 60,897.
- Above is the final ICB operational planning submissions. Please refer to slide 37, which focuses on Mental Health (MH) access for children and young people (CYP). This slide specifically addresses the number of CYP under the age of 18 who have been supported through NHS-funded mental health services, ensuring they receive at least one contact

The work being undertaken to address the gap

- There is recognition, that we have a higher number of children accessing services from lower deprived areas.
- The NENC MH Performance Overview Group recently undertook a deep dive into Children's and Young People's services across the NENC footprint and involved all key partners including commissioners and partners. A number of key themes emerged from this work including:
- High numbers of long waiters – specifically in relation to neurodevelopment pathways and in the main ADHD. Waiting times do vary across providers and place.
- Referral numbers have significantly increased; this increase began shortly before the Covid-19 pandemic and has continued to grow.
- Place and providers have differing models and pathways which results in differing data capture and analytics.
- Whilst the deep dive did not specifically focus on health inequalities, there is recognition across all partners there can be stark difference in the demographics of patients presenting and services need to ensure that they are accessible to all.
- Anecdotal feedback has been collected and has indicated that children and young people:

  "don’t always have someone to talk to about how they are feeling"

  "its not always clear who is going to talk to you"

  "my mum gets wrong if I'm not in school"
- This feedback highlights that as a system we need to make it easier to access help and They highlighted as part of the active listening event, that it needs to be easier to get help, and ensure that it is made clear which team will be supporting the individual.

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Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

Plans for narrowing the gap

- Following the deep dive referenced above, a system wide recovery plan is in development. The plan will draw upon areas of existing good practice that can be rolled out further but also include reviewing delivery models for standardisation (where appropriate) and ensure wider system integration; working with key partners such as Mental Health Support Teams in schools and local VCSE organisations, which can draw upon the knowledge of our local communities and identify and work to overcome any barriers relating to access to ensure that those CYPS who need support are signposted and encouraged to seek help.
- Work is already underway from a place perspective and includes the consideration of a single point of access for children's mental health services in North Cumbria perspective as well as potentially extending the Barnardos Link Worker service in GP Practices. Alongside this, a new Needs Led assessment template is currently being piloted for Neurodiversity within North Cumbria Integrated Care Trust. This is linked to the implementation of the Portsmouth Model in North Cumbria.
- North Tyneside has a Neurodiversity Transformation Programme called 'Think Differently' led by the Local Authority which aims to support and drive the transformation of services to ensure that the needs of children with neurodiverse needs are better supported to thrive at home, at school and in the community. A symposium event was held in November 2023 where priorities for the work programme were agreed with an emphasis on services across our local system working together, clarity over what is already available and supporting schools. all-age task and finish groups have been established to agree a model and effect change in North Tyneside.
- In Sunderland and South Tyneside, work has commenced with deep end surgeries across to target children with evidence of significant early year trauma, who are supported through deep end surgeries, whilst this is in initial stages earlier pilots have been positive.
- Across NENC we have significant coverage of schools who have access to a Mental Health Support Teams (MHST). The MHSTS are widely established and deliver evidence-based interventions for mild to moderate mental health issues. They are also heavily linked into formal specialist mental health services so that children and young people get access to the right support at the time that it is needed. As there is wide coverage across our footprint the teams can work with people from all IMD areas thus reducing potential inequality gaps.
- There are recognised national pressures in relation to capacity and demand resulting in extremely long waiting times within Neurodevelopmental pathways. As such NENC have mobilised an all age ADHD & Autism pathway transformation project to understand the cause driving the pressures in these pathways as well as looking at remedial actions to improve performance and reduce the significant waiting times to ensure equitable access for all.

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

CYP Epilepsy

Data Position

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

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

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

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

The causes for the inequality gap

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

The work being undertaken to address the gap

- A scheme of work has been undertaken since 2021 to support the delivery of improvements in paediatric epilepsy provision with a particular focus on narrowing the gap for those young people who are most vulnerable.
- Initial baselining work with published report, scoping of current position and identifying and escalating local challenges, understanding local need
- Education and awareness training for trainees, nurses and consultants through Paediatric Epilepsy Network North East and Cumbria (PENNEC) education forum and Child Health and Wellbeing Network (CHWN) online Huddle webinars
- Delivery of education opportunities to South Tees HealthStarters, Operational Delivery Network (ODN), education staff, Healthier Together Champions, Primary Care (collaboration session with adult epilepsy colleagues), and Tees Valley Managed Clinical Network Study Day
- Establishment and ongoing facilitation of the multi-agency PENNEC Alliance
- Education and capacity building in wider community through Alliance and the Mental Health mapping project (families to be supported in the community to reduce the need to access urgent care as needs are better managed)
- Islacare digital file transfer pilot to expedite diagnosis, support ongoing management and improve experience and outcomes
- NHS England CYP Transformation Programme Epilepsy Specialist Nurse (ESN) pilot - increased local capacity to enable resources to target those most vulnerable and to reduce variation and address health inequalities in local population. All but one secondary care services in NENC have access to Paediatric ESN

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Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

- Implementation of the interim Regional ESN Lead role to develop and embed pathways (secondary to tertiary, healthcare transition, referral to statutory mental health services) and to champion the ESN role
- NENC Healthier Together epilepsy information has been developed and published, signposting to credible national resources
- Youth Mental Health First Aid (YMHFA) training for ESNs and secondary care teams has been offered and taken up by 3 Trusts with follow up training being planned
- Roll out of the National Epilepsy Care Bundle (NECB) published Oct 23
- Service Improvement Planning programme locally with Trusts to improve access for CYP and to facilitate delivery of the NECB requirements (all 8 services completed Oct 24)
- Developing comprehensive care plan template
- Work with all age NENC Learning Disability Network on transitions (developmentally appropriate healthcare) implementation of the NENC pathway (NENC Regional Transitions Core Steering Group)
- Core 20 projects focussing on CYPwE and Learning Disability (LD) or Special Educational Needs (SEND) CYPwE and Mental Health (MH) needs and CYPwE from black minority ethnic (BME) communities is currently underway
- Education has been delivered across NENC, including HealthStarters, Operational Delivery Network (ODN), Education, HT Champions, Primary Care session (collaboration with adults epilepsy colleagues), Tees Valley Managed Clinical Network Study Day
- Working with scientific researcher who is looking at epilepsy and inequality across the country share our learning and collaborate on local projects
- Establishment of NEY HT Group for Epilepsy resources
- Sharing (and taking) learning through North East and Yorkshire Regional Epilepsy Leadership Group
- NENC are represented within the OPEN UK national forum which enables opportunity to share learning and participate and engage
- Clinical Lead is a member of the Epilepsy 12 National Audit Project Group and contributes to the building and content of the Audit project. LD metrics (ESN access) are currently being considered to be part of Epilepsy 12 outcomes and be included into the next cycle of the audit

