Middlesbrough
moving forward

Legal and Governance

EXECUTIVE

Date: **Monday, 28 October 2024**
Time: **12.30 p.m.**
Venue: **Mandela Room, Town Hall**

AGENDA

1. Welcome and Fire Evacuation Procedure

   In the event the fire alarm sounds, attendees will be advised to evacuate the building via the nearest fire exit and assemble at the Bottle of Notes opposite MIMA.

2. Apologies for Absence

3. Declarations of Interest

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THE MAYOR AND EXECUTIVE MEMBER FOR ADULT SOCIAL CARE AND PUBLIC HEALTH

5. Health and Wellbeing Strategy 7 - 76

EXECUTIVE MEMBER FOR FINANCE AND GOVERNANCE

6. Household Support Fund 2024/2025 77 - 100

7. Any other urgent items which in the opinion of the Chair, may be considered.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Friday, 18 October 2024

MEMBERSHIP

Mayor C Cooke (Chair) and Councillors T Furness, P Gavigan, P Storey, J Thompson, Z Uddin and N Walker.

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Scott Bonner / Chris Lunn, 01642 729708 / 01642 729742, scott_bonner@middlesbrough.gov.uk / chris_lunn@middlesbrough.gov.uk

EXECUTIVE

A meeting of the Executive was held on Wednesday 2 October 2024.

PRESENT: Mayor C Cooke (Chair), Councillors T Furness, P Storey, J Thompson, Z Uddin and N Walker

ALSO IN ATTENDANCE: M Barker, B Carr.

OFFICERS: C Benjamin, S Bonner, R Brown, G Field, C Heaphy, R Horniman, J Savage and E Scollay

APOLOGIES FOR ABSENCE: Councillor P Gavigan

24/31 **DECLARATIONS OF INTEREST**

There were no declarations of interest received at this point in the meeting.

24/32 **MINUTES - EXECUTIVE - 4 SEPTEMBER 2024**

The Mayor advised he had approached the Director for Environment and Community Services for further information relating to Licences for Houses in Multiple Occupation.

The minutes of the Executive meeting held on 4 September 2024 were submitted and approved as a correct record.

24/33 **ADULT SOCIAL CARE RESIDENTIAL CHARGING POLICY**

The Mayor and Executive Member for Adult Social Care and Public and the Executive Member for Finance and Governance submitted a report for Executive consideration.

The report's purpose was to seek approval of the Residential Charging Policy.

Central Government provided Local Authorities with Statutory Guidance issued under the Care Act 2014 in respect of a single legal framework for charging for care and support under sections 14 and 17. The Act was supported by the Care and Support Regulations (Statutory Instruments) and Care and Support Guidance and Annexes issued under the Care Act 2014 which Local Authorities must follow when charging individuals for their care and support needs.

The Residential Charging Policy would ensure that the current process for charging was transparent and consistent. This policy would continue with the principle that residents should only be required to pay what they could afford and in turn, be entitled to financial support through a means tested financial assessment.

The policy set out procedures for claiming financial help with residential social care charges. The policy would safeguard the interest of local taxpayers by ensuring the financial assessment process would include a welfare benefit check to ensure full entitlement was claimed. This would be undertaken initially by the Financial Assessment Team and if necessary, Welfare Rights. This would ensure the cost of care to the Council is minimised should unclaimed benefits be identified.

An improvement to the application process had also been introduced for both residential and non-residential financial assessments. Using an e-form, financial assessment information was gathered quickly, and online which sped up the process for assessing the cost of care packages. This approach improved the governance process as the information was held centrally, and only information necessary to process the assessment was gathered. Consequently, this had reduced the need for visits to residential care homes which historically has been necessary to gather the relevant information. The approach was extremely effective and efficient.

Where service users were unable to access online solutions, the service continued to provide residential care visits for vulnerable groups.

ORDERED that:

1. **Executive approve the Residential Charging Policy to take effect from 7 October 2024.**
2. **Delegated authority to approve any future minor revisions/modifications is provided to the Director of Finance and the Director of Adult Social Care and Health Integration, and the Executive Member for Finance and Governance and the Executive Member of Adult Social Care and Public Health to maintain effective service delivery and reflect revisions brought about by regulatory and/or statutory guidance changes.**

OPTIONS

The Care Act 2014 provided a single legal framework for charging for care and support under Sections 14 and 17. It enabled a local authority to decide whether to charge a person when it was arranging to meet a person's care and support needs. The implementation of a Residential Charging Policy provided residents or service users with clear guidelines around the assessment process or how to appeal should they disagree with the assessment carried out therefore minimising the risk of challenge.

The Council did have the option not to implement a policy and do nothing. The Financial Assessment team would still work within the Care and Support Regulations (Statutory Instruments) and Care and Support Guidance and Support Annexes issued under the Care Act 2014 but may have been open to challenge by residents as no Policy would have been in place.

REASONS
The Policy was a key decision that impacted on two or more wards and as such required Executive approval.

The policy upheld good practice within democratic processes and enabled the proposed policy to maintain visibility with the Executive and provide residents with a clear understanding of how a stay in residential care would be assessed from a financial perspective.

The proposed policy would result in no changes to the threshold to services and support provided, however would further strengthen current working arrangements should any queries arise in respect of any financial assessment.

The proposed policy provided clarification to residents with simplified and clear details of how the income, savings and property would be financially assessed should an individual require care in a residential setting.

That delegated authority to approve any future minor revisions/modifications was provided to the Director of Finance and the Executive Member for Finance and Governance as well as the Director of Adult Social Care and Health Integration and Executive Member for Adult Social Care and Public Health to reflect revisions brought about by regulatory and/or statutory guidance changes.

24/34 **ANY OTHER URGENT ITEMS WHICH IN THE OPINION OF THE CHAIR, MAY BE CONSIDERED.**

The Mayor advised Executive that an additional meeting of Executive had been scheduled for the 28th October 2024 to consider reports on the Household Support Fund and the Linthorpe Road Cycle Lane.

A discussion took place regarding consultation with Executive Members when Executive meetings were arranged outside of the agreed schedule.

NOTED

The decisions will come into force after five working days following the day the decision was published unless the decision becomes subject to the call in procedures.

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MIDDLESBROUGH COUNCIL	Middlesbrough moving forward

Report of:	Director of Public Health South Tees
Relevant Executive Member:	The Mayor and Exec Member for Adult Social Care and Health Integration
Submitted to:	Executive
Date:	28 October 2024
Title:	Health and Wellbeing Strategy
Report for:	Information
Status:	Public
Council Plan priority:	A healthy place
Key decision:	No
Why:	Not applicable
Subject to call in?:	No
Why:	

Proposed decision(s)
That the Executive notes the Health and Wellbeing Strategy approved at Health and Wellbeing Board on 12th September 2024 in support of the delivery of the Council Plan (2024 – 2027)

Executive summary
The Health and Wellbeing Strategy is owned by Live Well South Tees (the Health and Wellbeing Board for South Tees) and is a partnership strategy that aims to tackle complicated issues that cannot be solved by any single agency. The nine missions described in the Strategy will contribute significantly to the delivery of the Council Plan (2024 – 2027).

1. Purpose

1.1. The Health and Wellbeing Strategy is owned by the multi-agency LiveWell South Tees Health and Wellbeing Board and is a statutory requirement. The Strategy is built around nine ambitious missions, each of which is supported by relevant goals that further articulate and explain the mission.

1.2. Approves the adoption of the Health and Wellbeing Strategy in support of the delivery of the Council Plan (2024 – 2027)

2. Recommendations

2.1. That the Executive approves the adoption of the Health and Wellbeing Strategy in support of the delivery of the Council Plan (2024 – 2027)

3. Rationale for the recommended decision(s)

3.1. LiveWell South Tees is a formal statutory committee of the Council, and provides a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities as described in the Health and Social Care Act 2012.

3.2. The Health and Wellbeing Strategy tackles complicated problems which cannot be solved by any single agency, as described in the missions, and commits a wide range of partners to working together to explore local issues and challenges, agree priorities to respond collaboratively, using collective resources. The Joint Strategic Needs Assessment (JSNA) has been developed across a broad range of partners and provides the intelligence behind the missions.

3.3. The Health and Wellbeing Strategy contributes to all elements of the Council Plan (2024 – 2027) and is a vehicle for engaging partners to contribute to the delivery of that Plan.

4. Background and relevant information

4.1. The Council Plan (2024-27) which was agreed by Council in March 2024 aims to create a healthier, safer and more ambitious town. The Plan is built on four key pillars:

- A successful and ambitious town
- A healthy place
- Safe and resilient communities
- Delivering best value

4.2. The Health and Wellbeing Strategy is built around nine ambitious missions, each of which is supported by relevant goals that further articulate and explain the mission.

The missions are:

- We will narrow the attainment gap between children growing up in disadvantage and the national average.
- We want to improve education, training and work prospects for young people.
- We will prioritise and improve mental health and outcomes for young people
- We will reduce the proportion of our families who are living in poverty.
- We will create places and systems that promote wellbeing.
- We will support people and communities to build better health.
- We will build an inclusive model of care for people suffering from multiple disadvantage across all partners.
- We will promote independence for older people.
- We will ensure everyone has the right to a dignified death.

5. Other potential alternative(s) and why these have not been recommended

5.1. The Health and Wellbeing Strategy is owned by the multi-agency LiveWell South Tees Health and Wellbeing Board and is a statutory requirement for both the Council and the Integrated Care Board (NHS). The framework and mission-led approach was agreed through LiveWell South Tees Health and Wellbeing Board in September 2022 which in turn informed the development of the Joint Strategic Needs Assessment (JSNA). The recommendations in the Health and Wellbeing Strategy are drawn from the JSNA.

5.2. The development of the JSNA has involved more than 500 people (through workshops, meetings, attendance at key partnership boards and via email) which included more than 100 organisations and teams.

6. Impact of the recommended decision

6.1. Financial (including procurement and Social Value)

6.1.1. Making improvements with partners across the complex societal issues this strategy focusses on will help to mitigate some of the financial pressures facing the council.

6.1.2. The Strategy is consistent with the Social Value Policy and includes a commitment to the establishment of an Anchor Network to better understand and build social value across all anchor organisations.

6.2. Legal

6.2.1. The Council has a wide range of statutory responsibilities, which includes both the development of the JSNA and the Health and Wellbeing Strategy.

6.3. Risk

6.3.1. Increased health inequalities – without leadership and partnership working from the Local Authority key recommendations may fail to be delivered upon.

6.3.2. Weakened collaboration and partnerships – Local Authorities are a critical partner of the Health and Wellbeing Board and have a key role in facilitating partnership working between sectors. Non adoption of the Health and Wellbeing Strategy could result in further silo working reducing the effectiveness of interventions.

6.3.3. The recommendations within the Health and Wellbeing Strategy are based on the findings from the JSNA which is a statutory duty for the Local Authority and ICB to produce.

6.3.4. Impact on community consultation – the development of key actions to address the recommendations will be supported through public engagement and the local authority have key links and knowledge of local communities which will be invaluable in the successful delivery against the recommendations.

6.4. Human Rights, Public Sector Equality Duty and Community Cohesion

6.4.1. The Strategy will be delivered in line with all relevant obligations and includes a mission to "build an inclusive model of care for people suffering from multiple disadvantage across all partners" that will directly address issues affecting the most vulnerable in our communities including those with protected rights.

6.5. Climate Change / Environmental

6.5.1. The Strategy includes recommendations that will impact on local efforts to reduce the impact of climate change, including recommendations to leverage the planning process to promote healthy, inclusive, and safe places, to improve social spaces and walkability; to shift perceptions around active travel and public transport and to increase understanding of the value of green and blue spaces locally, their role in improving wellbeing, addressing climate change and creating liveable neighbourhoods.

6.6. Children and Young People Cared for by the Authority and Care Leavers

6.6.1. Substance Misuse, Domestic Violence and Mental Health are some of the leading factors locally for social care intervention. The strategy includes recommendations which aim to address the leading contributors towards these trio of vulnerabilities including poverty, employment, long term conditions and support for health inclusion groups.

6.7. Data Protection

6.7.1. A DPIA is not required as this Strategy does not refer 14to any personal/identifiable date. Should the delivery of the recommendations include the collection or use of any personal/identifiable data a DPIA will be completed.

Actions to be taken to implement the recommended decision(s)

Action	Responsible Officer	Deadline
Subject to Executive approval, the lead officer will: - Identify System Leaders for each Mission considering the importance of developing new system leaders and engaging with latent system leaders.	Director of Public Health	January 2025
- Establish our long-term approach to delivering on the recommendations	System Leaders (with support)	March 2025

Appendices

1	Health and Wellbeing Strategy
2	
3	

Background papers

Body	Report title	Date
The JSNA is a statutory requirement between the Council and North East and North Cumbria Integrated Care Board and provides the intelligence behind the missions.	Joint Strategic Needs Assessment	Published on the Council website in June 2024 following approval at the Live Well South Tees Health and Wellbeing Board (available on line here)
The Council Plan is the Council's overarching business plan for the medium-term, setting out the priorities of the Elected Mayor of Middlesbrough, the ambitions for our communities and the ways in which we seek to achieve them.	Council Plan (2024 – 2027)	March 2024

Contact: Mark Adams, Director of Public Health South Tees
Email: mark_adams@middlesbrough.gov.uk

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LiveWell SOUTH TEES

HEALTH & WELLBEING BOARD

Health and Wellbeing Strategy

2024 - 2030

September 2024

1. Contents

2. Foreword

Chris Cooke

Co-Chair of Live Well South Tees Health & Wellbeing Board and Elected Mayor and Executive Member for Adult Social Care & Public Health

Alec Brown

Co-Chair of Live Well South Tees Health & Wellbeing Board and Leader of Redcar & Cleveland Council

3. Introduction

3.1 What is the Health & Wellbeing Strategy?

The Health and Wellbeing Board was established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together **to improve the health and wellbeing of their local population**.

The South Tees Health & Wellbeing Board have a statutory duty to produce for their local population: a Joint Strategic Needs Assessment (JSNA) and Joint Health & Wellbeing Strategy. The Health & Wellbeing Strategy outlines how the Health & Wellbeing Board aims to improve the health and wellbeing of people living in South Tees and reduce health inequalities.

The Strategy aims to:

- Tackle **complicated problems which cannot be solved by any single agency**.
- Commit a wide range of partners to working together to explore local issues and challenges, **agree priorities to respond collaboratively**, using **collective resources**.
- Be informed by the **JSNA**, that uses data, intelligence and evidence to identify the current and future health and social care needs of the population in South Tees.

This mission-led Health & Wellbeing Strategy has been developed within the context of both the established vision and life-course approach as detailed below:

Vision	**Empower the citizens of South Tees to live longer and healthier lives**		
Aims	**Start Well**	**Live Well**	**Age Well**
Aspiration	**Children and Young People have the Best Start in Life** We want children and young people to grow up in a community that promotes safety, aspiration, resilience and healthy lifestyles	**People live healthier and longer lives** We want to improve the quality of life by providing opportunities and support so more people can choose and sustain a healthier lifestyle	**More people lead safe, independent lives** We want more people leading independent lives through integrated and sustainable support

3.2 Joint Strategic Needs Assessment (JSNA)

The JSNAs are an equal and joint statutory duty of Middlesbrough and Redcar & Cleveland Local Authorities and the North East & North Cumbria Integrated Care Boards (ICBs), through the South Tees Health and Wellbeing Board. JSNAs provide intelligence and insight on the current and future health, care and wellbeing needs of our local population and how well these needs are being met. They have a strong focus on inequality of outcome and inequity in access. The JSNA are a fundamental part of planning and commissioning services at a local level.

The South Tees JSNA refresh has adopted the missions and goals approach and the JSNA will provide the intelligence behind the Missions – it will develop our collective understanding of the Missions; the issues behind the Missions and broad contributing factors to the current outcomes experienced.

The JSNA has informed the development of this Strategy, creating the consensus and commitment across partners on meaningful, long-term approaches across or within agencies to develop long-term, systemic solutions to our local challenges.

Needs assessments have been completed and published in June 2024 across all 21 of the goals.

3.3 Mission-led Approach

The significant challenges we face today in South Tees are comprehensive, systemic and long-standing. The challenges are often dynamic and unpredictable, with a lack of consensus on meaningful, long-term approaches across or within agencies. Poorly defined problems, lack of consensus and commitment across partners mean that long term, systemic solutions remain elusive.

The way we work is compounded by short-termism of projects (and often their focus on linear, compartmentalised solutions that don't fit the complex nature of challenges), budgets and limited partnership working making it incredibly difficult to act strategically to address systemic challenges across agencies. All agencies have been focussed on financial survival for the past decade – a survival that has got increasingly precarious. This has exacerbated the pre-existing short-termism and limited understanding of the impact of decisions beyond the immediate budget area under consideration. This approach squeezes out innovative solutions across the whole system and reduces the appetite for risk whilst simultaneously not recognising the significant financial risks and poor outcomes contained within the status quo.

The Mission approach allows us to progress as a system and set of partners from pursuing incremental innovation and change, working within existing paradigms (and often within individual agencies), to working together across agency boundaries and with communities to challenge and transform the logic and existing paradigms that has led to the current situation of compounded crises and poor outcomes.

Each mission is a response to a significant local challenge, one where innovation, working together and aligning resources has a big part to play in driving large-scale change – missions cannot be resolved by any single agency acting in isolation. Each mission has a set of ambitious goals that further articulate and explain that mission.

4. Key Areas of Difference in the Mission-Led Approach

4.1 System Leadership

Systems leadership must exist within and across organisational, cultural and geographical boundaries; often without direct managerial control of resources. This moves beyond individual disciplines – we will not achieve the population shift required by operating within the boundaries of the individual organisations or departments. We need to move beyond the usual suspects in senior roles within public sector agencies and develop leadership roles more broadly across the system, including VCS leadership.

We will identify System Leaders for each Mission considering the importance of developing new system leaders and engaging with latent system leaders. We will establish our long-term approach

to give confidence that our System Leaders could be part of leading something that has the chance to produce real change across partners.

We will develop a model of support for System Leaders that considers: clarity on the role of System Leader, supportive methodologies for problem-solving and decision-making and training and support.

4.2 Mission-level Governance

Mission-oriented approaches require the ambition to transform landscapes rather than just fixing problems in existing ones. To deliver our missions we need to consider how we **break silos within and between agencies** and **coordinate action across portfolios and agencies**. Complex organisational structures, with rigid formal processes, limit the flow of information, reduce openness and constrain creativity.

Whilst the Health and Wellbeing Board and the South Tees Place Committee will provide over-arching governance of delivery of this Strategy – assuring progress, collating learning and removing barriers, we will develop a new bold and ambitious governance structure at a mission-level, that develops leadership across the system, facilitates cross-agency coordination, engages communities, encourages calculated risk- taking, embraces the learning approach, generates new perspectives and new thinking through engagement beyond the usual suspects, experimentation and development of innovative solutions.

We will build this approach on the existing local examples that are emerging, demonstrating a different approach to working, including the STRiVE Boards, Thrive at Five and the Increasing Attendance programmes in Redcar & Cleveland.

We will connect our mission-led approach to the Tees Valley Anchor Network to explore the additional value we can generate by coordinating missions across approaches to procurement (including coordinating procurement processes across value chains and agencies in delivery of the missions), employment, education and the environment.

4.3 Engaging Communities and People with Lived Experience

Engaging communities is a critical element of the mission-level governance and a key vehicle to generate new perspectives and new thinking and development of innovative solutions. Deeper connections into communities will also connect missions to assets that exist in our communities. We will develop a model of mission-level community engagement that is embedded into policy development, decision-making and learning processes to inform the development of our plans and approaches to deliver the Missions.

Throughout all that we do together as a system and within communities we will place developing an understanding of what the best life for an individual might be, rather than seeking to impose a set of values or belief system.

4.4 Developing our Learning Approach

A mission-based approach requires a methodology that seeks to develop, test, learn and scale a suite of interventions that are complementary and can shift complex systems by focusing on multiple intervention points at a given time. This will require a shift from a culture focussed on compliance and policing the boundaries to one of learning and continuously adapting; collectively embracing the complexity arising from a portfolio of diverse projects, activities and initiatives designed for long-term transformation together with communities, people with lived experience and strategic actors in the system.

The Sport England programme You've Got This has developed expertise in this area with their whole system approach to supporting the least active to be more active. YGT is developing a capacity-building package for leaders at all levels of the system that will help to define and outline approaches for how we can apply a learning approach, developing distributed leadership across the system and approaches to system change. We will develop our learning approach and shared understanding of system change building on the learning from YGT to coordinate action across agencies to deliver our Missions.

4.5 Delivery through the Policy Frameworks and Powers

To achieve sustainable change across the system we need to develop clear connections into the Policy Frameworks in both Councils and partners to develop real health in all policies and amplify the delivery of the Missions.

We also need to broaden our scope from commissioning and services to how we can exploit roles and powers of both Councils and partners to support the delivery of our Missions, including:

- General Power of Competence that gives councils the power to do anything an individual can do provided it is not prohibited by other legislation;
- Regulatory - including licensing, cumulative impact policies and potentially including alcohol minimum unit pricing;
- Planning - including affordable homes requirements, local energy planning;
- Convening - including to improve the performance of partners or collective action to reduce energy costs through community energy schemes;
- Asset and landowner– potential to develop community-based solutions using Council or NHS land or buildings;
- Bidding powers to bring in external resources to support delivery of the Missions;
- Finance powers including exploring innovative funding mechanisms.

We will work with both Councils and partners to embed the ambitions of the HWB Strategy into organisational policy frameworks.

We will consider how we can better use roles and powers of both Councils (and partners) to deliver our Missions.

