LiveWell SOUTH TEES
HEALTH & WELLBEING BOARD

SOUTH TEES JSNA

Joint Strategic Needs Assessment

JUNE 2024

MISSION

We will support people and communities to build better health.

GOAL

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

Contents

1. Introduction

1.1 Mission led approach.

The South Tees Health & Wellbeing Boards have agreed to a "mission-led" approach, structured across the lifecourse. 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. The Missions each have a set of ambitious goals that further articulate and explain the Mission.

The JSNA will provide the intelligence behind the Mission(s) – it will develop our collective understanding of the Mission(s); the issues behind and the broad contributing factors to the current outcomes experienced. We are working across the Tees Valley authorities to develop a process on that footprint that facilitates deeper engagement from the ICB.

The vision and aspirations under the lifecourse framework already exist following previous development sessions of the LiveWell Board. The lifecourse framework consists of three strategic aims – start well, live well and age well.

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

1.2 Live well strategic aim.

There are four missions within the live well strategic aim. **The first mission relates to reducing levels of poverty, the second mission relates to systems that promote wellbeing, the third mission relates to supporting people to build better health and the fourth mission looks at people suffering from multiple disadvantage**.

The second goal within the third mission, and the focus of this needs assessment is on finding diseases and ill health earlier and promoting clinical prevention interventions and pathways across the system.

Aims	**Mission**	**Goal**
Live Well	We will reduce the proportion of our families who are living in poverty.	We want to reduce levels of harmful debt in our communities
		We want to improve the levels of high-quality employment and increase skills in the employed population.
	We will create places and systems	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.

	that promote wellbeing.	We want to create places with high quality green spaces that reflect community needs, provide space for nature and are well connected.
		We want to create a transport system that promotes active and sustainable transport and has minimal impact on air quality.
		We will support the development of social capital to increase community cohesion, resilience and engagement
	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
		We want to find more diseases and ill health earlier and promote clinical prevention interventions and pathways across the system
	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
		We want to improve outcomes for inclusion health groups
		We want to understand and reduce the impact of parental substance misuse and trauma on children

2. What is our mission and why do we need to achieve it?

2.1 We will support people and communities to build better health.

Our mission is to support people and communities to build better health. This will help address health inequalities by understanding communities needs and developing solutions with them, by working with people and communities at places we can better tailor interventions and services to meet their needs and preferences, so that they are designed and delivered more effectively. This will ensure models of care for our clinical prevention interventions are suitable for the communities we service across South Tees.

South Tees makes up two neighbouring unitary authorities, Middlesbrough, and Redcar & Cleveland, whilst separate authorities they have common strengths, values and assets including a joint Public Health Team, and joint Health and Wellbeing Board. Other strategic partners cover either the same South Tees footprint or wider across Tees Valley, these include South Tees Hospital NHS Foundation Trust, Tees, Esk and Wear Valley NHS Foundation Trust, Tees Valley ICB, ELM GP Federation, Tees Valley Local Pharmaceutical Committee, Cleveland Police, Tees Valley Combined Authority and Teesside University).

South Tees makes up approximately 40% of the Tees Valley sub region within north England. South Tees has stark contrasts, comprising the large rural area of East Cleveland, through the coastal communities of Redburn and Saltburn and the urban conurbation that extends along the River Tees into Middlesbrough, the largest settlement of the area. Middlesbrough communities are amongst the most diverse in the region with around 50 nationalities are represented in the population of the town.

The health of people in South Tees is generally worse than England averages, with Middlesbrough being identified as the most deprived local authority nationally at neighbourhood level. Almost half (48.8%) of all lower super output areas (LSOAs) in Middlesbrough are ranked within the 10% most deprived, with Redcar & Cleveland seeing an increased rate of deprivation between 2015 and 2019 publication of the national index of multiple deprivation (IMD). For both areas life expectancy and healthy life expectancy is significantly below the England average for both males and females. In addition, significant intra-area variations exist between the most deprived and affluent wards within South Tees, with males and females in more deprived wards expected to live around 12.6 years and 12.0 years less in Middlesbrough and 11.0 years and 7.3 years in Redcar & Cleveland, respectively.

Residents in South Tees live shorter lives than the national average and furthermore spend a smaller proportion of their shorter lifespan healthy and disability free compared to England.

3. What is our goal and why do we need to achieve it?

3.1 We want to find more diseases early and promote clinical prevention interventions and pathways across the system.

There are 2 goals within the mission to support people and communities to build better health. By 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. **Detecting diseases and ill health earlier, when followed up by appropriate clinical interventions and pathways**, leads to better health outcomes and prevents premature death.

This needs assessment focuses on secondary prevention – detecting the causes of ill health earlier to prevent or reduce the chances of them leading to more serious conditions, it highlights key data and national policy drivers for change as well as what we are already doing locally in relation to these key priority areas. A list of recommendations is also provided under each section.

This JSNA focuses on the top 5 causes of death across South Tees and highlights the clinical prevention interventions and pathways currently in place to detect disease earlier including-:

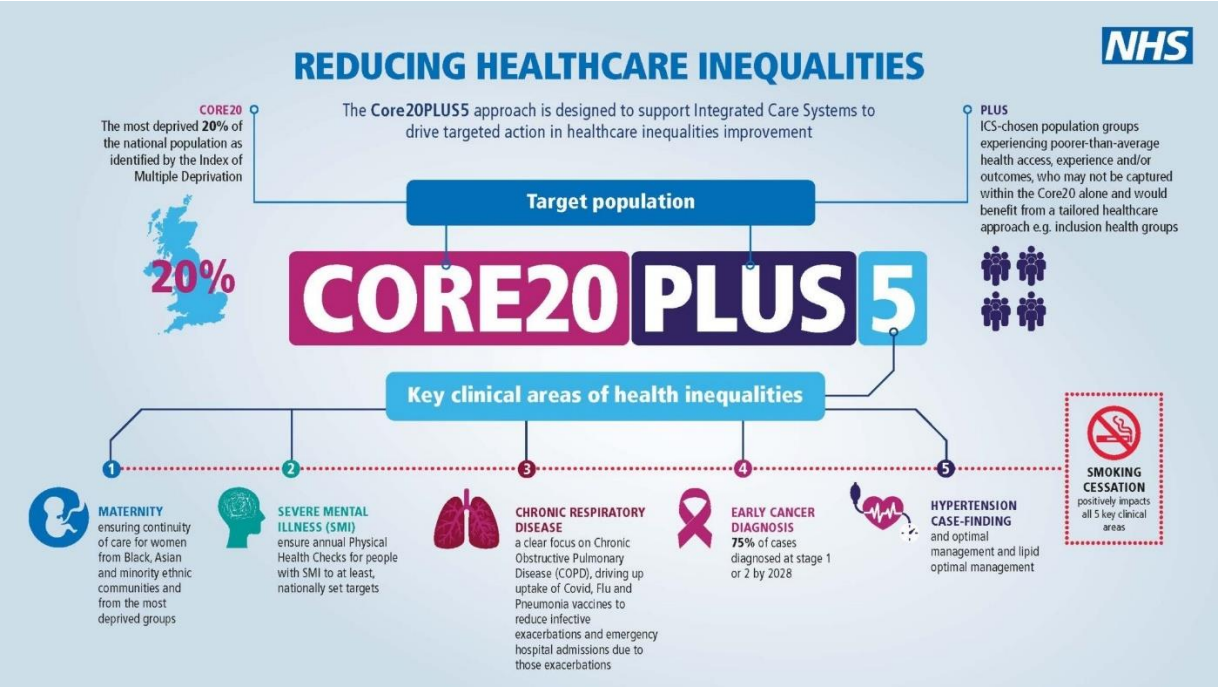
- Cancer
- Cardiovascular Disease
- Respiratory
- Diabetes
- External causes

Many conditions which can contribute to shorter life expectancy are preventable, therefore it is important that we take action to help people improve their health by offering targeted support to help reduce dependency on alcohol or tobacco, offering weight management services and encouraging people to be more active.

Poor social and economic circumstances affect health throughout life. People living in poverty have greater risks of serious illness and premature death and can face increasing health inequalities as well as spending a greater proportion of their shorter lives living with long term conditions and disabilities. Although the root causes of health inequalities are driven by factors outside of the NHS and social care, these services deal with the often-preventable consequences and should therefore play an active role in supporting local communities to build better health.

Core20Plus5 is a national NHS England and NHS Improvement approach to support reduction of health inequalities at both national and system level. The approach defines a target population cohort the Core20PLUS and identifies 5 focus clinical areas requiring accelerated improvement, as summarised in figure 1 below:

Figure 1: The Core20Plus5 approach to reducing health inequalities.



Source NHS England

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 is to implement effective prevention programmes. We therefore need to ensure we continue to work together across the system to implement evidence-based programmes of preventative interventions.

4. Cancer

4.1 What key data do we have and what are the drivers for change?

4.1.1 Cancer prevalence.

Cancer survivorship is higher than ever with fewer people dying from their cancer diagnosis, however, there is a significant health inequality gap within communities across our localities. More people from our deprived communities die from cancer or their quality-of-life post cancer treatment is worse than it should be when compared to the local, regional, and English averages.

We know that patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival. In Tees Valley, 82.5% of practices have a higher-than-average deprivation score (Eng. 21.8%). The prevalence of cancer is also high at 3.3% (Eng. Average .3%). The number of cancer cases is also higher with 593 per 100,000 compared to England average of 507.

Screening plays a big part in identifying cancer at an earlier stage. Although locally there has been progress in increasing the screening rates for Breast, Cervical and Colorectal and the impact of the covid pandemic means that a renewed focus is required to continue to increase uptake.

Current performance:

- TLHC – 63%
- Breast 35.8% – 74.6% (England 71.1%);
- Cervical: 25-49yrs 45.4% - 78.9% (England 68.6%), 50-64yrs 56.8 % - 79.0% (England 75.2).
- Bowel – 49.3% - 75.1% (England 69.5%)

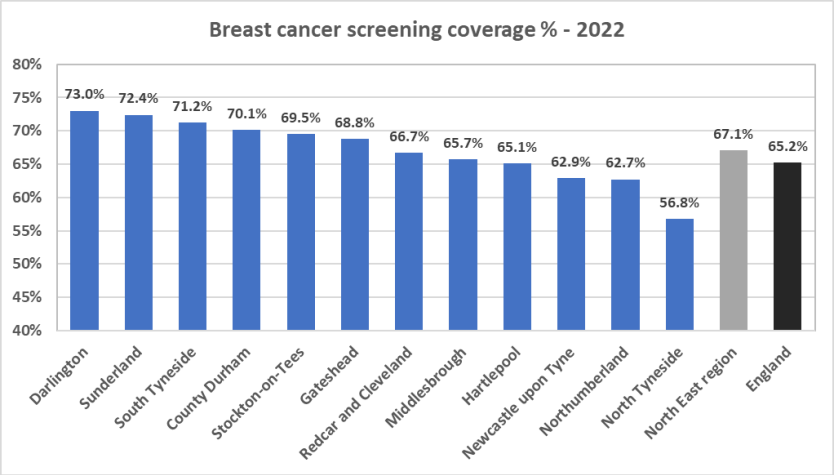
Key Metrics:

- Treated within 31 Days from decision to treat to first treatment (96% standard) (inc. surgery, anti-cancer drug and radiotherapy standards).
- Treated within 62 Days from referral to first treatment (including rare cancers) (85% standard) (inc. screening and consultant upgrade).
- 28-Day Faster Diagnosis Standard.
- Cancers diagnosed at early stage - new cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed.
- One-year survival from all cancers - number of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis. More people each year will survive their cancer for at least five years after diagnosis.
- Cancer patient experience and Cancer Quality of Life Survey.
- Diagnostics - Percentage of patients waiting 6 weeks or more for a diagnostic test.

