Health Inequalities – Tees Valley Overview

1 Purpose

The purpose of this briefing paper is to set out a high-level overview of our response to health inequalities in Middlesbrough and across the wider Tees Valley. The paper will set out the CCGs high level vision and key objectives in addressing health inequalities throughout the coming year and outline what plans we have put in place as a result of national and regional directives and local place based need. It is crucial that this response is a partnership approach across all stakeholders to ensure the most effective outcomes are achieved.

2 Background

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.[1]

It has been well documented that the recent pandemic has added to increased health inequalities across our population and focussed action on health inequalities is required to improve the lives of those living with the worst health outcomes.

Health inequalities are usually defined within four groups and below outlines examples of the characteristics of people/communities in each group (not exhaustive):

- Socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment).
- Protected characteristics: e.g. age, sex, race, sexual orientation, disability
- Vulnerable groups of society, or 'inclusion health' groups: e.g. vulnerable migrants; Gypsy, Roma and Traveller communities; rough sleepers and homeless people; and sex workers
- Geography: e.g. urban, rural.

3 Tees Valley Overview

Health across the Tees Valley is generally worse than the England average; with health inequalities between most and least deprived wards being significant. In the majority of areas, obesity in children is worse than the England average and the rate of alcohol-specific hospital stays among those under 18 is also worse than the national average. GCSE attainment is lower than average, rates of breastfeeding are lower than the national average and all localities have higher than average levels of smoking at time of delivery. In most areas, excess weight in adults and physical activity is worse than the England average.

There appear to be more similarities than differences amongst the general population across the five local authority areas.

<u>Impact on mortality and reduction in prevention, detection and management of conditions</u>

- The available information demonstrates that for nearly all locality areas, life expectancy and healthy life expectancy is worse than the England average.

[1] NHS England » Definitions for Health Inequalities (May 2021)

- Under 75 mortality rates from cancer are worse than the England average for all localities expect Darlington, which is similar. This is the same for the under 75 mortality rate from all CVD disease.

- The under 75 mortality rate from causes considered preventable is worse than the England average for all locality areas

- The Tees Valleys' flu vaccination coverage rate is considered worse than the England average

- Hartlepool, Middlesbrough and Redcar and Cleveland have more obese adults than the England average, with Stockton and Darlington localities having a similar rate to the rest of England.

- Smoking prevalence is higher than the England average in Hartlepool and Middlesbrough

- The under 75 mortality rate from respiratory disease is worse than the England average across all locality areas

- The under 75 mortality rate from liver disease is worse than the England average for all locality areas except Redcar and Cleveland where it is similar.

Wider societal determinants that affect health

- Children in care rates are higher than the England average across all locality areas

- The employment and support allowance claimant rate is higher than the England average across all locality areas

- The gap in the employment rate between those with a long-term health condition and the overall employment rate is worse than the England average for all localities except Darlington which is similar

- The % of people in employment is lower than the England average for all locality areas expect Darlington which is similar

Diversity within local communities

Within the Tees Valley there is a spread of BAME populations within localities, with around 4.4% of the population in HaST and Darlington localities belonging to BAME communities, and 6.8% in South Tees.

Across the Tees Valley therefore there is a BAME communities average of around 5.3% of the total population.

Deprivation

Tees Valley is the second ranked most deprived Local Enterprise Partnership (IMD 31.3% of neighbourhoods). Middlesbrough and Hartlepool are in the top 20 local authority districts with the highest levels of income deprivation. Middlesbrough, Hartlepool and Redcar & Cleveland are also in the top 20 local authority districts with the highest levels of employment deprivation.

Middlesbrough and Hartlepool are in the top 20 local authority districts with the highest proportion of children living in income deprived households[2].

These figures are taken from the published Index of Multiple Deprivation (IMD) for England 2015 and figures in 2019 are largely unchanged.

Figure 1: Health in summary

	Stockton-on-Tees	Darlington	Redcar and Cleveland	Middlesbrough	Hartlepool
Overall health	Varied compared with the England average. About 21% (7,600) of children live in low income families. Life expectancy for both men and women is lower than the England average.	Varied compared with the England average. About 20% (3,900) of children live in low income families. Life expectancy for both men and women is lower than the England average.	Generally worse than the England average. Redcar and Cleveland is one of the 20% most deprived districts/unitary authorities in England and about 24% (5,800) of children live in low income families. Life expectancy for both men and women is lower than the England average.	Generally worse than the England average. Middlesbrough is one of the 20% most deprived districts/unitary authorities in England and about 31% (8,900) of children live in low income families. Life expectancy for both men and women is lower than the England average.	Generally worse than the England average. Hartlepool is one of the 20% most deprived districts/unitary authorities in England and about 27% (4,800) of children live in low income families. Life expectancy for both men and women is lower than the England average
Health Inequalities	Life expectancy is 14.9 years lower for men and 13.9 years lower for women in the most deprived areas of Stockton-on-Tees than in the least deprived areas.	Life expectancy is 11.7 years lower for men and 8.5 years lower for women in the most deprived areas of Darlington than in the least deprived areas.	Life expectancy is 10.1 years lower for men and 7.0 years lower for women in the most deprived areas of Redcar and Cleveland than in the least deprived areas.	Life expectancy is 12.5 years lower for men and 13.0 years lower for women in the most deprived areas of Middlesbrough than in the least deprived areas.	Life expectancy is 11.7 years lower for men and 10.2 years lower for women in the most deprived areas of Hartlepool than in the least deprived areas.
Child Health	In Year 6, 21.1% (480) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is 75*, worse than the average for England. This represents 32 stays per year. Levels of teenage pregnancy, breastfeeding initiation and smoking at time	In Year 6, 22.5% (277) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 52*, worse than the average for England. This represents 12	In Year 6, 21.0% (307) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is 72*, worse than the average for England. This represents 20 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding	In Year 6, 22.7% (401) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 55*, worse than the average for England. This represents 18 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding	In Year 6, 23.3% (260) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 38*. This represents 8 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding

[2] North East IMD info.pdf (vonne.org.uk) (May 2021)