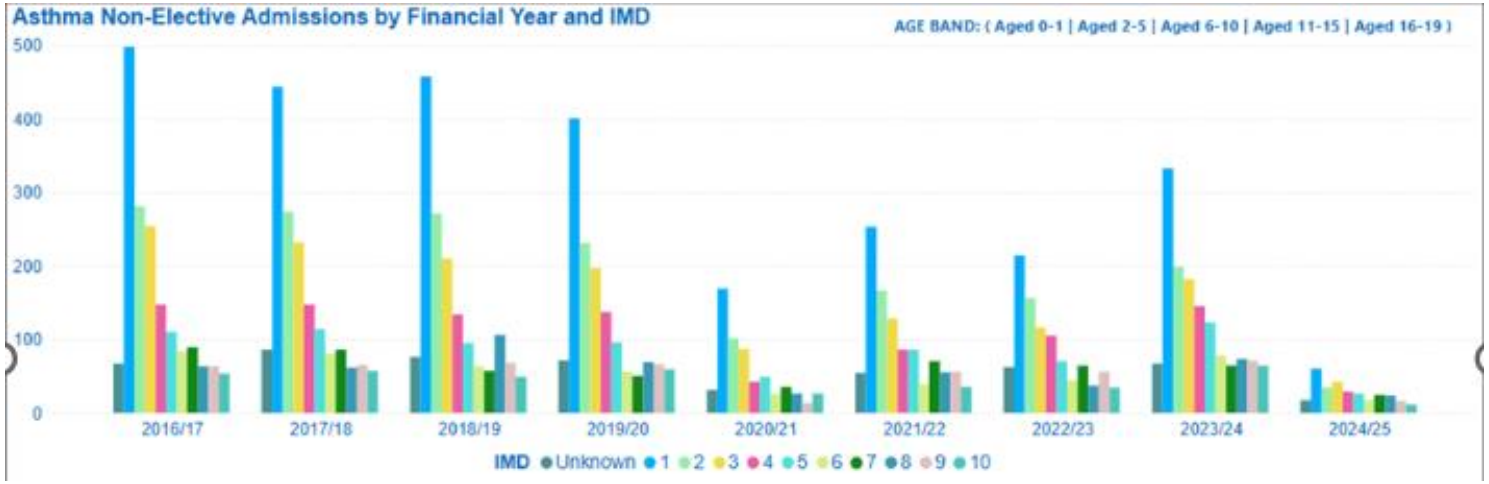
Plans for narrowing the gap

- Continue the roll out of the NECB
- Continue localised Service Improvement planning incorporating Health Inequalities focus. This will provide opportunity to measure the impact of the interventions and how we are narrowing that gap
- Implement the following Healthier and Fairer funded Paediatric Epilepsy projects:
- ESN - recruitment of an additional 1.0 wte ESN/RCN with Learning Disability interest to increase the overall clinical capacity which could be implemented at sites in the region (1.0wte could be shared between one or more sites)
- Children's Wellbeing Practitioner – this initiative will support with development of the epilepsy multidisciplinary team, which will redistribute and free up capacity within teams to enable ESN input to be targeted and delivered to those more vulnerable groups
- Continue to deliver education and signposting/top tips re paediatric epilepsy
- Work with services to ensure that CYP are seen by professionals with appropriate knowledge and skill to effectively manage their condition to reduce the potential for non-elective admission, targeting resources where it is most needed. This includes role definition and consensus agreement on skills and competency regarding Paediatrician with Expertise in Epilepsy (PwEE) and also regarding wider enquiry re ESN:Paed Patient ratio
- Championing the requirements of the Paed Epilepsy BPT 23-25NPS Annex DpC Guidance on best practice tariffs (see page 79)
- Establishment of NEY and NENC ESN Community of Practice

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

CYP Asthma

Number of non-elective Asthma admissions in NENC by IMD



Data Source: NHSE CYP Transformation Programme BI dashboard
Reporting Period: 2016/17 – 2024/25 (YTD)

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

The graph (left) shows a snapshot of the non-elective admissions data, by IMD over time from the NHS England CYP Transformation Programme BI dashboard.

The overall number of asthma admissions have reduced over time, particularly in the most deprived 10%. In 20/21, out of total unplanned paediatric asthma admissions, 44.6% were CYP from IMD 1 and 2 i.e. the most deprived deciles.

In 24/25 year to date up to end Sept 24, only 31.4% were CYP from IMD 1 and 2. This demonstrates a reduction in the deprivation inequalities gap over the previous 5-year period, however the gap may have reduced slightly as a result of an increase in the least deprived decile.

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

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

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Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

The causes for the inequality gap

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

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Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

The work being undertaken to address the gap

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

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Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

Plans for narrowing the gap

- Continue BAFS/BAFC roll out and ensure that we are capturing and monitoring health inequalities and demographic data re school/community group populations – we have a record and spreadsheet to capture local demography
- Continue BAFH development work in collaboration with the North East Housing Partnership and Making Every Contact Count (MECC)
- Consideration underway regarding smoking cessation voucher prescribing for secondary care
- Continue targeted intervention into GP practices based on relatively higher rates of admission in relation to population of CYP with asthma as primary diagnosis (outlying practices have been identified)
- Work with partners to establish primary care RAIDR dataflow regarding Personalised Asthma Action Plan (PAAP) / PAAP Review and 2-day review
- Sunderland pilot (bid through Healthy City grant) being explored in collaboration with Sunderland Public Health teams and Sunderland West PCN, which is a deprived area with many socioeconomic challenges and high rates of admission (funding secured October 2024)
- Work with Primary Care to improve uptake of annual asthma review with a focus on vulnerable groups
- Review QUOF coding regarding exemptions

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Giving Children and Young People a better start in Life
National guidance	CYP Core20PLUS5
Lead Team	Child Health and Wellbeing Network

Adult Diabetes

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

		2022/23	2023/24	Trend
Type 1 Diabetes	NENC ICB position	41.7%	41.6%	↓
	England Position	42.8%	44.3%	↑
	NENC Slope index of inequality	11.9	14.3	↑
	England Slope index of inequality	9.6	9.4	↓
Type 2 Diabetes	NENC ICB position	56.9%	60.0%	↑
	England Position	57.9%	62.3%	↑
	NENC Slope index of inequality	12.4	12.5	↑
	England Slope index of inequality	6.7	6.9	↑

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

The data relating to Diabetic patients receiving all 8 care processes is taken from NHSE Health inequalities data on diabetes (NHS Futures platform), reflecting the latest reporting period.

The methodology for the metric on 8 care processes has changed since the previous report but the previous year's data has been included for comparison. The reason for the methodology change is due to the availability of new data via NHSE.

The proportion of type 1 diabetics in NENC who received all 8 care processes in 2023/24 is 41.6%, a reduction compared with the previous year. This is considerably lower than the England average and following an opposite trend.

Not only is the overall proportion lower in NENC, but the inequalities are also broader than the England average. The slope index of inequality (a calculation which measures the breadth of the inequality gap) was 14.3 in NENC compared with 9.6 across England. The inequality gap also increased at a greater rate within the ICB compared with the last reporting period.