4.1.2 Breast cancer screening.

Breast screening supports early detection of cancer and is estimated to save 1,400 lives in England each year. This indicator provides an opportunity to incentivise screening promotion and other local initiatives to increase coverage of breast screening. Improvements in coverage would mean more breast cancers are detected at earlier, more treatable stages (Fingertips Cancer Screening, 2024). Figure 2 below highlights that Breast cancer uptake varies significantly across the North East. Both Middlesbrough and Redcar & Cleveland have higher uptake rates then the national average but sit below the North East rate. Middlesbrough and Redcar & Cleveland rank 89th and 93rd lowest respectively out of 150 local authorities in England.

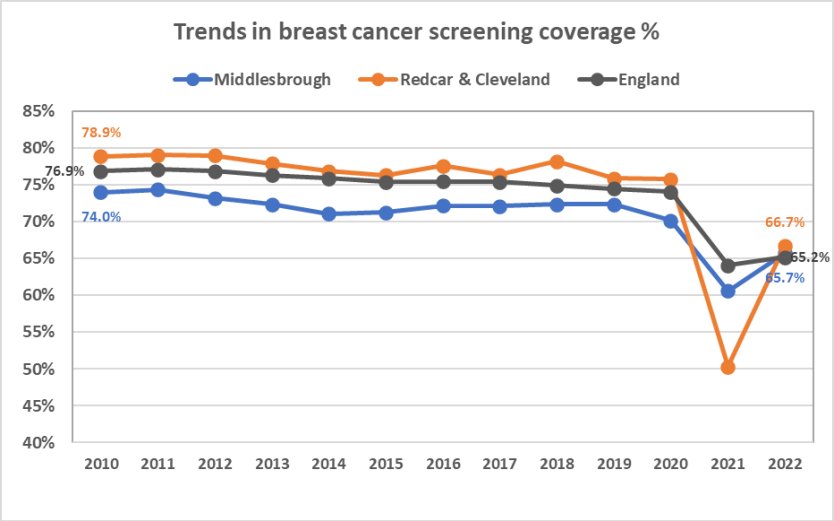
Figure 2: Breast cancer screening coverage



Source – OHID Fingertips

Redcar & Cleveland have historically had higher uptake rates compared to England, whilst Middlesbrough had significantly lower uptake rates – see figure 3 below. The Covid-19 pandemic had a huge impact on uptake rates in 2021, with Redcar & Cleveland falling from 75.8% in 2021 to 50.3% in 2022. Uptake rates have increased in 2022 but are still well below pre-pandemic levels.

Figure 3: Breast cancer screening coverage trends

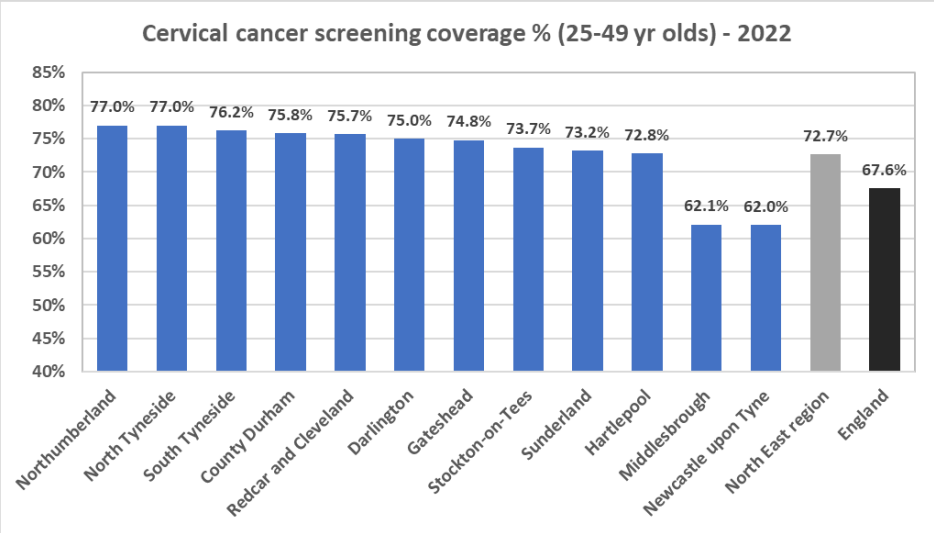


Source – OHID Fingertips

4.1.3 Cervical cancer screening.

Cervical screening is a way of preventing cancer. It tests for a virus called human papillomavirus (HPV). High risk HPV can cause cervical cells to become abnormal. Virtually all cases of cervical cancer are linked to high-risk HPV (Cancer Research UK, 2024). Figure 4 below shows that the majority of North East local authorities have higher rates compared to the England average of 67.6%. Redcar & Cleveland had an uptake rate of 75.7%, however the Middlesbrough uptake rate was much lower at 62.1%. Middlesbrough's rate of 62.1% ranks 34th lowest out of 150 local authorities.

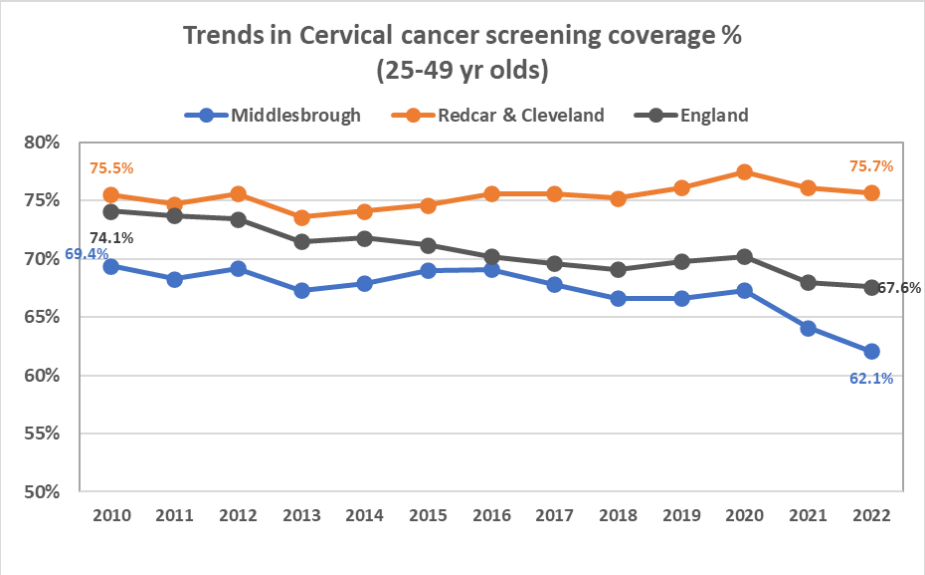
Figure 4: Cervical cancer screening coverage



Source – OHID Fingertips

Figure 5 below shows the trends in cervical uptake rates. The uptake rate in England has seen gradual decreases over recent years from 74.1% in 2010 to the latest figure of 67.6% in 2022. Redcar & Cleveland has seen the opposite trend, with increases between 2013 up to 2020, where rates have reduced in 2021 and 2022. The 2022 rate in Redcar & Cleveland is similar to the 2010 rate. Middlesbrough saw increases between 2013 and 2016, narrowing the gap with England, however since then the rates have reduced and the gap with England has widened, with the 2022 figure at 62.1% the lowest in the previous 12 years.

Figure 5: Cervical cancer screening coverage trends



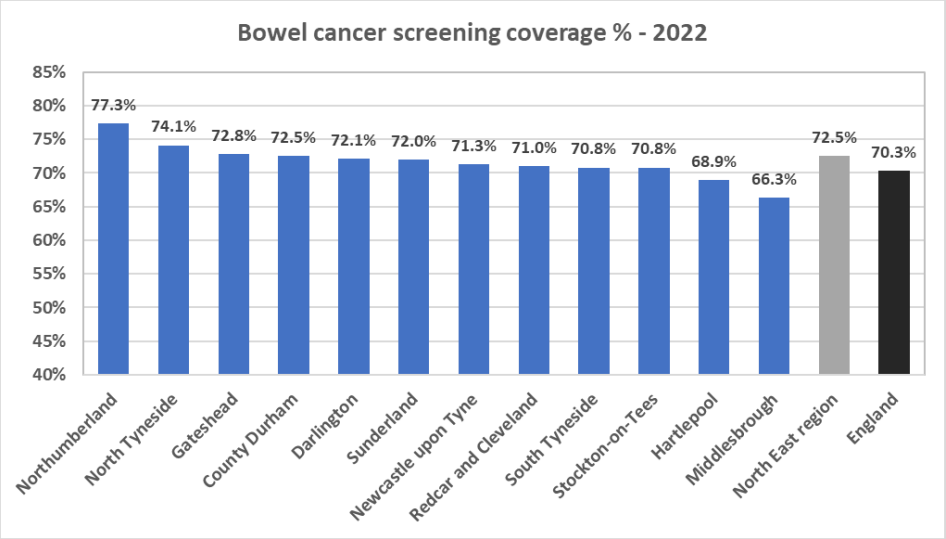
Source – OHID Fingertips

4.1.4 Bowel cancer screening.

NHS bowel screening is available to everyone aged 60-74 years. The programme is expanding from 50-59 years gradually over 4 years starting in April 2021. Bowel cancer in the 4th most common type of cancer and screening can help prevent bowel cancer or find it at an early stage (NHS Bowel Screening, 2024). The North East has a slightly higher uptake rate compared to England see figure 6

below. Redcar & Cleveland has a rate of 71% compared to the England rate of 70.3%, however Middlesbrough's uptake rate is much lower at 66.3%, this ranks Middlesbrough 48th lowest out of 150 local authorities.

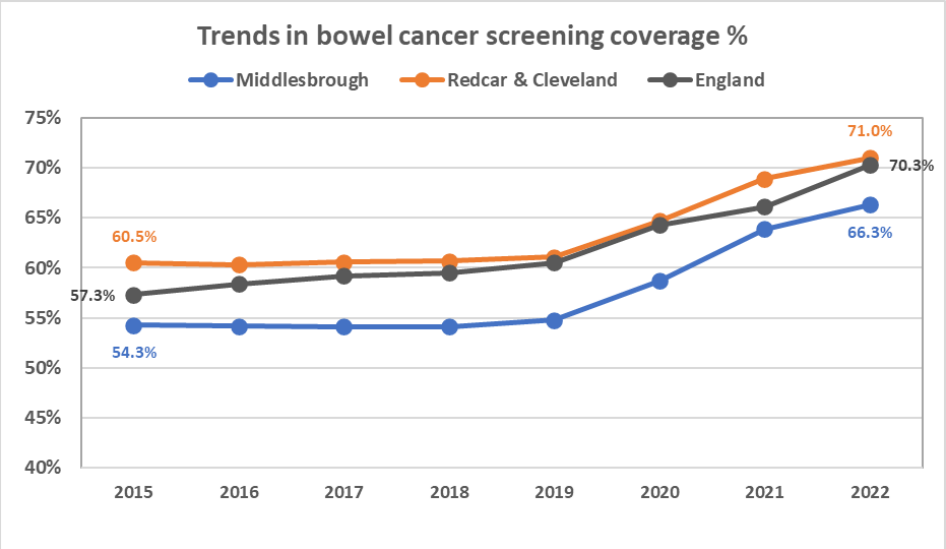
Figure 6: Bowel cancer screening coverage



Source – OHID Fingertips

Figure 7 below shows trends in the uptake rate for the bowel screening programme. Rates have increased at similar rates between 2019 and 2022 for both Middlesbrough, Redcar & Cleveland and England. Middlesbrough's rate has been consistently below that of Redcar & Cleveland and England for the majority of the period that the screening programme has ran.

Figure 7: Bowel cancer screening coverage trends



Source – OHID Fingertips

4.1.5 GP level cancer screening.

Figure 8 below shows the cancer screening uptake rates by GP practice in South Tees for 2021/22. The table is ordered by most deprived GP practice to least deprived. There is a clear correlation between the most deprived GP practices and low cancer screening uptake rates. For breast cancer screening The Eston Surgery in Redcar & Cleveland has the lowest rate at 51.6% compared to the

highest rate in Springwood Surgery, also in Redcar & Cleveland with 75%. There are larger inequalities in the bowel screening coverage with the lowest uptake in Thorntree Surgery in Middlesbrough with 44.5% compared to the highest in Springwood Surgery in Redcar & Cleveland with 79.3%. The lowest rate for cervical screening in the 25–49-year-olds was in Hirshel Medical Centre in Middlesbrough with 48.3% compared to the highest in The Saltscar Surgery in Redcar & Cleveland at 81.3%.