5. Start Well: Children and young people have the best start in life

5.1 Key areas of intelligence

School Readiness and Attainment

- **School readiness in reception** is 61% in Middlesbrough, whilst Redcar & Cleveland is similar to the England rate at 68%. The Middlesbrough rate is the 2nd lowest for local authorities in England. School readiness in Middlesbrough ranges from 39% in Central to 79% in Nunthorpe and 43% in South Bank and 83% in Saltburn within Redcar & Cleveland. SEN pupils, Free School Meal (FSM) eligible pupils and those not within those 2 cohorts perform significantly worse in Middlesbrough compared to Redcar & Cleveland and England.
- 56% of pupils in Middlesbrough **achieve a grade 4 in English and maths**, significantly lower than the Redcar & Cleveland rate of 66% and the England rate of 65%. Rates decrease to 38% for FSM pupils in Middlesbrough and 45% for FSM pupils in Redcar& Cleveland compared to 43% in England.
- **Progress 8 scores** show that both Middlesbrough (score -0.47) and Redcar & Cleveland (score -0.33) pupils are making less progress between key stage 2 and 4 compared to similar pupils nationally. The Middlesbrough score is 7th lowest and Redcar & Cleveland score 16th lowest nationally. Schools with higher proportions of FSM pupils have significantly lower progress 8 scores.
- Overall **school attendance** is lower in Middlesbrough at 90% and similar in Redcar & Cleveland compared to England at 92%. Persistent absence however is significantly greater in Middlesbrough at 33%, compared to 23% in Redcar & Cleveland and 24% in England. Both Middlesbrough and Redcar & Cleveland had a significantly higher permanent exclusion rate at 0.28 (73 pupils) and 0.29 (61 pupils) per 10,000 per compared to 0.11 in England. Redcar and Cleveland and Middlesbrough's rates are highest and 2nd highest in England.

Apprenticeships, training and work placement and NEETs

- In England, 93% of 16 to 17 years olds are in **full time education**, compared to 87% in Middlesbrough and 86% in Redcar & Cleveland. In England 5% are in apprenticeships, compared to 3% in Middlesbrough and 7% in Redcar & Cleveland and 1% are in employment combined with study in England compared to 5% in Middlesbrough and 4% in Redcar & Cleveland.
- South Tees has a greater proportion of those on an intermediate **apprenticeship** with 33% in Redcar & Cleveland and 31.4% in Middlesbrough compared to 26.2% in England. Proportions of those on advanced apprenticeships are similar both locally and nationally, however the proportion of those on higher level apprenticeships is much lower locally with 22.9% in Redcar & Cleveland and 25.5% in Middlesbrough compared to 30.5% in England.
- In Redcar & Cleveland, 6.1% of 16 to 17 years olds and 3.9% in Middlesbrough are **not in education, employment or training (NEETs),** compared to 3.2% in England. The Redcar & Cleveland rate is 30th highest in England.

School based mental health support and access to mental health support

- In Redcar & Cleveland 4.6% of pupils had a **social, emotional and mental health (SEMH)** need as the primary need as part of the SEND cohort and in Middlesbrough it's 4.4%. This is higher than the England rate of 3.7%. The Redcar & Cleveland rate is 22nd highest in England. In both local authorities in South Tees, 71% of SEMH pupils are males. Of the total SEMH cohort, 65% in Middlesbrough are also eligible for FSMs, 55% in Redcar & Cleveland and 47% in England.
- Under 18s had significantly higher rates for **attended contacts with community and outpatient mental health services** locally, with a rate of 68,837 per 100,000 in Redcar & Cleveland and 51,814 per 100,000 in Middlesbrough, compared to 28,396 per 100,000 in England. Middlesbrough and

Redcar & Cleveland also have higher rates of **new referrals to secondary mental health** services with 8,280 per 100,000 and 9,000 per 100,000 respectively compared to 6,977 per 100,000 in England.

- **Secondary care waiting times** have increased significantly, particularly in the longer wait times of 53 weeks and over across both local authority areas. This is driven by referrals for suspected autism and neurodevelopmental conditions.

5.2 Mission: We will narrow the attainment gap between children growing up in disadvantage and the national average

Goal: We want to eliminate the school readiness gap between those born into deprivation and their peers.

Goal: We want to eliminate the attainment gap at 16 among students receiving free school meals

5.2.1 The Challenge

The quality of a child's early experience is vital for their future as children that start school developmentally ready will have a happier, healthier life. Conversely those that start behind fall further behind as they progress through school. School readiness is shaped by many interrelated factors: the effects of poverty, the impact of high-quality early education and care, and the influence of 'good parenting', what parents and carers do daily with their children is important[1].

In Middlesbrough and in Redcar & Cleveland a significant number of children start school behind their peers without the skills necessary to flourish at school. These averages hide significant variances between areas of South Tees that contribute to the inequalities experienced – in some communities in South Tees it is more likely that a child will not be ready for school on starting at Reception

The attainment gap between pupils eligible for free school meals and their peers has continued to grow over the last 20 years, particularly in locations where poverty is at its highest, like South Tees where significant socio-economic challenges have driven inequalities in attainment in recent years.

You cannot achieve at school if you're frequently not there. Persistent absence from school is significantly greater in Middlesbrough than in Redcar & Cleveland and England and the rates of permanent exclusion in Middlesbrough and Redcar & Cleveland and are the top two highest rates in England.

It is important to highlight that whilst there are significant challenges, many local families overcome barriers daily just to get their children to school and are very resilient in lots of areas of their life.

5.2.2 Recommendations

1. Develop a system-wide **South Tees Attainment Partnership** to shift from reactive silo working to coordinated, collaborative policy development and decision making with a focus on prevention.

[1] www.gov.uk Are you ready? Good practice in School Readiness (2014). Available at: Are_you_ready_Good_practice_in_school_readiness.pdf (publishing.service.gov.uk) (accessed: 31 October 2023).

2. Develop improved relationships between education and health to improve school attendance, attainment and support at points of transition throughout education.

3. Each local authority should develop a **School Readiness Strategy** that addresses the high-level issues described in the JSNA through an agreed multiagency approach.

4. Develop a greater understanding of data collected across the system and explore data sharing agreements to enable joint analysis across services to build a more comprehensive understanding of the issues and solutions when following the journey of the family and child.

5. Develop collaboration between partners to effectively identify parents who need support to build confidence, skills and capacity to parent (including literacy) to create positive home learning environments and ensure services meet needs.

6. Build the voluntary and community sector into policy development, decision making and service provision, particularly specific tailored support to communities most in need.

7. Complete multi-agency deep dive intelligence gathering to better understand the key factors that that lead to significantly lower Progress 8 scores (that compare KS2 to KS4) than those in peer Authorities.

5.3 Mission: We want to improve education, training and work prospects for young people.

Goal: Extend offers of apprenticeships, training and work placements for young people to make the most of current and future local opportunities

Goal: We will have no NEETs in South Tees through extended employment, apprenticeship or training offers for 18–25 year olds.

5.3.1 The Challenge

At any age spending time not in employment, education, or training (NEET) has a detrimental effect on physical and mental health. This effect is greater or lasts for longer when that time is experienced at a younger age, increasing the likelihood of unemployment, low wages, or low-quality work later in life. These negative effects do not occur equally across the population, as the chance of being NEET is affected by area deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement, and school experiences.

The availability of training and re-engagement programmes has reduced in South Tees in the past two years, with the loss of European Social Funding and the Youth Employment Initiative which provided bespoke employment focussed support and brokerage for young people between 15 and 29 years.

Both Middlesbrough and Redcar & Cleveland have a strong track record of encouraging high volumes of apprenticeship participation, however since the introduction of the apprentice levy and new process for apprenticeships, there has been a significant reduction in the overall number of apprenticeships created nationally and in the Tees Valley.

Analysis of risk factors for being a young person (aged 13 to 25) not in employment, education, or training and the extent and degree of overlap between different forms of marginalisation was applied to all local authorities in England. **Middlesbrough (2) and Redcar & Cleveland (4) were both in the top five authorities most likely to have a high number of young people not in employment, education or training**.

Funding for skills and employment support is short-term, fragmented, and held centrally, making it extremely challenging for local authorities to provide place leadership and coordinate, plan, target, and join-up provision, or build in the right wider support for those with complex or additional needs.

5.3.2 Recommendations

1. Implement early identification systems within schools and communities to identify young people at risk of becoming NEET including; early assessment and tailored support, systems and data sharing, careers awareness and attendance management.

2. Establish a forum with statistically similar local authorities to share best practice and learning.

3. Redcar & Cleveland and Middlesbrough should ensure that reducing the numbers of young people not in education, employment or training is given greater priority and develop effective policy intervention and strategies to prevent young people becoming NEET.

4. Local Anchor organisations should make employment from those areas with the greatest numbers of NEETs or those in low quality employment a priority.

5. Develop a joint strategic working group to identify a joined-up approach to delivery of employment programmes.

6. Create a minimum of in-school and college support for personalised careers guidance for young people including one to one support.

7. Promote the importance of friends and family support to young people to ensure their success.

8. All services working with Young People should have a trained workforce with the knowledge and skills to support young people to make informed choices about education, employment, and training.

9. Share data across services to develop insights to improve support, target interventions and ensure more young people are able to access good employment.

5.4 Mission: We will prioritise and improve mental health and outcomes for young people

Goal: Improve access to mental health care and support for children, young people and families, led by needs.

Goal: Embed sustainable school based mental health support and support education partners in the establishment of whole school based programmes

5.4.1 The Challenge

Failure to support children and young people with mental health needs costs lives and money. Mental health problems often develop early - **half of all mental health problems in adulthood are established by the age of 14, with three quarters established by 24**. Early intervention prevents young people falling into crisis and avoids expensive and longer-term interventions in adulthood. Prompt access to appropriate support enables children and young people experiencing difficulties to maximise their prospects for a healthy and happy life.[1] The case for early intervention is strong and that support can enable children and young people to cope with difficult circumstances and prevent escalation into specialist services.

The rates of probable mental disorder increased significantly between 2017 and 2021. The most common issues in the teenage years include anxiety and depression, behavioural disorders, eating disorders, and self-harm. For some mental health issues may resolve with time, though many continue to have difficulties into adulthood. The impact of the Covid-19 pandemic on children and young people's mental health is not fully understood, whilst the evidence on the direct impact of lockdown on mental health and wellbeing of younger people was mixed, most studies show increased levels of distress, worry and anxiety.[2]

In South Tees attendance rates for community and outpatient mental health services for under 18s are double the rates for England, with referrals into secondary mental health services significantly higher too (19% higher for Middlesbrough and 29% higher for Redcar & Cleveland). Waiting times for secondary care have increased significantly, particularly in the longer wait times (53 weeks and over) across both local authority areas. This is driven by referrals for suspected autism and neurodevelopmental conditions.

Regular attendance in education settings is essential for all children and young people to benefit from an environment that will provide a safe space with the necessary protective factors to improve resilience and consequently achieve good emotional health; preventing and minimising the likelihood of mental ill-health at a young age and beyond. For those children and young people experiencing adverse childhood experience within the home and community, school can provide the only stability within their lives.

The Getting Help Collaborative works across local authorities, NHS and the VCS, and all educational settings across South Tees have access to Getting Help support. The funding model for this approach is patchwork and short term, making longer term planning and capacity building more difficult.

5.4.2 Recommendations

1. Introduce the concept of poverty proofing as standard practice with all service providers.

2. Develop a joint long-term commissioning approach to maintain the collaborative Getting Help whole school support service

3. Develop an approach to commissioning Getting More Help whole school support services.

4. Develop a comprehensive offer of "Getting Help" and "Getting More Help" for children and young people aged 5 – 19 in community settings.

5. Develop working relationship between education and health to improve school attendance and support children and young people at points of transition (also in M01)

6. Develop a greater understanding of data collected across the system and explore data sharing agreements to enable joint analysis across services (also in M01)

7. Develop a training model for children and young people workforce and staff in educational settings

8. Develop routes of engagement with parents and families to help shape and inform future delivery models.

9. Develop a user-friendly guide to available services and support

10. Use the iThrive approach develop a response to better support those waiting for triage, support and treatment to prevent further escalation and crisis.

6. Live Well: People live healthier and longer lives

6.1 Key areas of intelligence

Debt and Employment

- The Middlesbrough IMD score is ranked 5th **most deprived** of English local authorities whilst Redcar & Cleveland is ranked 31st most deprived. In Middlesbrough, 48.8% of Lower Super Output Areas (LSOAs) are within the **10% most deprived LSOAs** in England whilst in Redcar & Cleveland the proportion is 26.4%. The Middlesbrough rate is the highest rate out of all 153 local authorities in England, whilst the Redcar & Cleveland rate is 23rd highest.
- Middlesbrough had the highest rate of **personal insolvencies** in England at 52 per 10,000 adults and Redcar & Cleveland was ranked the seventh highest local authority with a rate of 42 per 10,000 adults. This was more than double the national average of 25 per 10,000 adults.
- Middlesbrough is ranked the highest out of 307 local authorities in England **for cost-of-living vulnerability**, whilst Redcar & Cleveland is ranked 12th highest
- 29.3% of working age adults are **economically Inactive** in Middlesbrough and 28.5% in Redcar & Cleveland, compared to 21.3% in England. A breakdown shows that Middlesbrough (32%) and more so Redcar & Cleveland (41%) has a higher proportion of those economically inactive due to long-term sickness compared to England (25%).

- Since the easing of lockdown restrictions, **unemployment-related claimant** rates have fallen to 5.9% in Middlesbrough and 4% in Redcar & Cleveland, an equivalent of approximated 8,400 people in South Tees. This is higher compared to 3.8% in England and still higher than pre-pandemic levels. Middlesbrough's rate is the 15th highest of local authorities in England. North Ormesby ward had the highest claimant rate in Middlesbrough at 23.4% and Grangetown ward in Redcar & Cleveland with 15.5%.

Housing, Green Spaces, Transport and Social Capital

- In Middlesbrough 40% of the private sector housing fails the **Decent Homes Standard**. With the figure in Redcar and Cleveland being slightly higher at 45%. Both figures are higher than the national average of 14%.
- Middlesbrough has a lower rate (19 sqm) of the **minimum standard of green space** provision (24 sqm per individual). This is compared to Redcar & Cleveland at 25 sqm and England at 29 sqm. Redcar & Cleveland's population has a lower average **distance to their nearest park, public garden or playing fields** compared to England whilst Middlesbrough has a greater distance. However the average size of these areas is significantly lower in Middlesbrough and more so in Redcar & Cleveland compared to England.
- Both Middlesbrough and Redcar & Cleveland have lower levels of **adults who walk or cycle** for any purpose compared to England. In South Tees, there are lower rates of **bus journeys** per head of population compared with England, with trends showing reductions over time. Even though Redcar & Cleveland has fewer concessionary journeys compared to Middlesbrough, the proportion of all journeys is higher than Middlesbrough and both are higher than England. However South Tees has seen large reductions.
- Redcar & Cleveland has twice the level of **total emissions** at 1,215 kilotons compared to Middlesbrough at 654. CO2 is the most prevalent greenhouse gas emissions, accounting for 86.4% in Middlesbrough, around two percentage points higher than England (84.3%). Redcar & Cleveland has a higher proportion at 93%.
- Data from ONS **personal wellbeing** estimates that mean scores for life satisfaction are lower in Redcar & Cleveland and Middlesbrough compared to England. Scores are also lower for the worthwhile measure locally. Middlesbrough saw the biggest difference in the happiness measure compared to England. Redcar & Cleveland residents score similar to England for levels of anxiety, whilst Middlesbrough residents score lower.

Risk factors for ill health and prevention

- The estimated **smoking prevalence** in Middlesbrough is 16.5%, significantly higher than the England rate of 12.7%. Redcar & Cleveland's rate is lower compared to Middlesbrough at 13.7%. Middlesbrough has a significantly smaller proportion of **adults who are classified as active**, with 54% compared to 63% in England. Redcar & Cleveland is slightly higher at 58% but still below the England average. Redcar & Cleveland has a higher rate of those **classified as overweight or obese** at 72% compared to 64% in England. Middlesbrough has a lower rate at 71%, similar to the North East rate.
- There is a strong correlation between **deprivation and life expectancy**, particularly for males. There is a 14.9 year gap between the lowest life expectancy ward of Central at 69.4 years to the highest life expectancy ward of Hutton with 84.3 years. The gap is smaller for females but still significant at 11.4 years between Berwick Hills & Pallister at 75.7 years and Kader with 87 years.
- 37% of deaths for Middlesbrough were **premature deaths** (under 75) and 35% in Redcar & Cleveland were premature deaths. This is significantly higher than the national rate of 25.5% of deaths were premature deaths.
- For **cancer screening**, both Middlesbrough and Redcar & Cleveland have similar breast cancer screening uptake rates then the national average but sit below the North East rate. Redcar & Cleveland had an uptake rate of 76% for cervical cancer screening, however the Middlesbrough

uptake rate was much lower at 62%, compared to 68% in England. Redcar & Cleveland has a rate of 71% for bowel cancer screening compared to the England rate of 70%, however Middlesbrough's uptake rate is much lower at 66%.

- Redcar & Cleveland has the highest **suicide rate** for local authorities in England with a rate of 18.3 per 100,000 compared to 10.3 in England. The Middlesbrough rate is also higher at 16.5 per 100,000.

Violence, Inclusion Health Groups and Parental Substance Misuse

- **Serious violent crimes** are increasing in terms of volume and rate per 1,000 population across South Tees, with the proportions of offences over time being consistently highest in Middlesbrough.
- Middlesbrough has almost double the rate of **hospital admissions for violence** per 100,000 of the population (124) than the rate for all English unitary authorities (64). Redcar & Cleveland has a much higher rate, at 175, which is almost triple the mean for all English Unitary Authorities.
- South Tees has a significantly higher rate of **drug-related deaths** than the national average; with a rate of 14.1 per 100,000 in Middlesbrough and 8.5 per 100,000 in Redcar & Cleveland compared to the national rate of 5.2.
- Middlesbrough has significantly higher rates of **households owed a duty under the homeless reduction act** compared to England, whilst Redcar & Cleveland is significantly lower.
- Of all **substance misuse clients in treatment**, 42% in Middlesbrough and 35% in Redcar & Cleveland were a parent (full or partial responsibility for one or more children under 18). This is significantly higher, particularly in Middlesbrough compared to 30% in England.

6.2 Mission: We will reduce the proportion of our families who are living in poverty

Goal: We want to reduce levels of harmful debt in our communities.
Goal: We want to improve the levels of high-quality employment and increase skills in the employed population.

6.2.1 The Challenge

Many communities in South Tees are in the 10% most deprived communities – almost half Middlesbrough's communities (the highest of all 153 local authorities) and just over a quarter in Redcar & Cleveland (the 23rd highest) are amongst the poorest communities in England.

There is a strong relationship between poverty, debt, ill-health and health inequalities.
Recent national analysis demonstrates that for a fifth of low-income families the cost-of-living crisis has resulted in new debt to pay bills like rent and energy. When debt or repayments become unsustainable, it can drive worsening mental and physical health with a strong correlation between problem debt and various mental health issues including stress and depression; relationship difficulties, alcoholism and financial exclusion from mainstream credit. In extreme cases problem debt can lead to homelessness or risk of homelessness through eviction due to rent arrears or mortgage repossession, being disconnected from utility supplies and court summons.

Problem debt is also driven by low financial resilience in the form of savings and events such as unexpected household expenses, the birth of a child, redundancy and ill health. Changes to the welfare system, including built-in delays on change in status and reduced levels of benefits, particularly affecting people with a disability and families with more than two children. Many

families have to pay back Universal Credit advances, or experience high housing costs or other deductions from their benefits that mean that their experiences are even worse. Public sector debt collection practices can make debt problems worse, placing greater pressure on household finances.

The National Poverty Commission states that it is not enough to just consider income, but plans should also consider unavoidable costs; specifically housing costs, childcare costs, costs of disability, energy costs and travel costs.

Significantly more working age adults are economically inactive in Middlesbrough and Redcar & Cleveland than England and a significantly higher proportion of those are inactive due to long-term sickness. Long term sickness is very socially profiled, being more prevalent in our poorest communities.

Unemployment claimant rates are still higher than England, affecting around 8,400 people across South Tees and significant variation across our communities with almost a quarter of working age adults unemployed is some wards.

Good work is important but not universally available or equitably distributed – people living in poorer areas are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often with poor working conditions that are harmful to health, and many are trapped in a cycle of low-paid, poor-quality work and unemployment. There are many barriers for some members of our communities to access high quality employment and skill development, including: financial, in particular the transition from benefits into insecure employment; affordable, accessible transport; caring responsibilities, including child care; security of housing; experience of criminal justice system; recovery from substance use; low level of educational attainment, qualification and skills and mental health issues.

6.2.2 Recommendations

1. Consider how partners can use their powers to reduce unavoidable costs - housing, childcare, energy and travel costs and costs of disability.

2. Increase income, reduce stigma and minimise punitive approaches for families in hardship:

    - Build routes between NHS and financial support agencies (poverty-proofing health) and from financial support agencies into health support, particularly MH support (health-proofing poverty);
    - Mainstream the Auto-enrolment of Free School Meals pilots to increase pupil premium payments to schools and savings on food costs for parents;
    - Develop a broader case-finding approach with partners to maximise uptake of benefits programmes;
    - Develop consistent best-practice within debt-collection teams (starting with public sector);
    - Statutory PHSE (personal, social, health and economic) curriculum in schools to include Money Management and Debt Education;
    - Normalise conversations about finance through a Make Every Contact Count approach, including in community settings

3. Increase the access and availability of good jobs in our poorest communities:

- Influence funders to develop long term funding for employment and skills programmes;
- Address barriers to accessing job and skills development opportunities (digital, language, childcare);
- Local Anchor organisations should make employment from those areas with the greatest deprivation or those in low quality employment a priority (reflects recommendation in the mission on youth employment);
- Increase private sector engagement with the Anchor Institution Network through the Better Health at Work Award;
- Ensure all employment and skills programmes have a focus on empowering people to address any underlying barriers to employment and skills development (mental ill health, transport, conviction etc);
- Educational establishments should support learners to meet the expectations of industry embedding in-demand skills in curricula and include the development of human skills;
- Develop targeted community-based advice and support.

4. Develop a Work and Health Strategy across ICB, DWP and Councils to reduce the numbers economically inactive through long term health issues.

5. Develop a greater understanding of data collected across the system and explore data sharing agreements to enable the development of shared intelligence to build a more comprehensive understanding of the issues and solutions.

6.3 Mission: We will create places and systems that promote wellbeing

Goal: We want to create a housing stock that is of high quality, reflects the needs of the life course and is affordable to buy, rent and run.
Goal: We want to create places with high quality green spaces that reflect community needs, provide space for nature and are well connected.
Goal: We want to create a transport system that promotes active and sustainable transport and has minimal impact on air quality.
Goal: We will support the development of social capital to increase community cohesion, resilience and engagement

6.3.1 The Challenge

A decent, affordable home is an essential requirement for tackling health inequalities and improving wellbeing. Housing is a wider determinant of health, and good quality housing which meets the needs of an individual, supplemented by support services where required, can promote independence and well-being. The rate of private sector housing failing the Decent Homes Standard is over 40% across South Tees – almost three times the national average.