Adult Diabetes

% of newly diagnosed Type 2 diabetics referred to Structured Education – by deprivation/ % of newly diagnosed Type 2 diabetics attending Structured Education – by deprivation

		May 2024	November 2024	Trend
Referred to Structured Education	NENC ICB position	48%	47%	↓
	Most deprived position	31%	47%	↑
	Least deprived position	23%	52%	↑
Attended Structured education	NENC ICB position	4%	9%	↑
	Most deprived position	3%	4%	↑
	Least deprived position	4%	7%	↑

Data Source: NENC Diabetes dashboard
Reporting Period: 2023/24

The data relating to Structured Education is taken from the NENC Diabetes dashboard..

The NENC ICB percentage of Type 2 diabetics receiving all 8 care processes in 2023/24 increased compared with the previous year. The ICB attainment remains below the England average. However, the inequality gap both locally and nationally increased between 2022/23 and 2023/24, highlighting that a smaller percentage of individuals from the most deprived communities are receiving 8 care processes compared with those from the least deprived.

Based upon the latest reporting period (December 2023 – November 2024) there has been 7,254 individuals from the most deprived communities newly diagnosed with type 2 diabetes. Of those, 3,376 (47%) were referred for Structured Education but only 276 (4%) attended. Fewer people from the least deprived communities were newly diagnosed (2,032) but a greater proportion were referred for structured education (52%).

Of the 2,032 newly diagnosed individuals from the least deprived communities, 152 (7%) attended Structured education, a greater proportion compared with the most deprived communities.

The causes for the inequality gap

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

The work being undertaken to address the gap:

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

Plans for narrowing the gap

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

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

Elective Recovery

% of elective waiting list waiting 18/ 52/ 65+ weeks

		January 2024	January 2025	Trend
18 week waiters	NENC ICB position	33.1%	33.1%	↔
	Inequality gap by deprivation	0.7%pt	0.2%pt	↓
	Inequality gap by ethnicity	-0.5%pt	-0.8%pts	↓
52 week waiters	NENC ICB position	2.6%	1.5%	↓
	Inequality gap by deprivation	0.1%pt	-0.3%pts	↓
	Inequality gap by ethnicity	-0.1pt	0	↑
65 week waiters	NENC ICB position	0.3%	0.1%	↓
	Inequality gap by deprivation	-0.1%pt	0	↑
	Inequality gap by ethnicity	0	0	↔

Data Source: Referral to Treatment data
Reporting Period: January 2025

The data included for Elective recovery has been taken from the Referral to treatment data for NENC, January 2025

33% of patients awaiting an elective procedure within the ICB have waited 18 weeks or more, no change since the last reporting period. The current position for 18 week waits shows a small but insignificant inequality gap by deprivation and an inverse inequality by ethnicity, meaning a smaller proportion of people of non-white ethnicity are waiting longer than 18 weeks compared with people of white ethnicity.

The proportion of people waiting longer than 52 or 65 weeks has reduced again compared with the last reporting period, with less than 0.5% across the ICB waiting more than 65 weeks. There are no apparent inequalities in long waiter by IMD or ethnicity.
There is continues to be significant variation in waits by Provider, potentially highlighting geographic inequalities. South Tees and North Cumbria Foundation trusts continue to report the highest proportion of 18 week waits and both have seen an increase since last reporting period.

The causes for the inequality gap

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

The work being undertaken to address the gap

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

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Core20PLUS5 / NHS Legal Statement
Lead Team	Long Term Conditions

Plans for narrowing the gap

- Further work with both the Theatres & Peri Op Group and Waiting Well with the support of RAIDR to link information into providers for effective scheduling, booking and validating of patients on Elective waiting lists
- Further work with Clinical Alliances and Elective Care Sub-groups, will focus on delivery of equitable care across the system collectively, for example:

  - reviewing access policies across the system

  - developing early risk assessments to support patients for planned surgery.

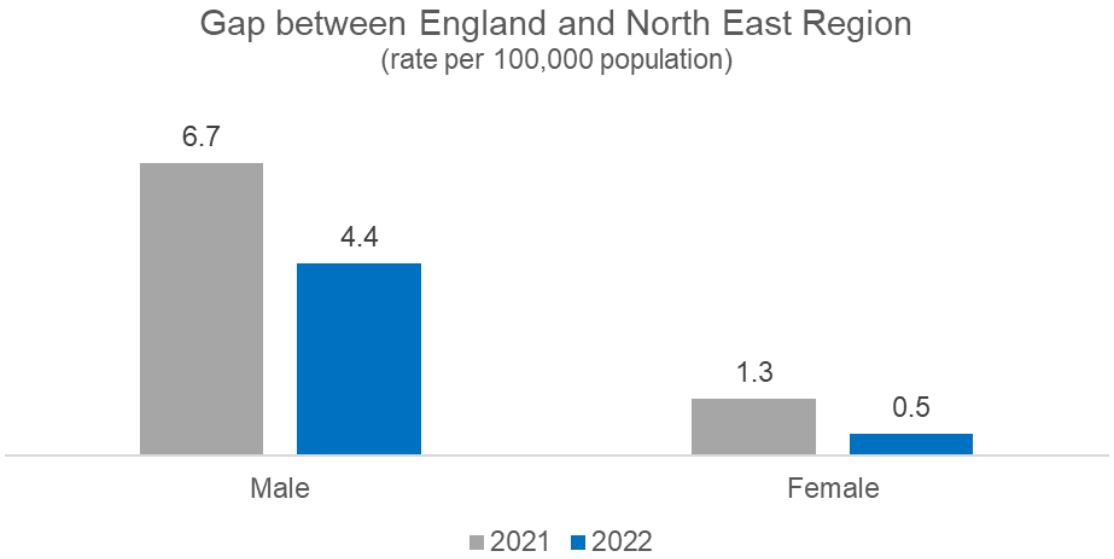
  - implementing single points of access across the system for specialties such as MSK and Eye Care.
- Work with analysts to identify at a more granular level, differentials related to ethnicity or other protected characteristics.
- MSCG to continue to review longest waiters and particular cohorts of patients under significant pressure. Regular monitoring of provider waiting lists and tracking of patient movement across the system as a whole to continue to be undertaken and refined.
- Approaching missed appointments via an inequalities lense, including different models of delivery such as evening and weekend appointments to help to ensure that services are more accessible and consideration of specialist CYP days such as 'Operation Tooth Fairy'.
- Communication campaigns for patients to promote support available for patients to access care.

Deaths by Suicide

Rate of deaths by Suicide per 100,000 population

	2021	2022	Trend
NENC ICB position	15.1	13.7	↓
England position	11.2	11.3	↑
Gap between England and NENC	3.9	2.4	↓
NENC Male	23.5	21.4	↓
England Male	16.8	17	↑
Male gap between England and NENC	6.7	4.4	↓
NENC Female	7.2	6.4	↓
England Female	5.9	5.9	↔
Female gap between England and NENC	1.3	0.5	↓

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



The suicide rate in the North East region varies by gender with the rate in males significantly higher than the rate in females. However, there is gap between region 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 North East Region and the England average.