There are some GP practices such as Kings Medical Centre, The Eston Surgery, South Grange Medical Group and Woodside Surgery that have low uptake rates for breast and bowel screening coverage but much higher rates for cervical screening across both the 25-49 and the 50–64-year-old age groups.

Figure 8: Cancer screening uptake by GP

South Tees GP Practice		Breast screening coverage (50-70 yrs old)		Bowel screening coverage (60-74 yrs old)		Cervical screening coverage (25-49 yrs old)		Cervical screening coverage (50-64 yrs old)	
		Count	%	Count	%	Count	%	Count	%
M'bro	Thorntree Surgery	128	52.7	122	44.5	265	63.2	115	64.6
M'bro	Westbourne Medical Centre	413	63.3	454	61.2	560	64.4	333	71.3
M'bro	Kings Medical Centre	569	67.4	583	60.8	798	71.8	445	75.6
M'bro	Crossfell Health Centre	716	56.5	940	63.9	914	64.9	550	65.4
R&C	The Eston Surgery	249	51.6	372	64.4	460	71.9	259	74.2
M'bro	Hirsel Medical Centre	234	60	238	48.1	313	48.3	133	50.8
M'bro	Prospect Surgery	340	61.2	480	61.9	554	52.2	248	67
M'bro	The Erimus Practice	446	61.4	479	56.7	632	51.6	323	58.5
M'bro	The Endeavour Practice	551	64.6	642	62.9	800	49.8	395	65.5
M'bro	The Discovery Practice	482	70.8	511	69.5	703	50	363	74.8
M'bro	Newlands Medical Centre	801	67.3	1,029	65.3	825	54.2	528	65.5
M'bro	Park Surgery	703	65.1	875	64.7	1,087	59	483	67.2
R&C	South Grange Medical Group	1,055	53.4	1,556	64.5	1,679	75.4	993	73.8
M'bro	The Linthorpe Surgery	1,366	58.2	1,958	64.8	1,786	56.9	988	63.1
R&C	Woodside Surgery	528	61.2	818	67.4	613	75	419	75.8
R&C	Normanby Medical Centre	1,113	60.4	1,669	72.2	1,611	75.4	926	75.3
M'bro	Village Medical Centre	782	65.8	944	68	880	69.5	615	74.5
R&C	The Manor House Surgery	779	61.9	1,062	72.6	930	74.8	642	75.4
M'bro	Martonside Medical Centre	645	63.5	965	71.3	886	66.9	477	73.3
M'bro	The Ravenscar Surgery	317	63.4	386	67.2	391	70.8	252	75
M'bro	Bentley Medical Practice	838	63.1	1,212	66.9	981	67.8	617	68.9
R&C	The Saltscar Surgery	805	64.8	1,050	69.6	1,036	81.3	662	79
R&C	The Coatham Road Surgery	588	64.3	772	68.1	705	74.2	490	77.8
R&C	Brotton Surgery	642	60.8	929	72.2	733	71	510	70.4
R&C	The Green House Surgery	927	64.8	1,208	70.8	1,096	75.1	759	77
M'bro	Coulby Medical Practice	932	72.7	1,114	71.6	1,117	78.4	642	77.4
M'bro	Borough Road & Nunthorpe Group	1,170	63.4	1,661	72.1	1,524	68.5	918	73.4
M'bro	Parkway Medical Centre	684	63.9	1,007	72.6	1,052	77.2	543	75.7
M'bro	Cambridge Medical Group	604	64.9	796	66.6	754	73.6	458	70.6
R&C	Hillside Practice	960	65.2	1,380	70.2	1,064	77.9	760	74.9
M'bro	Bluebell Medical Centre	897	67.5	1,280	72.9	1,385	77.5	697	81
R&C	Huntcliff Surgery	1,108	67.8	1,564	74.7	1,027	78.9	860	78.2
R&C	The Garth	1,250	71.9	1,710	74.9	1,261	79.9	887	77.2
R&C	Zetland Medical Practice	788	72	1,088	72.4	677	75.8	529	72.6
R&C	Springwood Surgery	928	75	1,416	79.3	861	79.9	604	77.5
	South Tees CCG	25,350	64	34,277	68.8	32,026	68.3	19,433	72.6
	England	4,716,816	62.3	6,446,929	70.3	7,142,114	68.6	3,986,392	75

Source – GP practice profiles, OHID

4.1.6 Drivers for change.

2023/24 Planning Guidance

- Improve primary and secondary prevention.
- Complete recovery and improve performance against cancer waiting times standards. Ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand.
- Improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31 day decision to treat to first treatment standard
- Make progress against the ambition in the Long-Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower – focusing on:
- Timely presentation and effective primary care pathways
- Faster diagnosis
- Targeted case finding and surveillance.

NHS Long Term Plan

The NHS Long Term Plan (LTP) sets a clear mission for improving cancer outcomes through collaborative inter-organisational working. Our three main areas of work will be:

- earlier and faster diagnosis,
- equitable access to optimal and more precise treatments and,
- more personalised follow up care.

This in turn will help achieve:

- an increase in the proportion of cancers diagnosed at early stage by up to 8% by 2028.
- an increase one-year survival by over 4% by 2025

NENC ICP Integrated Care Strategy

- Deliver the early diagnosis and faster diagnosis national targets.
- Exceed the national standards for screening uptake for all population segments.
- Reduce avoidable new cases of cancer.
- Improve the experience, care, and quality of life for people living with and beyond cancer as measured by the National Cancer Patient Survey

4.2 What are we doing already in relation to this goal?

- Continue to work in collaboration with primary care and others to raise awareness of cancer symptoms, promote early presentation and reduce health inequalities via support for the cancer elements of the Directed Enhanced Service (DES). This will primarily be via the GP Clinical Lead and Primary Care Cancer Facilitator continued support of the PCNs with the delivery of their DES, via visits, data sharing and sharing good practice.
- Continue to work in collaboration with primary care and other key stakeholders to improve the uptake of screening via Local and National Campaigns and supporting the training and development of practice-based Cancer Champions, Cancer Community Development Workers and Social Prescribers. Pilot and share screening uptake initiatives such as cervical screening saves lives.
- Continue the focus on Health Inequalities in Cancer collaboration between Primary Care, Acute Trusts, Public Health Teams, Pharmacy and VCS to explore new initiatives and share best practice.

- Facilitate early diagnosis by continuing to implement faster diagnostic pathways to support the radical overhaul of the way diagnostic services are delivered for patients with suspected cancer ensuring access to the best and safest test first.
- Review and assess compliance against the Best Practice Timed Pathways, to include Gynaecology and Head and Neck.
- Continue to improve performance against the Faster Diagnosis Standard and data completeness, identifying areas of risk and working with specialties to review the pathways, alongside the optimal pathways, where necessary.
- Support the early diagnosis of lung cancer by expanding Targeted Lung Health Checks for Tees Valley.
- Embed Tele-dermatology.
- Ensure lynch testing in place, with supporting services, for endometrial and colorectal cancer. Support the implementation of Liver surveillance where appropriate. Continue to support the NHS-Galleri trial.
- Continue to embed FIT testing across the Tees Valley and embed Colon Capsule Endoscopy.
- Continue to support and implement the appropriate outcomes of the Breast Managed Clinical Network.
- Work with Northern Cancer Alliance (NCA) and Specialised Commissioning colleagues to develop a service model for Gynae-oncology that provides a sustainable service for the future improving outcomes and equity.
- Support the NCA with the agreed Non-Surgical Oncology review to help the system develop a sustainable workforce to deliver an effective oncology service.
- Support the NCAs workforce strategy, specifically measures to recruit and retain CNSs and care co-ordinators/pathway navigators.
- Continue to support the recovery of cancer services and performance improvement, with a focus on the number of treatments, reduction in long waiters and improving access/uptake.
- Support and facilitate innovation, specifically the development of a shared digital PTL across the Tees Valley to utilise all available diagnostic and treatment capacity.

4.3 What are the key issues?

- Evidence shows that 4 out of 10 cancers are preventable.
- More people from our deprived communities die from cancer or their quality-of-life post cancer treatment is worse compared to English averages.
- Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival.
- There is a clear correlation between the most deprived GP practices and low cancer screening uptake rates across breast, bowel, and cervical screening.

4.4 What is the current evidence base in relation to this goal?

The below evidence base was collated by Teesside University as part of the Health Determinants Research Collaborative (HDRC):

- Evidence base from traditional routes demonstrates that cancers diagnosed earlier result in better outcomes, measured through cancer waiting times, and also through the adoption of international research, such as Targeted Lung Health Checks, and live clinical trials such as the Galleri Trial. In addition, there was a national call for evidence to support the development of the Long-Term Plan, with evidence requested on: awareness and prevention of the causes of

cancer; awareness of the signs and symptoms of cancer; diagnosing people quicker; improving access and experience of cancer treatment; and improving after-care and support services.

- Approximately 367,000 new incidents of cancer are diagnosed within the United Kingdom (UK) each year, with around 1,700 new cases being diagnosed in Middlesbrough. Compared to national averages, Middlesbrough has a lower percentage of early diagnose of cancer, and higher rate of age-standardised early deaths attributable to cancer (McGeechan *et al.*, 2020).
- Research suggests that the occurrence of most cancers is similar amongst People with Severe Mental Illness (PwSMI), People with Learning Disabilities (PwLD) and those without. However, PwSMI and/or PwLD tend to die 15–20 years earlier than the general population. Of these deaths, it is estimated that two out of three are from preventable physical illnesses, with higher rates of premature mortality in the North of England (Sykes *et al.*, 2022).
- Independent Review of Breast Screening Services found that despite "relatively clear governance structures", a senior responsible owner to ensure the system was functioning correctly was lacking (Richards, 2019).
- Women with Learning Difficulties WwLD may not attend cancer screening due to fear, concerns over pain, and the potential influence of family carers and paid care workers (Byrnes *et al.*, 2020).

The main recommendations put forward by the above papers include:

- It is recommended that more emphasis is put on the overarching campaign as awareness of the Reduce Your Risk banner was limited amongst members of the public even when individual campaigns were recognised.
- The use of financial incentives to increase attendance at cervical screening appointments is not universally accepted by members of the public.
- Nationally, there is the aim that three quarters of all cancers will be diagnosed at Stage 1 and 2 by 2028. As such, cancer screening must be a key consideration alongside diagnostic capacity for cancer more generally.
- People with Learning Difficulties need the same opportunities as the general population in accessing health care system, including cancer screening. Health care of WwLD needs to be proactive and person-centred throughout the cancer screening pathway. This can include modifications to the invitation process, to not rely on literacy alone and utilise various communication aids including Makaton, or through additional resources such as visual recordings.

4.5 What do local people say?

The National Cancer Patient Experience survey 2022 is a national survey for adult NHS patients with a confirmed diagnosis of cancer which stated that 563 local patients responded out of 1,076 (52%). Overall care at the Trust scored 8.8 out of 10, highlighting patients were pleased with the level of care received.

Brilliant - If it had not been what James Cook various 'experts' did for me I would possibly not be here now. The nurses - doctors - physios - food - cleaners army medics - fantastic. Their sense of humour was excellent. Follow up treatment at James Cook & the Ogden cancer unit at the Friarage, Northallerton, is first class. Thank you all. (Cancer Patient)

I was treated very well for cancer and am very satisfied with all the help and care I was given. I was treated quickly from the first GP appointment. I was assigned a breast nurse specialist who continually rang me throughout to make sure I was ok and couldn't do enough to help. The chemotherapy nurses

would listen to side effects and find a way to help. My oncologist has been very caring and given great advice. (Cancer Patient)

4.6 What are the key actions in relation to cancer?

- Use population data to deliver targeted case finding and surveillance to enable people to access diagnostics, assessment, and treatment earlier.
- Ensure lynch testing in place, with supporting services, for endometrial and colorectal cancer. Support the implementation of Liver surveillance where appropriate.
- Continue to support the NHS-Galleri trial.
- To continue with the key initiatives underway, particularly the implementation of the Best Practice Timed Pathways.
- We want to reduce inequalities in access, experience, and outcomes to screening programmes Some groups of the population have lower participation in routine screening or present at a later stage of disease progression, due to a range of barriers we therefore want to work with communities to understand barriers to access and how they want their cancer screening services delivered.
- Targeted Lung Health Checks, continue to roll out targeted lung health checks programme across convenient community locations.
- To further develop the initiatives in relation to prevention and screening working across primary care, community and public health, in addition to adopting evidence-based initiatives such as liver screening.