A green and blue environment can promote and protect good health, support recovery from illness and help manage poor health. Green and blue spaces are also associated with improved mental health and wellbeing outcomes including reduced levels of depression, anxiety, and fatigue, and

enhanced quality of life for both children and adults. Good quality spaces can help to improve social cohesion, reduce loneliness, and mitigate the negative effects of air pollution, noise, heat and flooding.

Increasing cycling, wheeling and walking and use of public transport can help tackle some of the most challenging issues we face as a society – improving air quality, combatting climate change, improving health and wellbeing, addressing inequalities and tackling congestion on our roads. Increasing opportunities for cycling and walking will help to create better places to live and work – with better connected, healthier and more sustainable communities. It will help deliver clean growth, by supporting local businesses, as well as helping an increase in prosperity.

Social capital – our connections to others, collective attitudes and behaviours in communities - is the 'glue' that holds societies together, higher levels of social capital are associated with better outcomes in health, education, employment and civic engagement. There are various factors that contribute to creating social capital in a place, including: sense of belonging, strength of social networks, participation, citizen power to affect place, diversity and trust and safety.

6.3.2 Recommendations

1. **Collaborate with local planning authorities (LPAs) in both Councils to leverage the planning process to promote healthy, inclusive, and safe places, fostering a health in all policies approach to Local Plan making, including**:

    - Co-produce ambitious health and well-being policies for both Local Plans, integrating local health inequality data and aligning with South Tees JSNA and this strategy's missions;
    - Co-produce new Health Impact Assessment toolkits, tailored to each authority's circumstances, and formalise in each Local Plan's health and well-being policy the requirement for all major developments, and any development that we believe might exacerbate the situation further in areas experiencing the most severe health inequalities, to address the wider determinants of health and well-being (energy-efficient homes, walkable neighbourhoods, access to quality green and blue spaces) from the conception of any proposal;
    - Increase understanding among both officers and members of the potential of planning and transport planning to create places that promote health and well-being by co-producing workforce training with officers across both LPAs;
    - Increase understanding of the value of green and blue spaces locally, their role in improving wellbeing, addressing climate change and creating livable neighbourhoods;
    - Increase social capital and community power in planning, developing and using green and blue spaces.

2. **Shift perceptions around active travel and public transport in our communities**:

    - Secure buy-in from decision-makers to prioritise active travel and public transport, including a cultural shift and investment;
    - Maximise opportunities for connectivity between active travel and public transport modes;
    - Engage with organisations to implement infrastructure improvements and working practices that enable active travel;

- Maximise the opportunity for the creation of zero-emission vehicle fleets.

3. **Ensure that public policy reflects community needs and addresses the barriers that stop local people from taking action and developing solutions for themselves**:

   - Build an understanding and value of social capital amongst decision makers;
   - Define and understand the role of anchor institutions of all sizes, particularly in relation to building social capital;
   - Value, support and develop a strong and thriving voluntary sector, recognising the sector's role in both achieving and maintaining social capital;
   - Improve our understanding of what volunteering is and the value it creates;
   - Understand, codesign and develop training around community needs.

4. **We will improve the standards of existing housing and revitalising neighbourhoods**:

   - Improve housing conditions in the private sector by ensuring owners and landlords understand their obligations regarding the safety of homes, enforcing standards and supporting tenants to raise concerns regarding poor housing conditions or management practices;
   - Work with landlords to improve the management of private rented sector homes;
   - Evaluate the operation of Selective Licensing Schemes and Landlord Charters;
   - Target investment in energy efficiency to those at most at risk of fuel poverty;
   - Explore funding opportunities to develop new empty homes initiatives;
   - Support appropriate groups who wish to develop community-led housing proposals;
   - Work with Registered Providers and others to deliver housing regeneration schemes in appropriate locations.

5. **We will meet the needs of our ageing population and support people of all ages to live independently**:

   - Increase the proportion of older person's accommodation within residential developments;
   - Maximise the coverage of extra care housing schemes for older people;
   - Minimise the impact of welfare reform through Discretionary Housing Payments to assist those households in the most severe financial need and supporting Registered Providers to develop income management and personal budgeting support for tenants;
   - Enabling independent living by increasing appropriate accommodation options for people requiring housing support (including inclusion health groups) and supporting the use of telecare and assistive technologies to help people remain independent in their own homes;
   - Review the needs of different client groups for supported accommodation to develop a more strategic approach to the development of supported housing.

6. Build our data, intelligence and insight to better understand of our green and blue spaces, their quality and how they are used and our understanding of social capital to inform better decision-making

6.4 Mission: We will support people and communities to build better health

Goal: We want to reduce the prevalence of the leading risk factors for ill health and premature mortality.

Goal: We want to find more diseases and ill health earlier and promote clinical prevention and pathways across the system**.**

6.4.1 The Challenge

Reducing the prevalence of leading risk factors of ill health and premature mortality, such as smoking, harmful alcohol use, physical inactivity and poor diet and obesity, will reduce the levels of poor health across South Tees and reduce inequalities. Detecting diseases and ill health earlier, when followed up by appropriate clinical interventions and pathways, leads to better health outcomes and prevents premature death.

Smoking remains the leading cause of preventable death in the UK, and local prevalence is higher than the England average, with the rate in Middlesbrough significantly higher. Smoking rates are heavily socially profiled, with rates much higher in more deprived areas. The costs of smoking drive families further into poverty – with more than 12,000 households estimated to be affected across South Tees. More than 20,000 children in South Tees live in households with adults who smoke. Smoking in the home not only damages the health of children through second hand smoke but increases their chance of becoming smokers four-fold.

Alcohol related admissions are higher in South Tees than the national average and deaths are increasing, particularly in our most deprived communities. Levels of alcohol related harm in Middlesbrough are among the highest in the country, both adults and young people are more likely to be admitted to hospital for alcohol related harm than in most other areas of England. Whilst alcohol is a significant part of the night-time economy the combination of night-time revellers, licensed premises and alcohol consumption leading to violence, vulnerability and harm causes significant demand for blue light services and A&E departments at times when such are under great pressure.

Poor diet and physical inactivity are leading risk factors for overweight and obesity, which significantly increase the risk of developing conditions including type 2 diabetes, some cancers, cardiovascular disease as well as contributing to poor mental health. Rates of overweight and obesity among adults and children have increased in the UK over the last decade with high levels of childhood and adult obesity across South Tees, higher than the national average, with physical inactivity levels low across Middlesbrough and Redcar & Cleveland.

The major causes of premature mortality across South Tees are: cancer, cardiovascular disease, respiratory conditions, diabetes and external causes.

6.4.2 Recommendations

1. Establish the governance for the Ill Health Prevention Board to ensure delivery of key actions across all prevention topics.

2. Implement a Health Equity Audit process across all prevention, screening and diagnostic services to ensure resources are distributed and health inequalities are not being widened, focusing on CORE20PLUS5.

3. Ensure the use of population health data to design and commission high quality joined up prevention, screening and diagnostic services that meets the needs of service users to improve access, experience and outcomes.

4. Develop and deliver a robust primary prevention offer that includes raising awareness of health status and risk as well as active case finding and case management working in partnership across the system.

5. Review and consider workforce training for adult social care, children services, front line services, health care, and education to deliver Make Every Contact Count at scale, connecting into neighbourhoods and raising awareness and increasing referral or signposting to ill health prevention services.

6. Engage with communities to inform the codesign and quality improvement of how new and existing services or approaches can better meet the needs of local people.

7. Work with partners to consider a systematic approach to integration across primary care, secondary care, public health and social care, exploring opportunities to pool or align budgets and jointly commission prevention services so they are joined up and person centred.

6.5 Mission: We will build an inclusive model of care for people suffering from multiple disadvantage across all partners

Goal: We want to reduce the prevalence and impact of violence in South Tees.
Goal: We want to improve outcomes for inclusion health groups**.**
Goal: We want to understand and reduce the impact of parental substance misuse and trauma on children

6.5.1 The Challenge

Inclusion health means improving health outcomes for people who are socially excluded typically experiencing multiple overlapping risk factors for poor health, including: poverty, adverse childhood experiences, violence, substance use, mental illness and complex trauma. They often experience stigma and discrimination and are not consistently accounted for in electronic records such as healthcare databases. Inclusion health groups include: people with drug and alcohol dependency; people with housing, homelessness or accommodation issues; Gypsy, Roma and Traveller community; people in contact with the justice system; sex workers; asylum seekers and refugees and victims of modern slavery.

Violence causes ill-health directly and indirectly, particularly in certain circumstances. Violent abuse in childhood can increase the risk of violence in later life and increase the risk of substance use in adulthood. Violence in communities can impact an individuals' autonomy and ability to make

healthier lifestyle choices, limiting ability to exercise, socialise, use outdoor facilities, and use public transport.

Difficulties securing a decent home make it very difficult for people to maintain or even contemplate positive behaviour changes. Inclusion health groups are competing with people who do not have rent arrears or a history of crime or anti-social behaviour. People are frequently housed in temporary or emergency accommodation, which is not a suitable environment to address their support needs. A significant issue in South Tees is the lack of stable move-on accommodation, combined with very high rents in private sector and challenging lettings policies within the registered landlords sector, it makes attaining stable accommodation increasingly difficult, especially for those with multiple disadvantages.

Whilst language can create barriers to accessing healthcare for refugees and asylum seekers due to the inability to speak English confidently and the need for interpreters, which is routinely refused, barriers to accessing health care for migrants are much more ingrained and systematic. Asylum seekers and refugees can be wrongly refused access to primary and secondary care, or asked to pay upfront for assistance that is not urgent. Gypsy, Roma and Traveller communities face similar barriers to primary care, with GPs routinely requiring proof of address or identification in order to register, despite there being no regulatory requirement to provide these details. Digital exclusion and low levels of literacy create further barriers to access.

Sex work is strongly associated with poverty, drug addiction, social exclusion and problematic family backgrounds. Stable housing is regarded as a key factor in enabling women to complete drug treatment and exit sex work successfully. There is a lack of appropriate temporary and permanent accommodation for street homeless women who continue to be involved in sex work, and for those women who are trying to exit sex work.

The barriers faced by people experiencing multiple disadvantages to access support, in particular women, can be twofold, external or structural such as location, availability, suitability of programme, staff attitudes; or internal such as stigma and feelings of inadequacy, emotional stability, judgement and fear. Such challenges can be far reaching and permeate throughout people's lives particularly when a multi-agency approach is used, resulting in numerous appointments and goals to reach.

6.5.2 Recommendations

1. **The Supported Housing Needs Assessment(s) should consider increased housing options and support for inclusion health groups identified through the JSNA, in particular**:

   - support recovery journeys and behaviour change and reduce reliance on temporary accommodation;
   - improve support from custody to community including the provision of suitable housing, particularly for women;
   - improve housing support for asylum seekers and refugees;
   - addressing the negative impact accommodation insecurity has on Gypsies' and Travellers' physical and mental health.

2. **The broad system of support for inclusion health groups should ensure**:

   - all services are trauma-informed and flexible in their provision, including consideration of out of hours support, recognising that vulnerable people may have more specific needs;

- drug & alcohol misuse services, maternity services and children's health and social care services should forge links that will enable them to respond in a co-ordinated way to the needs of the children;
- the local Maternity Unit should ensure that it provides a service that is accessible and non-judgemental of pregnant problem drug users and able to offer high quality care;
- care teams providing services for drug users should ensure that the health and well-being of their children are also being met, in partnership with the school health service, children and family teams and other services as appropriate;
- General Practitioners should take steps to ensure that drug users have access to appropriate contraceptive and family planning advice and management; contraceptive services should be provided through specialist drug services;
- all resources should be understandable to all people accessing services, including consideration of the reading age of materials and available in other languages, as standard practice, to remove language barriers to accessing care and support.

3. **Increase support and understanding for the children of parents with substance misuse issues**:

   - Cleveland Police should seek to develop a multi-agency abuse prevention strategy which incorporates measures to safeguard the children of problem drug users;
   - All women's prisons should ensure they have facilities that enable pregnant drug users to receive antenatal care and treatment of drug dependence to the same standard in the community;
   - All social care workers receive pre-qualification and in-service training that addresses the potential harm to children of parental substance misuse and what practical steps can be taken to reduce it;
   - Develop means of enabling the children of problem drug users safely to express their thoughts and feelings about their circumstances to inform their care and support

4. Develop a greater understanding of and consider the multiple needs of women in inclusion health groups, including those who are exploited through the sex industry or involved in the criminal justice system.

5. Strategies should focus on improving the social determinants that affect health and wellbeing in order to outcomes for inclusion health groups in particular asylum seekers and refugees, support from custody to community and people experiencing homelessness.

6. Children's Services departments should aim to achieve an integrated approach via a common assessment framework between early intervention workers, health visitors and GPs, nursery staff and teachers, child and adolescent mental health services.

7. Develop and deliver a Housing First-style approach locally on a small scale and explore external funding to expand provision across South Tees.

8. **All relevant agencies should continue and strengthen their commitment to collaborative commissioning through the Cleveland Unit to Reduce Violence (CURV)** to identify existing

system issues and work collaboratively to address them; collectively deciding on priorities and outcomes, including:

- maintaining and where possible increase investment in services and support to positively impact psychosocial risk factors behind violent behaviour, including commissioning service that aim to address mental health, substance misuse, neurodiversity, domestic abuse, safeguarding and family support;
- improve school attendance and reduce school exclusions to improve the influence of school as a protective factor for violence (links to Start Well Mission to narrow the outcome gap between children growing up in disadvantage and the national average);
- increase investment in neighbourhood facilities to provide young people with spaces to form meaningful connections, whilst keeping them off the street, such as youth clubs and community centres.

9. **Local authorities should collaborate with CURV to develop training programmes for multiple audiences**, including:
   - identification of those at risk of violent crime and interventions to prevent crime and the establishment of clear referral routes for early interventions;
   - preventative programmes to educate children and young people on the consequences of violence and awareness of all forms of online abuse

10. Local authorities should ensure that a diverse range of perspectives are considered and integrated into responses to their Serious Violence Duty, including those with lived experience and children and young people.

11. Review Substance Misuse Services and Plan for different funding scenarios across South Tees for 2025/26 onwards, based on different scenarios.

12. Review gaps in data and identify opportunities to improve data collection, analysis and sharing to inform policy development and decision-making.

7. Age Well: More people lead safe, independent lives

7.1 Key areas of intelligence

Loneliness and isolation, Frailty and Dementia

- Across 16 risk factors areas that potentially increase the **risk of loneliness and isolation** in older people, Middlesbrough's rates were similar or higher compared to England for 14 areas and Redcar & Cleveland was similar or higher for 13 areas.
- **Frailty scores for patients admitted by deprivation quintile** at South Tees Hospitals NHS Foundation Trust shows 44% of patients in Middlesbrough and Redcar & Cleveland were identified to have some level of frailty, with 9% classified as a high level of frailty. Looking at admissions by deprivation quintile, those in the most deprived areas of Middlesbrough and Redcar & Cleveland had higher rates of frailty compared to those in the least deprived with 50% compared to 38% respectively.

- A **frailty case finder** completed by NECS identified 3,437 patients in Middlesbrough who did not have a frailty diagnosis. This equates to 49% of the patients identified. In Redcar & Cleveland there were 4,889 who did not have a frailty diagnosis which equated to 54% of the patients identified.
- There are 15 **public health risk factors** (specific to over 65s) that are involved with frailty and increase the risk. Rates for datasets for these factors show Middlesbrough has significantly higher rates compared to England for 8 of the factors, suggesting there are more people at risk of frailty compared to England, whilst Redcar & Cleveland had higher rates for 4 risk factors.
- In South Tees only 48% of dementia patients had their **care plan reviewed** in the previous 12 months. This is lower than the national average of 52% and significantly lower than the regional average of 55%. Data by GP practice across South Tees shows significant variation in care plan reviews with two practices in the area are above 85% whilst there are 12 practices with rates below the minimum QOF threshold of 35%.

End of life

- **Place of death** data shows for over 65s that both South Tees LA's are similar to England for deaths occurring in hospital and care homes, however have slightly higher rates of those dying at home and lower rates of those dying in a hospice.
- Middlesbrough has a higher rate of people who **lived and died in a care home** as a percentage of all deaths, whilst Redcar & Cleveland has a lower rate compared to England. Middlesbrough has a higher rate of persons who **lived elsewhere and died in a care home** whilst Redcar & Cleveland has a significantly higher rate compared to England for those under 85 years. Middlesbrough has a higher rate compared to England for those who **live in a care home and died elsewhere** for both under and over 85s.
- Middlesbrough and Redcar & Cleveland have the highest rates in England for **permanent admissions to care homes** for those aged 65+. Middlesbrough also has a very high rate of care home and nursing home beds per population, the highest and 2nd highest in England respectively.
- Tees Valley has a higher rate of **deaths with 3 or more emergency admissions in the last 3 months of life** compared to England. PCNs such as Holgate PCN (7%) and Redcar Coastal PCN (8%) have lower multiple admission rates prior to death and a small proportion who died in hospital. Eston PCN has a much higher proportion at 12.4% who had 3 admissions and also a greater proportion who died in hospital at 56%.

7.2 Mission: We will promote independence for older people

Goal: We want to reduce the levels of loneliness and isolation in our communities and ensure our places promote healthy ageing.
Goal: We want to reduce the level of frailty to improve healthy ageing**.**
Goal: We want to ensure our communities are dementia friendly**.**

7.2.1 The Challenge

Loneliness and isolation are public health issues linked to ill-health and health inequalities. **Social isolation** is an objective measure of the number of contacts that people have. It is about quantity and not quality of relationships. **Loneliness** is a subjective feeling about the gap between a person's desired levels of social contact and their actual level of social contact and the perceived quality of the person's relationships. Loneliness and isolation are complex multi-faceted issues with far reaching implications for individuals, communities and health and care services. Loneliness and isolation are damaging to individuals and communities and can adversely affect both our physical and mental

health due to a lack of positive connections and interactions. Chronic loneliness is often linked to early deaths on a par with smoking 15 cigarettes a day and obesity. [2]

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication.

The risk of the onset of disability, dementia and frailty can be reduced or the onset delayed by adopting approaches that also improve general health, including: stopping smoking, being more active, reducing alcohol consumption, improving diet and maintaining a healthy weight. The rates for factors that are involved with frailty, particularly in Middlesbrough, are much higher compared to England for several of the risk factors for frailty.

Dementia is a complex, life changing and progressive condition that poses significant challenges to the individual, their families, and carers. It affects memory, thinking, orientation, language, judgement, calculation and learning capacity. Whilst most common in older people, dementia can be diagnosed in people under the age of 65, known as early onset dementia.

Caring for a person with dementia can have a big impact on Carers own mental and physical health and wellbeing and often have reduced quality of life with many carers neglecting their own needs due to the impact of their caring role.

A dementia friendly community is a city, town, or village where people with dementia are understood, respected, and supported. Dementia friendly communities are vital in helping people live well with dementia and feel a part of their community. It is where people with dementia are empowered to have high aspirations and feel confident, knowing that they can contribute and participate in activities that are meaningful to them and can continue to live the way they want to in a community that they choose.

7.2.2 Recommendations

1. Develop governance, connections and collaboration between existing Older People's partnerships ensuring a strategic and coordinated approach to addressing isolation, loneliness and healthy ageing across the system, with a clear reporting line to the Health and Wellbeing Board.

2. Expand Age Friendly Communities approach across South Tees, guided by the World Health Organisations Age Friendly Communities framework and learning from Middlesbrough, and coproduce solutions to system wide barriers to ageing well (transport, housing, health services, community space and buildings, social participation)

3. Embed Health Inequalities Impact assessments into the development and implementation of all key policies, strategies and plans, ensuring consideration of social connections and isolation, frailty and dementia are included.

[2] Campaign to End Loneliness, Threat to Health, 2022

4. Embed Making Every Contact Count at scale across organisations and communities, ensuring easy access to health and wellbeing self-care information, community activities and services, alongside normalising conversations around isolation and loneliness.

5. Build value and develop infrastructure to expand and embed Social Prescribing across the system ensuring equitable access across all population groups. Ensure existing and future referrals to psychological therapy (IAPT) where low mood or depression are identified are also systematically offered a referral to social prescribing to address broader needs.

6. Develop a collective, coordinated approach to volunteering opportunities and recruitment, with communities and partners, and maximise volunteering capacity through social value in contracts.

7. Develop data and intelligence sharing to inform local strategies and plans:

    - between Primary Care, Adult Social Care, and the Voluntary Community Sector Organisations to better identify and support people in the community with dementia;
    - share community engagement plans and insight on isolation and loneliness;
    - on digital exclusion of over 65s and use this to ensure existing digital inclusion programmes are addressing and targeting the areas of greatest need.

8. Patients living with dementia should be identified on hospital admission or attendance at A&E or Outpatients and cared for sensitively and seamlessly through a dementia protocol, including Johns Law and the rights of Carers. Carer's details should also be included in healthcare records.

9. Review Reablement and Rehabilitation Care to develop an integrated pathway to prevent unnecessary admissions to hospitals and residential care and ensure a timely transfer from hospital to community.

10. Reduce the variation in diagnosis and reviews by GP practice and standardise screening tools to improve the early diagnosis and effective management of dementia and identifying and managing frailty. In addition:
    - Explore the roles of specialist GPs for dementia and frailty and social prescribers to provide more localised support with dementia and frailty;
    - Improve identification of carers through GP Practices and social prescribers signposting carers to support services and community activities;
    - Raise awareness in communities of the need for patients to seek regular medication reviews to reduce potential adverse consequences of polypharmacy, through increased uptake of medication reviews.

11. Explore the potential for an Integrated Frailty Service working in a more integrated way to deliver frailty care across acute, community, and social care services to optimise opportunities to provide effective person-centred care and avoid unplanned admissions.

12. Develop a broad package of training to include:

- workforce across hospital, care homes and community to be trained in the management of frailty and dementia;
- early identification and intervention to slow decline of frailty and avoid hospital admission;
- frailty and dementia awareness and education into the community and across the system.

13. Ensure that wellbeing activities and participatory arts are an integral component of quality care for older people living in care homes.

14. Ensure information and advice is widely available so that people understand the risk factors for frailty and dementia and how their risks could be reduced. Include improved interventions around modifiable risk factors such as smoking and exercise.