The data included above is ONS data and includes all deaths by misadventure determined by the coroner. This relates to both confirmed and suspected suicides, representing the broader impact rather than just deaths which are absolutely suicide.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome — Longer and Healthier Lives
National guidance
Lead Team — Long Term Conditions

Mental Health Act Detentions

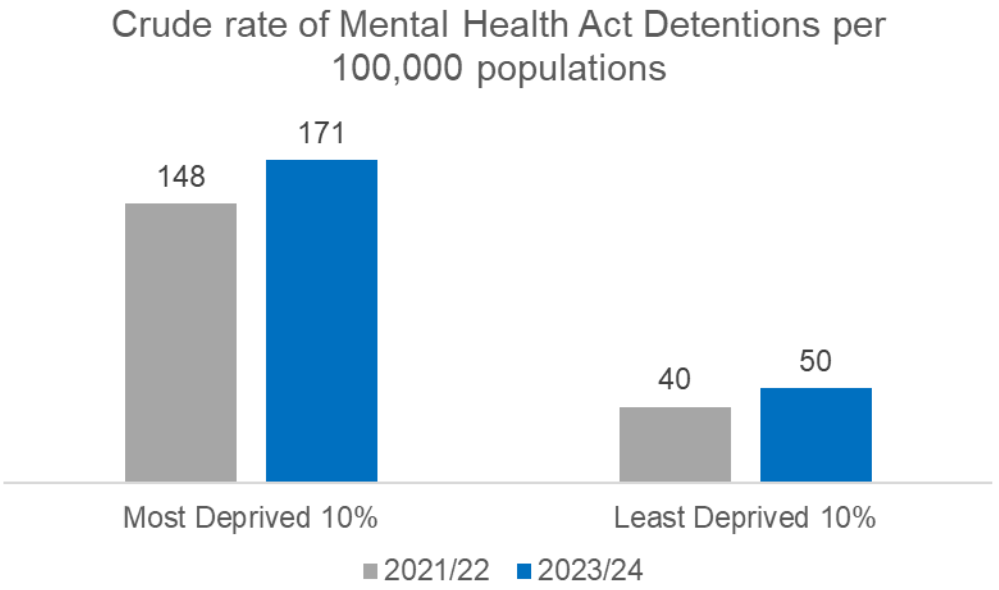
Crude rate of Mental Health Act Detentions per 100,000 populations

	2021/22	2023/24	Trend
NENC ICB Position	100	101.5	↑
NENC Most deprived (10%)	148	171	↑
England Most deprived (10%)	153	151	↓
NENC Least deprived (10%)	40	50	↑
England Least deprived (10%)	42.1	43.4	↑
NENC White ethnicity	93.9	95	↑
England White ethnicity	68.5	69.5	↑
NENC non-white ethnicity**	237.7	292	↑
England non-white ethnicity	246.3	239	↓

Data Source: NHS Digital, Mental Health Act Time series Dashboard [accessed February 2025]
Reporting Period: 2023/24

The data included above is taken from the most recently available Mental Health Act statistics from NHS Digital and related to 2023/24.

During the latest period there were 3,050 reported mental health act detentions within NENC. Equating to a rate of 101.5 per 100,000 population. A slight increase compared with previous years.



The rate for those residing within the most deprived communities (10%) is significantly greater than the rate in the least deprived. It is not possible to determine whether this is positive or negative and it may simply highlight a greater need for these interventions with the most deprived communities.

The inequality gap between the most and least deprived has reduced this reporting period from 128 per 100,000 population to 121. The gap remains broader than the England average.

The rate for those within ethnic minority communities is significantly greater than the rate for those of white ethnicity. The numbers within the non-white ethnicity categories are small and susceptible to large fluctuations in rate with the slightest change in count.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Legal Statement
Lead Team	Long Term Conditions

Causes for the inequality gap

There are significant social stressors involved with living in poverty which contribute to poor mental health and increase the likelihood of admission. There are additional barriers faced by those from black and minoritised ethnic backgrounds in accessing preventative services, such as possible language barriers within the system, previous poor health, and care experiences, as well as an increased likelihood of living in poverty and the social stressors which come with this. Experiences of racism on an individual and system level will compound these. Within NENC we have an established Inpatient Quality Transformation Programme and this works in partnership with all our local authorities.

Generally mental health admissions rates have reduced across the region since 2019/2020. However, we do not that there are consistently higher admission rates in Tees Valley and County Durham than the rest of the region (reporting period 2019-2024).

The work being undertaken to address the Gap

There are a number of direct and indirect work programmes underway which should support the gap reduction in this area. Examples are provided below:

- TEWV have a dedicated BAME link worker.
- There are numerous VCSE organisations and groups working specifically with minoritised ethnic groups in our area. These include (but are not limited to) JET North, Action Foundation, North East Refugee Service, Holding Hands and the Gateshead Ethnic Minorities Support Group. Whilst these groups do not provide specific mental health support, they are a vital resource in ensuring people from minoritised ethnic backgrounds are supported to access welfare advice and preventative and early intervention services, including GP surgeries. It is anticipated that this level of support will reduce additional stressors on people and not exacerbate any mental conditions which could re4sult in a hospital admission.
- The Inpatient Quality Transformation Programme completed a bed census in September 2024. Further work is planned to analyse data specific to deprivation and ethnically and culturally diverse populations in relation to MHA detentions. This will enable us to better understand both the current position and the reasons for any inequalities.
- The Key principles of the IPQT include services being 'equitable' which means personalised care, needs led and culturally safe. The Culture of Care Programme has sign up from all NHS providers and some Independent Sector providers within the region.
- Community scaffolding services have been commissioned to offer alternatives for help rather than reaching crisis point and requiring hospital admission or detention.
- Provision of a six-bed crisis house which offers step up step down and a number of drop-in support sessions in various areas around West Cumbria which offers support with mental health. There are 1:1 sessions offered by the third-sector provider.
- Considering mobilising a third sector service to support people with mild learning disabilities and autism to transition from acute mental health wards to the community. This will support individuals to access appropriate support on discharge and hopefully prevent people returning to hospital inappropriately.

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Legal Statement
Lead Team	Long Term Conditions

Plans for Narrowing the Gap

There is an increase in the commissioning and use of Hub models, crisis cafes and alternatives to admission services which provide support and will be accessible to all members of the community.

There is a plan to launch a regional Mental Health Dashboard in 2025 to enable better understanding of the inpatient population over time and further our understanding of people from deprived and BAME communities and how this can impact on admission rates.

Providers are now using the Patient Carer Race Equality Framework (PCREF) to eliminate disparities in access, experience, and outcomes. The aim of this is to deliver culturally appropriate care and ultimately reduce any inequality gaps. Each of our local MH Foundation Trusts have an executive lead to drive this forward.