	Stockton-on-Tees	Darlington	Redcar and Cleveland	Middlesbrough	Hartlepool
	of delivery are worse than the England average.	stays per year. Levels of smoking at time of delivery are worse than the England average.	initiation and smoking at time of delivery are worse than the England average.	initiation and smoking at time of delivery are worse than the England average.	initiation and smoking at time of delivery are worse than the England average.
Adult Health	The rate of alcohol-related harm hospital stays is 901*, worse than the average for England. This represents 1,698 stays per year. The rate of self-harm hospital stays is 239*, worse than the average for England. This represents 467 stays per year. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average. Rates of early deaths from cardiovascular diseases and early deaths from cancer are worse than average	The rate of alcohol-related harm hospital stays is 769*, worse than the average for England. This represents 802 stays per year. The rate of self-harm hospital stays is 212*. This represents 217 stays per year. Estimated levels of adult smoking in routine and manual occupations are better than the England average. Rates of people killed and seriously injured on roads and TB are better than average.	The rate of alcohol-related harm hospital stays is 768*, worse than the average for England. This represents 1,032 stays per year. The rate of self-harm hospital stays is 261*, worse than the average for England. This represents 329 stays per year. Estimated levels of adult excess weight are worse than the England average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average.	The rate of alcohol-related harm hospital stays is 898*, worse than the average for England. This represents 1,159 stays per year. The rate of self-harm hospital stays is 331*, worse than the average for England. This represents 476 stays per year. Estimated levels of adult smoking and physical activity are worse than the England average. The rate of hip fractures is worse than average. Rates of sexually transmitted infections and people killed and seriously injured on roads are better than average.	The rate of alcohol-related harm hospital stays is 952*, worse than the average for England. This represents 862 stays per year. The rate of self-harm hospital stays is 230*, worse than the average for England. This represents 205 stays per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. Rates of sexually transmitted infections and TB are better than average.

Source: https://fingertips.phe.org.uk/profile/health-profiles

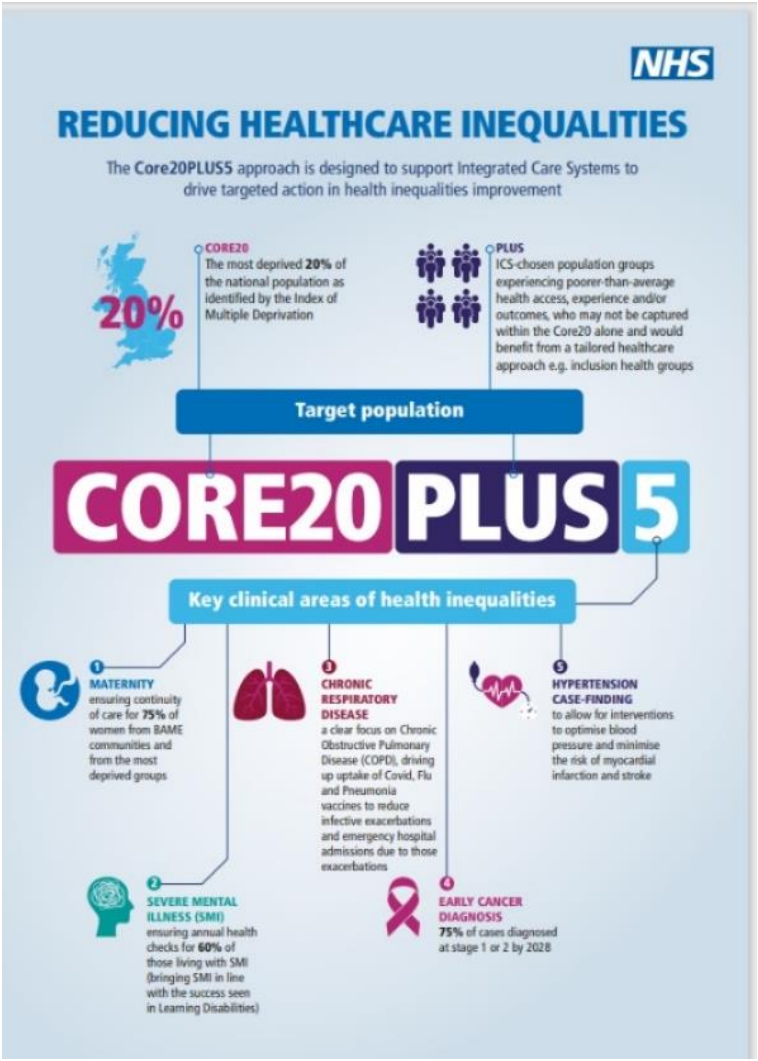
More information can be found in Appendix 1.

4 National and Regional Directives

A central part of the COVID recovery response is aimed at tackling health inequalities by increasing the scale and pace of NHS action. Nationally, eight urgent actions were originally identified and systems have since been asked to focus on five of these priority areas, distilled from the original eight actions. These are:

- Restore NHS services inclusively
- Mitigate against digital exclusion
- Ensure datasets are complete and timely
- Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- Strengthen leadership and accountability

Building on these focus areas, systems are also asked to overlay the 'Core20PLUS5' approach which helps to defines a target population cohort and identifies 5 focus clinical areas which require improvement. Systems are therefore asked to use the Core20PLUS5 approach when agreeing and implementing actions that meet the 5 priority areas.



As an ICS, North East North Cumbria also have a Health Inequalities Advisory Group in place, which aims to offer a multi-agency expert resource, utilising the skills of all partners to achieve a more systematic approach to health inequalities across the system. The aim of this group is to build upon existing place-based working to ensure a health inequalities focus in all ICS workstreams and decision making and to align with Marmot to build back fairer. The advisory group focuses on:

- **Leadership and culture**
- **Governance and accountability**
- **Intelligence and insight**
- **Capacity and capability**
- **Resources**
- **Research and Development**
- **Anchor Institutions**

A regional, high level action plan has been developed by the group, focussed on the 5 key propriety areas, which is then further expanded at each place-based level to tackle health inequalities.

4 Framework for Action

In order to ensure health inequalities are positively impacted across all services, it is imperative that we work collaboratively as a place-based system to agree a framework for action, focused around the 5 key priority areas and using intelligence from the Core20PLUS5 approach, plus building upon the information, support and intelligence flowing from the ICS Advisory Group.

The framework should set out how partners will work together and utilise all available networks, resources and governance arrangements in place to improve prevention, access to care and wider societal determinants of health.

In response to general planning guidance and specific guidance in relation to health inequalities including the ICS action plan, the CCG has led on the development of a series of OGIM (objectives, goals, initiatives and measures) documents that set out a system response to a number of key themes/areas. The aim of these high-level documents is that they are recognised and owned by the system and all partners input into and put plans in place to deliver action against the agreed themes/areas.

OGIM development has been focussed around areas identified through the Core20PLUS5 approach alongside local place-based need and within each OGIM, the 5 health inequality key priority areas are a thread through all actions identified. Tees Valley OGIMs include:

- Prevention (healthy lifestyles)
- Cancer
- Long Term Condition Management (Respiratory, CVD, Diabetes)
- Vaccination programmes
- Access
- Mental Health
- Palliative and End of Life Care
- Maternity
- Children and Young People
- Elective Recovery

This is in addition to work led by partners that supports addressing the wider societal determinants of health including employment, housing, air pollution and transport.