15. Develop a Tees Valley Dementia Strategy, engaging people living with dementia and their carers, to establish how Councils, wider Health and Social Care Partners and the Tees Valley Integrated Care Partnership, will work with other organisations to support people with dementia, their families, and carers to obtain a diagnosis, maintain their independence and enjoy a good quality of life.

16. Develop Dementia Friendly Transport through dementia awareness training for bus operatives and taxi drivers to increase access to support and improve connectivity.

17. Develop the role of the housing sector in promoting independent living through joint planning and service delivery, availability of appropriate housing, equipment, telecare and assistive technology and adaptations; including Dementia Training for social housing providers and private sector landlords.

18. All Care Homes across South Tees to adopt the Dementia Friendly Best Practice Care Home Guide to improve the dementia services offer in all Care Homes to contribute towards CQC registration and improved ratings.

7.3 Mission: We will ensure everyone has the right to a dignified death

Goal: We want to improve the identification of people who are approaching end of life and enable choice - relating to personalised and coordinated care**.**

7.3.1 The Challenge

People are defined as approaching the end of life when they are likely to die within a year.
Some people die in their preferred place and some people experience excellent care in hospitals, hospices, care homes and in their own homes. However, the reality is that many do not. Many people also experience unnecessary pain and other symptoms and there are distressing reports of people not being treated with dignity and respect and some not dying in a place where they chose to die.
We want to ensure that people at the end of their life are supported to make decisions that allow them and their family or carers to be prepared for their death and that their care is well coordinated and planned so that they can die in the place and in the way that they have chosen. It is critical that we address inequalities in palliative and end of life care, to improve equity of access to services and reducing inequity of outcomes and experience.

There is an urgent need to improve end of life care services to ensure that everyone, regardless of their circumstances, receives the best possible personalised care, including ensuring that people can die in the place of their choice. We need to understand the barriers people are facing from a diverse range of communities and take appropriate steps to make end of life care policy and practice as socially inclusive as possible and for all people to receive the appropriate support and care in their last stage of life.

Sudden death, terminal illness, organ failure, and frailty are the four most common types of illness trajectories found in end-of-life care. Evidence suggests that the need for services at the end of life to assist with essential activities of daily living is at least as great for older people dying from organ failure and frailty as for those dying from a more traditional terminal condition such as cancer, and that the need is much greater for older people dying from advanced dementia. The absence of a predictable disability trajectory based on the condition leading to death for most decedents poses challenges for the proper allocation of resources to care for older persons at the end of life.[3]

Palliative care is defined by the World Health Organisation as an approach that improves the quality of life of patients and their families who are facing problems associated with life limiting illness, usually progressive. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems whether physical, psychosocial, or spiritual. Palliative care also helps those receiving care, families and carers deal with emotional, spiritual or practical issues arising from the illness. People of all ages can benefit from palliative care and at all stages of their illness.

7.3.2 Recommendations

1. Improve the early identification of palliative patients to ensure they are supported on their end-of-life journey and patients, families, and carers are better informed, both from a health perspective in managing their advance care planning needs and also from a social welfare perspective.

2. Ensure care is joined up across health and social care teams to identify patients on the palliative care register who also have other long-term conditions. This should include improved system interoperability (shared access to SystmOne)

3. Introduce strategies to increase awareness with families, professionals, and wider communities on the variety of social welfare support for end-of-life patients utilising population health management approaches to identify priority groups.

4. Embed Social Prescribing within end of life palliative care pathways to increase available support and increase take up of social welfare support for end-of-life patients and their families.

5. ICB, local authorities and local Trusts should work collaboratively to review current training programmes for staff (including cares home and GP practices) and agree consistent programmes that focus on provision of good quality palliative and end of life care.

6. Consider the costs and benefits of investing in the Gold Standard Framework to increase the number of accredited GP practices and Care Homes.

7. Review the commissioning of community palliative care services and aim to increase availabiliy to seven days a week.

8. Explore strategies with primary care to increase the number of care plan conversations and the number of plans that are developed and implemented.

9. Use the Compassionate Communities Civic Charter as a framework to develop a Public Health approach to palliative and end of life care that enhances non-clinical support for those with life limiting illness, loss and grief. Commit to working towards achieving Compassionate Communities Accreditation.

8. Building the work programme of the HDRC: Areas for Further Research

We will work through the Health Determinants Research Collaborative to attract funding and partners to explore issues that affect wellbeing in South Tees. This will work to improve our in-depth understanding, develop insights and connect the HDRC directly to policy development and decision-making.

Mission	Area of Research
We will narrow the outcome gap between children growing up in disadvantage and the national average	Better understand why Middlesbrough performs significantly worse than Redcar & Cleveland and other North East LAs. Not only do SEN and FSM children perform worse in Middlesbrough but also Non FSM and No SEN children also perform worse compared to regional and national comparisons.
	Deep dive intelligence gathering involving tracking children through key stages to better understand why the local Progress 8 scores that compare KS2 to KS4 are lower locally (particularly in Middlesbrough) when comparing local children to other similarly performing children nationally.
We want to improve education, training and work prospects for young people	Investigate why Middlesbrough and Redcar & Cleveland had higher proportions of children who are 16/17 year olds who are NEET and also SEN compared to the rest of the North East and England and why this has seen increases in recent years.
We will prioritise and improve mental health and outcomes for young people	To develop a greater understanding of the data collected across the system and develop data sharing agreements across sectors to facilitate a greater understanding of need and more effective design and commissioning of services.

Mission	Area of Research
We will reduce the proportion of our families who are living in poverty	Engage with communities affected by low pay and worklessness to build insights and coproduce employability solutions with communities and partners.
We will create places and systems that promote wellbeing	Review of existing data assets show a good understanding of the range and diversity of green spaces in South Tees. Expand the collation of qualitative data to better understand how green spaces are used by communities and what the barriers to use are.
	Better understand the fall in cycling and walking alongside bus use, particularly concessionary passholders since the pandemic.
	Explore datasets that help to clarify the definition of social capital and how it can be measured.
We will build an inclusive model of care for people suffering from multiple disadvantage across all partners	Develop local inclusion health research to examine the distribution of impacts of interventions across socio-economically disadvantaged areas and groups.
We will promote independence for older people	Explore datasets that help to demonstrate the prevalence of loneliness and social isolation within our elderly population with a focus around digital exclusion.
	Better understand the variation in frailty diagnosis across GP practices and relationship to hospital frailty scores including examining the missing frailty diagnoses from case finder project.
	Research effective social activities for over 65's across South Tees, ensuring that consideration is given to needs-led intelligence, accessibility, inclusivity, the voice of residents and sustainability. Influence funders to develop long term funding for this provision.
	Deep dive intelligence gathering with primary care data to understand the lower dementia care plan review rates in South Tees and the large variation across GP practices
We will ensure everyone has the right to a dignified death	Investigate why higher proportions of residents in Middlesbrough across all ages are dying in hospital with a higher proportion of care home residents (particularly in Middlesbrough but also in R&C) are dying in hospital compared to the national average.

9. Outcomes Framework

The Outcomes Framework details high-level key metrics for each mission to provide a platform for LiveWell South Tees to demonstrate progress. In addition we will develop more detailed metrics and outcomes for each mission.

The Outcomes Framework is detailed in appendix 11.4.

10. Involvement in the JSNA Development

The JSNA was developed with significant engagement across many partners and community groups. The Engagement Log is detailed in appendix 11.5.

11. Appendices

These appendices expand the detail covered in the main body of this Strategy.

11.1 Start Well: Children and young people have the best start in life

11.1.1 Key areas of intelligence

School Readiness and Attainment

- 33% of children in Middlesbrough and 26% in Redcar & Cleveland **live in poverty**, compared to 17% in England. Middlesbrough has the highest rate for local authorities in England, whilst Redcar & Cleveland is 19th. Child poverty in Middlesbrough ranges from 5% in Nunthorpe to 56% in Brambles & Thorntree, and 4% in Hutton and 57% in Grangetown within Redcar & Cleveland.
- The Middlesbrough rate of **children looked after** is twice the England rate at 150 per 10,000 and Redcar & Cleveland is also higher at 125 per 10,000. This is 6th highest for Middlesbrough and 7th highest for Redcar & Cleveland
- **School readiness in reception** is 61% in Middlesbrough, whilst Redcar & Cleveland is similar to the England rate at 68%. The Middlesbrough rate is the 2nd lowest for local authorities in England. School readiness in Middlesbrough ranges from 39% in Central to 79% in Nunthorpe and 43% in South Bank and 83% in Saltburn within Redcar & Cleveland. SEN pupils, Free School Meal (FSM) eligible pupils and those not within those 2 cohorts perform significantly worse in Middlesbrough compared to Redcar & Cleveland and England.
- At aged five the **prevalence of obesity** in reception year at school is 14.1% in Middlesbrough and 10.6% in Redcar and Cleveland compared to the England average of 10.1%. The percentage of children with **dental decay** at five in Redcar and Cleveland is 24.6% and Middlesbrough 31.2% compared to 23.7% in England.
- 56% of pupils in Middlesbrough **achieve a grade 4 in English and maths**, significantly lower than the Redcar & Cleveland rate of 66% and the England rate of 65%. Rates decrease to 38% for FSM pupils in Middlesbrough and 45% for FSM pupils in Redcar& Cleveland compared to 43% in England.
- **Progress 8 scores** show that both Middlesbrough (score -0.47) and Redcar & Cleveland (score -0.33) pupils are making less progress between key stage 2 and 4 compared to similar pupils nationally. The Middlesbrough score is 7th lowest and Redcar & Cleveland score 16th lowest nationally. Schools with higher proportions of FSM pupils have significantly lower progress 8 scores.
- Overall **school attendance** is lower in Middlesbrough at 90% and similar in Redcar & Cleveland compared to England at 92%. Persistent absence however is significantly greater in Middlesbrough at 33%, compared to 23% in Redcar & Cleveland and 24% in England. Both Middlesbrough and Redcar & Cleveland had a significantly higher permanent exclusion rate at 0.28 (73 pupils) and 0.29 (61 pupils) per 10,000 per compared to 0.11 in England. Redcar and Cleveland and Middlesbrough's rates are highest and 2nd highest in England.

Apprenticeships, training and work placement and NEETs

- In England, 93% of 16 to 17 years olds are in **full time education**, compared to 87% in Middlesbrough and 86% in Redcar & Cleveland. In England 5% are in apprenticeships, compared to 3% in Middlesbrough and 7% in Redcar & Cleveland and 1% are in employment combined with study in England compared to 5% in Middlesbrough and 4% in Redcar & Cleveland.
- South Tees has a greater proportion of those on an intermediate **apprenticeship** with 33% in Redcar & Cleveland and 31.4% in Middlesbrough compared to 26.2% in England. Proportions of those on advanced apprenticeships are similar both locally and nationally, however the proportion

of those on higher level apprenticeships is much lower locally with 22.9% in Redcar & Cleveland and 25.5% in Middlesbrough compared to 30.5% in England.

- In Redcar & Cleveland, 6.1% of 16 to 17 years olds and 3.9% in Middlesbrough are **not in education, employment or training (NEETs),** compared to 3.2% in England. The Redcar & Cleveland rate is 30th highest in England.

School based mental health support and access to mental health support

- In Redcar & Cleveland 4.6% of pupils had a **social, emotional and mental health (SEMH)** need as the primary need as part of the SEND cohort and in Middlesbrough it's 4.4%. This is higher than the England rate of 3.7%. The Redcar & Cleveland rate is 22nd highest in England. In both local authorities in South Tees, 71% of SEMH pupils are males. Of the total SEMH cohort, 65% in Middlesbrough are also eligible for FSMs, 55% in Redcar & Cleveland and 47% in England.
- Under 18s had significantly higher rates for **attended contacts with community and outpatient mental health services** locally, with a rate of 68,837 per 100,000 in Redcar & Cleveland and 51,814 per 100,000 in Middlesbrough, compared to 28,396 per 100,000 in England. Middlesbrough and Redcar & Cleveland also have higher rates of **new referrals to secondary mental health** services with 8,280 per 100,000 and 9,000 per 100,000 respectively compared to 6,977 per 100,000 in England.
- **Secondary care waiting times** have increased significantly, particularly in the longer wait times of 53 weeks and over across both local authority areas. This is driven by referrals for suspected autism and neurodevelopmental conditions.

11.1.2 The Challenge: we will narrow the outcome gap between children growing up in disadvantage and the national average

The quality of a child's early experience is vital for their future as children that start school developmentally ready will have a happier, healthier life. Conversely those that start behind fall further behind as they progress through school. School readiness is shaped by many interrelated factors: the effects of poverty, the impact of high-quality early education and care, and the influence of 'good parenting', what parents and carers do daily with their children is important[3].

Children are assessed when they start school to assess their level of development. Those children that are "school ready" have the "broad range of knowledge and skills that provide the right foundation for good future progress through school and life"[4].

In Middlesbrough 39% of children and in Redcar & Cleveland 32% start school behind their peers without the skills necessary to flourish at school.

These averages hide significant variances between areas of South Tees that contribute to the inequalities experienced. In Central and South Bank wards around 60% of children start school behind their peers, falling to around 20% in Nunthorpe and Saltburn.

School readiness is heavily socially profiled and the school readiness figures are reflective of the child poverty figures. 33% of children in Middlesbrough and 26% in Redcar & Cleveland live in poverty; in

[3] www.gov.uk Are you ready? Good practice in School Readiness (2014). Available at: Are_you_ready_Good_practice_in_school_readiness.pdf (publishing.service.gov.uk) (accessed: 31 October 2023).
[4] www.gov.uk (2023), "Statutory framework for the early years foundation stage Setting the standards for learning, development and care for children from birth to five", Department for Education (2023), Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1170108/EYFS_framework_from_September_2023.pdf (accessed: 10 November 2023).

South Bank and Central wards around 41% of children live in poverty, compared to 10% in Saltburn and Nunthorpe wards. These are not the extremes for child poverty in South Tees – in Grangetown and Brambles & Thorntree wards around 57% of children live in poverty, compared to 5% in Hutton and Nunthorpe wards.

The attainment gap between pupils eligible for free school meals and their peers has continued to grow over the last 20 years, particularly in locations where poverty is at its highest, like South Tees where significant socio-economic challenges have driven inequalities in attainment in recent years.

The following factors are highlighted as areas that have advanced the attainment gap through primary school[5]:

- parental aspirations for higher education;
- how far parents and children believe their own actions can affect their lives; and
- children's behavioural problems, including levels of hyperactivity, conduct issues and problems relating to their peers.

Other factors affecting low attainment include: low familial literacy levels, poor health, poverty, disadvantage and poverty of opportunity and entry into the criminal justice system.

The issues affecting poor attainment and the social profile of attainment start early on entry to school, as described above, and cannot solely be attributed to experiences in school. However, the school experience does not narrow the gap that exists on starting school.

56% of pupils in Middlesbrough achieve a grade 4 in English and maths, significantly lower than the Redcar & Cleveland rate of 66% and the England rate of 65%. For those receiving free school meals those rates decrease to 38% for pupils in Middlesbrough and 45% for Redcar& Cleveland compared to 43% in England.

Progress 8 scores show that both Middlesbrough and Redcar & Cleveland pupils are making less progress between key stage 2 and 4 compared to similar pupils nationally. The Middlesbrough score is 7th lowest and Redcar & Cleveland score 16th lowest nationally. Schools with higher proportions of pupils receiving free school meals have significantly lower progress 8 scores.

You cannot achieve at school if you're frequently not there. School attendance is slightly lower than the England average at 92%, however persistent absence is significantly greater in Middlesbrough at 33%, compared to 23% in Redcar & Cleveland and 24% in England. The rates of permanent exclusion are similar in Middlesbrough and Redcar & Cleveland and are the top two highest rates in England.

It is important to highlight that whilst there are significant challenges, many local families overcome barriers daily just to get their children to school and are very resilient in lots of areas of their life.

[5] https://www.jrf.org.uk Poorer children's educational attainment: how important are attitudes and behaviour? (2010), available at https://www.jrf.org.uk/care/poorer-childrens-educational-attainment-how-important-are-attitudes-and-behaviour (accessed 12/08/2024)(2010), available at https://www.jrf.org.uk/care/poorer-childrens-educational-attainment-how-important-are-attitudes-and-behaviour (accessed 1

11.1.3 The Challenge: We want to improve education, training and work prospects for young people

At any age spending time not in employment, education, or training (NEET) has a detrimental effect on physical and mental health. This effect is greater or lasts for longer when that time is experienced at a younger age, increasing the likelihood of unemployment, low wages, or low-quality work later in life. It can also have an impact on unhealthy behaviours and involvement in crime, as well as having a place-based impact. These negative effects do not occur equally across the population, as the chance of being NEET is affected by area deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement, and school experiences.

Being NEET therefore occurs disproportionately among those already experiencing other sources of multiple disadvantages and wards with the highest levels of deprivation also have the highest numbers of young people who are NEET.

The availability of training and re-engagement programmes has reduced in South Tees in the past two years, with the loss of European Social Funding and the Youth Employment Initiative which provided bespoke employment focussed support and brokerage for young people between 15 and 29 years.

Both Middlesbrough and Redcar & Cleveland have a strong track record of encouraging high volumes of apprenticeship participation, however since the introduction of the apprentice levy and new process for apprenticeships, there has been a significant reduction in the overall number of apprenticeships created nationally and in the Tees Valley.

There are fewer options for young people who complete level 3 qualifications to progress further if they do not wish to undertake an academic route and go to university. In England 5% of 16 to 17 years are in apprenticeships, compared to 3% in Middlesbrough and 7% in Redcar & Cleveland. Higher and degree level apprenticeships are growing but there is a lot of competition for these, consequently the proportions of young people on higher level apprenticeships is much lower locally at just over two thirds of the rate in England.

Analysis of risk factors for being a young person (aged 13 to 25) not in employment, education, or training and the extent and degree of overlap between different forms of marginalisation considered six risk clusters, containing between 2 and 3 risk factors, where clusters were developed from those risks factors more likely to be found together. The clusters include: exclusion from school, contact with the police; having a child before 25; living in a single parent household, engaging in anti-social behaviour; special educational needs, low educational attainment; having a parent with a disability, having caring responsibilities; having a limiting disability, having experienced a mental health problem.

The analysis was applied to all local authorities in England, using a weighted average of NEET factors to determine where young people have a higher likelihood of being NEET. **Middlesbrough (2) and Redcar & Cleveland (4) were both in the top five authorities most likely to have a high number of young people not in employment, education or training**.

Funding for skills and employment support is short-term, fragmented, and held centrally, making it extremely challenging for local authorities to provide place leadership and coordinate, plan, target, and join-up provision, or build in the right wider support for those with complex or additional needs. Despite these challenges, Councils continue to work hard to support participation in education, employment and training through commissioning devolved and local provision, and by joining-up and adding value to national schemes.

Transport is fundamental to connecting young people with education, training, job opportunities and support services. The high cost of public transport, lack of transport and long journey times in some areas, especially rural such as Redcar & Cleveland, is a significant issue and barrier for young people.

11.1.4 The Challenge: We will prioritise and improve mental health and outcomes for young people

Failure to support children and young people with mental health needs costs lives and money. Mental health problems often develop early - **half of all mental health problems in adulthood are established by the age of 14, with three quarters established by 24**. Early intervention prevents young people falling into crisis and avoids expensive and longer-term interventions in adulthood. Prompt access to appropriate support enables children and young people experiencing difficulties to maximise their prospects for a healthy and happy life.[4] The case for early intervention is strong and that support can enable children and young people to cope with difficult circumstances and prevent escalation into specialist services.

Mental health problems impact upon every aspect of a young person's life. This includes their ability to engage with education, make and keep friends, engage in constructive family relationships and find their own way in the world. Poor mental wellbeing in childhood increases the likelihood in later life of poor educational attainment, antisocial behaviour, smoking, drug and alcohol misuse, teenage pregnancy, involvement in criminal activity and mental health problems.[5]

The rates of probable mental disorder increased significantly between 2017 and 2021 – rising from one in nine to one in six for children aged between 6 and 16 and from one in ten to one in six for those aged between 17 and 19 years.

The most common issues in the teenage years include anxiety and depression, behavioural disorders, eating disorders, and self-harm. For some mental health issues may resolve with time, though many continue to have difficulties into adulthood.

The impact of the Covid-19 pandemic on children and young people's mental health is not fully understood, whilst the evidence on the direct impact of lockdown on mental health and wellbeing of younger people was mixed, most studies show increased levels of distress, worry and anxiety.[6]

Nationally there has been continued growth in the number of referrals for children and young people aged 18 and under to children and young people's mental health services. In the six months up to February 2023, there were more than double the number of referrals compared to the same period in 2019/20. This compares to a 1% increase in referrals to mental health services for adults during the same period.[7]

In South Tees attendance rates for community and outpatient mental health services for under 18s are double the rates for England, with referrals into secondary mental health services significantly

higher too (19% higher for Middlesbrough and 29% higher for Redcar & Cleveland). Waiting times for secondary care have increased significantly, particularly in the longer wait times (53 weeks and over) across both local authority areas. This is driven by referrals for suspected autism and neurodevelopmental conditions.

The impact of the home life on the mental health of children and young people is hugely significant. A child's healthy development depends on their parents—and other caregivers—who serve as their first sources of support in becoming independent and leading healthy and successful lives. The vast majority of parents and caregivers want only for their children to be happy and provide a stable family life.

Parents' understanding of the sources of support they can access to better support the wellbeing of their children can be limited and that support may not be universally available due to geography or eligibility criteria. Families living with disadvantage and trauma may be less likely to seek support as the issues they face and circumstances in which they live leave little energy to seek out services and reach out for help. There is still stigma surrounding mental ill-health and many parents feel they will be judged for being inadequate if they do ask for help.

Schools should be a safe space where the education and well-being of those attending is the primary aim. All schools have a statutory duty to promote the welfare of their pupils, which includes preventing impairment of children's health or development, and taking action to enable all children to have the best outcomes.

Schools provide a first line of defence – recognising signs and symptoms at a very early stage and preventing conditions escalating. Schools are essential in promoting resilience, particularly for those pupils who have less supportive and secure home environments. Schools should be a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems. Risk is cumulative; the greater the number of adverse experiences and level of disadvantage experienced - the more protective factors are required.

Regular attendance in education settings is essential for all children and young people to benefit from an environment that will provide a safe space with the necessary protective factors to improve resilience and consequently achieve good emotional health; preventing and minimising the likelihood of mental ill-health at a young age and beyond.

For those children and young people experiencing adverse childhood experience within the home and community, school can provide the only stability within their lives.