5. Cardiovascular Disease

5.1 What key data do we have and what are the drivers for change?

5.1.1 Cardiovascular disease prevalence.

Cardiovascular disease causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. Prevention, early detection, and treatment of CVD can help individuals live longer, healthier lives. There are still too many people living with undetected high-risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation (AF), with the prevalence of AF in 2021/2022 across the North East and North Cumbria ICB at 2.41% which is higher than the national prevalence in England at 2.09%.

Working with partners across South Tees is essential to ensure that people are able to access services that will allow them to prevent and detect health conditions, and upon diagnosis ensure that conditions are managed and optimised effectively. Of those with known AF, 12.9% (22.1% in 2020/21) do not have a stroke risk assessment using CHA2DS2-vasc score recorded. We must support the system to diagnose and treat people with the 3 key high-risk conditions described above known as the ABC's of CVD, to reduce the impact of cardiovascular risk factors – there is an ambition to prevent 130 new cases/deaths across the Tees Valley.

The NHS Long Term Plan recognises that a comprehensive approach to preventing ill-health depends on action that only individuals, companies, communities, and national government can take to tackle wider threats to health, and ensure health is hardwired into social and economic policy.

5.1.2 Drivers for change and local key priorities.

2023/24 Planning Guidance

- Improve Primary and Secondary Prevention.
- Update prevention plans including smoking cessation, CVD and Diabetes.
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 per cent on lipid lowering therapies to 60%.

NENC ICP Integrated Care Strategy

- Key prevention and health promotion programmes required: smoking, alcohol, weight management.
- Support the development of integrated care models for long term conditions (LTDs) to reduce admissions to hospital.
- Deliver against the CORE20PLUS5 requirements.
- Improve how we respond to LTCs including better prevention, improving case finding, EoL, self-management and structured education, reduce exacerbations, better utilisation of the VCSE.
- Support the development of integrated care models for long term conditions to reduce admissions to hospital.

NHS Long Term Plan

- CVD: Improve the effectiveness of approaches such as the NHS Health Check to rapidly treat those identified with the high-risk conditions, including atrial fibrillation (AF), high blood pressure and high cholesterol (ABC).
- CVD: Support people with heart failure and heart valve disease through increased access to testing in primary care and through multi-disciplinary teams as part of primary care networks.
- CVD: Work with partner organisations to increase the number of people who know their ABC and provide opportunities for the public to check on their health.
- CVD: Increase access to cardiac rehabilitation, a programme of exercise and information to help people recover following a heart attack, heart surgery or procedure.
- CVD: Work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest.
- CVD: Expand access to genetic testing for Familial Hypercholesterolaemia (FH); enabling us to diagnose and treat those at genetic risk of sudden cardiac death.

5.2 What are we doing already in relation to this goal?

5.2.1 NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.

Figure 9 below shows the number and proportion of the eligible population who were invited for an NHS health in the 2022/23 year and of those who were invited, how many received a health check. Local areas are required to invite 20% of their eligible population each year. The data shows that Redcar & Cleveland has a higher rate of 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 32.8% compared to 37.4% in Middlesbrough and 38.9% in England.

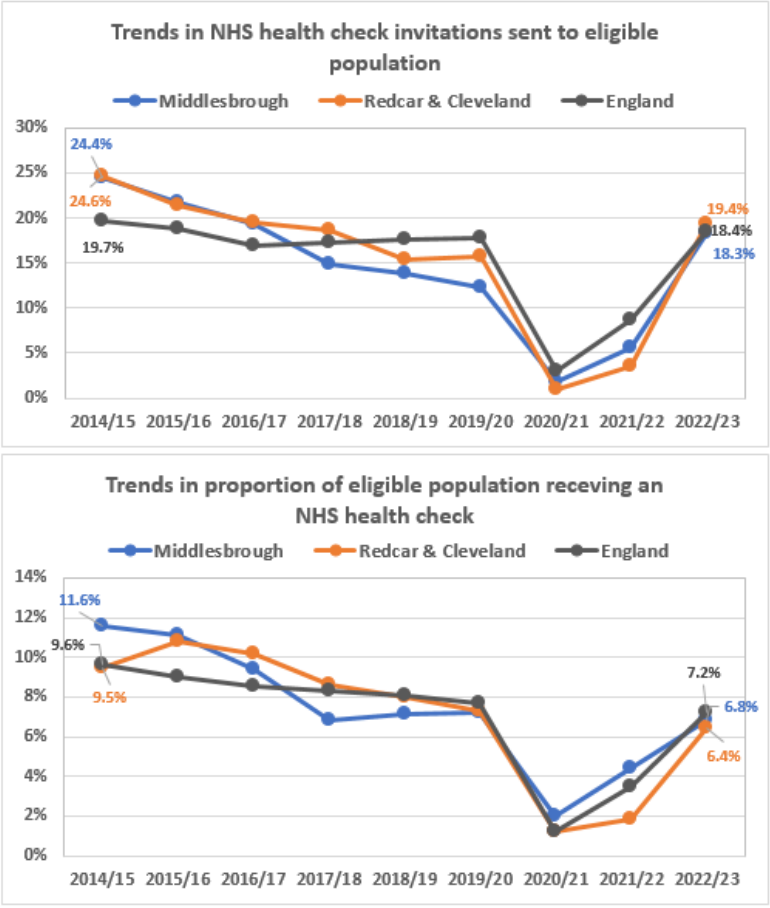
Figure 9: NHS health check invites and take up

	Eligible	Invited		Received	
	No.	*No.*	*%*	*No.*	*%*
Middlesbrough	36,091	6,589	18.3%	2,464	37.4%
Redcar and Cleveland	40,126	7,794	19.4%	2,553	32.8%
North East	746,046	141,075	18.9%	49,180	34.9%
England	15,894,229	2,925,325	18.4%	1,136,770	38.9%

Source – OHID Fingertips

Figure 10 below shows the trends in health check in invitations as a proportion of eligible population and the proportion who received a health check as a proportion of the eligible population. Trends show both invitations and take up rates were decreasing locally before the Covid19 pandemic where the NHS health check programme was suspended. Rates have increase and in 2022/23 are similar to pre-pandemic levels.

Figure 10: Trends in NHS health check invites and take up



Source – OHID Fingertips

5.3 What are the key issues?

- There are still too many people living with undetected high-risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation.
- Prevention, early detection, and treatment of CVD can help individuals live longer, healthier lives.
- Rates for NHS Health Checks have increased in 2022/23 and are now similar to pre-pandemic levels.
- Uptake for NHS Health Checks is lower amongst those living in the most deprived areas
- Health literacy, access and experience are barriers to uptake for NHS health checks

5.4 What is the current evidence base in relation to this goal?

The below evidence base was collated by Teesside University as part of the Health Determinants Research Collaborative (HDRC):

- There was marked geographical variation in offers (9.2%-95.8%) with greater uptake by the White ethnic group living in least deprived areas, but also among Asian and Black ethnic groups living in more deprived areas. Uptake was lowest among those in the most deprived areas for all ethnicities but especially for White. (Patel *et al.*, 2021).

- Of those attending an NHS Health Check, CVD risk factors differed by ethnic group, with diabetes and obesity more prevalent among Asian, raised blood pressure in Black and alcohol use in White ethnic groups (Patel *et al.*, 2021).
- Deprivation showed a clear positive association for smoking, obesity, and alcohol dependence. Proportionally more interventions were offered to those from deprived areas and Asian and Black ethnic groups, even after adjusting for baseline risk, indicating active efforts to target inequalities (Patel *et al.*, 2021).
- Reasons for not attending included lack of awareness or knowledge, misunderstanding the purpose of the NHS Health Check, aversion to preventive medicine, time constraints, difficulties with access to general practices, and doubts regarding pharmacies as appropriate settings (Harte *et al.*, 2018).
- Methods of invitation (letter, email, text etc.) has a significant impact on uptake numbers, with text messages often leading to the highest rates of invitations converted to appointments (Divers, 2023).

The main recommendations put forward by the above papers include:

- The NHSHC offers important opportunities to address health inequality through proportionate universalism and targeting the needs of specific groups. The program is achieving this goal but needs to be offered more equitably and widely across the country with greater efforts to engage those who remain unengaged to support the levelling up agenda.
- There is a need to reduce regional variations in invitations to NHS Health Checks, especially in areas with high deprivation.

5.5 What do local people say?

The Innovation for Healthcare Inequalities Programme (InHIP) CVD health checks focus groups identified the following themes:

- Lack of GP appointments/waiting times
- Language barriers/health literacy
- Occupations / Unsociable working hours
- Gender appropriate services
- Staff attitudes
- Trust issues / dismissive
- COVID style social marketing
- Discrimination
- Not understanding what a health is check.
- Community outreach needed to deliver health checks.
- Cost of transport to access health checks

5.6 What are our key actions in relation to cardiovascular disease?

- The NHSHC offers important opportunities to address health inequality through proportionate universalism and targeting the needs of specific groups. The program is achieving this goal but needs to be offered more equitably and widely across the country with greater efforts to engage those who remain unengaged to support the levelling up agenda.
- There is a need to reduce regional variations in invitations to NHS Health Checks, especially in areas with high deprivation.

- Collaborate with the South Tees Health Champions network to build more capacity for community-based health checks.
- Work in partnership Ethnic Minority charities to deliver bespoke Cultural Competency Training to all front-line staff.
- Collaboration with Tees Valley PCN CVD leads, and GP Practice Managers to resolve data transfer from community outreach CVD health checks back into GP practice IT systems for optimisation.
- Implement patient evaluation of current NHS health check model.
- Standardised approach of what a health check / MOT / health assessment / mini–MOT is and the range/types of equipment that can / cannot be used, this would include a standardised training and competency framework for anyone carrying out health checks.
- Ensure recipients are given information about local services via the MECC website this could be printed or sent by e-mail/text, and where appropriate onward referrals to those services are made.
- That data is properly collated, because now only NHS health checks commissioned by Public Health are counted in the mandated quarterly returns to the Secretary of State. If more checks are completed in the community and not submitted to Secretary of State it doesn't give the full picture re: performance / need.
- Continued collaborative working with Public Health Partners around the CVD prevention agenda to improve rates for smoking and obesity as well as general improvements in healthy living for our communities, including the increase in uptake of Healthy Heart Checks
- Utilise all opportunities to work with partners to ensure that people are able to access services that will allow them to prevent and detect CVD related health conditions. Reducing the impact of cardiovascular risk factors – the ABCs of CVD (**A**trial fibrillation, high **B**lood pressure/hypertension and **C**holesterol).
- Upon diagnosis, ensure that conditions are managed and optimised effectively with the aim of improving the overall health of our population and reducing the risk of associated events.
- To deliver tangible improvements in health outcomes and patient experience and help reduce local health inequalities, taking a population health management approach where possible.

6. Respiratory

6.1 What key data do we have and what are the drivers for change?

6.1.1 Respiratory prevalence

Lung conditions are estimated to cost wider society around £9.9 billion each year. Respiratory disease affects one in five people in England and is the third biggest cause of death. Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally and remain a major factor in the winter pressures faced by the NHS. Over the next ten years we will be targeting investment in improved treatment and support for those with respiratory disease.

Incidence and mortality rates for those with respiratory disease are higher in disadvantaged groups and areas of social deprivation, where there is often higher smoking incidence, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards. The local authorities in the Tees Valley area are some of the most deprived in England. All five are within the top 25% most deprived. There are higher levels of disease prevalence of COPD in the Tees Valley, with many people still undiagnosed.