These OGIMs and the resulting actions that are implemented will be reviewing on an ongoing basis and will be driven by relevant national, regional and local emerging guidance and local population health management approaches.

It is important to note that at the time of writing this paper, health planning guidance has just been released which may lead to a refresh of plans. As a result, OGIMs and associated health inequality actions may change slightly to reflect this updated national mandate.

5 Tackling Neighbourhood Inequalities - Population Health Management (PHM) Approaches In Primary Care

PHM is a critical building block for integrated care systems and enables Primary Care Networks (PCNs) to deliver with their local partners, true personalised care. Together, the three Ps (PHM, PCNs, Personalised Care) form a core offer for local people which ensures care is tailored to their personal needs and delivered as close to home as possible.

PHM enables systems and local teams to understand and look for the best solutions to people's needs – not just medically but also socially – including the wider determinants of people's health.

Alongside the wider OGIMs, specific work at a Primary Care Network level is taking place, which aligns to delivering the outcomes of the Tackling Neighbourhood Inequalities DES. The DES tasks Primary Care Networks with specific asks around identifying a population experiencing inequality in provision and/or outcomes and implementing, with system partners, plans to addressing this unmet need. Plans need to deliver relevant interventions or referrals to services that provide interventions for the selected population.

Locally, this programme is being supported by NECS, using population health management approaches, which includes data intelligence gathering, coaching and access to best practice evidence based interventions such as a range of anticipatory care interventions. Primary Care Networks have also been further incentivised to engage in this programme by the CCG via access to a development fund with the specific aim of reducing health inequalities through understanding their population needs and implementing interventions which will help increase population health outcomes

Although national directives have been issued to pause the majority of primary care work apart from urgent interventions and the vaccination programme, locally PCNs are still engaged with this programme and across the Tees Valley, are in varying stages of identification of a population cohort and development of plans to support this cohort.

Locality/ PCN	Key progress/ update
Middlesbrough PCNs [Central, Greater and Holgate PCNs]	**January 2022-** The PCNs are working in collaboration with Central, Holgate and the Local Authority. The group have agreed that the underlying factor to most of the inequalities in the area is Poverty and this was the area PCNs will focus their improvement plans around. The PCNs have agreed they would focus their plan around Mental Health, Alcohol and Frequent Flyers to Primary Care. This approach to all these health inequalities will be driven by the overarching theme of Poverty, as will any improvement plan that is developed. A project group has been established and the CCG and Business Intelligence Colleagues have been invited to attend.
Darlington	**December/ January 2022-** A PHM Workshop was held on 17th December with PCN and wider system partners which helped

	the PCN identify the key demographics which could benefit from PHM-related interventions e.g. obesity, travelling communities, learning disability etc. The NECS Analytics team will help to develop profiles to support the next Darlington Workshop e.g. obesity profile and other analytics for Darlington locality. A system group reconvened on the 18th February to help the PCN understand the data better and narrow the population focus. It was agreed that the PCN will focus on loneliness, frequent attenders to primary care and unknown to services.
Hartlepool [One Life, Hartlepool Health, Hartlepool Network]	**January 2022-** Following the PCNs agreeing that alcohol was their chosen priority a Hartlepool workshop was held on 19th January 2022 and helped the PCNs identify potential cohorts to target their alcohol-related focus on PHM e.g. unplanned care, for males aged 30-54 within most deprived decile for example. The ICS has approached the PCN Clinical Directors to present back at a future ICS meeting and have been highlighted at a regional level due to the great engagement and collaborative work being undertaken.
Stockton on Tees [Billingham and Norton PCN, Stockton PCN, North Stockton PCN and BYTES]	**January 22-** Sarah Bowman-Obuna [Local Authority] has offered her teams support once PCNs have agreed on their chosen priority and will ensure her team members are members of the PCNs working groups. The CCG will be working with PCNs during Feb to finalise priorities so that interventions can be agreed.
Redcar and Cleveland [Redcar Coastal, East Cleveland Group and Eston PCNs]	**January 22-** PCNs are continuing to agree their priority and additional actions required. The CCG will be working with PCNs during Feb to finalise priorities so that interventions can be agreed. The initial priorities identified are: Frequent flyers and healthy weight.

These place-based programmes will be tied in to the broader OGIM initiatives to ensure no duplication and to build upon existing/emerging work programmes so the best outcomes can be achieved overall.

6 Tees Valley – Action on Health Inequalities

As identified, a systematic approach to tackling health inequalities has been applied across the Tees Valley, working in collaboration as a system to aim to achieve the best outcomes for our population.

For the purposes of this paper, health inequality-related actions contained within each OGIM have been extracted to focus a response around this agenda. The summary below provides an overview of Tees Valley health inequality plans and progress to date, with specific reference to the 5 national key priority areas.

Priority Area	Overarching Planning Actions agreed at ICS Level	Additional place-based actions/progress
Restore NHS services inclusively	• Excellent examples **where Trusts are starting to include the Index of Multiple Deprivation** (IMD) quintile in several key data sets and reports, including the inpatient and outpatient waiting lists examples included within the elective recovery section. This approach needs to be rolled out across the ICS. • As an ICS system we are supporting opportunities and frameworks using examples of best practice to support the rapid roll out of a standardised approach (where applicable) as services are restored. A Trust Health Inequalities toolkit has been rolled out and development of a Primary Care toolkit is underway • **Development and implementation of additional indicators to monitor inclusiveness of restoration plans** using indicators of vulnerability and or disadvantage (being developed for monthly NHS reporting to include deprivation (patients from the 20% most deprived neighbourhoods) and ethnicity • **Sharing of good practice** across the ICS and beyond – linking locally, regionally and nationally through networks for example AHSN roundtable, ADPHs to understand promising practice • **Addressing backlog** of services including CHC and ensure an increased proportion of patients managed through advice and guidance in certain specialties • Completion of **all patient ethnicity datasets** to be used to inform prioritisation and planning • Continue to **monitor the effectiveness of arrangements in place,** specifically, the balance between face to face and virtual appointments with a key focus on increasing appropriate access to appointments. For example **Involve North East** have been commissioned to engage with and listen to patients at a local level to understand their digital experience. Findings from the project will be used to help inform the future development of digital services. • Through our developing NE&NC ICS Health Inequalities approach, **ensure join up** for NHS restoration plans with wider NHS system and partner plans e.g. Health & Wellbeing Strategies • Across the NE&NC we have now successfully recruited **5 Consultants in Public Health who are working into FTs with the overall aim to increase PH capacity within the NHS and the wider system.** The CPHs are supporting their respective FTs to implement approaches to support reduction in Health Inequalities. A full evaluation of this approach has been carried out by Newcastle University. Further recruitment of CPHs to take place 2021/22 in remaining Trusts. • Implement the recommendations from the **NE Health Inequality Impact Assessment** - to understand the direct and non-direct health impact of COVID-19 on the population in the North East whilst addressing wider social determinants	Diagnostic spirometry services are being restored across primary care – mobilisation plans in place and service went live late January 2022 Work ongoing with our local AHSN to roll out a number of projects which support the restoration and enhancement of local services, including improved Atrial Fibrillation detection a targeted heart value disease programme. Work also ongoing to roll out the 'proactive care@home' primary care programme which aims to improve risk stratified access to long term condition management, coupled with a more personalised approach to the delivery of care As part of Tees Valley CCG's post COVID work, a survey has been undertaken with the public to understand their experiences of receiving support for ongoing symptom management. The results of this survey will help the CCG/LA in commissioning the appropriate support. Further analysis is being undertaken to better understand inequalities in this patient group to enable more targeted support in the future.