The Getting Help Collaborative works across local authorities, NHS and the VCS, and all educational settings across South Tees have access to Getting Help support. The funding model for this approach is patchwork and short term, making longer term planning and capacity building more difficult.

11.2 Live Well: People live healthier and longer lives

11.2.1 Key areas of intelligence

Debt and Employment

- The Middlesbrough IMD score is ranked 5th **most deprived** of English local authorities whilst Redcar & Cleveland is ranked 31st most deprived. Middlesbrough ranks the lowest for the income

domain and 3rd lowest for employment. Redcar & Cleveland ranks 8th lowest in the employment domain.

- In Middlesbrough, 48.8% of LSOAs are within the **10% most deprived LSOAs** in England. In Redcar & Cleveland the proportion is 26.4% of LSOAs are within the most deprived 10% nationally. The Middlesbrough rate is the highest rate out of all 153 local authorities in England, whilst the Redcar & Cleveland rate is 23rd highest.
- Middlesbrough had the highest rate of **personal insolvencies** in England at 52 per 10,000 adults and Redcar & Cleveland was ranked the seventh highest local authority with a rate of 42 per 10,000 adults. This was more than double the national average of 25 per 10,000 adults.
- Over the last 3 years Middlesbrough CAB has supported a total of 2,027 residents with debt issues. The wards with the highest demand for **support with debt issues** came from residents in Newport; Central; Longlands & Beechwood; Berwick Hills & Pallister and Brambles & Thorntree wards. Redcar and Cleveland CAB has supported a total of 1,639 residents with debt issues, with the highest demand coming from residents living in Coatham, Kirkleatham, Eston, Dormanstown, Grangetown and Guisborough wards.
- The number of **social housing tenants with rent arrears** in Redcar & Cleveland is increasing year on year. In 2022/23 the Beyond Housing Group had 3,188 tenants living with rent arrears (33% of their total tenants). In Middlesbrough, the Thirteen Group had 5,265 tenants living with rent arrears (42% of their total tenants.
- Middlesbrough is ranked the highest out of 307 local authorities in England **for cost-of-living vulnerability**, whilst Redcar & Cleveland is ranked 12th highest

- 29.3% of working age adults are **economically Inactive** in Middlesbrough and 28.5% in Redcar & Cleveland, compared to 21.3% in England. A breakdown shows that Middlesbrough (32%) and more so Redcar & Cleveland (41%) has a higher proportion of those economically inactive due to long-term sickness compared to England (25%).
- Of the 44 wards in South Tees, 32 have a higher rate of **economic inactivity due to long term sickness or disability** then then England average.
- Since the easing of lockdown restrictions, **unemployment-related claimant** rates have fallen to 5.9% in Middlesbrough and 4% in Redcar & Cleveland, an equivalent of approximated 8,400 people in South Tees. This is higher compared to 3.8% in England and still higher than pre-pandemic levels. Middlesbrough's rate is the 15th highest of local authorities in England. North Ormesby ward had the highest claimant rate in Middlesbrough at 23.4% and Grangetown ward in Redcar & Cleveland with 15.5%.
- There is a smaller proportion of those in **professional occupations** with 34% in Middlesbrough and 41% in Redcar & Cleveland compared to 52% in England. A large difference is seen in the elementary and routine occupation group where the Middlesbrough proportion is 29% and Redcar & Cleveland is 22% compared to only 15% in England.
- The **average salary** in Middlesbrough is £35.6k and £34.7k in Redcar & Cleveland in 2023. This is significantly lower than the UK average income of £42.2k.
- Middlesbrough has a much higher proportion of the population who have **no qualifications** at 23.9% and Redcar & Cleveland at 22%, compared to 18.1% in England.

<u>Housing, Green Spaces, Transport and Social Capital</u>

- Redcar and Cleveland has a **housing stock** of nearly 66,000 residential properties, with 83% falling within the lower Council tax bands A to C. In Middlesbrough, there are approximately 65,500 dwellings, with 85% falling within the lowest three tax bands. The proportion of dwellings in bands D to H in both boroughs (17% and 15% respectively) is low compared to England at 35%.
- Redcar & Cleveland has a higher proportion of properties that are **privately owned** at 65%, compared to 61% in England. Middlesbrough's proportion is much lower at 55%. Middlesbrough has a higher proportion of socially rented properties at 23% compared to 19% in Redcar &

Cleveland and 17% in England. Private rented property rates are similar in Middlesbrough at 21% compared to England at 21%, however Redcar & Cleveland is lower at 16%.

- In Middlesbrough 40% of the private sector housing fails the **Decent Homes Standard**. With the figure in Redcar and Cleveland being slightly higher at 45%. Both figures are higher than the national average of 14%.

- Middlesbrough has a lower rate (19 sqm) of the **minimum standard of green space** provision (24 sqm per individual). This is compared to Redcar & Cleveland at 25 sqm and England at 29 sqm.
- Redcar & Cleveland's population has a lower average **distance to their nearest park, public garden or playing fields** compared to England whilst Middlesbrough has a greater distance. However the average size of these areas is significantly lower in Middlesbrough and more so in Redcar & Cleveland compared to England.
- Just over a quarter of residents in Redcar and Cleveland have opportunities for **regular local access to natural spaces**; whereas it's closer to a third of the residents of Middlesbrough with access
- Redcar & Cleveland has a significantly higher rate of residents who have **access to woodland** at 30% compared to England at 15%. This is the 17th highest nationally for local authorities in England. Middlesbrough's value is significantly lower at 10%.
- Properties in South Tees have a higher proportion with **access to private open space** compared to England, however these areas are smaller than the national average.

- Both Middlesbrough and Redcar & Cleveland have lower levels of **adults who walk or cycle** for any purpose compared to England.
- In South Tees, there are lower rates of **bus journeys** per head of population compared with England, with trends showing reductions over time. Concessionary journeys as a proportion of all journeys. Even though Redcar & Cleveland has fewer journeys, the proportion that are concessionary is higher than Middlesbrough and both are higher than England. South Tees has seen large reductions.
- Middlesbrough has the higher proportion of the population who **travel less than 10km to work** (64%) compared to Redcar & Cleveland (46%) and England (41%). Redcar & Cleveland residents are travelling further distances to work. Significantly fewer people are working mainly from home in Middlesbrough and Redcar & Cleveland compared to England. The data demonstrates that over 51,000 people in South Tees travel less than 10km to work.
- Redcar & Cleveland and Middlesbrough have higher proportions of residents who use a **car or van to travel to work** compared to England. Middlesbrough has higher rates of those who use a taxi, who are a passenger in a car or van and who walk on foot compared to England. Bicycle journeys in Middlesbrough are very similar to England, but lower for Redcar & Cleveland.
- Between 2018-20, Redcar & Cleveland had the highest rate of **children killed or seriously injured on roads** with a rate per 100,000 of 26.9 compared to 15.9 in England. This is the 13th highest rate for local authorities in England. Middlesbrough was slightly lower compared to England with a rate of 13.5.
- Redcar & Cleveland has twice the level of **total emissions** at 1,215 kilotonnes compared to Middlesbrough at 654. CO2 is the most prevalent greenhouse gas emissions, accounting for 86.4% in Middlesbrough, around two percentage points higher than England (84.3%). Redcar & Cleveland has a higher proportion at 93%.

- The **thriving places index** shows that within the people and community domain, both Middlesbrough and Redcar & Cleveland score lower compared to England. In Middlesbrough, scores are lowest for the participation and culture subdomain, whilst community cohesion is above the England average. In Redcar & Cleveland the lowest subdomain is participation, followed by culture. Again, community cohesion is above the national average.

- Data from ONS **personal wellbeing** estimates that mean scores for life satisfaction are lower in Redcar & Cleveland and Middlesbrough compared to England. Scores are also lower for the worthwhile measure locally. Middlesbrough saw the biggest difference in the happiness measure compared to England. Redcar & Cleveland residents score similar to England for levels of anxiety, whilst Middlesbrough residents score lower.

Risk factors for ill health and prevention

- The estimated **smoking prevalence** in Middlesbrough for adults in 2022 is 16.5%, significantly higher than the England rate of 12.7%. Redcar & Cleveland's rate is lower compared to Middlesbrough at 13.7%.
- GP patient survey for 2022 shows prevalence of **regular or occasional smokers by South Tees GP practices** which highlights the significant variation across the local area with rates highest at just under 30% and lowest at approximately 6%. There are 7 GP practices with prevalence of over 20%, 6 of which are in Middlesbrough.
- Middlesbrough and Redcar & Cleveland both have a value of 14% for women **smoking at time of delivery**. This is the 12th and 13th highest local authority rates in England.
- Middlesbrough and Redcar & Cleveland have significantly higher rates of **potential years of life lost (PYLL)** compared to England for both males and females. The Middlesbrough rate of PYLL for males is 8th highest of local authorities in England and the Redcar & Cleveland rank is 10th highest. For females the ranks are even higher where Middlesbrough is ranked 5th highest and Redcar & Cleveland is ranked 8th highest.
- Middlesbrough has a significantly smaller proportion of **adults who are classified as active**, with 54% compared to 63% in England. Redcar & Cleveland is slightly higher at 58% but still below the England average. Middlesbrough's rate is ranked the 20th highest in England.
- **Levels of activity for the most deprived** (deciles 1-3) communities in Middlesbrough and Redcar & Cleveland are lower at 48% compared to the most deprived areas in England. The most affluent areas (deciles 7-10) in Middlesbrough do have higher rates at 61% but these are still below the most affluent areas across the rest of England. Redcar & Cleveland is higher at 65% but still below the England average.
- Redcar & Cleveland has a higher rate of those **classified as overweight or obese** at 72% compared to 71% in North East and 64% in England. Middlesbrough has a lower rate at 71%, similar to the North East rate. Redcar & Cleveland is ranked 12th highest local authority in England and Middlesbrough is ranked 23rd highest.
- The **life expectancy** for Middlesbrough males is 75.4 which is 4 years below the England value of 79.4 and 9.3 years below the highest local authority in England. Redcar & Cleveland is slightly higher at 77.5 but still below the England value. Middlesbrough has the second lowest life expectancy for males for local authorities in England.
- Female **life expectancy** is also lower in Middlesbrough at 79.8 years, 3.3 years below the England value and 8.1 years below the highest local authority in England. Middlesbrough has the 4th lowest life expectancy rate for females for local authorities in England.
- There is a strong correlation between **deprivation and life expectancy**, particularly for males. There is a 14.9 year gap between the lowest life expectancy ward of Central at 69.4 years to the highest life expectancy ward of Hutton with 84.3 years. The gap is smaller for females but still significant at 11.4 years between Berwick Hills & Pallister at 75.7 years and Kader with 87 years.
- **Healthy life expectancy** for both men and women is lower in Redcar & Cleveland compared to Middlesbrough and England and is the 8th lowest for males and 21st lowest for females compared to all local authorities in England. Healthy life expectancy for women in Redcar & Cleveland reduced from 61.4 in 2015-17 to 58.5 in 2018-20.
- 37% of deaths for Middlesbrough were **premature deaths** (under 75) and 35% in Redcar & Cleveland were premature deaths. This is significantly higher than the national rate of 25.5% of deaths were premature deaths.

- In **Middlesbrough** for males, external causes (deaths from injuries, poisonings, and suicide) contributed most to the life expectancy gap with 26% follower by other with 15% and cancer with 15%. For females, cancer contributed the most to the life expectancy gap with 23% followed by circulatory (including coronary heart disease and stroke) with 16% and respiratory (including flu, pneumonia, and chronic lower respiratory disease) with 12%.
- In **Redcar & Cleveland** for males, external causes contributed most to the life expectancy gap with 45% followed by cancer with 23% and other with 12%. For females, cancer contributed the most to the life expectancy gap with 40% followed by external causes with 19% and digestive (including alcohol-related conditions) with 15%.
- The **prevalence of CHD, stroke and hypertension** in GP patient registers is significantly higher in Redcar & Cleveland compared to England. Middlesbrough rates are similar to England levels.
- **Lung cancer** is the most common cause of cancer death locally and nationally. Of the under 75 deaths from cancer in 2021, 30% in Middlesbrough and 26% in Redcar & Cleveland were for lung cancer.
- The **prevalence of COPD** in GP patients is significantly higher in South Tees with 3.5% in Redcar & Cleveland and 2.8% in England. The Redcar & Cleveland rate is the 3rd highest of local authorities in England. Those living with COPD in Middlesbrough have a much greater rate of emergency admissions, the 6th highest nationally with a 45 rate of 832 per 100,000 compared to 415 per 100,000 in England.

- For **cancer screening**, both Middlesbrough and Redcar & Cleveland have higher breast cancer screening uptake rates then the national average but sit below the North East rate. Redcar & Cleveland had an uptake rate of 76% for cervical cancer screening, however the Middlesbrough uptake rate was much lower at 62%, compared to 68% in England. Middlesbrough's rate of 62% ranks 34th lowest out of 150 local authorities. Redcar & Cleveland has a rate of 71% for bowel cancer screening compared to the England rate of 70%, however Middlesbrough's uptake rate is much lower at 66%, this ranks Middlesbrough 48th lowest out of 150 local authorities.
- Redcar & Cleveland has a higher rate of **NHS health check** invitations compared to England and Middlesbrough, however of those invited individuals, Redcar & Cleveland has a lower rate of those who received a health check at 33% compared to 37% in Middlesbrough and 39% in England.
- Middlesbrough and Redcar & Cleveland have significantly higher prevalence rates of **common mental health disorders** compared to England. Data from GPs shows the QOF prevalence for depression is lower in Middlesbrough at 12% compared to England at 13% but significantly higher in Redcar & Cleveland at 17%, the 9th highest nationally for local authorities. ESA claimant rates for mental and behavioural disorders is significantly higher in South Tees compared to England with Middlesbrough having the 4th highest rate of local authorities in England.
- The rate of **inpatient stays in secondary mental health services** in Middlesbrough is significantly higher at 556 per 100,000 compared to England at 241 per 100,000. Middlesbrough's rate is the highest of any local authority. Redcar & Cleveland has a lower rate at 391 per 100,000 but still significantly higher than England.
- Redcar & Cleveland has the highest **suicide rate** for local authorities in England with a rate of 18.3 per 100,000 compared to 10.3 in England. The Middlesbrough rate is also higher at 16.5 per 100,000.
- All **new STI diagnoses** per 100,000 shows the Middlesbrough rate is significantly higher at 757 per 100,000 compared to England rate of 694 per 100,000. Redcar & Cleveland's rate is significantly lower compared to England at 565 per 100,000.
- The **Syphilis diagnostic rate** locally, particularly in Middlesbrough is significantly higher at 45 per 100,000 compared to the England rate of 15 per 100,000. Redcar & Cleveland's rate is lower than Middlesbrough at 21 per 100,000 but still higher than the England rate.

Violence, Inclusion Health Groups and Parental Substance Misuse

- **Serious violent crimes** are increasing in terms of volume and rate per 1,000 population across South Tees, with the proportions of offences over time being consistently highest in Middlesbrough.
- Middlesbrough had a much higher rate of **total recorded crime** than Redcar and Cleveland. For Middlesbrough, this constituted a 24% increase from the previous year, whilst the increase was slightly lower for Redcar and Cleveland, at 14%. Recent data collected by Middlesbrough's Community Safety Partnership shows that 1 in every 12 violent crimes in Middlesbrough are serious violence offences.
- **Violent crimes in South Tees shows increases across all categories** for both Redcar & Cleveland and Middlesbrough. Both areas saw relatively similar increases in sexual offences, with Middlesbrough seeing a 27% increase, and Redcar & Cleveland seeing slightly more, at 29%. Similarly, increases in stalking and harassment were similar. However, when looking at violence with injury, violence without injury and violence against the person, differences are clear, with Middlesbrough seeing higher increases.
- **Knife crime** in Cleveland is of concerning prevalence, with statistics showing that Cleveland ranks second highest nationally for the rate of offences involving knives and sharp instrument.
- Within Cleveland, **domestic violence** was identified as the most significant driver behind serious violence, with levels accounting for one fifth (20%) of all serious violence.
- Middlesbrough has almost double the rate of **hospital admissions for violence** per 100,000 of the population (124) than the rate for all English unitary authorities (64). Redcar & Cleveland has a much higher rate, at 175, which is almost triple the mean for all English Unitary Authorities.

- South Tees has a higher proportion of the adult population in **alcohol and substance misuse treatment**, with 1.9% in Middlesbrough and 1.1% in Redcar & Cleveland compared to 0.6% in England.
- South Tees has a significantly higher rate of **drug-related deaths** than the national average; with a rate of 14.1 per 100,000 in Middlesbrough and 8.5 per 100,000 in Redcar & Cleveland compared to the national rate of 5.2.
- The rate of **alcohol-related admissions** is 1,027 per 100,000 population in South Tees, compared to the national rate of 648 per 100,000.
- Middlesbrough has significantly higher rates of **households owed a duty under the homeless reduction act** compared to England, whilst Redcar & Cleveland is significantly lower.
- Regionally, the North East hosts the most **asylum seekers and resettled refugees** out of all regions. In 2021 Middlesbrough had a higher proportion of migrants from outside of the UK that arrived in the country (1.6%) than England as a whole (0.9%).
- Middlesbrough recorded the second highest number of **migrant GP registrations** of all local authorities in the region, whilst Redcar & Cleveland had the lowest number.
- Redcar & Cleveland have the second highest number of **first-time entrants into the youth justice system**, with a rate of 247 per 100,000 population. This is significantly higher than the national value (149) and the regional value (152). Middlesbrough has the fifth highest prevalence, with a value of 189.

- Approximately 19% of children aged 0-17 in South Tees are estimated to live in households with any of the three **trio of vulnerabilities** (alcohol/substance misuse, domestic abuse and mental health) present (10,472 children). Approximately 17% of children aged 0-4 in South Tees are estimated to live in a household with any of these three factors (2,556 children).
- Of all **drug clients in treatment**, 42% in Middlesbrough and 33% in Redcar & Cleveland were a parent (full or partial responsibility for one or more children under 18). This is significantly higher, particularly in Middlesbrough compared to 29% in England. Of those that had a record of parental status, 29% in Middlesbrough and 30% in Redcar & Cleveland had recorded that all the children live with the client, higher than the national rate of 26%.

- Of all **alcohol clients in treatment**, 42% in Middlesbrough and 38% in Redcar & Cleveland were a parent. This is significantly higher compared to 31% in England. Much higher proportions of all are children living with the clients in alcohol treatment compared to drug treatment. In Middlesbrough 42% and 38% in Redcar & Cleveland have all children living with client compared to 31% in England.
- Data from Middlesbrough Council's **children's social care** shows the assessment factor information for episodes relating to child in need. 18% had parental alcohol misuse as a factor identified and 23% had parental drug misuse as a factor.
- The rate of **emergency hospital admissions for accidental poisoning in children** ages 0-4 year is significantly higher in Middlesbrough with a rate of 209 per 100,000 and Redcar & Cleveland with a rate of 140 per 100,000 compared to the England rate of 114 per 100,000.

11.2.2 The Challenge: we will reduce the proportion of our families who are living in poverty

Many communities in South Tees are in the 10% most deprived communities (called lower super-output areas or LSOAs) – almost half Middlesbrough's LSOA's and just over a quarter in Redcar & Cleveland are amongst the poorest communities in England. The Middlesbrough rate is the highest of all 153 local authorities in England, whilst the Redcar & Cleveland rate is 23rd highest.

Consequently Middlesbrough had the highest rate of personal insolvencies in England (double the national average) and Redcar & Cleveland the seventh highest rate; the numbers of social housing tenants with rest arrears is significant and increasing in both areas as is the demand for support with issues arising from debt.

There is a strong relationship between poverty, debt, ill-health and health inequalities.
Recent national analysis demonstrates that for a fifth of low-income families the cost-of-living crisis has resulted in new debt to pay bills like rent and energy. In May 2023 5.7 million families amongst the poorest 40% had over £14 billion in unsecured debt (personal loans, credit cards, overdrafts, pay-day lenders, and doorstep loans); an average of £2,500 per family.

The Citizens Advice Bureau define a person as being in problem debt if they are unable to afford their debt repayments. When debt or repayments become unsustainable, it can drive worsening mental and physical health and there is evidence of a strong correlation between problem debt and various mental health issues including stress and depression, relationship difficulties, alcoholism and financial exclusion from mainstream credit. In extreme cases problem debt can lead to homelessness or risk of homelessness through eviction due to rent arrears or mortgage repossession, being disconnected from utility supplies and court summons. At the most extreme end, the link between problem debt and suicide is well established.

Problem debt has profound health, wellbeing, economic and social impacts for families and communities. From not having enough money to cover basic needs to social exclusion (for both adults and children) as households reduce spending on social activities or become isolated from friends due to feelings of shame and stigma because of their financial difficulties and lack of money. Being unable to purchase basic white goods such as washers and fridges has a huge impact on families, and many are tempted to use high interest store loans for household goods and many are also struggling with furniture poverty, impacted further when local charitable furniture services cease.

The characteristics of households with problem debt reflect the characteristics of households in poverty, reflecting the link between problem debt and low income. Problem debt is also driven by

low financial resilience in the form of savings and events such as unexpected household expenses, the birth of a child, redundancy and ill health.

The cost of living crisis has increased costs for energy and food, rent and fuel although it disproportionately impacts on households with lower incomes. In higher-income households this can mean cutting back on non-essential items; however, in lower income households it can mean cutting back on necessities like food to pay for heating. Many people have fallen into arrears or using credit to pay for essentials or being taken advantage of by predatory non-regulated lenders charging excessive interest, making problems worse. Households can end up paying back substantially more than they borrowed and those struggling can end up in a "debt-spiral" where households borrow more to service existing debts.

Debts to the public sector are an increasing source of problem debt, typically for those already in need of financial support. More than one in ten of the nearly 5 million Universal Credit claimants have money deducted from their benefits for debt repayments, often leaving people with less than they need for necessities. Changes to the welfare system, including built-in delays on change in status and reduced levels of benefits, particularly affecting people with a disability and families with more than two children. Many families have to pay back Universal Credit advances, or experience high housing costs or other deductions from their benefits that mean that their experiences are even worse. Public sector debt collection practices can make debt problems worse, placing greater pressure on household finances.

The National Poverty Commission states that it is not enough to just consider income, but plans should also consider unavoidable costs; specifically housing costs, childcare costs, costs of disability, energy costs and travel costs.