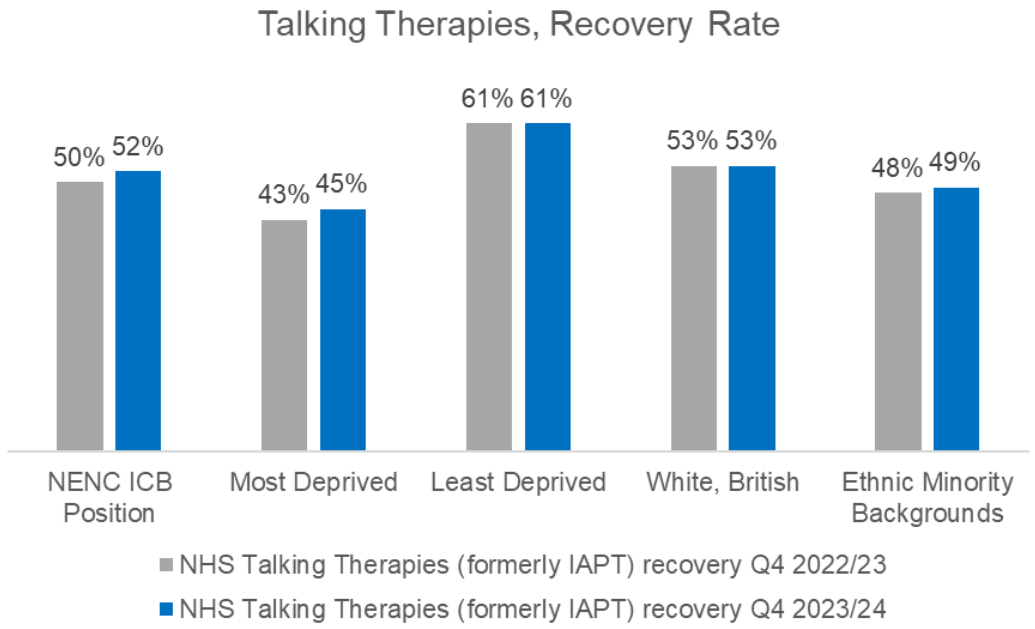
The ICB is developing and starting to socialise our intentions around trauma informed approaches which we could reasonably expect to have an impact on us better understanding the needs of our communities and considering the best approaches to make healthcare services accessible.

Talking Therapy Recovery Rate

Recovery rate from Talking Therapies

	2022/23	2023/24	Trend
NENC ICB position	50%	52%	↑
England position	*	50%	
NENC most deprived position	43%	45%	↑
NENC least deprived position	61%	61%	↔
NENC white ethnicity position	53%	53%	↔
NENC non-white	48%	49%	↑

Data Source: NHS Digital, Talking Therapy Annual Dashboards
Reporting Period: 2023/24



The data included here is taken from the most recently available Talking therapies data from NHS Digital. The data relates to the most recent annual statistics.

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 NENC recovery rate is shown to have increased in 2023/24 to 52%.

The recovery rate for patients from the 10% most deprived communities in 2023/24 is lower than the ICB average at 45%. This is an improvement compared with 2022/23. Patients from the least deprived communities, have a 61% recovery rate. There is a 15%pt inequality gap in recovery, this has reduced since last reporting period because of the improvement for those from the most deprived communities.

The recovery rate for patients from ethnic minority communities is also lower at 49%. Patients of white ethnicity, report a 53% recovery rate, leading to an inequality gap by ethnicity of 4%pts.

North East North Cumbria Health & Care Partnership

Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Legal Statement
Lead Team	Mental Health

The causes for the inequality gap

- At present, we have not been able to identify any specific causes which would account for the gap, however anecdotal feedback collected covers areas such as:
- Recognition that people from an ethnic background are less likely to seek support for the mental health and wellbeing issues and linked to this lack of a workforce that represents the diverse ethnic community.
- Accessibility for people who struggle with technology or written word.
- Understanding of the link between physical health / depression / anxiety
- Access to talking therapy support for people who are house bound.
- Non - Neurodivergent pathways
- These areas will be considered in the developing regional talking therapies project that is underway.

The work being undertaken to address the gap

The Mental Health Transformation Team are leading on reform of Talking Therapies is as follows:

- Seek to develop a standard service specification across the full ICB footprint.
- Review pathways for psychological support, to ensure people get to the most appropriate service to meet their needs when required
- Develop a contracting and procurement plan.
- Develop an interlinked commissioning and workforce transformation plan for 25/26 moving forwards, inclusive of identified SDF spend in 25/26.
- Consider and monitor the number of patients who withdraw from treatment and understand what drives this and whether adjustments need to be made to ensure people from all levels of deprivation and ethnicity feel supported to maintain engagement with their pathway.
- Development of a talking therapies recovery plan, covering key national metrics to ensure patients receive the best service available. This plan, will include reliable recovery and reliable improvement and where possible include this against patient demographics (ethnicity and deprivation)
- Introduction of dedicated learning disabilities pathways, to enable the person to remain engaged with the service throughout the pathway
- For older people there is now a dedicated pathway, to access talking therapy service to target people who would benefit from the approach.
- Establishment of a dedicated post linked with year of care reviews for people with long term conditions who can proactively seek out appropriate patients for Talking Therapies, ensuring equity of access from all IMD rates.

Plans for narrowing the gap

In addition to the above, work is underway at pace to improve performance and narrow any inequality gaps and include the commissioning of a specific element of talking therapies for Asylum seekers and refugees

North East North Cumbria Health & Care Partnership

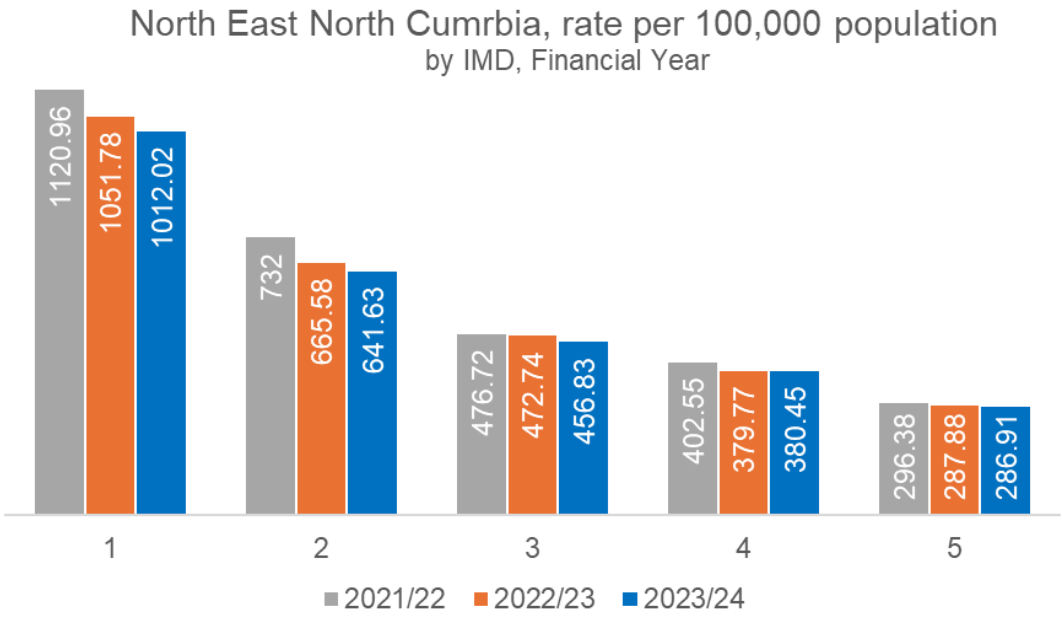
Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Legal Statement
Lead Team	Mental Health