	• Development of a **NE&NC ICS Health Inequality Advisory Board** to provide expertise to support to the ICS in the development of their approaches (developed and in place) • **NECs are implementing routine monitoring of recovery data (referrals and activity) to include IMD decile**. This will help inform recovery in relation to health inequalities • **Northern and Yorkshire Region mapping of elective care and health inequalities will be shared** to inform future approaches • **Support the ICS to roll out waiting list analysis** through a Health Inequalities lens to support the Elective Recovery programme. • To build on work underway to explore how **health literacy** has an impact on access and knowledge within our population • **Continue to work with all relevant parts of the system** to ensure ethnicity data is recorded and accurate • **Self-assessment tool is being developed** to enable systems to assess where they are against strategic and operational delivery plans and collectively agree and commit to key local priorities regarding health and well being • Ensure the restoration of services across the ICS takes account of the **NE&NC Digital Inclusion Plan and Strategy.** • The North East and North Cumbria Integrated Care System (ICS) is currently working together across Commissioners and Acute Providers to support the recovery of Elective services. In the main this is to target the delivery of elective activity in excess of historic trends to big significant inroads against the well-publicised waiting lists that have grown through the covid-19 pandemic. This is a developing piece of work; the following confirms the steps taken to date and the future planned steps: **Actions completed** ▪ A Project Management Office has been established ▪ Delivery tool and meeting schedule in place to monitor progress ▪ Weekly Business Intelligence reports to track progress of waiting lists ▪ Regular dialogue to understand NHS and Independent Sector hospital capacity ▪ Supporting the proactive of managements of patients waiting excessively with the potential of offering choice of alternative provider **Future plans** ▪ Development of transformation programme to focus on making changes to deliver sustainable solutions – e.g. Outpatient transformation, MSK and Ophthalmology pathway redesign and the development of options for Elective Hubs	

Mitigate against digital exclusion	Our NE&NC ICS digital inclusion plan is now in place alongside a roadmap for delivery of the NENC ICS Digital Strategy 2020-24. A key focus for the ICS as a result of the COVID-19 pandemic, is that it has become more apparent that there is a growing need and dependency on digital systems and services, however, not all people have the ability, capability or willingness to interact digitally. • **Collation of the evaluation** to gain feedback from staff and patients about the significant shift to digital pathways of care - ensure no detrimental impact on health inequalities and, where appropriate put mitigating action in place. • Acceleration of the **Axiom / Single Version of the Truth** (SVoT) across the whole NENC ICS footprint to support direct patient care, improve outcomes and target the reduction in health inequalities. • The development of the **Trusted Research Environment** (TRE) strategy and implementation plan. • Expansion to all PCNs in one area to **National Digital Accelerator site** Plans for delivering outstanding commitments • In one Trust the **equity audit carried out for outpatients** identified higher DNA rates by deprivation, gender, age and learning disabilities. Analysis of virtual consultations identified the need to ensure recording of the outcome of the consultations to enable an assessment of equity across digital consultations. Understand how we roll this out across the ICS. • Work is underway to tackle digital exclusion through **working with other partners** to increase access through a number of other services and community assets. • Development of a **Hospital Healthpathways** system to be implemented, expanding on the Community Healthpathways to provide seamless pathways of care that can be adopted across partners and services to ensure we are provide quality, consistent care for all. • **ICS digital inclusion plan and strategy to support local digital inclusion strategies**. Working on alignment and standardisation of partners digital strategies including the CCG, Local Authority, Healthwatch, VONNE and Citizens Advice Bureau so that all relevant partners have same outcomes. • **Implement outputs from mHabitat work -** understand needs and priorities and co-design enhancements which help to build equity and inclusion.	Recently re-procured e-consultation software across primary care to continue to offer access to care via a range of access points Continued review and roll out of alternative access for patients who can engage in a digital solution across local pathways, such as BP Monitoring, rehab programmes etc Ensure personalised care approaches are instigated across all pathways and focussed on in any pathway review – to ensure that a patient centred, patient activated approach is offered to health care
Ensure datasets are complete and timely		

	• **Improving the recording of ethnicity** within general practice is a priority as we know that in some areas RAIDR data identifies that ethnicity unknown or unspecified is as high as approximately 40%. • **We recognise the need to work with practices to improve the quality and level of coding** in order to be able to better identify those adults who will be eligible for flu vaccination and the groups who are also typically likely to be at risk of COVID-19**.** • **Availability of regional maternity dataset** including intelligence relating to BAME and other vulnerable groups • **Dashboards to support programmes of work in development such as Alcohol, Tobacco, Maternity and Primary care LD dashboard** highlighting health inequalities. Links across dashboards to ensure consistent data sources are used. Dashboards to include measures to monitor access, experience and outcomes where possible. • An item will be included in **provider Data Quality improvement** plans within schedule 6 of the standard contract. DQIP will be jointly developed and managed through recovery meetings. • **To work both with NECS and with system partners to ensure datasets and analytics tools are suitable for work on tackling health inequalities**, for example to include postcodes, ethnicity and deprivation data; and to link more widely with partner datasets, e.g. County/District Councils. • Ensure datasets are complete and timely to support development of Axiom /Single Version of the Truth; to inform prioritisation and planning across the ICS system. • Work with **PCNs to improve ethnicity coding** • Working to increase LD registers through QOF and IIF • Plan to address **interface between maternity information system and PAS** • **LD dashboard scope agreed and under development** • As part of each **organisational arrangements and the PHM approach** work is underway to ensure the data bases are complete and timely. • Plans are in place for greater integration of datasets across primary, secondary, council and other sectors – **Axiom / Single Version of the Truth** • **A review of the current data in CHESS** to access the extent of any gaps in the submitted data. Re-establish the data flows and ensure that ethnicity is included in new entries and retrospectively.	Improving ethnicity coding, LD registers and identifying patients with an SMI is a requirement of the PCN DES from October 2021. A PCN self-assessment completed by all PCNs has confirmed their intention to meet the DES requirements to ensure the recording of the ethnicity of all patients registered with the PCN (or have recorded that the patient has chosen not to provide their ethnicity)
Accelerate preventative programmes which	The developing NE&NC ICS approach to Health Inequalities and Population Health Management will ensure the acceleration of preventative programmes at 'place' (CCG/LA) are complimented by ICS approaches and support. The developing PHM programme will be flexible to support all levels within our system – ICS, ICP, Place and PCN as examples. We will specifically support the segmentation	