It is recognised that the current design, capacity, and capability of services may be insufficient to cope with the projected increase in the number of people with COPD. There is low awareness of lung health and COPD in sub-groups that are at high risk (for example current and ex-smokers and women). The Taskforce for Lung Health anticipates that across the UK there are 1million undiagnosed cases of COPD.

Emergency hospital admissions for a range of respiratory conditions are higher than the national average for areas in the Tees Valley. The rate of admissions for COPD, particularly in the South Tees area is significantly higher than the England average. Admissions for asthma in adults are particularly high in Hartlepool and Stockton-On-Tees with the 5th highest rate nationally. Admissions for pneumonia and respiratory diseases are also significantly higher. The under 75 mortality rates from respiratory disease is worse than the England average across all locality areas.

Locally there is a requirement for further work to ensure that people can access high quality spirometry across primary and community care in a consistent way. The level of qualified staff to perform this diagnostic test is low across the Tees Valley and must be addressed to ensure equitable access to diagnosis to improve detection and management of COPD and asthma.

Pneumonia continues to place a huge burden on the NHS – improving our response will help to relieve the pressure, particularly during winter. Community acquired pneumonia is a leading cause of admission to hospital, despite being avoidable in many cases. Pneumonia also disproportionally affects older people, with incidence doubling for those aged 85-95 compared with 65-69. For every degree drop in temperature below five degrees Celsius, there is a 10.5% increase in primary care respiratory consultations and a 0.8% increase in respiratory admissions. Acute pneumonia admissions have risen by 35% since 2013 with stays in hospitals getting shorter, indicating admission may not have always been essential. Consistent use and application of risk scoring for deteriorating patients may reduce avoidable admissions to hospital.

Patients identified with community acquired pneumonia in emergency departments will be supported to be cared for safely out of hospital by receiving nurse-led supported discharge services.

An additional consideration is the impact of long-term respiratory complications in people following COVID-19 infection. Emerging data in figure 10 indicates that many patients experience persistent respiratory symptoms months after their initial illness.

Figure 11: Trends in NHS health check invites and take up ***Respiratory matrix***

Measure		Middlesbrough		Redcar		Tees Valley	
		Baseline	Latest	Baseline	Latest	Baseline	Latest
COPD prevalence.	Sep-23	2.8%	**2.8%** ↑	3.5%	**3.5%** ↓	2.9%	**3.0%** ↑
Patients with COPD who have had a COPD review in the preceding 12 months.	Sep-23	81.2%	**71.8%** ↓	81.3%	**71.2%** ↓	80.0%	**72.0%** ↓
Patients with asthma who have had an asthma review in the preceding 12 months.	Sep-23	67.8%	**61.8%** ↓	69.8%	**65.4%** ↓	69.7%	**66.5%** ↓
Patients with COPD who have had influenza immunisation.	Sep-23	48.3%	**10.7%** ↓	43.9%	**17.4%** ↓	42.9%	**13.2%** ↓
A&E attendances associated with respiratory problems, as a percentage of all attendances.	12m rolling to Aug 23	7.8%	**7.4%** ↓	8.1%	**8.0%** ↓	8.6%	**8.2%** ↓
Number of A&E attendances associated with respiratory problems.	12m rolling to Aug 23	4,485	**4,266** ↓	2,846	**2,806** ↓	15,201	**14,760** ↓
Emergency admissions associated with respiratory problems, as a percentage of all emergency admissions.	12m rolling to Aug 23	15.3%	**14.9%** ↓	16.0%	**15.1%** ↓	13.9%	**13.4%** ↓
Number of Emergency admissions associated with respiratory problems.	12m rolling to Aug 23	2,705	**2,704** ↓	2,460	**2,437** ↓	12,839	**12,436** ↓
Average length of stay (days) of emergency admissions associated with respiratory problems.	12m rolling to Aug 23	5.8	**5.6** ↓	6.9	**6.5** ↓	5.8	**5.6** ↓
Percentage of people with a respiratory long term condition (COPD/asthma/bronchiectasis) having a personalised care plan.	Sep-23	1.0%	**1.0%** ↓	0.5%	**0.5%** ↑	0.4%	**0.4%** ↓

Data source: North East and North Cumbria Integrated Care Board Respiratory matrix. 01/11/2023

6.1.2 Drivers for change and local key priorities

2023/24 Planning Guidance

- Improve Primary and Secondary Prevention, including for COPD.
- Reflect CORE20PLUS5 across all plans.

NENC ICP Integrated Care Strategy

- Utilise 'what matters to me' and embed personalised care approaches across all pathways and workstreams.
- Support the development of primary care MDT teams aligned to secondary care specialist teams.
- Support the development of integrated care models for long term conditions to reduce admissions to hospital.
- Develop plans to support people to age well including plans for COPD.
- Deliver against the CORE20PLUS5 requirements.
- Improve how we respond to LTCs including better prevention, improving case finding, End of Life, self-management and structured education, reduce exacerbations, better utilisation of the VCSE.
- Provide digital tools such as smartphone apps to enable more people to access online NHS services and support self-management.

NHS Long Term Plan

- Respiratory: Ensure more patients have access to testing, such as spirometry testing, so that respiratory problems are diagnosed and treated earlier.
- Respiratory: Ensure patients with respiratory disease receive and use the right medication, including educating patients on the correct use of inhalers.

- Respiratory: Expand rehabilitation services, including pulmonary rehabilitation and digital tools so that more patients have access to them and have the support they need to best self-manage their condition and live as independently as possible.
- Respiratory: Improve the treatment and care of people with pneumonia.
- Roll out the NHS Comprehensive Model for Personalised Care across England, so that 2.5 million people can have choice and control over support for their mental and physical health.
- Implement new asthma discharge bundle (for inpatients with asthma exacerbation) BPT once available.
- Potentially prepare to adopt new breathlessness / shared rehab models in 2023/24 for cardiac and respiratory patients, once optimal models have been identified nationally through testing and evaluation.

6.2 What are we already doing in relation to this goal?

6.2.1 Targeted Lung Health Checks

The TLHC 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 lung cancer.

The TLHC 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 health check (LHC), over a period of two years. Following the lung health check those assessed as high risk will be offered a low dose Computerised Tomography scan (LDCT).

TLHC is a nationally funded programme with a centrally mandated clinical pathway. National fixed funding is provided to support the implementation and national variable income is generated per LHC and LDCT completed. NHS England have selected Tees Valley as a site for the programme based on lung cancer incidence and mortality.

The service is provided in a partnership between the North East & North Cumbria Integrated Care Board (ICB), the three Tees Valley NHS Foundation Trusts, Primary Care Networks (PCNs), Public Health teams, and InHealth, a private provider of the TLHC pathway.

Fingertips data in 2021 highlights that mortality rates from lung cancer in Middlesbrough were 80.2 per 100,000 people and in Redcar & Cleveland were 63.2 per 100,000 people, and that the standardised incidence ratio for lung cancer in Middlesbrough was 177.7 and in Redcar & Cleveland was 132.8.

Figure 12: Fingertips data for mortality rates from lung cancer

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
Mortality rate from lung cancer, all ages (Persons)	2021	48.5	66.0	62.9	56.6	80.7	75.4	80.2	74.1	56.8	47.7	63.2	71.2	56.9	87.1
Mortality rate from lung cancer, all ages (Male)	2021	56.2	73.0	67.5	49.0	78.5	93.8	99.6	83.3	64.4	61.7	62.8	74.6	70.6	93.7
Mortality rate from lung cancer, all ages (Female)	2021	42.4	60.9	59.5	62.8	84.0	63.1	64.0	66.7	50.9	38.1	63.7	68.4	45.9	82.6
Lung cancer registrations	2017 - 19	77.1	104.7	102.6	91.9	114.5	112.8	147.6	118.9	102.8	78.0	101.3	113.4	97.4	116.3
Incidence of lung cancer, standardised incidence ratio	2015 - 19	100.0	-	133.6	125.1	151.1	157.0	177.7	163.0	135.8	101.8	132.6	151.4	128.7	151.0
Under 75 mortality rate from lung cancer (Persons)	2021	26.0	35.0	32.6	30.2	42.9	42.8	48.2	40.4	26.9	21.7	37.9	41.1	29.5	47.1
Under 75 mortality rate from lung cancer (Male)	2021	28.7	37.2	33.6	25.5	39.3	48.3	56.2	44.4	28.2	25.5	41.3	37.7	30.9	55.8
Under 75 mortality rate from lung cancer (Female)	2021	23.5	32.8	31.7	34.2	46.4	37.9	40.6	36.6	25.7	18.1	34.6	44.2	28.1	39.0

LHCs and initial scans will be carried out in the first two years of the programme; the remaining two years will focus on the 3 month, 12 month and 24 month surveillance scans resulting in approximately 12,114 follow up scans.

In terms of the clinical impact of TLHC, national modelling shows that **536** lung cancers may be identified over the four years and **274** (51%) would be suitable for curative surgical treatment. Locally, there is currently an 80/20 split of treatments for patients, with 80% having palliative treatment and 20% having curative treatment. It is expected that through TLHC up to 80% may have curative surgical treatment and 20% have palliative treatment. This could take the current local survival rates from around 8% to over 20%.

The TLHC service started inviting patients in August 2022 and scanned the first patients in September 2022. The Stockton PCNs and North Tees and Hartlepool NHS Trust have been the first organisations to participate in the service, with scanning recently moving across to Middlesbrough in May 2023. The mobile scanner is currently located at Asda on Portrack Lane.

The following activity has been seen in Year 1:

Total telephone triage completed.	18100
Total **Baseline** CT scans completed.	6901
Total **3 month recall** CT scans completed.	876
Total **12 month recall** CT scans completed.	2
Total **24 month recall** CT scans completed	0
Total **ALL** CT scans completed	7779

Current conversion rates for year 1

Telephone triage uptake	66.6%
Conversion to High Risk	54.6%

Total cancers to date:

Confirmed lung cancer with staging	Suspected lung cancer awaiting confirmation and staging	Confirmed other (breast, renal cancers)
70	28	12

To date, **70 lung cancers** have been diagnosed and treated: **75% at stages I and II**.

6.3 What are the key issues?

- Respiratory disease affects one in five people in England and is the third biggest cause of death.
- Respiratory disease and the increase in hospital admissions remain a major factor in the winter pressures faced by the NHS.
- Incidence and mortality rates for those with respiratory disease are higher in disadvantaged groups and areas of social deprivation.
- The rate of admissions for COPD, particularly in the South Tees area is significantly higher than the England average.
- Admissions for pneumonia and respiratory diseases are also significantly higher.
- The under 75 mortality rates from respiratory disease is worse than the England average across South Tees.

6.4 What is the current evidence base in relation to this goal?

The below evidence base was collated by Teesside University as part of the Health Determinants Research Collaborative (HDRC):

- Pre and post-operative High Intensity Inspiratory Muscle Training (HI-IMT) leads to improvements in Maximal Inspiratory Pressure (MIP) before and after surgery in individuals with known or suspected lung cancer referred for a lung resection. Surgery has a negative impact on MIP. The majority of patients felt HI-IMT helped prepare them for surgery and facilitated recovery (Bowe *et al.*, 2020)
- SARS-CoV-2 can cause respiratory diseases with various manifestations. However, little is known about its potential for lung recovery. Lung ultrasound has shown characteristic changes during COVID-19 and has proven to be useful for triage, diagnosis, and therapy (Burkert *et al.*, 2023)
- Rheumatoid arthritis (RA) is associated with a ten-fold increased risk of interstitial lung disease (ILD). The presence of ILD in a patient with RA influences both prognosis and the choice of therapeutic intervention (Kelly *et al.*, 2021)

The main recommendations put forward by the above papers include:

- Lung ultrasound can be a useful tool for long-term monitoring of COVID-19 lung disease, avoiding repeated exposure to ionizing radiation, and may distinguish between acute and past infections.
- The development of a screening approach based on established risk factors is a priority.
- Learning how to identify patients with RA-associated ILD early and then monitoring their condition to assess progression and measure the potential influence of therapeutic interventions is essential.