Prevention – Alcohol Related Admissions

Rate of Alcohol Admissions per 100,000 population

	2021/22	2022/23	2023/24	**Trend** (last 3 years)
NENC ICB position	892	835	809	↓
Most Deprived 20% position	1121	1052	1012	↓
Least Deprived 20% position	296	288	287	↓

Data Source: NENC ICB Alcohol power BI Dashboard
Reporting Period: 2023/24



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

The latest full financial year (April 2023 – March 2024) reports a rate of 809 per 100,000 population which is a reduction compared with the previous year and a 9.3% reduction since 2021/22.

The admission rate within the most deprived communities (quintile 1 shown in figure 1) remains higher than the rate within the least deprived communities (quintile 5 shown in figure 1). However, since 2021/22 a greater % reduction in rate can be seen in the most deprived communities compared to the least.

For those in the most deprived communities, the rate of admissions has reduced by 9.7%.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Fairer Outcomes for All
National guidance	NHS Long Term Plan
Lead Team	Healthier and Fairer

The causes for the inequality gap

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

The work being undertaken to address the gap

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

Plans for narrowing the gap

- We will continue to build on this strategic approach to reduce alcohol harm and ensure that all projects in the alcohol programme workplan address health/healthcare inequalities. Anticipated projects for 25/26 include the development of a NENC strategic plan to support the prevention of alcohol harm in primary care, building on existing work that has already been successfully adopted by other partner organisations in our region, such as the Programme for Alcohol Studies, Alcohol Let's Talk initiative and Stigma Kills campaign, in addition to scaling up population health management projects that have been evaluated as pilots.
- It must be noted that the approach taken by NENC ICS Alcohol Programme focuses on the contribution that the NHS can make to preventing alcohol related harm, within the context of a complex system in which alcohol treatment is the responsibility of local authorities and is often provided by the VCSE sector. The rate of alcohol related admissions (and the most deprived decile within this indicator) is a broad population level indicator and is therefore influenced by many confounding factors within and beyond this care system.
- The NENC ICB contribution to improving 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.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome	Fairer Outcomes for All
National guidance	NHS Long Term Plan
Lead Team	Healthier and Fairer

Prevention – Tobacco Control

Reduce the rate and prevalence of Smoking

		2022	2023	Trend
Proportion of adult acute & mental health inpatient settings offering smoking cessation services	NENC ICB position	100%	100%	↔
Proportion of maternity inpatient settings offering smoking cessation services	NENC ICB position	100%	100%	↔
Reduce smoking from 13% of adults in 2020 to 5% or below	NENC ICB position	13%	10.9%	↓
	England Position	12.7%	11.6%	↓
	NENC Routine and Manual workers	21.5%	17.8%	↓
	England Routine and Manual workers	22.5%	19.5%	↓

Data Source:
PHE Fingertips – Smoking Profile
Reporting Period: 2023
Smoking cessations provided by local commissioners

The data included is taken from the official prevalence on smoking figures published within PHE Fingertip. The data source is the Annual Population Survey 2023, which is the nationally recommended source for smoking prevalence. The information relating to smoking cessation services has come local commissioners.

The official trend in smoking prevalence for NENC is significantly reducing from 15.7% in 2020 to 10.9% in 2023. This means NENC is no longer significantly higher than the England average in relation to smoking prevalence.

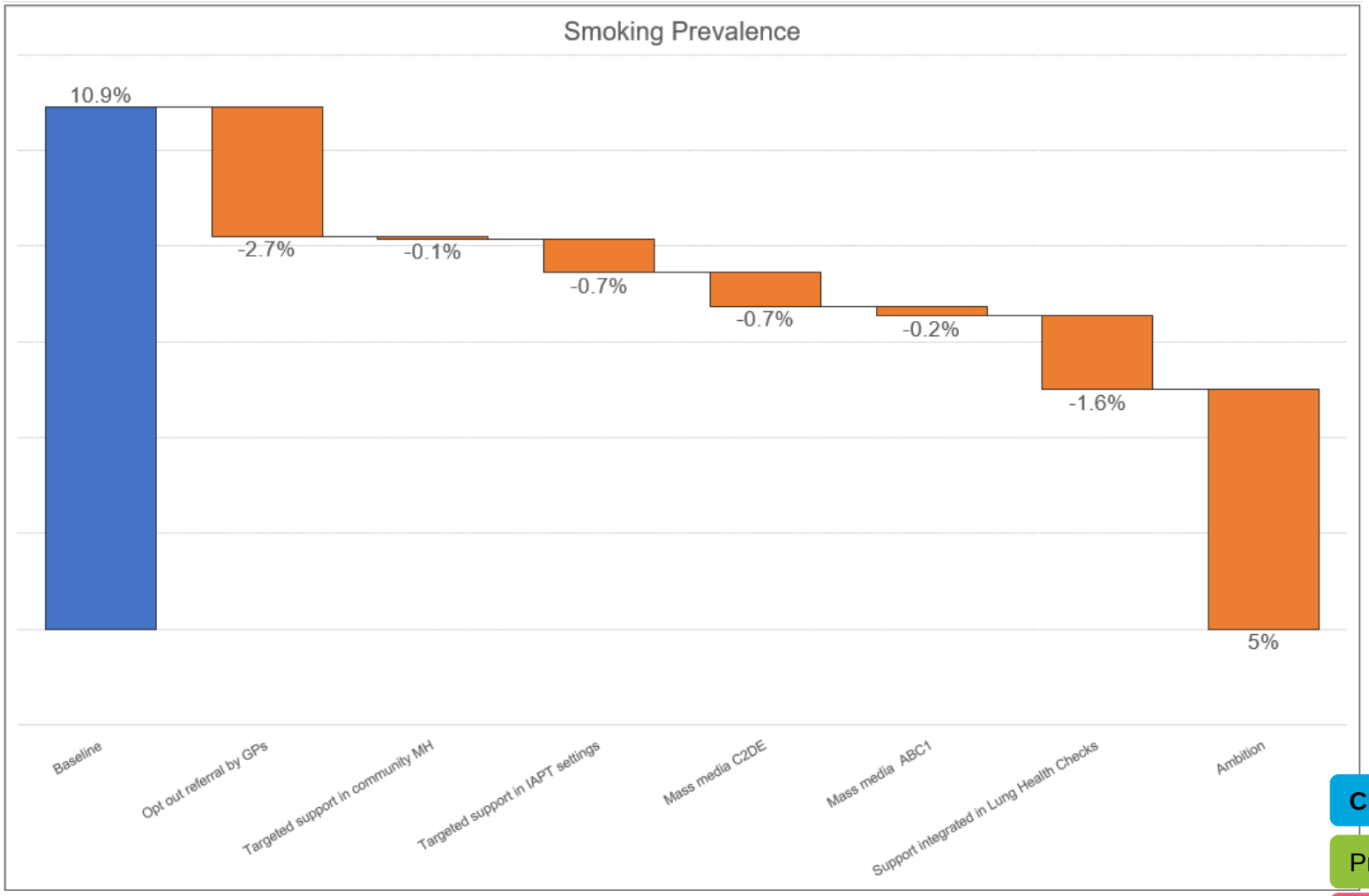
The official data is not segmented by deprivation at local level but it is segmented by socio-economic group and sex. By socioeconomic grouping, routine and manual workers are reported as having the higher prevalence of smoking at 17.9%, closely followed by those who have never worked or are in long term unemployment (17.4%). The prevalence in the routine and manual worker category has reported a stark reduction compared with the findings in 2022, reducing by 3.6%pts.