proactively engage those at greatest risk of poor health outcomes	of populations to identify those at greatest risk of poor health outcomes and work with the relevant partners to identify evidence based interventions to proactively engage and support individuals. **Covid-19 Vaccination programme:** • Ensure comprehensive information is used to analyse the **effectiveness of the vaccination programme** –Across the ICS and in each LA area, we have established a Health Equity vaccination group to ensure collective action to proactively reach and support communities where vaccine uptake is low **MH, LD and Autism:** • **SMI Health checks delivery** – plans are being drawn up to improve uptake of SMI health checks across the ICS which are not at the 60% standard • To **regionally achieve target for those with a learning disability** having a health check	Weekly data is shared through BI on the uptake of the vaccine in pregnant women. A targeted approach will be rolled out with LAs/PHs. This will be targeted at low uptake localities but will also have a focus on the BAME community. Q2 data for physical health checks for SMI patients was published in November. Tees Valley CCG is the 23rd Highest achieving CCG, nationally, out-turning at 37.55% in Q2. This exceeds the North East and Yorkshire region's achievement of 37.31%. The North East and Yorkshire region remains the highest achieving region nationally; national achievement currently stands at 29.98%. An ICS recovery planning template has been developed which is in the process of being scrutinised and completed. Outreach monies for increasing the uptake of physical health checks have been invested with Middlesbrough and Stockton Mind who are working with PCNs to identify and share examples of good practice to increase uptake. Data for LD AHC at 31st Oct was 33% for across the Tees Valley. There is significant variation across practices from 0%-77% completion of checks. The CCG are supporting practices by targeting support to lower performing practices, led by CCG LD Clinical Lead, in collaboration with TEWV. This is around quality of the check, not just completion.

	Cancer: • Ongoing work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on under-represented groups for example we are developing a health inequalities programme for the uptake of our cancer screening programmes. *Further actions included within the more detailed cancer section of the plan*	There has been additional recurrent investment into TEWV to expand the LD physical health team this year, which will increase capacity to support patients to access AHC and support primary care to offer reasonable adjustments. The Tees Valley was successful in its application to be a pilot site for the Targeted Lung Health Check programme. The Targeted Lung Health Checks programme is a new and ground-breaking flagship programme of work in England which will contribute to the ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer. The programme targets those most at risk of lung cancer, people aged between 55 – 74 years and 364 days, who have ever smoked and invites them to a free lung check, over a period of two years. Following the lung health check those assessed as high risk will be offered a low dose CT scan. It is anticipated that this programme will support the diagnosis of lung cancers at an earlier stage, allowing earlier and curative treatment to be offered, which will save lives. It is expected that this programme will commence early in 2022/23.
	Maternity: • To **regionally achieve continuity of carer** target for pregnant women, with a particular focus on BAME and vulnerable women being prioritised	The Local Maternity and Neonatal System will work across the ICS footprint to gain a greater understanding of the BAME population, resulting in the development of individual Trust maternity CoC action plans in order to

		improve outcomes. Vulnerable women are also being prioritised as a cohort that would benefit from CoC
	LTC management: • **Increase the number of Social Prescribing Link workers**, care co-ordinators and health & wellbeing coaches • **Service improvement - rapid diagnostics pathways rollout** e.g. gynae, joint GI, vague symptoms, FIT testing; Smear testing catch up • **Lung Health checks** - Roll out of Lung Health Checks: mobile scanning, with vans sited in some of our most deprived communities to increase uptake in these communities. • **Making Every Contact Count (MECC) – continued roll out of** MECC and expansion to MECC for mental health. • **Smoke Free NHS/Treating Tobacco Dependency - reduce smoking by 5% to tackle inequalities** Support regional delivery of Don't wait campaign, systematic roll out of acute tobacco dependency programme to add value to existing community based smoking cessation services and further work to improve support in primary care • **Alcohol** Link with MH ICS workstream to improve pathways for people with dual diagnosis and ensure ACTs have clear pathways in and out of LA commissioned community services • **Healthy Weight** – ICS Prevention and Population Health Board to develop a regional approach **to compliment work already developed at an ICP and place level on a whole systems approach** • Addressing antimicrobial resistance and the ambitions outlined in the AMR 5 year plan have been a continual focus of CCGs and their system partners since publication of the plan in 2019 and early adoption of the National AMR strategy in 2013.	The number of link workers continue to increase across PCNs with 43 WTE in post as at October 21. A self assessment of PCN link workers was undertaken before Christmas to identify areas of opportunity and gather additional intel regarding the patients they support and are seeking to work within the future, and the support they may require from the CCG to progress. CCG supporting Specialist Stop Smoking Service in Stockton with developing a pathway to send automated text messages from primary care systems to registered smokers to increase uptake of specialist services. Rolled out a comprehensive training programme, supported by NHSE and funded via personalised care monies to increase access to MECC, health coaching training etc during 21/22. Further programme to also be rolled out in 22/23. 'You've got this' programme and Active Hospital programme locally supported by the CCG The CCG are involved in supporting the development of Alcohol Care Teams in each FT and ensuring links to community service provision. Local GP practices have signed up to the weight management DES. Developed comms material to support signposting and referral into relevant weight management services. Continued roll out of the