6.5 What are the key actions in relation to respiratory?

- Improve services and outcomes for respiratory disease by taking an integrated approach to delivery, which involves communities, voluntary organisations and the wider health and care system.
- Ensure that there is sufficient focus on prevention, early detection and diagnosis and optimal treatment options, concentrating interventions initially on populations at greater risk.
- Ensure that across the geographical footprint services are provided equitably, taking health inequalities into consideration to ensure those identified within CORE20PLUS5 have access to the support they need, when they need it.

7. Diabetes

7.1 What key data do we have and what are the drivers for change?

7.1.1 Diabetes prevalence

The prevalence of diabetes across Tees Valley place is 7.7% compared to an England average of 7.1%, with the risk of developing Type 2 Diabetes up to six times higher in certain Ethnic Minority groups. Expanding the NHS Diabetes Prevention Programme is a key vehicle for focussing on prevention and tackling health inequalities, with significantly higher engagement from Ethnic Minority groups needed.

Obesity rates in adults across locality can range between 28% and 33% compared to a national rate of 9.0%. Poor diet and physical inactivity are causal factors of obesity and obesity disproportionately affects the most deprived communities, with between 36% and 45% of the population living in the most deprived quintile.

Compliance with the three treatment targets is lower than the England average for people with Type 1 (Tees Valley 19.8% v. England 21.5%) and compliance with the eight care processes is below the England average for both Type 1 and Type 2 Diabetes. Tees Valley has a higher rate of major amputations (9 per 10,000 compared to an England average of 8.10 per 10,000) and very low attendance at Structured Education, however it is acknowledged that this is a national issue.

Equity of service provision is needed to ensure a robust patient pathway across the system from increased structured education, achievement of treatment targets as well as a multidisciplinary footcare team in the community and a specialist inpatient nurse in the trust.

7.1.2 Drivers for change and local key priorities

2023/24 Planning Guidance

- Improve Primary and Secondary Prevention.
- Update prevention plans including smoking cessation, CVD and Diabetes.
- Reflect CORE20PLUS5 across all plans.
- Fuller Stocktake Report: Work alongside local people and communities [in planning and implementation of the actions to transform primary care within systems].

NENC ICP Integrated Care Strategy

- Develop plans to support people to age well including plans across diabetes, COPD and heart disease.

NHS Long Term Plan

- Make sure that more people can access support to help control their diabetes.
- Provide digital tools such as smartphone apps to enable more people to access online NHS services and support self-management.

7.2 What are we doing already in relation to this goal?

7.2.1 National Diabetes Prevention Programme

Structured education: Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND). The DESMOND Diabetes Education Programme is available for all newly diagnosed with type 2 diabetes up to 12 months after diagnosis. The service is delivered by the community diabetes service in conjunction with your GP.

7.2.2 Type 2 Diabetes in the Young

Type 2 Diabetes in the Young Programme is a 2-year initiative for 23/24 and 24/25 aiming to improve care for people with Early Onset of Type 2 Diabetes aged between 18 and 39 years of age. The aim of the programme is to support improved care delivered via additional reviews focused on opportunistic completion of remaining care processes, optimisation of glycaemia, cardio-vascular risk and weight, contraception and preparation for pregnancy and supporting any unmet psychological or social need.

7.2.3 Type 2 Diabetes Remission Service

The Type 2 Diabetes Remission Programme is a 12-month low calorie diet treatment for people in South Tees living with Type 2 Diabetes who are above a healthy weight. Delivered by Momenta, its based on the DiRECT study which showed this approach could help people lose weight, improve their diabetes control, reduce diabetes-related medication, and achieve remission. The programme is free and people need to be referred by their GP

7.3 What are the key issues?

- The prevalence of Type 2 Diabetes is higher in Tees Valley compared to England.
- Individuals from some black, ethnic minority groups are at higher risk of developing Type 2 diabetes.
- Rates of obesity in adults and children locally are higher than the national average.
- Tees Valley has a higher rate of major amputations (9 per 10,000 compared to an England average of 8.10 per 10,000)
- Tees Valley has very low attendance at Structured Diabetes Education programmes

7.4 What is the current evidence base in relation to this goal?

The below evidence base was collated by Teesside University as part of the Health Determinants Research Collaborative (HDRC):

- Type 1 diabetes (T1D) is the most common form of diabetes in children, accounting for 96% of cases, with 29 000 children affected in the UK. Studies have recently identified immunotherapies that safely delay the development of Type 1 Diabetes for at least 3 years, and further therapies are in development.
- General population screening programs in other countries can now accurately identify children with presymptomatic T1D who can be entered into prevention studies. The UK does not have such a system in place (Quinn *et al.*, 2022).

- Diabetic retinopathy screening (DRS) attendance in young adults is consistently below recommended levels Nation-wide (Prothero *et al.*, 2021).
- Compared with current practice, alternative surveillance strategies resulted in up to a 4% reduction in the number of elective AAA repairs but with an increase of up to 1.6% in the number of AAA ruptures and AAA-related deaths (Sweeting *et al.*, 2021).
- The Screening Management and Referral Tracking system used by NAAASP is 97% accurate in holding patient contact details, and nonattenders are four times more likely to respond to telephone contact. Reasons for failing to attend screening invitations include factors that can be addressed at a regional level such as: inconvenient timings/locations of screening clinics and a lack of awareness or understanding of what AAA screening means as well as language/literacy barriers. The incidence of AAAs in the non-attendee group was almost 3 times that of our general (attending) population. Afro-Caribbean men were disproportionately less likely to attend for screening (Ahmad *et al.*, 2021).

The main recommendations put forward by the above papers include:

- A dedicated, coordinated strategy should be devised across healthcare specialisms to ensure that diabetes screening and detection opportunities are not missed.
- Problems associated with a lack of integration between DRS with other diabetes care processes were identified as a major barrier to providing holistic care to young adults and supporting diabetes self-management.
- For AAA, there is particular importance of regional attempts to contact and engage nonattenders as they may be most at risk of developing AAAs.
- Identifying areas and populations with poor uptake is important as we have shown that some of the most vulnerable men, living in the most deprived areas of our population, have a higher incidence of an AAA and some of the barriers they have to screening can be modified and improved by the screening program.

7.5 What are the key actions in relation to diabetes?

- To identify people at risk of developing Type 2 Diabetes and support them to reduce their risk through lifestyle change.
- To support primary care to work with patients to improve their compliance with the three treatment targets and eight care processes to enable the best outcomes and reduce long term complications.
- To provide support for people living with Type 2 Diabetes to work towards remission of their diabetes through the Changing Health and NHSE Low Calorie Diet offers.
- To increase support for people living with Type 1 and Type 2 Diabetes to enable them to manage their own health through an enhanced support offer which will include both digital and face to face options.
- To reduce the variation of care provided and improve health utilisation costs across the system.
- To increase the uptake of Structured Education, Foot Checks and Retinal Screening so patients can maintain the best health and detect any early issues to ensure timely intervention.
- Ensure that across the geographical footprint services are provided equitably, taking health inequalities into consideration to ensure those identified within CORE20PLUS5 have access to the support they need, when they need it.

8. Mental Health

8.1 What key data do we have and what are the drivers for change?

8.1.1 Mental health prevalence

Figure 13 below shows a selection of mental health indicators for Middlesbrough and Redcar & Cleveland for 2022. The table includes the numbers, rates, ranks against national local authorities and the England rate for comparison. 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 11.6% compared to England at 12.7% 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. GP prevalence of severe mental illness is similar in Middlesbrough and Redcar & Cleveland compared to 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 in 2019/20. Redcar & Cleveland has a lower rate at 391 per 100,000 but still significantly higher than England. Rates are also significantly higher for rates of emergency hospital admissions for self-harm in both local authorities locally, with Middlesbrough's rate at 282 per 100,000 and Redcar & Cleveland's rate at 262 per 100,000 compared to 164 per 100,000 in England.

Rate of premature mortality in adults with severe mental illness are significantly higher locally with a rate of 193 per 100,000 in Middlesbrough (4th highest nationally) and 146 per 100,000 in Redcar & Cleveland compared to 104 per 100,000 in England. Suicide rates locally are also amongst the highest in England. The Middlesbrough rate is 14.9 per 100,000 compared to 10.4 per 100,000 in England. Redcar & Cleveland has the highest suicide rate in England in 2019-21 at 19.8 per 100,000. Redcar & Cleveland has seen a drastic rise in the suicide rates, increasing from 10.8 per 100,000 in 2016-18 to 19.8 per 100,000 in 2019-21.

Figure 13: Mental health indicators

Indicator		Period	Middlesbrough			Redcar & Cleveland			England
			Number	Value	Rank (LA)*	Number	Value	Rank (LA)*	Value
Mental Health Prevalence	Prevalence of common mental health disorders (16+)	2017	21,881	19.6%	28/148	20,183	18.1%	65/148	16.9%
	Depression: QOF prevalence (18+)	2021/22	-	11.6%	99/152	-	17.0%	9/152	12.7%
	ESA claimants for mental & behavioural disorders (rate per 1,000 working age)	2018	4,490	51.6	4/150	3,540	44.2	14/150	27.3
	Severe mental health: QOF prevalence (all ages)	2021/22	1,573	0.94%	77/152	1,430	1.04%	44/152	0.95%
Services	Inpatient stays in secondary mental health services (rate per 100,000)	2019/20	775	556.0	1/151	530	391.0	12/151	241.0
	Emergency hospital admissions for intentional self-harm	2021/22	415	282.2	8/150	330	262.0	19/150	163.9
Mortality	Premature mortality in adults with severe mental illness (rate per 100,000)	2018-20	-	192.7	4/148	-	145.7	24/148	103.6
	Suicide rate (per 100,000)	2019-21	54	14.9	12/149	69	19.8	1/149	10.4

Compared against England
Significantly higher
Similar
Significantly lower

Source – NHS Digital

Figure 14 below shows the prevalence of patients with severe mental illness (SMI) by PCN and GP practice across South Tees. There was a total of 3,003 patients with SMI in 2021/22 or 1% of the practice population. Some practices have higher rates with Foundations practice (specialist practice for substance misusers and vulnerable patients) at 1.9% and Thorntree practice at 1.8%. The table also shows the rate of care plan reviews in the preceding 12 months. Care plan reviews should be documented primary care consultations that acknowledges, especially in the event of a relapse, a plan for care. Locally there are significant variations across GP practices with high rates in GPs such as Brotton Surgery at 97.1% and Zetland Medical Practice at 87.3% and very low rates in practices such as Coulby Medical Practice at 1.9%.