More working age adults are economically inactive in Middlesbrough (29.3%) and Redcar & Cleveland (28.5%) than England (21.3%) and a significantly higher proportion of those are inactive due to long-term sickness - 32 of the 44 wards in South Tees have a higher rate of economic inactivity due to long term sickness or disability then then England average. Long term sickness is very socially profiled, being more prevalent in our poorest communities. Unemployment claimant rates are still higher than England, affecting around 8,400 people across South Tees. Middlesbrough's unemployment rate (5.9%; Redcar & Cleveland is 4%, similar to the England rate) is the 15th highest of local authorities in England. Some of our communities experience significantly higher rates of unemployment - North Ormesby had the highest claimant rate in Middlesbrough at 23.4% and Grangetown ward in Redcar & Cleveland with 15.5%.

Those that are in work are less likely to be in professional occupations, more likely to be earning less (around 83% of the England average) and more likely to have no qualifications than the England average.

Work and skills both have a significant impact on health and wellbeing. The relationship between work and health is complex. Good work can maintain health, and poor work can be detrimental to health. To maintain health, work needs to be paid adequately, be safe and stable, offer opportunity for development, prevent social isolation, and offer a degree of control or decision making.

Good work is important but not universally available or equitably distributed – people living in poorer areas are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often with poor working conditions that are harmful to health, and many are trapped in a cycle of low-paid, poor-quality work and unemployment.

Good quality work protects against social exclusion, which in turn leads to better health. Conversely no work, or poorer working conditions can pose a risk to an individual's health and wellbeing. There are many barriers for some members of our communities to access high quality employment and skill development, including: financial, in particular the transition from benefits into insecure employment; affordable, accessible transport; caring responsibilities, including child care; security of housing; experience of criminal justice system; recovery from substance use; low level of educational attainment, qualification and skills and mental health issues.

In addition to building our communities, investing in skills development and good employment has a positive impact on social wellbeing and inclusion. High-quality employment opportunities provide individuals with financial stability, self-worth, and a sense of purpose, promoting overall social wellbeing and inclusion. It can then help to reduce the socio-economic disparities within the area, ensuring that everyone has access to decent work and fair wages.

11.2.3 The Challenge: we will create places and systems that promote wellbeing

There are just over 130,000 residential properties in South Tees, with more than 80% in the lowest Council tax bands (A to C). The proportion of properties in the highest Council tax bands (D to H) is less than half the England average.

Housing has an important impact on health and well-being: good quality, affordable and appropriate to needs in places where people want to live has a positive influence on reducing deprivation and health inequalities by facilitating stable and secure family lives. This in turn helps to improve social, environmental, personal, and economic well-being. Conversely, living in housing which is in poor condition, overcrowded or unsuitable will adversely affect the health and well-being of individuals and families.

A decent, affordable home is an essential requirement for tackling health inequalities and reducing the burden on health and social care services and cost to the public purse. Housing is a wider determinant of health, and good quality housing which meets the needs of an individual, supplemented by support services where required, can promote independence and well-being. The rate of private sector housing failing the Decent Homes Standard is over 40% across South Tees – almost three times the national average of 14%.

Formal and informal green spaces, including formal parks, more natural habitats, allotments and private gardens, are increasingly recognised as important assets for supporting health and wellbeing. "Natural capital" can support our response to health and wider social issues that we face locally in South Tees, including improving health and wellbeing, reducing health and social care costs, tackling health inequalities, improving social cohesion and taking positive action on the climate crisis. There is also growing evidence for the importance of blue spaces – outdoor areas that include water, including coasts, rivers, canals and even fountains - in improving health and wellbeing, which is particularly relevant for South Tees, with extensive access to the coast, rivers, and other wetlands within the geography. "Grey spaces", such as backyards and alleyways, can also contribute to improving wellbeing.

A green and blue environment can promote and protect good health, support recovery from illness and help manage poor health. Green and blue spaces are also associated with improved mental health and wellbeing outcomes including reduced levels of depression, anxiety, and fatigue, and enhanced quality of life for both children and adults. Specific initiatives, such as green social

prescribing and green hubs, are now recognised as valuable in improving both physical and mental wellbeing, alongside less formal connectedness with nature. Green space can help to improve social cohesion, reduce loneliness, and mitigate the negative effects of air pollution, noise, heat and flooding. Disadvantaged groups may gain a more significant health benefit and have reduced socioeconomic-related inequalities in health when living in greener communities, so a greener environment can also be used as an important tool in tackling social and economic inequalities.

Despite the potential and importance outlined above, it can be challenging to make a compelling case for the maintenance or improvement of green space, which is often seen as a liability rather than an asset. The full extent of the benefits can be unrealised because they are difficult to measure or are accumulated over an extended time period. Natural capital accounting methodology and tools have now evolved that can support a greater understanding of the value of our green and blue spaces.

Increasing cycling, wheeling and walking can help tackle some of the most challenging issues we face as a society – improving air quality, combatting climate change, improving health and wellbeing, addressing inequalities and tackling congestion on our roads.

Concerted action to increase the opportunities for cycling and walking will help to create better places to live and work – with better connected, healthier and more sustainable communities. It will help deliver clean growth, by supporting local businesses, as well as helping an increase in prosperity.

There are national examples that demonstrate that significant changes to urban infrastructure can effectively promote cycling and walking, leading to a safer, healthier, and more vibrant urban environment. The scheme's success highlights the importance of leadership, community engagement, collaboration, and adaptability in implementing such transformative initiatives.

The use of public transport may also bring about health benefits. Reducing the number of journeys made by car will assist with reducing air pollution and improving air quality. Using public transport can contribute to meeting the Chief Medical Officer's guidelines on levels of physical activity. One in three public transport users meet physical activity guidelines suggesting that shifts from sedentary travel modes, such as driving a car, to public transport could dramatically raise the proportion of populations achieving recommended levels of physical activity.

The UK Health Security Agency estimates the burden of long-term exposure to air pollution in the UK is equivalent to between 29,000 to 43,000 deaths for adults aged 30 and over. Air pollution comes from a variety of sources, with road use contributing significantly to nitrous oxide and particulate matter levels. It is the largest environmental health risk in the UK, shortens lives and contributes to chronic illness. There is currently no clear evidence of a safe level of exposure to air pollution below which there is no risk of adverse health effects.

Social capital is the 'glue' that holds societies together, defined as: "the extent and nature of our connections with others and the collective attitudes and behaviours between people that support a well-functioning, close-knit society." Higher levels of social capital are beneficial and can be associated with better outcomes in health, education, employment and civic engagement.

There are various factors that contribute to creating social capital in a place, including: sense of belonging, strength of social networks, participation, citizen power to affect place, diversity and trust and safety.

Social capital is created by deepening existing relationships, creating new relationships, and leveraging relationships with people in power.

11.2.4 The Challenge: we will support people and communities to build better health

Reducing the prevalence of leading risk factors of ill health and premature mortality, such as smoking, harmful alcohol use, physical inactivity and poor diet and obesity, will reduce the levels of poor health across South Tees and reduce inequalities. Detecting diseases and ill health earlier, when followed up by appropriate clinical interventions and pathways, leads to better health outcomes and prevents premature death.

Smoking remains the leading cause of preventable death in the UK, and local prevalence is higher than the England average, with the rate in Middlesbrough significantly higher. Smoking rates are heavily socially profiled, with rates much higher in more deprived areas. The costs of smoking drive families further into poverty – with more than 12,000 households estimated to be affected across South Tees. More than 20,000 children in South Tees live in households with adults who smoke. Smoking in the home not only damages the health of children through second hand smoke but increases their chance of becoming smokers four-fold.

The average smoker spends just under £2,000 a year on tobacco, a total of £32.95M in Redcar & Cleveland and £36.14M in Middlesbrough every year.

Alcohol related admissions are higher in South Tees than the national average and deaths are increasing, particularly in our most deprived communities. Levels of alcohol related harm in Middlesbrough are among the highest in the country, both adults and young people are more likely to be admitted to hospital for alcohol related harm than in most other areas of England. Whilst alcohol is a significant part of the night-time economy the combination of night-time revellers, licensed premises and alcohol consumption leading to violence, vulnerability and harm causes significant demand for blue light services and A&E departments at times when such are under great pressure.

Poor diet and physical inactivity are leading risk factors for overweight and obesity, which significantly increase the risk of developing conditions including type 2 diabetes, some cancers, cardiovascular disease as well as contributing to poor mental health. Rates of overweight and obesity among adults and children have increased in the UK over the last decade with high levels of childhood and adult obesity across South Tees, higher than the national average, with physical inactivity levels low across Middlesbrough and Redcar & Cleveland.

Reducing the prevalence of leading risk factors such as smoking, harmful alcohol use, physical inactivity and poor diet and obesity, we will be able to reduce the subsequent ill health and premature mortality that is evident across South Tees particularly in our more deprived areas. In addition to reducing risk factors detecting diseases and ill health earlier, when followed up by appropriate clinical interventions and pathways, leads to better health outcomes and prevents premature death.

The major causes of premature mortality across South Tees are: cancer, cardiovascular disease, respiratory conditions, diabetes and external causes.

Core20Plus5 is a national NHS approach to support reduction of health inequalities. The approach defines a target population cohort (those living in the 20% most deprived neighbourhoods and those with multiple disadvantage - the "Core20PLUS") and identifies five clinical areas that require accelerated improvement: maternity care, in particular continuity of care for disadvantaged groups; improving the physical health of those with severe mental illness; increasing vaccine uptake to reduce exacerbation of respiratory conditions; early cancer diagnosis and hypertension case finding (high blood pressure).

Cancer is one of the leading causes of premature mortality, and evidence has shown that 4 out of 10 cancers are preventable. Data from ONS shows that for total deaths in Middlesbrough, Redcar & Cleveland, Cancer is the most common cause of death accounting for 25.6% in Middlesbrough and 27.2% in Redcar and Cleveland. Locally there are also higher rates for chronic lower respiratory diseases and accidents.

The biggest long-term difference we can make to premature mortality and healthy life expectancy is to implement effective, evidence-based prevention programmes across the local health and care system.

11.2.5 The Challenge: we will build an inclusive model of care for people suffering from multiple disadvantage across all partners

Violence causes ill-health directly and indirectly, particularly in certain circumstances. Violent abuse in childhood can increase the risk of violence in later life and increase the risk of substance use in adulthood. Violence in communities can impact an individuals' autonomy and ability to make healthier lifestyle choices, limiting ability to exercise, socialise, use outdoor facilities, and use public transport.

Violent crimes in South Tees have increased across all categories, with similar increases in both areas for sexual offences (around 28%) and increases in stalking and harassment. However, Middlesbrough has much higher increases for violence with injury, violence without injury and violence against the person,.

Knife crime is a significant issue, and the Cleveland Police area ranks second highest nationally for the rate of offences involving knives and sharp instrument. Domestic violence is the most significant driver behind serious violence, with levels accounting for 20% of all serious violence in Cleveland.

The rate of hospital admissions for violence in South Tees is much higher than the rate for England – the admission rate for Redcar & Cleveland is almost triple the England rate Middlesbrough is almost double.

There is a clear link between drug and alcohol misuse and crime, in particular violent crime. Nationally between a third and a half of new receptions to prison were estimated to be problem drug users and 1 in 8 arrests are estimated to be problem heroin and/or crack users. Victims of violent crimes perceived offenders to be under the influence of alcohol in over half the cases.

Inclusion health means improving health outcomes for people who are socially excluded typically experiencing multiple overlapping risk factors for poor health, including: poverty, adverse childhood experiences, violence, substance use, mental illness and complex trauma. They often experience

stigma and discrimination and are not consistently accounted for in electronic records such as healthcare databases.

These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes, often much worse than the general population, lower average age of death, contributing considerably to increasing health inequalities.

Inclusion health groups include: people with drug and alcohol dependency; people with housing, homelessness or accommodation issues; Gypsy, Roma and Traveller community; people in contact with the justice system; sex workers; asylum seekers and refugees and victims of modern slavery.

Inclusion health groups are relatively small but significant populations with high needs for healthcare, but who face a range of barriers in accessing healthcare services. People in inclusion health groups are also more likely to experience range of morbidities particularly mental health problems and substance dependence, and often have untreated long-term conditions. The children of parents in inclusion health groups are more likely to have poor health across their life-course because of their extremely disadvantaged start in life. There is a risk that disadvantages in socially excluded groups flow from generation to generation – from parent, to child, to grandchildren.

South Tees has a much higher proportion of the adult population in alcohol and substance misuse treatment, with Middlesbrough triple and Redcar & Cleveland double the England average. Similarly the rates of drug-related deaths and alcohol-related hospital admissions are much higher in South Tees, with Middlesbrough higher than Redcar & Cleveland.

South Tees has some of the highest rates of first-time entrants into the youth justice system in England, with Redcar & Cleveland having the second highest rate and Middlesbrough has the fifth highest.

Regionally, the North East hosts the most asylum seekers and resettled refugees out of all regions. Middlesbrough recorded the second highest number of migrant GP registrations of all local authorities in the region, whilst Redcar & Cleveland had the lowest number.

The issues affecting inclusion health groups also significantly affect children - around 19% of children in South Tees (10,472 children) are estimated to live in households with any of the three trio of vulnerabilities present (alcohol or substance misuse, domestic abuse and mental health). Many drug clients in treatment in South Tees are parents, with the rate in Middlesbrough (42%) significantly higher and the Redcar & Cleveland rate (33%) similar to the England rate (29%). The rates of parents in alcohol treatment are similar in both areas at around 40% and significantly higher than the England rate (31%).

There are an increasing number of people having no suitable accommodation options. Government estimates that there needs to be a 30% increase in supported housing accommodation compared to current levels by 2030 to meet demand. A significant issue in South Tees is the lack of stable move-on accommodation, combined with very high rents in private sector and challenging lettings policies within the registered landlords sector, it makes attaining stable accommodation increasingly difficult, especially for those with multiple disadvantages.

Difficulties securing a decent home make it very difficult for people to maintain or even contemplate positive behaviour changes. Inclusion health groups are competing with people who do not have rent arrears or a history of crime or anti-social behaviour. People are frequently housed in

temporary or emergency accommodation, which is not a suitable environment to address their support needs.

Whilst language can create barriers to accessing healthcare for refugees and asylum seekers due to the inability to speak English confidently and the need for interpreters, which is routinely refused, barriers to accessing health care for migrants are much more ingrained and systematic.

This includes administrative barriers when attempting to register with a GP, caused by confusion among administrative staff and doctors around who is eligible and what documents they need to register. This can often lead to demands for proof of ID or address when individuals had expired ID documentation or were living in precarious accommodation. Asylum seekers and refugees can be wrongly refused access to primary and secondary care, or being asked to pay upfront for assistance that is not urgent.

Refugees and asylum seekers often live in digital poverty and do not have access to telephones, internet or printers. This can prevent them from contacting GP practices and from being able to provide paper copies of forms and official documents to register with GPs. Financial barriers can prevent access to healthcare and cause negative health outcomes, for example due to the inability to pay for medication or secondary care, or the need to seek private healthcare as a result of being unable to register with the NHS.

The specialist GP practice for asylum seekers in South Tees closed at the end of March in 2023. The existing patients were allocated practices and new patients also access the standard primary care offer upon registration. It is not yet known what impact the lack of a specialist practice with tailored support has had, as there is no specific data available.

Gypsy, Roma and Traveller communities face similar barriers to primary care, with GPs routinely requiring proof of address or identification in order to register, despite there being no regulatory requirement to provide these details. Digital exclusion and low levels of literacy create further barriers to access.

Sex work is strongly associated with poverty, drug addiction, social exclusion and problematic family backgrounds. Focus groups conducted by the North East Sex Work forum (NESWF) indicated that local services were largely unaware of need and the changing face of the sex industry across Tees, so there is no accurate local data available.

Stable housing is regarded as a key factor in enabling women to complete drug treatment and exit sex work successfully. There is a lack of appropriate temporary and permanent accommodation for street homeless women who continue to be involved in sex work, and for those women who are trying to exit sex work.

The barriers faced by people experiencing multiple disadvantages to access support, in particular women, can be twofold, external or structural such as location, availability, suitability of programme, staff attitudes; or internal such as stigma and feelings of inadequacy, emotional stability, judgement and fear. Such challenges can be far reaching and permeate throughout people's lives particularly when a multi-agency approach is used, resulting in numerous appointments and goals to reach.

Stigma and discrimination associated with criminal records and substance misuse can deter individuals from seeking help and accessing services in South Tees. Insufficient support for people transitioning out of custody can also be a challenge. Failing to ensure continuity of care for those transitioning from custody to community can often result in relapse and re-offending. Access to

appropriate mental health care is also often limited locally, particularly for those with dual diagnoses of mental health issues and substance misuse.

11.3 Age Well: More people lead safe, independent lives

11.3.1 Key areas of intelligence

Loneliness and isolation, Frailty and Dementia

- Redcar & Cleveland has a higher proportion (7.2%) of those **over 65 living alone** compared to Middlesbrough (5.5%) and England (5.4%).
- Data for all adults shows that Middlesbrough has a higher level of **loneliness** at 28%, compared to England at 25% and Redcar & Cleveland at 23%.
- Data for adult social care carers who have enough **social contact** shows that Middlesbrough has higher rates compared to England at 38% compared to 29%, whilst Redcar & Cleveland is significantly lower at 19.5%.
- Across 16 risk factors areas that potentially increase the **risk of loneliness and isolation** in older people, Middlesbrough's rates were similar or higher compared to England for 14 areas and Redcar & Cleveland was similar or higher for 13 areas.

- South Tees PCNs have a greater proportion of moderate **frailty** with 10% compared to 8% in Tees Valley and a higher proportion of patients with severe frailty.
- Some **PCNs** in both Middlesbrough and Redcar & Cleveland have significantly higher levels of frailty. Greater Middlesbrough PCN has a rate of 41% of patients over 65 with some level of frailty, followed closely by Eston PCN with a rate of 40%. This compared with Redcar Coastal PCN which has the lowest level of frailty in South Tees at 18%.
- **Frailty scores for patients admitted by deprivation quintile** at South Tees Hospitals NHS Foundation Trust shows 44% of patients in Middlesbrough and Redcar & Cleveland were identified to have some level of frailty, with 9% classified as a high level of frailty. Looking at admissions by deprivation quintile, those in the most deprived areas of Middlesbrough and Redcar & Cleveland had higher rates of frailty compared to those in the least deprived with 50% compared to 38% respectively.
- A **frailty case finder** completed by NECS identified 3,437 patients in Middlesbrough who did not have a frailty diagnosis. This equates to 49% of the patients identified. In Redcar & Cleveland there were 4,889 who did not have a frailty diagnosis which equated to 54% of the patients identified.
- **Hospital admissions by recorded frailty score** shows a clear relationship between recorded frailty and emergency admission within 30 days of discharge. However, while severe frailty is most closely associated with re-admission, for the Tees Valley, patients aged 65+ without frailty recorded have higher re-admission rates than those with recorded moderate or mild frailty
- There are 15 **public health risk factors** (specific to over 65s) that are involved with frailty and increase the risk. Rates for datasets for these factors show Middlesbrough has significantly higher rates compared to England for 8 of the factors, suggesting there are more people at risk of frailty compared to England, whilst Redcar & Cleveland had higher rates for 4 risk factors.

- Redcar & Cleveland has a higher **dementia prevalence** rate at 1% compared to 0.7% in Middlesbrough and Redcar & Cleveland. This reflects the age profile of the area, with highest ward rates seen in Saltburn at 24 per 1,000 and Stainton & Thornton with 23 per 1,000.

- Estimated **dementia prevalence projections** show that in South Tees there will be a 53% increase in prevalence between 2020 to 2040. This prevalence rate projection increases with age with only a 4% increase in the 65-69 age cohort compared to a 95% increase in the 90+ age cohort.
- In South Tees only 48% of dementia patients had their **care plan reviewed** in the previous 12 months. This is lower than the national average of 52% and significantly lower than the regional average of 55%. Data by GP practice across South Tees shows significant variation in care plan reviews with two practices in the area are above 85% whilst there are 12 practices with rates below the minimum QOF threshold of 35%.
- Rates of **emergency admissions for dementia** in over 65s show Middlesbrough had higher admissions compared to England whilst Redcar & Cleveland admission rate were significantly lower.

End of life

- **Place of death** data shows for over 65s that both South Tees LA's are similar to England for deaths occurring in hospital and care homes, however have slightly higher rates of those dying at home and lower rates of those dying in a hospice.
- In Middlesbrough, of all people who **died in a care home**, 42% **died with dementia** and in Redcar and Cleveland, 46% died with dementia compared to 47% in England. In Middlesbrough, of all people who died with dementia, 55% died in a care home, compared to 62% in Redcar and Cleveland and 55% in England.
- Middlesbrough has a higher rate of people who **lived and died in a care home** as a percentage of all deaths, whilst Redcar & Cleveland has a lower rate compared to England. Middlesbrough has a higher rate of persons who **lived elsewhere and died in a care home** whilst Redcar & Cleveland has a significantly higher rate compared to England for those under 85 years. Middlesbrough has a higher rate compared to England for those who **live in a care home and died elsewhere** for both under and over 85s.
- Middlesbrough and Redcar & Cleveland have the highest rates in England for **permanent admissions to care homes** for those aged 65+. Middlesbrough also has a very high rate of care home and nursing home beds per population, the highest and 2nd highest in England respectively.
- Tees Valley has a higher rate of **deaths with 3 or more emergency admissions in the last 3 months of life** compared to England. PCNs such as Holgate PCN (7%) and Redcar Coastal PCN (8%) have lower multiple admission rates prior to death and a small proportion who died in hospital. Eston PCN has a much higher proportion at 12.4% who had 3 admissions and also a greater proportion who died in hospital at 56%.

11.3.2 The Challenge: we will promote independence for older people

Loneliness and isolation are public health issues linked to ill-health and health inequalities. **Social isolation** is an objective measure of the number of contacts that people have. It is about quantity and not quality of relationships. **Loneliness** is a subjective feeling about the gap between a person's desired levels of social contact and their actual level of social contact and the perceived quality of the person's relationships. Loneliness and isolation are complex multi-faceted issues with far reaching implications for individuals, communities and health and care services.

Loneliness does not always come from having no one around. It can also result from the perception of being alone or not having support or a sense of community. Even if you are surrounded by other

people daily, you could still experience loneliness if you do not feel that you have a particularly close emotional bond with anyone.