		National Diabetes Prevention Programme. Expecting to roll out low calorie diet programme during early 22/23 Hypertension Detection and Optimisation Programme – Audit, Data analysis, and education programme to be rolled out across Primary Care. Local variations of the programme will be designed and implemented to build on progress throughout 2021/22 Comprehensive review of Cardiac Rehabilitation services will be undertaken with the aim of increasing referral and uptake of cardiac rehabilitation during 22/23. Work closely with Primary Care Networks to support implementation of the new DES for CVD in 22/23, plus support to identify CVD champions at a PCN level and utilisation of the CVDPREVENT programmes Implemented increased access to flash glucose monitoring Review and re-design, where appropriate, community diabetes teams to enhance structured education and self-management. Using Treatment and Care Transformation funding from NHSE, implement MDFTs in South Tees and HAST localities whilst continuing to provide a comprehensive diabetes inpatient specialist nurse service. Undertake joint piece of work with County Durham CCG in a NDA QI project looking at cardiovascular disease and diabetes focussing on UCAR testing and outcomes. The CCG has developed a close working relationship with the ICS population management team. This builds on the work PCNs undertook in 20/21 to identify population priorities. There have been a series of

	Primary Care: • **PHM programme for PCNs** to support identification of population requiring targeted support • **Implement NE&NC Deep End network priority actions –** utilise the information and intelligence gathered from the 34 Deep End Practices to ensure those areas which will impact positively on delivery of services and ultimately outcomes for their population are supported and implemented	locality and ICP meetings during 21/22 to ensure the ICS team supports PCNs to identify priorities and populations to tackle health inequalities. Alongside the DES, the CCG has been able to incentivise this work and funds have been set aside to support a number of projects at PCNs level to tackle the priorities highlighted via this PHM work. The PHM approach is being rolled out with PCNs, with wider system support and involvement from DPHs. Plans and priorities across all locality areas currently being finalised.
	Adopting an ICS approach • To review and implement the recommendations arising from the **NE COVID Health Inequalities Impact Assessment** • **Working with public health colleagues to develop an ICS strategic approach** to tackle key public health issues impacting on health inequalities that can be best delivered at scale – including obesity, smoking, alcohol, physical activity, CVD, mental health and wellbeing • Development and co-production of **practical health inequalities tools** for organisations to ensure they mitigate health inequalities in recovery. • **Scope and create a regional healthy weight programme** – linking programmes across Health and Public Health including the National Diabetes Prevention Programme for example • **A North East and North Cumbria ICS Personalised Care Programme training offer**. This is being developed with a view to upskilling and supporting the expansion of the health, care and VCSE sector workforce during 2021 • **Roll out of Alcohol Care Teams** under a regional umbrella, with development of a bid to ensure access across a regional footprint • Utilise the **Better Health at Work Award** programme and other business networks to share learning and good practice across sectors in relation to supporting and promoting staff health and wellbeing. • **Plans to risk stratify and targeting patients** who have not received education or have had limited contact during the pandemic • **Healthy Weight** –Local place based multi agency groups are being established and will consider early age obesity issues and obesity linked to key factors such as BAME diabetic activity.	Supported and encouraged the rollout of the health inequalities toolkit across provider organisations. Identified CCG would be willing to roll out/trial a PCN version once available NDPP already rolled out across the CCG with expansion plans agreed such as additional digital options

	• Utilising the learning across the ICS for example **one Local Authority is developing a transport vision** for the city so that as a place the wellbeing and health of future generations is not compromised • Roll out a PHM approach which supports systems at all levels to identify priority areas and implement appropriate interventions **MH, LD and Autism:** • **Learning Disabilities:** multi-agency, multi-professional Learning Disabilities Health Group been established which has developed a Learning Disabilities Action Plan and includes measures to increase uptake of screening and health checks as well as identifying improvements in community and hospital based pathways for people with learning disabilities and/or autism. • **NE & NC ICS LD programme has recently reframed priorities** and is building these using an inequalities lens, primarily focusing on accurate business intelligence. • **Reframed regional mental health ICS work stream** – reducing the life impact of mental illness and learning disability **Maternity:** • **3 regional LMS groups are co-ordinating achievement of continuity of carer for pregnant women,** strong links with public health prevention in maternity services approach for example, which includes smoking in pregnancy, maternal healthy weight and maternal mental health	The 3 regional LMNS's have merged into 1 across North East and Cumbria (NENC) and deliverables including key priorities have been agreed. Governance arrangements for the one LMNS taking on greater responsibility of maternity services are still to be agreed. Representation from the TVCCG Director of Commissioning, Strategy and Delivery for Children, Young people and Maternity, sits on the Board. Through the creation of the ICS Public Health Prevention in Maternity group (PHPiM), Key Deliverables have been agreed which will link to CoC plans and include reducing SATOD, improvement of pre conceptive advice on tobacco dependency; alcohol use, positive mental health, postnatal contraception, nutrition and physical activity

	LTC management: • Development of frailty services to reduce pressure on hospitals • Development of community based services to support individuals in their own home for example roll out of pulse oximetry and blood pressure monitors so patients care can be managed at home • Effective delivery of the AMR agenda is informed by the North East and North Cumbria (NE&NC) AMR and HCAI Improvement Board of which CCGs are an active member. The Board is chaired by the SRO for Infection Prevention and Control across NE&NC. This includes developing a more robust overarching AMR / HCAI strategy for NE&NC and engaging with the Academic Health Sciences Network to support unmet needs and innovation influencing future evaluation and audit. The Board aims to facilitate the harmonisation of local AMR / HCAI plans and delivery frameworks to ensure coordination of efforts by primary, secondary and social care. It will also deliver a standard quality assurance framework, based on the Health and Social Care Act 2008 Code of Practice and the National Institute for Health and Care Excellence Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use - Baseline Assessment Tool, across all health and social care organisations. The Board has a workstream that specifically targets antimicrobial resistance and has been working (although delayed by the pandemic) on mapping prescribing data across NE&NC, developing a measure for good prescribing, exploring Nursing Stewardship and developing a coordinated PCR testing approach across the patch. **Primary Care:** • Utilising intelligence and information to ensure a **targeted approach to flu and vaccination programmes** • Further support and share the **learning from the Deep End Network** and understand implications of rural deprivation against urban deprivation	**Acute Frailty Teams** in place in all Acute South ICP Hospitals South Tees Foundation NHS Foundation Trust, North Tees Hospitals NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust Implemented comprehensive pulse oximetry@home model across all locality areas, supported by a virtual ward discharge approach at STHFT and CDDFT. Secured access to BP devices to roll out across primary care in early 22/23 to increase monitoring. Developed a broader @home approach, currently working with NHSE as a wave 2 site to roll out the proactive care@home programme across primary care, plus scoping a more co-ordinated community approach to @home models, inclusive of PR@Home and HF@Home roll out. Currently scoping plans to pilot Acute Respiratory Infection@Home also As per above, PHM approach being rolled out across all PCNs with targeted plans being developed that learn from the deep end work
Strengthen leadership and accountability	There are high levels of commitment from ICS leadership to adopting and further developing a NE&NC ICS health inequalities approach underpinned by a Population Health Management methodology. Development of a Health Inequalities advisory group to support the ICS has been endorsed. This multi-professional group includes the NHS, LAs, PHE, Applied Research Collaborative and the Voluntary sector. The Chair is a Chief Executive of NT&H FT. There is also the development of a Health Inequalities network to support leads across all NHS organisations and we are keen to expand this to include Chairs of Health & wellbeing Boards. This will ensure	