In contrast, 6.6% those employed within managerial and professional roles are reported as current smokers. This rate has not changed in the last 3 publications of the survey.

Clinical Conditions Strategic Plan measure

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Legal Statement
Lead Team	Healthier and Fairer

Smoking Prevalence



The waterfall chart shown to the left shows the Prevalence of smoking in NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream, as set out in the NENC joint strategic plan is to reduce the prevalence to 5%. In order to do so, an increase in the number of people offered stop smoking services and increasing the number of people quitting has been identified as the most effective method. The following interventions will be delivered with the **estimated** following impact;

- Opt out referrals by GPs (-2.7%pts)
- Targeted support in Community Mental Health Services (-0.1%pts)
- Targeted support in IAPT settings (-0.7%)
- Mass media campaigns (-0.9%pts)
- Support integrated in Lung Health Checks (-1.6%)

Clinical Conditions Strategic Plan measure

Primary ICB Outcome	Longer and Healthier Lives
National guidance	Legal Statement
Lead Team	Healthier and Fairer

North East North Cumbria Health & Care Partnership

Note on the data position

There are other measures that have direct impact on prevalence reduction not captured here such as impact of regional programmes like Fresh on illicit tobacco promotion & marketing; advocacy for legislation . The Latest research from UCL(2025) showed the NE had the fastest drop in adult smoking prevalence in England and regional tobacco control programme contributed to this. The NE is the only place that has maintained regional programme over the last two decades directly contributing to reducing the health inequalities gap

The causes for the inequality gap

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

The work being undertaken to address the gap

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

Plans for narrowing the gap

- The TDTS services funding mainstreamed and secured through existing contracts. Treating tobacco dependency embedded as routine clinical care led by Smokefree NHS Taskforce.
- Use data driven insights to improve quality and outcomes.
- Whole system approach (as per regional vision) - region wide tobacco control programme an approach through Fresh needs long term funding as this will have population wide impact on reducing adult smoking rates.
- There is recognition that the use of all tobacco dependency treatment services are by definition, proportionally universal, given the prevalence of tobacco is skewed towards lower socioeconomic communities and inclusion health groups.

North East North Cumbria Health & Care Partnership

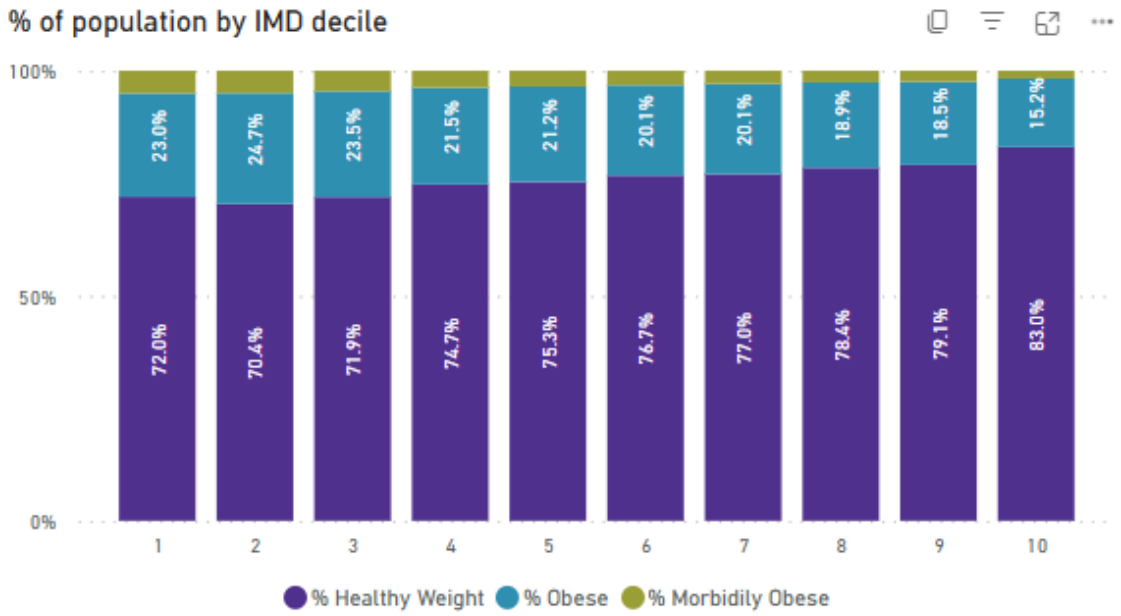
Clinical Conditions Strategic Plan measure	
Primary ICB Outcome	Longer and Healthier Lives
National guidance	Legal Statement
Lead Team	Healthier and Fairer

Prevention – Prevalence of Class III Obesity

Prevalence of Class III obesity by IMD

	December 2025	December 2025 (%)
NENC ICB position	96,868	3.8%
Most deprived communities' position	38,640	5.0%
Least deprived communities' position	7,208	2.2%

Data Source: NENC ICB Healthy Weight and Treating Obesity Power BI dashboard
Reporting Period: December 2025



The data included in this report is taken from the NENC Healthy weight and treating obesity dashboard. Almost 100,000 adults within NENC are classified as meeting the criteria for class iii obesity (BMI=>40). This equates to 3.8% of the population.

There are inequalities in the prevalence of class iii obesity by deprivation, ranging from 5% in the most deprived communities to 2.2% in the least deprived communities.

North East North Cumbria Health & Care Partnership

Primary ICB Outcome — Longer and Healthier Lives
National guidance
Lead Team — Healthier and Fairer

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.