Figure 14: SMI prevalence by GP practice (2021/22)

		Patients with SMI			Care plan in the preceding 12 months (%)
PCN name	Practice name	GP list size	Register	Prevalence (%)	
Central Middlesbrough PCN	Martonside Medical Centre	8,090	71	0.9	13.8
	Park Surgery	10,969	115	1.0	46.8
	Prospect Surgery	7,233	63	0.9	61.4
	The Discovery Practice	7,752	57	0.7	64.6
	The Endeavour Practice	8,744	111	1.3	48.5
	The Erimus Practice	7,388	69	0.9	84.2
	Thorntree Surgery	2,503	44	1.8	59.0
East Cleveland PCN	Brotton Surgery	7,075	72	1.0	97.1
	Hillside Practice	9,680	81	0.8	79.4
	Springwood Surgery	8,082	83	1.0	66.7
	The Garth	11,268	121	1.1	51.0
	Woodside Surgery	6,153	97	1.6	8.1
Eston PCN	Cambridge Medical Group	6,613	54	0.8	83.3
	Normanby Medical Centre	13,725	91	0.7	11.7
	South Grange Medical Group Practice	14,471	144	1.0	54.5
	The Eston Surgery	3,801	37	1.0	48.5
	The Manor House Surgery	8,575	86	1.0	20.3
Greater Middlesbrough PCN	Acklam Medical Centre	11,104	73	0.7	69.7
	Coulby Medical Practice	9,135	86	0.9	1.9
	Crossfell Health Centre	8,997	80	0.9	21.7
	Hirsel Medical Centre	3,842	38	1.0	5.7
	Kings Medical Centre	6,638	62	0.9	42.3
	Newlands Medical Centre	10,085	119	1.2	48.2
	Parkway Medical Centre	8,018	58	0.7	31.9
	Westbourne Medical Centre	5,249	52	1.0	14.9
Holgate PCN	Borough Road & Nunthorpe Medical Gro	14,481	116	0.8	44.1
	Foundations	718	14	1.9	61.5
	Foundations -Harris Street	1,587	3	0.2	0.0
	Linthorpe Surgery	20,052	168	0.8	19.9
	Village Medical Centre	8,277	120	1.4	52.9
Redcar Coastal PCN	Bentley Medical Practice	10,129	158	1.6	33.8
	Huntcliff Surgery	9,981	126	1.3	51.8
	The Coatham Road Surgery	6,320	63	1.0	16.0
	The Green House Surgery	9,661	97	1.0	29.3
	The Ravenscar Surgery	3,445	33	1.0	61.5
	The Saltscar Surgery	8,397	80	1.0	53.6
	Zetland Medical Practice	7,139	61	0.9	87.3
	Total	305,377	3,003	1.0	44.5

Source – QOF, NHS Digital

8.2 What are we doing already in relation to this goal?

8.2.1 SMI physical health checks

Annual health check for people with severe mental health conditions are available for anyone aged 18 or over who has schizophrenia, bipolar disorder or psychosis. Eligible people will receive a letter from their GP surgery inviting them for an annual health check. The health check includes a physical check-up, including weight, heart rate and blood pressure, ensuring an individual is up to date with vaccines as well as discussions round any long term condition such as asthma and diabetes

8.3 What are the key issues?

- People with a severe and enduring mental illness have much poorer physical health outcomes are likely to die as much as twenty years younger than the general population.
- The demand for both children's and adult mental health services has risen significantly, and many services are currently operating with long waiting lists and operational pressures.
- For those accessing mental health services there are several barriers to improving an individual's physical health, such as disjointed mental and physical health care and prescribing, overshadowing, poor access to good food, limited access to environments for physical activity, addictions, living conditions and financial worries which make physical and mental health worse.
- People with severe mental illness are more likely to be living with multiple long-term conditions.
- Reduce Inequalities for this population – need to deliver consistent standards in screening intervention, monitoring, and review of physical health.

8.4 What is the current evidence base in relation to this goal?

The below evidence base was collated by Teesside University as part of the Health Determinants Research Collaborative (HDRC):

- Some COVID-19 policy responses such as furloughing may have been effective in mitigating the increase in Common Mental Disorders for some groups of employees. Despite some reduction in levels of pandemic and lockdown-related stressors by the middle of 2020, loneliness and financial stressors remained key determinants of incidence in CMD among the UK adult population (Chandola *et al.*, 2022).
- The mental health of parents who gave birth during the pandemic remains an area of concern moving forward (Diba *et al.*, 2022).
- Peer support forms an important part of mental health recovery and management (Dixon *et al.*, 2019).
- Although little is currently known on the subject, young people are willing to engage in mindful practice and felt it better equipped them to deal with stressful situations. This could however, lead to stigmatization amongst peers (McGeechan *et al.*, 2019).

The main recommendations put forward by the above papers include:

- The impact of COVID and related measures to control infection remains a significant contributor to mental health issues still present from time. More needs to be done to understand these phenomena.

- More efficient information sharing is a key priority. This was noted to be a central anticipated benefit of an integrated service, leading to several further benefits for both service users and commissioners/practitioners.
- The most salient benefit of efficient information sharing between organisations is the elimination of the need to 'tell one's story' multiple times to different members of staff, which is experienced as very stressful by service users.
- More investment should be made in updating/upgrading current information sharing systems, along with staff training to navigate these systems effectively, to improve service provision and delivery.
- Provisions should be made for different types of service delivery, suited to the needs of the service user, especially those who are not tech-savvy and familiar with ICTs.
- Provisions should be made for alternative access to services, in terms of times and days. Services are not always needed from 9-5, and more flexible provision of services (or access points) would be of great benefit to people needing support out of standard office hours, or over weekend.

8.5 What do local people say?

8.5.1 Mental Health, Wellbeing and You

The Tees Valley Healthwatch Network worked together to co-design a survey with Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) which enabled us to gain an insight into people's experiences of accessing mental health and well-being services. This report details the findings of our survey and focus groups for South Tees. We received a total of 525 survey responses and spoke to 65 people during the six focus group sessions we facilitated. We made it our priority to connect with seldom heard groups to truly reflect the diversity of South Tees communities. During our focus groups, we spoke to carers, older people, ethnic minority groups and people with a visual impairment. The feedback from our survey showed that:

- There is a lack of information on what services are available, what is open and how to access these services.
- Leaflets are not provided in different languages or large print and are not easily accessible.
- The resounding theme throughout the feedback is that people want to be given choices.

Full report can be accessed here: Mental Health, Wellbeing and You | Healthwatch Middlesbrough

8.6 What are the key actions in relation to mental health?

- Improving the physical health of people with severe and enduring mental illness, including targeted prevention and health programmes and participation in screening programmes
- Identify those with risk factors for ill health and refer on to specialist behaviour change support i.e., smoking cessation, weigh management, alcohol dependency.
- Embed Making Every contact count at scale. Treatment for any of the co-occurring conditions is available through every contact point, as is support for physical or social concerns.
- Develop a network of expertise in dual diagnosis across Mental Health Trusts
- An improved service offer for people with substance misuse issue and poor mental wellbeing or mental ill health.
- Improved working/interface between South Tees Foundation Trust and Tees, Esk, and Wear Valley Mental Health Trust, this may include in reach provision into a particular speciality or provide shadowing opportunities for staff to share expertise.

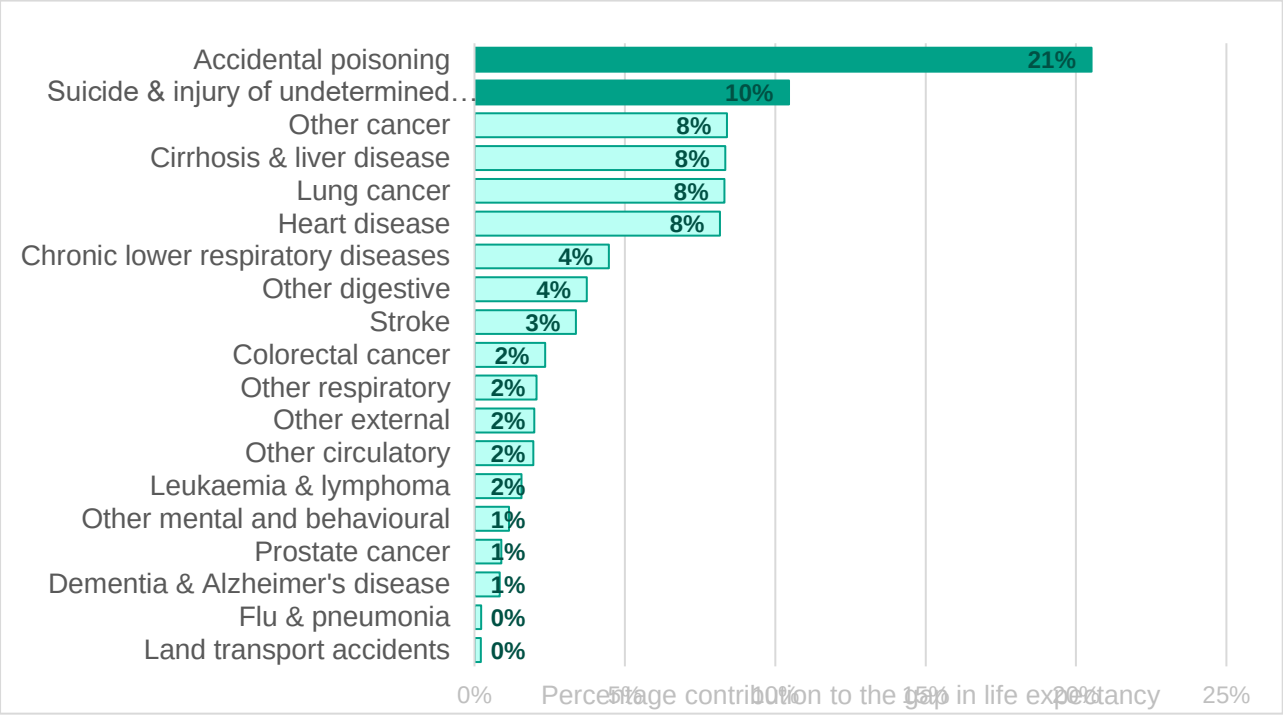
9. External Causes

9.1 What key data do we have and what are the drivers for change?

9.1.1 Specific causes of death that drive the gap in life expectancy.

Breakdown of the life expectancy gap between the most and least deprived quintiles of by detailed cause of death, 2020 to 2021 (Provisional) contribution to the gap expressed in percentages (excludes other category). In men accidental poisoning and suicide & injury of undetermined intent are the two most prominent conditions.

Figure 15: Specific other causes of death

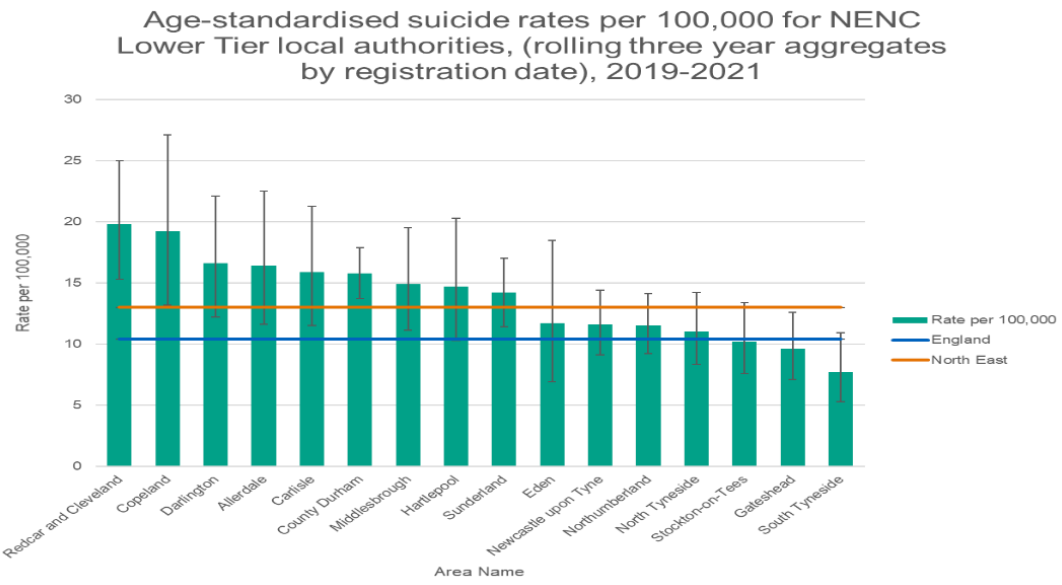


Source *- Population weighted provisional estimates based on data from OHID Segment tool . OHID based on ONS death registration data (provisional for 2021) and 2020 mid-year population estimates.*

9.1.2 Deaths of Despair

Accidental poisoning, suicide and injury of undetermined intent and cirrhosis and liver disease contribute considerably to the gap in life expectancy between NENC and England. For women these causes contribute 20% (310 excess deaths) to the gap in life expectancy. For men, these causes contribute 39% (700 excess deaths) to the gap in life expectancy. Figure 16 below shows that rates for Middlesbrough and Redcar & Cleveland are higher than North East and England