	appropriate governance and accountability in place and links to well-led framework and place based working. • **Ensure all PCNs identify a named** health inequality lead. • **Organisations will be developing and publishing their action plans** showing how over the next five years their board (and non execs) and senior staffing will, in percentage terms at least, match the overall BAME composition of their overall workforce, or their local community, whichever is the higher. • **Roll out of HI Toolkit across the NHS** • **NE&NC Health Inequalities Network** being established to bring together and to support named HI leads • **NE&NC Health Inequalities advisory group** to be established • Under the direction of a NE&NC ICS Health Inequalities SRO **develop a Regional** approach to ensure we use the **appropriate data, evidence and guidance** in the ICS developments and that we develop a HI strategic plan • **Ensure links are made between locally developed tools and approaches to support and nationally developed tools and approaches** such as Well Led Framework • **Use opportunities within NHS planning guidance** to continually engage across the system • **Link with the NE&NC ICS Prevention and Population Health Board and NE Health Inequalities Impact Assessment Group** to develop resources, interactive toolkits, guides and examples of the practical actions to be taken to tackle health inequalities • **Work with Local Authorities, in particular the Directors of Public Health,** to further build on and align with existing leadership arrangements at a place based level via the Health & Wellbeing Boards. • **Build on existing networks** to share practice and identify gaps in evidence in order to take further action to reduce health inequalities • **Active participation in a national HEP leadership programme**	Locally, each area has a named health inequality lead

Appendix 1: Fingertips data sources

Better 95% | Similar | Worse 95% | Not compared | *Quintiles:* Best | | | | Worst

Not applicable

Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Children and young people															
Infant mortality rate	2017 - 19	3.9	3.4	3.2	3.7	4.0	3.0	3.2	3.9	3.5	3.2	3.4	2.6	3.6	3.0
Older people															
Life expectancy at 65 (Male)	2017 - 19	19.0	18.1	18.2	18.9	18.1	17.9	16.7	18.2	18.2	19.1	18.3	17.3	18.5	17.4
Life expectancy at 65 (Female)	2017 - 19	21.3	20.2	20.1	20.1	20.2	20.0	19.4	20.0	20.1	20.8	20.4	20.1	20.1	19.9
Healthy life expectancy at 65 (Male)	2017 - 19	10.6	9.1	8.3	8.6	9.7	8.5	8.8	11.1	8.4	10.2	10.3	9.1	9.0	8.2
Healthy life expectancy at 65 (Female)	2017 - 19	11.1	9.3	9.0	9.7	8.8	9.2	9.2	9.6	9.4	9.4	10.6	9.7	8.8	9.1
Whole population															
Life expectancy at birth (Male)	2017 - 19	79.8	78.0	78.3	78.8	77.8	76.9	75.4	77.9	78.2	79.5	78.2	77.0	78.5	77.0
Life expectancy at birth (Female)	2017 - 19	83.4	81.8	81.8	81.9	81.8	81.3	80.3	81.9	82.0	82.8	81.8	81.8	81.7	81.4
Healthy life expectancy at birth (Male)	2017 - 19	63.2	59.4	59.6	58.1	58.2	57.0	58.5	61.0	60.6	60.9	60.2	60.4	57.8	57.5
Healthy life expectancy at birth (Female)	2017 - 19	63.5	59.0	58.3	62.2	59.7	57.4	58.5	58.7	59.3	61.7	60.3	58.5	56.8	57.3
Inequality in life expectancy at birth (Male)	2017 - 19	9.4	12.2	9.8	11.9	10.7	13.1	12.9	12.6	11.7	11.2	13.6	10.3	14.3	11.0
Inequality in life expectancy at birth (Female)	2017 - 19	7.6	9.7	7.9	9.7	9.6	10.4	11.0	8.4	10.6	9.9	8.6	6.9	13.3	8.7

Better 95% | Similar | Worse 95% | Lower | Similar | Higher | Not compared

Quintiles: Low | High | Not applicable

Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Children and young people															
Low birth weight of term babies	2019	2.90	3.11	3.27	2.56	3.11	3.92	3.19	3.58	2.64	2.50	2.11	3.22	3.08	3.55
Smoking status at time of delivery	2019/20	10.4	15.2*	16.8	16.4	12.8	16.5	16.5	12.8	11.7	13.8	16.5	13.9	16.5	18.3
Breastfeeding prevalence at 6-8 weeks after birth - current method	2019/20	48.0*	34.4*	27.8	33.5	38.7	*	32.6	50.9*	42.2	38.8	27.6	*	*	25.7
Proportion of infants receiving a 6 to 8 week review	2019/20	85.1*	91.6*	95.1	93.9	95.5	79.0	96.7	86.4*	95.2	86.6	94.1	89.1	85.3	96.6
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2019/20	90.6	95.1	96.8	94.3	94.2	92.7	91.3	93.8	96.9	94.0	93.8	96.7	94.7	97.6
Percentage of 5 year olds with experience of visually obvious dental decay	2018/19	23.4	23.3	26.8	22.3	26.6	15.9	38.1	24.2	12.7	20.3	28.0	22.1	19.5	32.5
Working age adults															
Cancer screening coverage - breast cancer	2020	74.1*	76.3*	77.9	76.6	77.6	74.1	70.2	72.9	75.6	78.5	75.8	76.6	75.4	76.9
Cancer screening coverage - cervical cancer (aged 25 to 49 years old)	2020	70.2*	74.9*	76.9	77.3	75.7	75.4	67.3	65.0	77.9	78.4	77.5	77.2	75.9	76.9
Cancer screening coverage - cervical cancer (aged 50 to 64 years old)	2020	76.1*	76.5*	77.4	78.0	76.1	72.3	71.9	75.7	76.2	78.6	76.3	76.0	75.4	77.5
Cancer screening coverage - bowel cancer	2020	63.8*	65.1*	66.0	65.7	66.3	60.5	58.6	63.8	65.4	69.6	64.2	63.4	63.0	64.5
Hypertension: QOF prevalence (all ages)	2019/20	14.1	16.0	17.0	16.2	16.3	17.2	13.4	12.0	15.6	17.9	17.3	15.8	15.3	17.4
Older people															
Population vaccination coverage - Flu (aged 65+) <75% ≥75%	2019/20	72.4	73.8*	72.1	73.7	74.2	72.5	72.5	75.0	74.7	75.1	75.0	74.6	73.5	73.0
Population vaccination coverage - Shingles vaccination coverage (70 years old) <50% 50% to 60% ≥60%	2017/18	44.4	45.0	47.6	49.7	40.7	29.1	36.3	43.9	42.6	46.4	51.1	54.0	44.9	41.6
Abdominal Aortic Aneurysm Screening - Coverage	2019/20	76.1*	78.3*	80.4	79.6	75.3	80.1	78.1	72.3	75.9	78.8	80.6	77.2	80.5	79.9
Rate of newly diagnosed dementia registrations (Experimental)	2018/19	11.4	11.8	10.7	13.1	13.2	13.0	11.9	13.8	12.0	10.8	10.5	12.2	13.7	10.7
Dementia: Recorded prevalence (aged 65 years and over)	2020	3.97*	4.09	3.88	4.26	4.41	4.40	4.57	4.47	4.07	3.75	4.14	3.98	4.69	3.75