Anyone can experience loneliness, but there are some risk factors that can increase the chances of chronic loneliness. These factors can be at the individual level, connected to personal circumstances, or at the community or wider societal level, and include individual factor: being widowed, being single, divorced or never married or living alone; living on low income can mean lower levels of mobility, less access to technology and reduced ability to participate in leisure activities; retirement, becoming a carer or giving up caring responsibilities. There are also community factors that can create or increase loneliness: access to public and private transport, access to digital technology, safe public spaces and social capital.

Loneliness and isolation are damaging to individuals and communities and can adversely affect both our physical and mental health due to a lack of positive connections and interactions. Chronic loneliness is often linked to early deaths on a par with smoking 15 cigarettes a day and obesity. [6]

We understand the importance of looking after our physical health and increasingly our mental health, we must also look after our social connections, and understand that they are key to our wellbeing. This builds on the World Health Organisation's definition of health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."[7]

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication.

In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care. Around 10% of people aged over 65 years have frailty, rising to between 25% and 50% of those aged over 85.

It is important to differentiate between frailty, long term conditions and disability. Many people with multiple long-term conditions will also have frailty, which may be masked. Some people whose only long-term condition is frailty may not be regularly known to their GP (until they become bed bound, immobile or delirious as a result of an apparently minor illness).

The risk of the onset of disability, dementia and frailty can be reduced or the onset delayed by adopting approaches that also improve general health, including: stopping smoking, being more active, reducing alcohol consumption, improving diet and maintaining a healthy weight.

Identifying people living with moderate or severe frailty earlier is the most effective way at managing and possibly revering some aspects of frailty. The electronic frailty index applies a "cumulative deficit" model, which measures frailty on the basis of the accumulation of a range of deficits, which can be clinical signs (e.g. tremor), symptoms (e.g. vision problems), diseases, disabilities and abnormal test values. GP Practices are required to use an appropriate tool, such as the electronic frailty index, to identify patients over the age of 65 who are living with moderate and severe frailty.

[6] Campaign to End Loneliness, Threat to Health, 2022
[7] World Health Organisation, Health Promotion Glossary of terms, 2021

The rates for factors that are involved with frailty, particularly in Middlesbrough, are much higher compared to England for several of the risk factors for frailty suggesting there are more people at risk of frailty locally compared to England.

Dementia is a complex, life changing and progressive condition that poses significant challenges to the individual, their families, and carers. It affects memory, thinking, orientation, language, judgement, calculation and learning capacity. Whilst most common in older people, dementia can be diagnosed in people under the age of 65, known as early onset dementia.

Dementia is caused by many different diseases or injuries that directly and indirectly damage the brain. As an umbrella term, dementia describes the symptoms that occur when the brain is affected by certain diseases or conditions. There are over 200 subtypes of dementia including Alzheimer disease, which is the most common form of dementia and contributes to around 60–70% of cases of dementia today. Its prevalence continues to increase with an ageing population.

Dementia can also develop after a stroke or following infections such as HIV; through harmful use of alcohol; repetitive physical injuries to the brain or nutritional deficiencies.

Most symptoms of dementia become worse over time, while others might disappear or only occur in the later stages of dementia. As the disease progresses, the need for help with personal care increases. People with dementia may not be able to recognise family members or friends, develop difficulties moving around, lose control over their bladder and bowls, have trouble eating and drinking and experience behaviour changes such as aggression that are distressing to the person with dementia as well as those around them.

Caring for a person with dementia can have a big impact on Carers own mental and physical health and wellbeing and often have reduced quality of life with many carers neglecting their own needs due to the impact of their caring role.

There is considerable evidence demonstrating that family carers of people with dementia have a lower quality of life (QoL) than non-dementia carers and non-carers. Studies show that existing carer interventions, such as psychoeducation interventions and cognitive behaviour therapy are effective for reducing carer burden and depression in family carers of people with dementia.[8]

Many people affected by dementia feel like society fails to understand the condition they live with, its impact, or how to interact with them and people with dementia sometimes feel they need to withdraw from their community as the condition progresses.

A dementia friendly community is a city, town, or village where people with dementia are understood, respected, and supported. Dementia friendly communities are vital in helping people live well with dementia and feel a part of their community. It is where people with dementia are empowered to have high aspirations and feel confident, knowing that they can contribute and participate in activities that are meaningful to them and can continue to live the way they want to in a community that they choose.

11.3.3 The Challenge: we will ensure everyone has the right to a dignified death

People are defined as approaching the end of life when they are likely to die within a year.
Some people die in their preferred place and some people experience excellent care in hospitals, hospices, care homes and in their own homes. However, the reality is that many do not. Many people also experience unnecessary pain and other symptoms and there are distressing reports of people not being treated with dignity and respect and some not dying in a place where they chose to die.

We want to ensure that people at the end of their life are supported to make decisions that allow them and their family or carers to be prepared for their death and that their care is well coordinated and planned so that they can die in the place and in the way that they have chosen. It is critical that we address inequalities in palliative and end of life care, to improve equity of access to services and reducing inequity of outcomes and experience.

There is an urgent need to improve end of life care services to ensure that everyone, regardless of their circumstances, receives the best possible personalised care, including ensuring that people can die in the place of their choice. We need to understand the barriers people are facing from a diverse range of communities and take appropriate steps to make end of life care policy and practice as socially inclusive as possible and for all people to receive the appropriate support and care in their last stage of life.

All partners need to work collaboratively, including local authorities, Integrated Care Board (ICB), primary and secondary care, and community organisations, to identify people early and enable appropriate conversations and care planning as early as possible, which will lead to higher quality of end-of-life care, as well as fewer unplanned hospital admissions with more people experiencing a good death, in a place where they choose to die.

Sudden death, terminal illness, organ failure, and frailty are the four most common types of illness trajectories found in end-of-life care. Evidence suggests that the need for services at the end of life to assist with essential activities of daily living is at least as great for older people dying from organ failure and frailty as for those dying from a more traditional terminal condition such as cancer, and that the need is much greater for older people dying from advanced dementia. The absence of a predictable disability trajectory based on the condition leading to death for most decedents poses challenges for the proper allocation of resources to care for older persons at the end of life.[9]
End of life care encompasses care and support for a person's mental and emotional needs, physical comfort, spiritual needs, and practical tasks. Around half a million people die in England each year and with an ageing population, the annual number of deaths is estimated to increase. Effective end of life care improves the quality of life of the dying person and those important to them.

Palliative care is defined by the World Health Organisation as an approach that improves the quality of life of patients and their families who are facing problems associated with life limiting illness, usually progressive. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems whether physical, psychosocial, or spiritual. Palliative care also helps those receiving care, families and carers deal with emotional, spiritual or practical issues arising from the illness. People of all ages can benefit from palliative care and at all stages of their illness.

Approximately 1% of patients within every general practice are likely to die within the next year and should be identified within the register. Whilst numbers on the palliative care register within general practice in Tees Valley have increased over the last few years, they are still some way below the 1% expected level at 0.7%. Early identification of patients who are likely to die within the next year enables well-coordinated, pro-active quality care, and allows healthcare professionals to focus on better meeting patient's needs.

11.4 Outcomes Framework

Lifecourse	Mission	Goals	Key Performance Metrics
Start Well ***Children and Young People have the Best Start in Life***	**We will narrow the outcome gap between children growing up in disadvantage and the national average by 2030**	We want to eliminate the **school readiness** gap between those born into deprivation and their peers.	Children achieving a good level of development in reception (%)
			Gap between FSM eligible and non-FSM eligible pupil rate of good level of development (%)
		We want to eliminate the **attainment** gap at 16 among students receiving free school meals	Pupils achieving GCSE grade 4 or above in English and maths (%)
			Progress 8 scores at LA level and by individual secondary schools (%)
	We want to improve education, training and work prospects for young people	Extend offers of **apprenticeships, training and work placements** for young people to make the most of current and future local opportunities	Apprenticeship starts and achievements by level of apprenticeship (No.)
			Apprenticeship starts by subject area (No.)
		We will have no **NEETs** in South Tees through extended employment, apprenticeship or training offers for 18–25 year olds.	Proportion of 16, 17 & 18 year olds who are NEET/not known, split by age (%)
			Proportion of 16, 17 & 18 year olds who are participating in full or part-time education or apprenticeship, split by age (%)
	We will prioritise and improve mental health and outcomes for young people	Embed sustainable **school based mental health support** and support education partners in the establishment of whole school based programmes	Pupils in primary, secondary and special schools with social, emotional and mental health needs (%)
			Rate of common mental health disorders, anxiety disorders and depression in under 18s (rater per 1,000)
		Improve **access to mental health care and support** for	Rate of children & young people mental health referrals (rate per 1,000)

Lifecourse	Mission	Goals	Key Performance Metrics
		children, young people and families, led by needs.	Average wait times for children & young people secondary care mental health treatment (excl neurodevelopmental conditions)
Live Well ***People live healthier and longer lives***	**We will reduce the proportion of our families who are living in poverty**	We want to reduce levels of **harmful debt** in our communities	Child poverty estimated rate after housing costs (%)
			Residents accessing Citizens Advice Bureau (CAB) and Welfare Rights Unit (No.)
		We want to improve the levels of high quality **employment and increase skills** in the employed population.	Proportion of working age population who are claiming unemployment-related Universal Credit (%)
			Proportion of working age population who are economically inactive by reason (%)
	We will create places and systems that promote wellbeing	We want to create a **housing stock** that is of high quality, reflects the needs of the life course and is affordable to buy, rent and run.	Rate of landlord repossessions per 100,000 households
			Proportion of social and private sector houosing that fails the Decent Homes Standard (%)
		We want to create places with **high quality green spaces** that reflect community needs, provide space for nature and are well connected.	Average distance to nearest park, public garden or playing field and average size
			Quality of green and blue spaces - Green Flag Award and bathing water quality
		We want to create a **transport system** that promotes active and sustainable transport and has minimal impact on air quality.	Proportion of population who walk, cycle or use public transport to travel to work (%)
			Levels of total greenhouse gas emissions, split by CO2, methane and N20 emissions (kilo tonnes and per capita)
		We will support the **development of social**	ONS Personal well-being estimates covering life satisfaction, worthwhile, happiness and anxiety (scores)

Lifecourse	Mission	Goals	Key Performance Metrics
		capital to increase community cohesion, resilience and engagement	Thriving places index split by domain (scores)
	We will support people and communities to build better health	We want to reduce the prevalence of the leading **risk factors for ill health and premature mortality**	Prevalence of adult smoking, physical activity and obesity (%)
			Prevalence of cancers (type), COPD, CHD, stroke and hypertension (%)
		We want to find more diseases and ill health earlier and promote clinical **prevention** interventions and pathways across the system	Uptake rates across three cancer screening programmes (%)
			NHS health check invitations, completed checks and referrals (%)
	We will build an inclusive model of care for people suffering from multiple disadvantage across all partners	We want to reduce the prevalence and impact of **violence** in South Tees	Rate of total recorded crime and proportion that are violent crime and domestic violence (rate per 1,000)
			Rate of hospital admissions for violence (rate per 100,000)
		We want to improve outcomes for **inclusion health groups**	Rate of alcohol and substance misuse related emergency hospital aadmissions (rate per 100,000)
			Homelessness - Households owed a duty under the homeless reduction act (rate per 1,000)
		We want to understand and reduce the impact of **parental substance misuse** and trauma on children	Clients in drug/alcohol treatment who have full/part parental responsibility and have children living with client - engaged with treatment and social care
			Rate of episodes in children's social care (split by threshold level) that have parental alcohol and/or drug misuse as factors identified (%)
Age Well ***More people lead safe, independent lives***	**We will promote independence for older people**	We want to reduce the levels of **loneliness and isolation** in our communities and ensure our places promote healthy ageing	Population who feel lonely often, always or some of the time (%)
			Proportion of adult social care service users and carers who have enough social contact (%)

Lifecourse	Mission	Goals	Key Performance Metrics
		We want to reduce the level of **frailty** to improve healthy ageing	Proportion of over 65s patients at GPs who are living with mild, moderate or severe frailty (%)
			Rate of emergency readmissions within 30 days of discharge by frailty score (%)
		We want to ensure our communities are **dementia** friendly	Rate of emergency admissions for those living with dementia (rate per 100,000)
			Proportion of dementia patients who have had their care plan reviewed in previous 12 months (%)
	We will ensure everyone has the right to a dignified death	We want to improve the identification of people who are ready to die and enable choice around **end of life** - relating to planning about care and about life	Proportion of deaths that occurred in usual place of residence (%)
			Proportion of deaths with 3 or more emergency admissions in the last 3 months of life (%)

11.5 **Engagement Log** (to update)

See separate file “Appendix 11.5 Engagement Log”

12. References

[1] https://ayph-youthhealthdata.org.uk/key-data/mental-health/

[2] https://www.mentalhealth.org.uk/explore-mental-health/publications/impacts-lockdown-mental-health-children-and-young-people

[3] Trajectories of Disability in the Last Year of Life | NEJM

[4] https://ayph-youthhealthdata.org.uk/key-data/mental-health/

[5] https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/5-children-and-young-people

[6] https://www.mentalhealth.org.uk/explore-mental-health/publications/impacts-lockdown-mental-health-children-and-young-people

[7] https://www.nuffieldtrust.org.uk/news-item/growing-problems-one-year-on-the-state-of-childrens-health-care-and-the-covid-19-backlog?gclid=EAIaIQobChMIhPXuvp-_ggMV8ZaDBx2XNggLEAAYAiAAEgLLuvD_BwE#toc-header-4

[8] Factors predicting quality of life in family carers of people with dementia: The role of psychological inflexibility - ScienceDirect

[9] Trajectories of Disability in the Last Year of Life | NEJM

Agenda Item 6

MIDDLESBROUGH COUNCIL	Middlesbrough moving forward

Report of:	Director of Finance
Relevant Executive Member:	Executive Member for Finance and Governance
Submitted to:	Executive
Date:	28 October 2024
Title:	Household Support Fund 2024/2025
Report for:	Decision
Status:	Public
Council Plan priority:	A healthy place
Key decision:	Yes
Why:	Decision(s) will incur expenditure or savings above £250,000 and have a significant impact in two or more wards
Subject to call in?:	No
Why:	The decision is urgent in that it is required to be implemented immediately and call-in is therefore not possible.

Proposed decision(s)

That Executive approves:

The Household Support Fund (HSF) delivery plan for 2024/25, which will be delivered between 1 October 2024 and 31 March 2025 and as set out in Table 1 (paragraph 4.7) to target the main groups below where each has a Council Tax or rental liability for their home:

- Families with children in receipt of benefits.
- Pensioners in receipt of Council Tax Reduction but not eligible for the Winter Fuel Payment.
- Pensioners who are not in receipt of Council Tax Reduction subject to the qualifying criteria (listed in table 1, para 4.7).
- Singles/Couples which includes those of pensionable age in receipt of benefits.
- Application-based awards for residents not in receipt of CTR or other benefits.

That any remaining funds following the implementation of the delivery plan are allocated to Council Tax accounts, with a then current award of CTR and where an outstanding balance remains following the issue of a summons in the 2024/25 financial year. The

Council also reserves the right to widen the group to include those accounts not in receipt of CTR. Priority will be given to taxpayers who did not receive HSF from the allocation that remained in September 2024, with the intention that the balances for those in each group will be reduced by the same extent across both schemes so far as is possible.

That delegated authority is provided to the Director of Finance to make any modifications or minor revisions to the scheme and make decisions in respect of any remaining funds to ensure they are distributed in line with the guidance and within the defined timescales. Any revisions or modifications will be made in consultation with the Executive Member for Finance and Governance.

Executive summary

An urgent decision is required as, if made, the decision is required to be implemented immediately and call-in is therefore not possible.

On 2 September 2024 Central Government advised a further round of the Household Support Fund (HSF). Guidance was provided to Local Authorities on 24 September 2024 advising that a detailed plan should be submitted to the Department of Works and Pensions (DWP) by 1 November 2024, hence the short timescale and the need for the urgency of the decision.

The HSF to provide crisis support to vulnerable households in most need with the cost of essentials.

Middlesbrough Council has been allocated £1,653,614.95 and the funds must be distributed between 1 October 2024 and 31 March 2025.

The Council is required to submit a delivery plan to the DWP which has been approved by the Council's Section 151 Officer and Executive by 1 November 2024.

The delivery plan has been designed to provide support to the town's most vulnerable residents and low-income households who have a Council Tax or rental liability for their home in a similar way as for previous rounds, as outlined below:

- Families with children in receipt of benefits.
- Singles/Couples which includes those of pensionable age in receipt of benefits.
- Application-based awards for residents not in receipt of CTR or other benefits.

In addition to the above, the Council acknowledge that a number of pensioners will not receive a Winter Fuel Payment (WFP) this year. The Delivery Plan also includes an element of support for these pensioners:

- Pensioners in receipt of Council Tax Reduction but not eligible for the Winter Fuel Payment.
- Pensioners who are not in receipt of Council Tax Reduction subject to the qualifying criteria (listed in table 1, para 4.7)

A total of £1.521m will be distributed to the above groups, with the remaining 8% (£0.132m) - allocated to the administrative cost involved with delivery of the plan.

Following implementation of the delivery plan, any remaining funds will be allocated to Council Tax accounts with a then current award of CTR where an outstanding balance remains following the issue of a summons in the 2024/25 financial year. The Council also reserves the right to widen the group to include those accounts not in receipt of CTR. Priority will be given to taxpayers who did not receive HSF from the allocation that remained in September 2024, with the intention that the balances for those in each group will be reduced by the same extent across both schemes so far as is possible.

The full breakdown and associated estimated costs are outlined in Table 1 (paragraph 4.7)

1. Purpose

To seek approval of the Household Support Fund Scheme (HSF) for the second half of 2024/25 and seek delegated authority to be provided to the Director of Finance to make any modifications or minor revisions to the scheme and make decisions in respect of any remaining funds to ensure they are distributed in line with the guidance and within the defined timescales. Any revisions or modifications will be made in consultation with the Executive Member for Finance and Governance.

2. Recommendations

2.1 That Executive

Approves the HSF delivery plan for 2024/25, which will be delivered between 1 October 2024 and 31 March 2025 and as set out in Table 1 (paragraph 4.7) to target the main groups below where each has a Council Tax or rental liability for their home:

- Families with children in receipt of benefits.
- Pensioners in receipt of Council Tax Reduction but not eligible for the Winter Fuel Payment.
- Pensioners who are not in receipt of Council Tax Reduction subject to the qualifying criteria (listed in table 1, para 4.7).
- Singles/Couples which includes those of pensionable age in receipt of benefits.
- Application-based awards for residents not in receipt of CTR or other benefits.

2.2 Approves that any remaining funds following implementation of the delivery plan are allocated to Council Tax accounts, with a then current award of CTR and where an outstanding balance remains following the issue of a summons in the 2024/25 financial year. The Council also reserves the right to widen the group to include those accounts not in receipt of CTR. Priority will be given to taxpayers who did not receive HSF from the allocation that remained in September 2024, with the intention that the balances for those in each group will be reduced by the same extent across both schemes so far as is possible.

2.3 Approves that delegated authority is provided to the Director of Finance to make any modifications or minor revisions to the scheme and make decisions in respect of any remaining funds to ensure they are distributed in line with the guidance and within the defined timescales. Any revisions or modifications will be made in consultation with the Executive Member for Finance and Governance.

3 Rationale for the recommended decision(s)

3.1 The Urgent decision is required as Central Government advised of a further round of the HSF. This funding had been due to end on 30 September 2024, the guidance on this was not provided until 24 September 2024, and the HSF delivery plan must be submitted to the DWP by the 1 November 2024, hence the short timescale for implementation.

3.2 As the forward work programme requirements in Part 6.32 of the constitution cannot be met, the decision may still be taken in accordance with the General Exception in part 6.35 of the constitution as it is impracticable to deter the decision until it has been included in the next forward work programme and the formalities in part 6.35 have been complied with.

3.3 Central Government has provided funding to Local Authorities through the HSF to provide crisis support to vulnerable households in most need with the cost of essentials.

3.4 The Council needs to confirm an approach and submit an approved delivery plan to the DWP by 1 November 2024 for awards to be made between 1 October 2024 and 31 March 2025.

3.5 The policy is a key decision that impacts on two or more wards and will incur expenditure above £250,000.

3.6 The minor amendments that may be required will result in no changes to the threshold to services and support provided.

3.7 That delegated authority is provided to the Director of Finance to make any modifications or minor revisions to the scheme and make decisions in respect of any remaining funds to ensure they are distributed in line with the guidance and within the defined timescales. Any revisions or modifications will be made in consultation with the Executive Member for Finance and Governance.

4. Background and relevant information

4.1 On 2 September 2024, the Secretary of State for Work and Pensions announced that the HSF would be extended for a further 6 months, from 1 October 2024 to 31 March 2025. Government support extended to help struggling households with bills and essential costs over winter - GOV.UK (www.gov.uk)

4.2 Each local authority is required to prepare a local scheme to determine how the funding provided will be allocated. The grant amount allocated to Middlesbrough is £1,653,614.95.

4.3 Government guidance requires local authorities to clearly advertise the scheme to residents, including publication on the Council's website.

4.4 The value of individual awards is to be determined by local authorities in accordance with the parameters set out in the guidance.

4.5 The proposed scheme is based on the Council's previous successful HSF schemes and further extended to include an additional amount for pensioners who will not be eligible for the state Winter Fuel Payment under recently changed criteria.

4.6 The scheme is designed to support vulnerable residents and low-income households that include children, pensioners, people with disabilities and other households who may be experiencing financial difficulties brought about by the economic challenges.

4.7 The proposed scheme is set out in Table 1.

Table 1 Household Support Fund 2024

	Detail	**Cost (£m)**
Children (up to age 20 if child benefit received)	Households eligible for free school meals £60 payable per child in one payment - automated payment	0.612
	Application based claim for those in receipt of CTR/UC/HB £60 payable per child in one payment	0.156
	Section 17 Additional Support	0.040
	Application based claim for non-CTR/benefit residents £35 for a single applicant, £45 for a couple, £60 per child for households with children	0.020
Pensioners (from 66 years old)	In receipt of Council Tax Reduction (CTR) but not eligible for the Winter Fuel Payment, per household Born pre-23 September 1944 £200 Born between 23 September 1944 and 22 September 1958 £150 Application and automated payment methods	0.312
	In receipt of Attendance Allowance, not entitled to the Winter Fuel Payment or another part of the Household Support Funding £100 per household Application based	0.050
	Application based claim for non-CTR/ non-benefit pensioners Income must be less than £20,000 if single household and £26,000 if a couple £100 per household Application based	0.083
Other	Back to work incentive Via third party provider	0.012
	Third party support Applications to Community Grants	0.058

	Application based claim for non-CTR/benefit residents. £35 for a single applicant, £45 for a couple	0.020
	Singles or couples in receipt of CTR / UC / HB (no children). Including pensioners where they are not eligible for the above. £35 single applicant, £45 couple	0.118
	Community Support (All household composites) Through application for crisis support	0.040
	Sub Total	**1.521**
	Administration Costs @ 8%	0.132
	TOTAL	**1.653**

*UC Universal Credit * HB Housing Benefit *

4.8 Estimated expenditure equates to £1.521m (excluding administration costs).

4.9 In line with the guidance, the Council is able to recover administration costs to deliver the scheme and these have been calculated at £0.132m. This equates to 8% of the scheme funding which is consistent with the previously submitted plan.