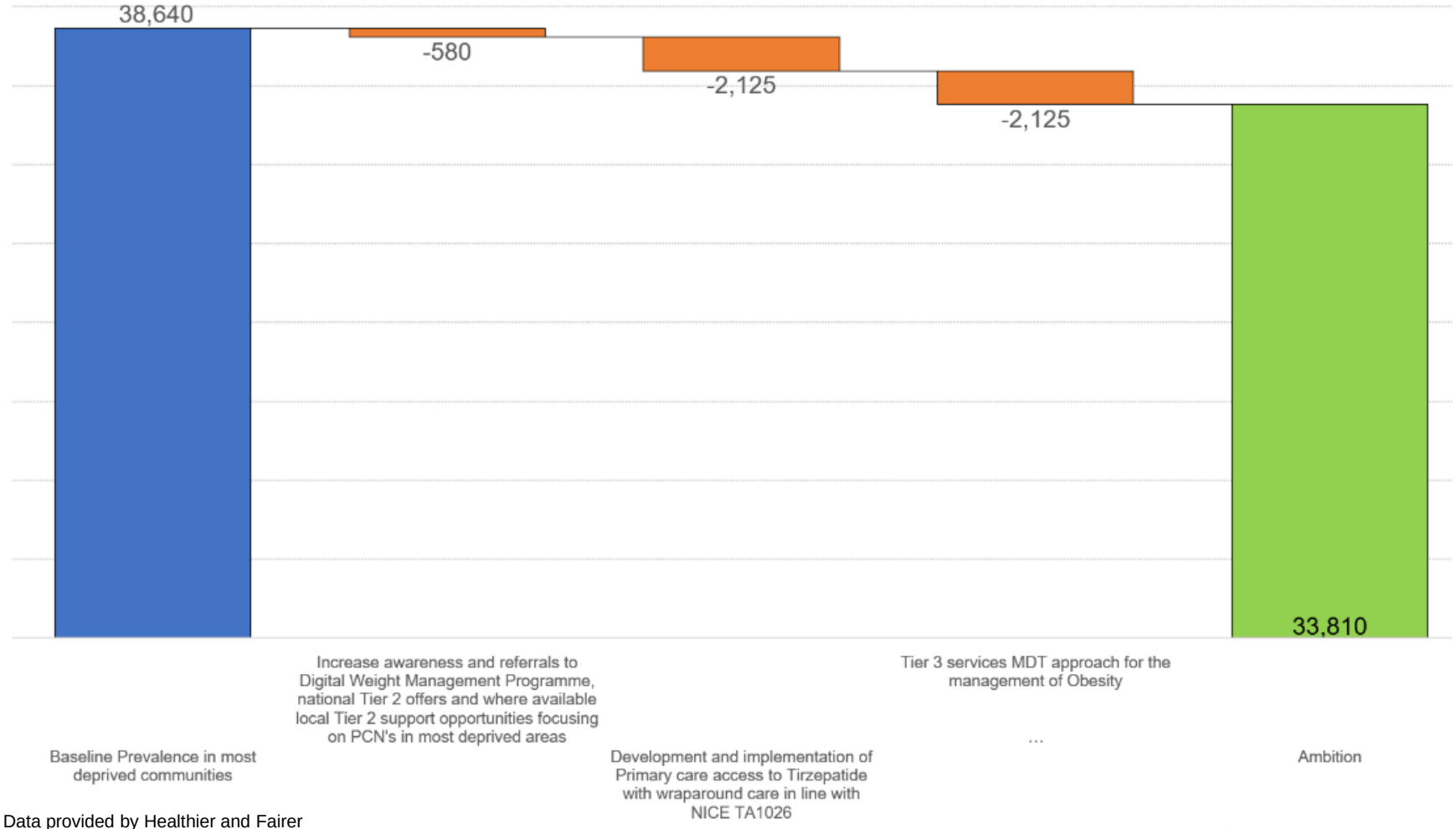
The work being undertaken to address the gap

- Healthy Weight and Treating Obesity Healthcare Needs Assessment to inform and support the ICS Healthy Weight and Treating Obesity Programme and strategic plans
- Development and implementation of 4 Strategic Themes that underpin the Healthy Weight and Treating Obesity Strategy, workstream and workplan.
- Whole System Approach
- Food Environment/Commercial Determinants
  - Service Provision
  - Workforce
- Working closely with PCN's across NENC to increase referrals to DWMP and weight management support services particularly in areas of deprivation
- Investment in specialist weight management services that meet policy minimum standards targeted at patients living in the 20% most deprived wards.
- Expanding access to Tier 3 services and introduction of prescribers to support GLP-1 prescribing in secondary care in line with NICE guidance.
- Launched online school of Healthy Weight and Treating Obesity to provide access to a range of nationally developed content along with locally developed content from specialists in Obesity to support current and future healthcare staff.

Plans for narrowing the gap

- Development and implementation of a NENC Whole Systems Approach for Healthy Weight and Treating Obesity across the ICB
- Launch of NENC Healthy Weight and Treating Obesity Strategy
- Working with NHSE to support rollout of NICE TA1026 for Tirzepatide within primary care
- Development of whole system pathway that will support primary prevention through to more intensive and specialised support.

Prevalence of Class III Obesity in Core20 population



Data provided by Healthier and Fairer

The waterfall chart shown to the left shows the prevalence of class III obesity (BMI>40) in the most deprived communities of NENC at baseline. It also includes the ambition set by the work stream and the interventions to be implemented in order to reach the ambition by 2030.

The ambition of the workstream is to reduce the prevalence of class III obesity 38,640 individuals to 33,810. In order to do so, the following interventions will be delivered with the **estimated** following impact;

- Increase awareness and referrals to Digital Weight Management Programme, national Tier 2 offers and where available local Tier 2 support opportunities focusing on PCN's in most deprived areas (-580 people)
- Development and implementation of Primary care access to Tirzepatide with wraparound care in line with NICE TA1026 (-2,125 people)
- Tier 3 services MDT approach for the management of Obesity Tier 3 services MDT approach along with prescribing of GLP-1 medications (-2,125 people)

North East North Cumbria Health & Care Partnership

Primary ICB Outcome — Longer and Healthier Lives

National guidance

Lead Team — Healthier and Fairer

Data Sources

Data Source	Link
Health Foundation - Health inequalities in 2040	Health inequalities in 2040 | The Health Foundation
NHSE Inequalities update	Health Inequalities - North East and Yorkshire Analytics - FutureNHS Collaboration Platform
CVD Prevent	Regional & ICS Insights | CVDPREVENT
NENC Healthier and Fairer Dashboard	Healthier and Fairer
NHSE CYP Diabetes dashboard	NPDA Dashboard
NHS Digital Mental Health Bulletin	Microsoft Power BI
NENC Diabetes Dashboard	NECS BI Portal
ONS Deaths from Suicide data	https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2022registrations
NHS Digital Mental Health act time series	Mental Health Act statistics - NHS England Digital
NHS Digital Talking Therapies	NHS Talking Therapies - NHS England Digital
NENC Alcohol Dashboard – Alcohol related admissions	Alcohol
PHE Fingertips - Smoking Profiles	https://fingertips.phe.org.uk/profile/tobacco-control
NENC Healthy Weight and Treating Obesity Dashboard	Healthy Weight.