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

C16 - Percentage of adults (aged 18+) classified as overweight or obese

New data 2019/20 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	62.8	62.6	63.0
County and UA	–	-	-	-	-
Hartlepool	–	-	73.0	68.7	77.3
Redcar and Cleveland	–	-	72.9	68.7	77.0
Middlesbrough	–	-	71.7	67.4	76.1
Stockton-on-Tees	–	-	67.0	62.5	71.5
Darlington	–	-	63.8	59.1	68.4

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

E03 - Under 75 mortality rate from causes considered preventable (2019 definition)

2017 - 19 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	207,045	142.2	141.6	142.9
County and UA	–	-	-	-	-
Middlesbrough	–	830	245.0	228.5	262.3
Hartlepool	–	522	205.3	188.0	223.8
Redcar and Cleveland	–	773	192.9	179.4	207.1
Stockton-on-Tees	–	943	179.5	168.2	191.3
Darlington	–	502	169.1	154.6	184.6

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

C18 - Smoking Prevalence in adults (18+) - current smokers (APS)

2019 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,144,703	13.9	13.6	14.1
County and UA	–	-	-	-	-
Hartlepool	–	14,180	19.3	16.6	22.0
Middlesbrough	–	18,578	17.2	14.6	19.8
Redcar and Cleveland	–	16,942	15.5	13.1	17.8
Darlington	–	11,552	13.7	11.4	16.0
Stockton-on-Tees	–	20,294	13.2	10.9	15.6

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

E04a - Under 75 mortality rate from all cardiovascular diseases 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	102,225	70.4	70.0	70.9
County and UA	–	-	-	-	-
Middlesbrough	–	342	100.8	90.4	112.1
Hartlepool	–	253	99.1	87.2	112.2
Redcar and Cleveland	–	362	88.0	79.1	97.6
Darlington	–	223	74.3	64.8	84.7
Stockton-on-Tees	–	385	73.1	66.0	80.8

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

E05a - Under 75 mortality rate from cancer 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	187,314	129.2	128.6	129.8
County and UA	–	-	-	-	-
Middlesbrough	–	590	175.1	161.2	189.9
Hartlepool	–	411	160.1	144.9	176.4
Redcar and Cleveland	–	629	150.8	139.2	163.1
Stockton-on-Tees	–	773	146.8	136.6	157.5
Darlington	–	413	137.4	124.5	151.4

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

E07a - Under 75 mortality rate from respiratory disease 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	49,555	34.2	33.9	34.5
County and UA	–	-	-	-	-
Middlesbrough	–	233	69.3	60.7	78.8
Hartlepool	–	126	49.4	41.1	58.8
Redcar and Cleveland	–	207	49.0	42.6	56.2
Darlington	–	143	47.3	39.9	55.7
Stockton-on-Tees	–	220	42.0	36.6	47.9

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

E06a - Under 75 mortality rate from liver disease 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	26,857	18.5	18.3	18.7
County and UA	–	-	-	-	-
Middlesbrough	–	99	29.0	23.6	35.3
Hartlepool	–	73	28.5	22.3	35.9
Stockton-on-Tees	–	141	26.9	22.7	31.8
Darlington	–	76	26.1	20.5	32.6
Redcar and Cleveland	–	85	21.8	17.3	27.0

Better 95% | Similar | Worse 95% | Not compared | *Quintiles:* Low | High

Not applicable

Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Children and young people															
Under 18s conception rate / 1,000	2018	16.7	24.9	26.4	19.5	16.9	38.0	39.4	24.2	18.4	17.3	34.6	20.1	26.8	29.0
Children in care	2020	67	108	90	120	105	158	189	113	71	73	126	97	131	106
Free school meals: % uptake among all pupils	2018	13.5	18.4	18.1	16.5	15.9	25.8	24.2	25.5	12.6	12.3	17.9	19.2	16.4	20.9
Child development: percentage of children achieving a good level of development at 2-2½ years	2019/20	83.3	87.4	89.8	93.9	85.6	62.1	89.4	85.7	87.8	91.2	88.0	*	89.8	83.2
School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19	71.8	71.8	71.8	71.7	73.4	72.2	63.1	70.4	72.0	74.8	71.1	73.3	73.8	72.6
Pupils with special educational needs (SEN): % of school pupils with special educational needs	2018	14.4	15.4	14.5	15.1	14.6	14.9	17.6	16.0	13.8	14.2	17.4	19.4	15.4	15.4
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2019	5.5	5.9	4.8	4.2	5.2	3.7	4.7	9.2	3.8	4.7	5.5	7.3	4.9	10.6
Children killed and seriously injured (KSI) on England's roads	2017 - 19	18.0	23.9	25.4	29.8	20.8	26.1	17.0	23.0	29.6	27.4	24.3	19.9	18.7	23.2
Working age adults															
Percentage of people aged 16-64 in employment	2019/20	76.2	71.1	71.4	74.9	73.4	68.1	65.2	67.0	79.1	73.1	66.1	69.9	72.7	70.3
Gap in the employment rate between those with a long-term health condition and the overall employment rate	2019/20	10.6	14.2	12.9	12.7	12.8	14.1	13.9	12.1	12.0	15.3	19.2	18.4	15.1	15.3
Employment and Support Allowance claimants	2018	5.4	7.4	7.8	6.5	7.0	7.4	9.7	5.6	6.7	6.2	8.6	8.4	6.8	9.0
Whole population															
Social Isolation: percentage of adult social care users who have as much social contact as they would	2019/20	45.9	49.9	51.1	46.8	52.3	53.6	47.0	46.5	47.3	49.7	49.5	47.9	48.7	55.1