4.10 Any remaining funds following implementation of the delivery plan (and administrative costs) will be allocated to Council Tax accounts with a then current award of CTR and an outstanding balance remains following the issue of a summons in the 2024/25 financial year. This may also be widened to incorporate accounts not in receipt of CTR. Priority will be given to taxpayers who did not receive HSF from the allocation that remained in September 2024, with the intention that the balances for those in each group will be reduced by the same extent across both schemes so far as is possible.

4.11 The scheme has been designed to provide support across the defined six-month period for awards.

4.12 The scheme will be subject to periodic reviews to allow alterations to be made should the scheme requirements need to change to keep pace with events.

4.13 Appropriate counter fraud measures will be put in place to minimise risk in accordance with the Council's policies and procedures Counter fraud | Middlesbrough Council.

5. Other potential alternative(s) and why these have not been recommended

5.1 Do nothing; however, without a suitable scheme with sufficient defined criteria approved by the Council's Executive and presented to the DWP, the funds will not be able to be utilised by the Council to benefit vulnerable residents and low-income households and would need to be repaid to the DWP.

5.2 Funding could be distributed differently amongst the groups identified or across different groups. The plan presented has taken account of the government guidance and experience gained through prior schemes to ensure maximum reach to those in need of support.

6. Impact(s) of the recommended decision(s)

6.1 *Financial (including procurement and Social Value)*

6.1.1 Central Government has allocated the Council £1,653,614.95 from the HSF as outlined in the Executive summary. With an approved delivery plan the Council can distribute funds within the defined timescale between 1 October 2024 and 31 March 2025 to support the town's most vulnerable and low-income households.

6.1.2 An administration cost of £0.132m will apply to delivery of the scheme that is funded from the grant allocation. This equates to 8% of the scheme which is consistent with the previously submitted plan. The effect of this will be monitored as part of the quarterly budget monitoring reports to Executive in 2024/25.

6.1.3 The Council can utilise the grant as per Central Government guidance and will not exceed the grant funding available. All funds will be distributed by 31 March 2025.

6.2 *Legal*

Central Government guidance provides Local Authorities with the option to set its own scheme using funding provided, and whilst there are no legal requirements to implement a scheme should the Council decline this would subject the local authority to criticism by both Central Government and residents of the town.

6.3 Risk

The scheme supports the delivery of the Council's strategic priority 'A Healthy Place' to reduce poverty as set out in the Council Plan 2024-2027. Council Plan | Middlesbrough Council

The HSF scheme will assist residents to meet their council tax instalments and debt liabilities, which in turn, will mean that the Council has funding to work with communities and other public services in Middlesbrough to continue to improve the lives of local residents.

The proposed decision will impact positively on the following risks within the Strategic Risk Register:

SR02 - The risk that **demand and cost of and children's social care** continues to escalate on the scale experienced in 2022/23, is the single biggest risk to the Councils financial viability. More financially sustainable solutions for meeting social care needs of children need to be secured with urgency to ensure delivery within the approved budget

SR03 - The potential for underlying **demand and cost pressures to arise in adult social care** presents a significant risk to the Council's overall financial viability and measures must be put in place to manage within approved budget.

6.4 Human Rights, Public Sector Equality Duty and Community Cohesion

There are no disproportionate adverse impacts on any group or individuals with characteristics protected in UK equity law. An impact assessment has been carried out and is attached.

6.5 Climate Change / Environmental

There are no disproportionate adverse impacts on the aspirations of the Council to achieve net zero, net carbon neutral or be the lead authority on environmental issues.

6.6 Children and Young People Cared for by the Authority and Care Leavers

The HSF 2024/2025 plan does not differentiate based on applicant background and therefore has no adverse impact on children and young people cared for by the Authority for Care Leavers.

6.7 Data Protection

The collation and use of personal data will be managed in accordance with the Council's Data Protection policy and the Benefits, Council Tax and Business Rates Privacy Notice Privacy notice - Housing Benefit and Council Tax Reduction | Middlesbrough Council

Actions to be taken to implement the recommended decision(s)

Action	Responsible Officer	Deadline
Implementation and publication of the plan	Janette Savage	Immediately following approval.
Periodic Review of the Scheme	Janette Savage	Every 2 months.

Appendices

1	Delivery Plan
2	Impact Assessment

Background papers

Body	Report title	Date
Department for Work and Pensions	Household Support Fund: Guidance for County Councils and Unitary Authorities in England (1 October 2024 to 31 March 2025)	24 September 2024

Contact: Janette Savage (Head of Resident and Business Support)
Email: Janette_savage@middlesbrough.gov.uk

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HSF6 Delivery plan

Department for Work & Pensions

1) LA details

Local authority	LA code	Has the return been completed in full?
Middlesbrough UA	LA041	✗

Notes
To complete the Governance tab, please ensure to:
a) choose your Local Authority name in Table 1
b) enter the return date in Table 2 (dd/mm/yyyy)
c) complete all cells in Tables 3 and 4

A summary and explanation of the traffic light system is included below and in the guidance tab. It details how the system is applied throughout the template.

When a green circle with a white tick appears next to Tables 1 to 4, the tables are compliant.

When a green circle with a white tick appears in Table 1 'Has the return been completed in full?', the delivery plan is compliant and ready for submission.

2) Reporting period

Reporting period	Report type	Return date (dd/mm/yyyy)
01/10/2024- 31/03/2025	Delivery Plan	

3) Section 151 officer sign off

I have reviewed the financial procedures in place and I am satisfied that they are robust enough to protect public funds and that the total anticipated Grant spend by the Grant Recipient in this template is exclusively for the purposes set out in the Grant Determination Letter between the Grant Recipient and the Secretary of State for Work and Pensions in respect of the delivery of the Household Support Fund:

Section 151 officer signature	Section 151 officer's email

4) Governance

Cabinet Member (name)	Cabinet Member's email	Has the Cabinet Member approved this plan? (dropdown)	Is the Section 151 Officer/CFO copied into the return email?

5) Totals

Anticipated spend for vulnerable households (£)	Anticipated admin costs (£)	Anticipated total LA spend (£)	Allocation (£)	Percentage of allocation accounted for in delivery plan (%)
£ 1,521,325.00	£ 132,289.20	£ 1,653,614.20	£ 1,653,614.95	100%

Traffic Light Guidance System

The traffic light guidance system is used throughout this workbook to help inform the user, Cabinet Member and Section 151 officer of any outstanding required inputs. The icons can be found next to each table.

The green circle with a white tick indicates that the adjacent table is compliant:	✓
The red circle with a white cross indicates that the adjacent table is non-compliant:	✗

For DWP use only:	
Governance	✗
Anticipated spend	✓
Anticipated volumes	✓
Anticipated No of households	✓
Planned activities	✓

End

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HSF6 Anticipated spend

Notes
The totals cells which auto populate have been greyed out and locked for editing. Please only input into the green cells.

The totals in the auto populated cells of tables 7 to 10 must be the same for the return to be compliant.

Please input values in full (e.g. 120,000.00) to enable us to process the return accordingly. Only numbers (eg 123.00) can be entered into each cell. If any other format is input an error message will appear. Please ensure that any spend figures you provide are presented to 2 decimal places, if this is not followed your Delivery Plan will be returned for completion

The traffic light system will help you ensure the template is completed in full. For the return to be compliant, all traffic lights must be green with a white tick.

If there is no anticipated spend to report, in order to enable the green light with white tick next to each table, the cells should still be completed with 0 (zero as a numerical value rather than typing out 'NIL', for example). This will help us process the return promptly for you.

'Has the spend tab been completed correctly?' - the traffic light will turn green with a white tick once Tables 6 to 12 are compliant.

The acronym FSM used in the tables below refers to Free School Meals.

6) Anticipated admin spend

Admin spend
£ 132,289.20

Traffic light check
Has the anticipated spend tab been completed correctly?
✓

7) Anticipated spend (£) split by household composition

Households with children (£)	Households with pensioners (£)	Households with a disabled person (£)	Other households (£)	Anticipated total spend (by household composition) (£)
£ 885,170.00	£ 465,950.00	£ 57,850.00	£ 112,355.00	£ 1,521,325.00

8) Anticipated spend (£) split by types of support

Vouchers (£)	Cash awards (£)	Third party organisations (£)	Tangible items (£)	Other (£)	Anticipated total spend (by types of support) (£)
£ 915,905.00	£ 485,500.00	£ 59,920.00	£ 40,000.00	£ 20,000.00	£ 1,521,325.00

9) Anticipated spend (£) split by access routes

Application-based support (£)	Proactive support (£)	Other (£)	Anticipated total spend (by access routes) (£)
£ 540,000.00	£ 921,405.00	£ 59,920.00	£ 1,521,325.00

10) Anticipated spend (£) split by category

Food (excluding FSM support in the holidays) (£)	FSM support in the holidays (£)	Energy and water (£)	Essentials linked to energy and water (£)	Wider essentials (£)	Housing costs (£) (Please also compete table 11)	Advice services (£)	Anticipated total spend (by category) (£)
£ 945,105.00	£ -	£ 464,220.00	£ 32,000.00	£ 68,000.00	£ -	£ 12,000.00	£ 1,521,325.00

11) Anticipated housing Costs

For your anticipated Housing Costs spend please select the appropriate option. If this is zero please select option 4):	*If you have reported spend on Housing Costs, please confirm the particular groups and types of support that you have provided including value of spend. If this is zero please input N/A:*
4. Not applicable (no Housing Costs spend)	*n/a*

12) Preventative support

Please give an overview of the preventative support you intend to provide through the fund:	Please give an estimate of the anticipated amount to be spent on preventative support
Third party support to provide help to residents to gain employment.	£ 12,000.00

End

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HSF6 Anticipated volumes

Notes
The totals cells which autopopulate have been greyed out and locked for editing. Please only input into the blue cells.

Please ensure that any anticipated volume figures you provide are presented in whole numbers. If any other format is input an error message will appear. If this is not followed your Delivery Plan will be returned for completion

The traffic light system will help you ensure the template is completed in full. For the return to be compliant, all traffic lights must be green with a white tick.

If there are no anticipated volumes to report, in order to enable the green light with white tick next to each table, the cells should still be completed with 0 (zero as a numerical value rather than typing out 'NIL', for example).

The acronym FSM used in the tables below refers to Free School Meals.

13) Anticipated volume of awards split by household composition

Households with children	Households with pensioners	Households with a disabled person	Other households	Anticipated total volume of awards (by household composition)
16059	4744	748	2542	24093

14) Anticipated volume of awards split by types of support

Vouchers	Cash awards	Third party organisations	Tangible items	Other	Anticipated total volume of awards (by types of support)
16175	3854	3419	145	500	24093

15) Anticipated volume of awards split by access routes

Application-based support	Proactive support	Other support	Anticipated total volume of awards (by access routes)
6477	14197	3419	24093

16) Anticipated volume of awards split by category

Food (excluding FSM support in the holidays)	FSM support in the holidays	Energy and water	Essentials linked to energy and water	Wider essentials	Housing costs	Advice services	Anticipated total volume of awards (by category)
19154	0	3460	116	1100	0	263	24093

End

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HSF6 Anticipated number of households helped

Notes
The totals cells which autopopulate have been greyed out and locked for editing. Please only input into the blue cells.

Please ensure that any anticpated volume figures you provide are presented in whole numbers. If any other format is input an error message will appear. If this is not followed your Delivery Plan will be returned for completion.

The traffic light system will help you ensure the template is completed in full. For the return to be compliant, all traffic lights must be green with a white tick.

If there are no anticipated numbers to report, in order to enable the green light with white tick next to each table, the cells should still be completed with 0 (zero as a numerical value rather than typing out 'NIL', for example).

The acronym FSM used in the tables below refers to Free School Meals.

17) Anticipated number of households helped split by household composition

Households with children	Households with pensioners	Households with a disabled person	Other households	Anticipated total number of vulnerable households helped (by household composition)
10335	4739	743	2537	18354

18) Anticipated number of households helped split by types of support

Vouchers	Cash awards	Third party organisations	Tangible items	Other	Anticipated total number of vulnerable households helped (by types of support)
10486	3854	3369	145	500	18354

19) Anticipated number of households helped split by access routes

Application-based support	Proactive support	Other	Anticipated total number of vulnerable households helped (by access routes)
5322	9663	3369	18354

20) Anticipated number of households helped split by category

Food (excluding FSM support in the holidays)	FSM support in the holidays	Energy and water	Essentials linked to energy and water	Wider essentials	Housing costs	Advice services	Anticipated total number of vulnerable households helped (by category)
13494	0	3381	116	1100	0	263	18354

End

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HSF6 Planned activites

Notes
All grey boxes require a written response.

If there is nothing to report in a cell, write "N/A". Only use "N/A" where you have no reported spend for that category. For example, if you have reported a spend of 0 for tangible items, you will record "N/A" in the box below "tangible items".

Any sections which have had a reported spend in previous tabs needs a written explanation.

The traffic light system will help you ensure the template is completed in full. For the return to be compliant, all traffic lights must be green with a white tick.

You must refer to the full guidance document when completing this tab to ensure you have provided all necessary information.

21) Planned activities - Categories

Food (excluding FSM support in the holidays)	FSM support in the holidays	Energy and water	Essentials linked to energy and water	Wider essentials	Housing costs	Advice services
Families in receipt of FSM one off £60 voucher per child Other Middlesbrough families in receipt of FSM, on UC/HB or have CTR by application (£60 voucher per child). Part of the offering for those not in receipt of benefits will allow them to choose between this or wider essentials support. Amount of award is £35 for a single applicant, for a couple £45 or for households with children, £60 per child (voucher if choosing food support). Singles / Couples in receipt of benefits, £35 voucher for a single person and £45 voucher for a couple Funds will be provided to third party providers	N/A	Energy vouchers can be provided to those who have a pre-payment meter Payment to pensioners in receipt of CTR who do not qualify for a winter fuel payment to support with energy costs, Payment, per household Born pre 23 September 1944 £200 Born between 23 September 1944 and 22 September 1958 £150 In receipt of Attendance Allowance, not entitled to the Winter Fuel Payment or another part of the Household Support Funding £100 per household Application based claim for non-CTR/benefit pensioners Income must be less than £20,000 if single household and £26,000 if a	funding has been assigned to provide residents with energy efficient white goods	£40k, has been assigned to children's services to provide essentials to families / children who are presenting as vulnerable. Nb.... Part of the offering for those not in receipt of benefits allows for people to make a choice between food voucher or support with other essentials	N/A	£12k has been assigned to support 3rd party organisations.

22) Planned activities - Types of Support

Vouchers	Cash awards	Third party organisations	Tangible items	Other
Energy vouchers will be issued where people have the required meter Food vouchers will be used to support people on most routes and this is done to allow them to free up disposable income to support with energy costs	These will be made where we are not able to provide vouchers digitally, mainly for pensioners, and is designed to support with energy costs	Funds have been assigned to various third parties who have applied for help - food banks, eco shops, energy support and HAF support to extend the scheme	Energy effecient white goods are available to residents in crisis who require support as well as essentials such as beds, coats etc	Advice services have been assigned to this currently As part of the application process for those not in receipt of benefits we are offering different methods of support for their wider essentials, this amount may change depending on what choice the resident makes

23) Planned activities - Access Routes

Application-based support	Proactive support	Other
Application for households in receipt of FSM where children are not of school age or attend an out of area school There will be an application form for people not in receipt of benefits Applications for tangible items. An application form for people in receipt of benefits and an application process for pensioners	Those in receipt of FSM in Middlesbrough schools. Pensioners who have entitlement to Council Tax Reduction and will not receive a winter fuel payment, will receive automatic awards where details were gathered by application under the previous scheme	Third party support has currently been loaded in to this section

24) Planned activities - Further information

Please refer to guidance document for questions to respond to using this field
A detailed plan and timeline has been put together ensuring support will be available to different categories of households throughout the fund period. We have a dedicated website page which contains all links to applications and details of eligibility. We utilise digital support such as facebook and depending on who we are trying to reach we will write to households or send text messages to promote applications. We also work closely with other departments to ensure that people such as social workers, welfare rights team etc are aware and can verbally promote the scheme and assist with applications where necessary. We are targeting housholds in receipt of benefits across varying household compositions and we are also targeting those in work who are not in receipt of benefits where they are struggling to meet their basic needs due to inflationary pressures. Targeted support for pensioners who are no longer eligible for the Winter Fuel Payment but on a low income. Residents are verified using the council tax / benefits data held; bank statements and other evidence is collected for some of the applications. Third party organisations have a template to provide regular updates on how the funding is being used and will have a meeting every 2 months to review this. We do have a local welfare assistance scheme that continues to run alongside the HSF funding; this opens up additional avenues to offer support to residents who present in crisis allowing us to point people to the most appropriate support for their needs. We evaluate effectiveness of the different elements of the scheme on an on-going basis and this is done within the normal administration costs.

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Impact Assessment Level 1: Initial screening assessment

Subject of assessment:	Household Support Fund (HSF) scheme 2024/2025			
Coverage:	Crosscutting			
This is a decision relating to:	☐ **Strategy**	☐ **Policy**	☐ **Service**	☐ **Function**
	☐ **Process/procedure**	☒ **Programme**	☐ **Project**	☐ **Review**
	☐ **Organisational change**	☐ **Other (please state)**		
It is a:	**New approach:**	☐	**Revision of an existing approach:**	☒
It is driven by:	**Legislation:**	☒	**Local or corporate requirements:**	☐

Description:	**Key aims, objectives and activities** To assess the impact of proceeding with the adoption of the proposed Household Support Fund 2024/25 scheme. **Statutory drivers** The Council is required to adopt a new scheme as part of the Household Support Fund to distribute £1.65m. The funds are provided by Central Government to support households who would otherwise struggle to buy food or pay essential utility bills or meet other essential living costs or housing costs (in exceptional cases of genuine emergency) and to promote or undertake activity that prevents households facing similar hardship in the future. The delivery plan is due to be returned to the DWP by 1 November 2024. **Differences from any previous approach** The Council acknowledge that a number of pensioners will not receive a Winter Fuel Payment (WFP) this year. The Delivery Plan also includes an element of support for these pensioners: • Pensioners in receipt of Council Tax Reduction but not eligible for the Winter Fuel Payment. • Pensioners who are not in receipt of Council Tax Reduction subject to the qualifying criteria. **Key stakeholders and intended beneficiaries (internal and external as appropriate)** Key stakeholders: Council and local residents. **Intended outcomes.** To seek approval for the delivery plan required by the DWP in line with Central Government criteria. That delegated authority is provided to the Director of Finance to make any modifications or minor revisions to the scheme and make decisions in respect of any remaining funds to ensure they are distributed in line with the guidance and within the defined timescales. Any revisions or modifications will be done in consultation with the Executive Member for Finance and Governance.
Live date:	The Executive Member for Finance and Governance will consider the HSF scheme by 28 October 2024.
Lifespan:	Funding has been provided for the period 1 October 2024 to 31 March 2025.
Date of next review:	April 2025

Screening questions	Response			Evidence
	No	Yes	Uncertain	
Human Rights Could the decision impact negatively on individual Human Rights as enshrined in UK legislation?*	☒	☐	☐	The HSF scheme is provided by central government to provide crisis support to vulnerable households in most need with the cost of essentials. The local scheme is based on government guidance and criteria, and is designed to support households with children, pensioners, those with disabilities and other households who may be experiencing financial difficulties. This support does not reduce or replace other existing forms of support and therefore no resident will be adversely affected. Support will be provided through a combination of direct automated awards and application-based claims. In addition, contingency is in place to provide for situations where an award of relief might be justifiable outside of the eligibility criteria. In light of the above, it is not considered that the report will have an adverse impact on individuals in terms of human rights.
Equality Could the decision result in adverse differential impacts on groups or individuals with characteristics protected in UK equality law? Could the decision impact differently on other commonly disadvantaged groups?*	☒	☐	☐	The HSF scheme is provided by central government to provide crisis support to vulnerable households in most need with the cost of essentials. The local scheme is based on government guidance and criteria, and is designed to support households with children, pensioners, those with disabilities and other households who may be experiencing financial difficulties. This support does not reduce or replace other existing forms of support and therefore no individuals will be adversely affected. Support will be provided through a combination of direct automated awards and application-based claims. In addition, contingency is in place to provide for situations where an award of relief might be justifiable outside of the eligibility criteria. In light of the above, it is not considered that the report will have an adverse impact on different groups or individuals in terms of equality.

* Consult the Impact Assessment further guidance appendix for details on the issues covered by each of these broad questions prior to completion.

Screening questions	Response			Evidence
Community cohesion Could the decision impact negatively on relationships between different groups, communities of interest or neighbourhoods within the town?*	☒	☐	☐	The HSF scheme is provided by central government to provide crisis support to vulnerable households in most need with the cost of essentials. The local scheme is based on government guidance and criteria, and is designed to support households with children, pensioners, those with disabilities and other households who may be experiencing financial difficulties. This support does not reduce or replace other existing forms of support and therefore no community groups will be adversely affected as a result. Support will be provided through a combination of direct automated awards and application-based claims. In addition, contingency is in place to provide for situations where an award of relief might be justifiable outside of the eligibility criteria. In light of the above, it is not considered that the report will have an adverse impact on relationships between different groups, communities of interest or neighbourhoods within the town.

Next steps:

- If the answer to all of the above screening questions is No then the process is completed.
- If the answer of any of the questions is Yes or Uncertain, then a Level 2 Full Impact Assessment must be completed.

Assessment completed by:	Rachael Burton	**Head of Service:**	Janette Savage
Date:	10.10.2024	**Date:**	10.10.2024