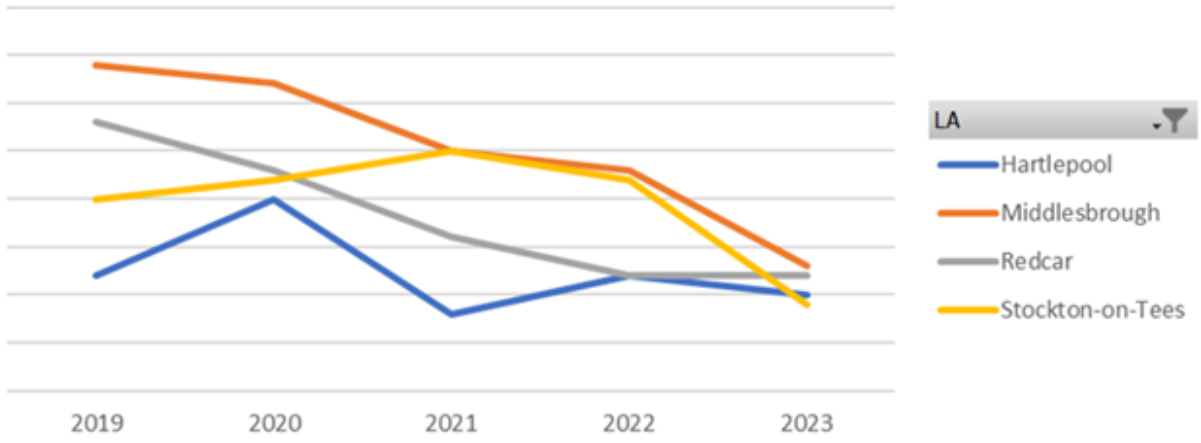
Figure 16: Age standardised suicide rates per 100,000 for NENC



Source - Office for National Statistics – in England and Wales

Figure 17 below highlights South Tees local authorities' comparison to the neighbouring local authorities of Teesside for suspected suicides. Redcar has seen a steadier decline which has plateaued from 2022 to 2023 with no decrease in numbers over the past year whereas Middlesbrough has continued to have a decline in deaths with current numbers well over half of 2019 figures.

Figure 17: Age standardised suicide rates per 100,000 for NENC



Source - NECS Real Time Surveillance System

9.1.3 Drivers for change and local key priorities

Suicide prevention strategy for England: 2023 to 2028

This strategy sets out the national ambitions for suicide prevention over the next 5 years and the steps we will collectively need to take to achieve them. This includes individuals, organisations across national and local government, the NHS, the private sector, the VCSE sectors, and academia.

The new National Strategy has identified the following priority areas for action to achieve these aims. These are to:

- improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted.
- provide tailored, targeted support to priority groups, including those at higher risk.
- address common risk factors linked to suicide at a population level by providing early intervention and tailored support.
- promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- provide effective crisis support across sectors for those who reach crisis point.
- reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- provide effective bereavement support to those affected by suicide.
- make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

NENC ICB Suicide Prevention Plan (2022)

The rates of suicide in the northeast and north Cumbria are the highest in the country at 13.4 per 100,000 people. Suicide is the leading cause of death in our region for men aged 15 – 49 and women aged 20-34. This amounts to hundreds of lives lost, families devastated and incalculable economic and social consequences. Better health and wellbeing for all an integrated care strategy for the North East and North Cumbria (2022) has identified suicide prevention as a priority and agreed the goal to - ***Halve the difference in the suicide rate between our ICP and England in 2019/2021 (three year rolling average) by 2029/31***

NHS Mental Health Implementation Plan 2019/20 – 2023/24 (longtermplan.nhs.uk)

Ambitions for 23/24

- The current suicide prevention programme will cover every local area in the country.
- All systems will have suicide bereavement support services providing timely and appropriate support to families and staff.

9.2 What are we doing already in relation to this goal?

Governance/Strategy

- Establishment of local multi-agency partnership for Suicide Prevention (Tees Suicide Prevention Taskforce). Wide representation across all sectors of local workforce.
- Tees Suicide Prevention Implementation Plan, developed and delivered by Tees Suicide Prevention Taskforce which includes six key priority areas for action as set out by National Strategy.

Data Management

- Real time surveillance and data collection process of suspected suicides to monitor deaths, trend analysis and inform local action.
- Cluster and increasing trends management plan developed.

Targeted Programmes

- Support in place for those bereaved or affected by suicide across South Tees, this includes community response (schools, workplaces, scene of death). Suicide bereavement is prioritised

due to evidence of imitative suicidal behaviour and increased risk of mental health and emotional problems of bereaved family and friends.

- Developing the workforce - Suicide Prevention Training offer for the local workforce and includes access to a commissioned Mental Health Training Hub. The training hub is a key contributor to the delivery of the suicide prevention implementation plan. The hub brings about opportunities for staff and volunteers throughout Teesside to access the very highest quality, needs-led accredited mental health training to raise awareness and build capacity to prevent suicides.
- Samaritans support signage in place across high risk/frequency locations and community settings and on the back of council parking tickets.
- Prevention programmes with key partners established to monitor and manage risk, for example James Cook Rail Station and Cliffs at Saltburn.
- A wide range of organisations across sectors provide various support interventions to local population to improve emotional wellbeing and mental health.

Guidance (media/social media)

- All local media outlets have received and comply with Samaritans media reporting guidelines to ensure sensitive and responsible reporting of suspected suicides.
- Support and roll out of Samaritans Guidance for Practitioners Internet Safety – Suicide and Self-Harm. https://www.e-lfh.org.uk/programmes/internet-safety-suicide-and-self-harm/

9.3 What are the key issues?

- In our ICP area we have some of the highest rates of suicide in England.
- Suicide is the leading cause of death for men aged 15-49 and women aged 20-34.
- Success of local suicide prevention planning requires actions by a range of organisations, local authorities, mental health and care services, primary care, voluntary sector organisations, employers, educational settings, police, transport, fire brigade and others.

9.4 What is the current evidence base in relation to this goal?

The below evidence base was collated by Teesside University as part of the Health Determinants Research Collaborative (HDRC):

- Studies by the Office for National Statistics (ONS), the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), the Multicentre Study of Self-Harm in England, the Adult Psychiatric Morbidity Survey and others have improved our understanding of suicide and self-harm trends among people from ethnic minority backgrounds, people diagnosed with severe health conditions, people in certain occupations, students, people experiencing homelessness and middle-aged men.
- DHSC has funded the National Suicide Prevention Alliance (NSPA), in part to ensure that insights from their Lived Experience Network can inform policy and help government departments understand key issues.
- There is also increasing evidence of the association between exposure to harmful content on the internet, and suicide and self-harm in children and young people.
- There are several factors that have been particularly strongly linked to suicide in middle-aged men. Socioeconomic disadvantage is strongly associated with suicide among this demographic and middle-aged men did not have the highest rates of suicide of any group until after the 2008 recession, suggesting a link between recession and suicides. National evidence on suicide in middle-aged men shows that factors such as living in the most deprived areas and experiencing

unemployment or financial difficulties (including debt and housing difficulties) have also been particularly linked to suicide in this group.

- NICE guidance on the assessment, management, and prevention of recurrence of self-harm
- NICE published updated guidelines that reiterate the importance of risk-assessment tools and scales not being used to predict future suicide or repetition of self-harm, or to determine who should and should not be offered treatment or discharged.
- Suicide prevention: developing a local action plan - GOV.UK (www.gov.uk)

9.5 What do local people say?

9.5.1 Suicide Prevention Event Feedback.

In November 2023 an Annual Suicide Prevention Event was attended by a wide range of organisations across Teesside to contribute to views about local challenges, development of local suicide prevention plan and gain an understanding of local support services, including community grassroots projects.

Emerging themes from the event:

- Lack of awareness of local support services for signposting and collaboration
- Need for training for people in relevant public services to identify and support those who may be at risk of suicide.
- Challenges and multiple complexities facing our population – social determinants (poverty, housing, employment etc), risk factors (substance misuse, debt)
- Lived experience stories, importance of access to support following a bereavement.
- The need for cross sector collaboration was highlighted.

9.6 What are the key actions in relation to external causes?

- To contribute to the reduction of local suicides and support the development and key areas of action in the Tees Suicide Prevention Strategic Plan in line with national strategy guidance.
- To review and refresh the local multi-agency suicide prevention plan which reflects the collective work of the partnership, local priorities, and national suicide prevention strategy.
- To improve cross sector collaboration. Suicide is everybody's business - Everyone should feel they have the confidence and skills to play their part in preventing suicides, not just those who work in mental health and/or suicide prevention directly.
- Provide timely and appropriate support to individuals or communities bereaved or affected by suicide.
- To increase mental health knowledge and skills across a range of settings and target training to organisations most likely to meet those most at risk of poor mental health.

10. Sexual Health

10.1 What key data do we have and what are the drivers for change?

The consequences of poor sexual health include unplanned or unwanted pregnancies, including teenage pregnancies, which can lead to abortions, poorer maternity outcomes for mother and baby and poorer educational and socioeconomic outcomes for teenage parents and their children. Poor sexual health can also manifest in sexually transmitted infections which can result in recurrent infections, pelvic inflammatory disease, ectopic pregnancies, infertility, hepatitis, chronic liver disease, liver cancer, cervical and other genital cancers.

10.1.1 Condoms

The local condom distribution scheme was mainly delivered through community pharmacies. There has been a reduction in the number of individuals accessing pharmacies to receive condoms either through an existing c-card or to obtain one in the last 3 years. In 2021 there were 161 individuals from across Teesside issued condoms via pharmacies compared to 222 in 2020 and 518 in 2019.

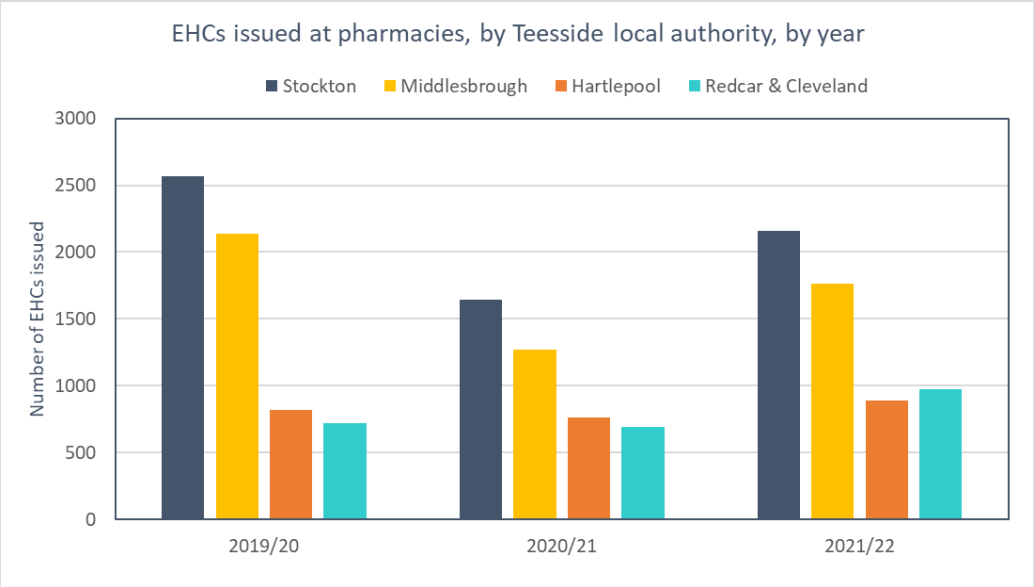
In 2022, 21.7% of individuals accessing condoms through pharmacies were Middlesbrough residents and 33.5% were Redcar & Cleveland residents. Excluding persons aged 25 and over, this equates to an estimated rate of 3.2 per 1,000 population of Redcar & Cleveland and 1.6 in Middlesbrough.

From April 22 to March 23 there were 160 condom packs given out to Middlesbrough residents and 214 condom packs to Redcar & Cleveland residents.

10.1.2 Emergency Hormonal Contraception (EHC)

Emergency hormonal contraception (EHC) is provided free of charge from all sexual health clinics and subcontracted community pharmacies across Tees from the age of 13 years. The vast majority of EHC is issued from pharmacies (96.8% in 2021/22).

Figure 18: Number of EHCs issued across Teesside at pharmacies, 2019/20 to 2021/22



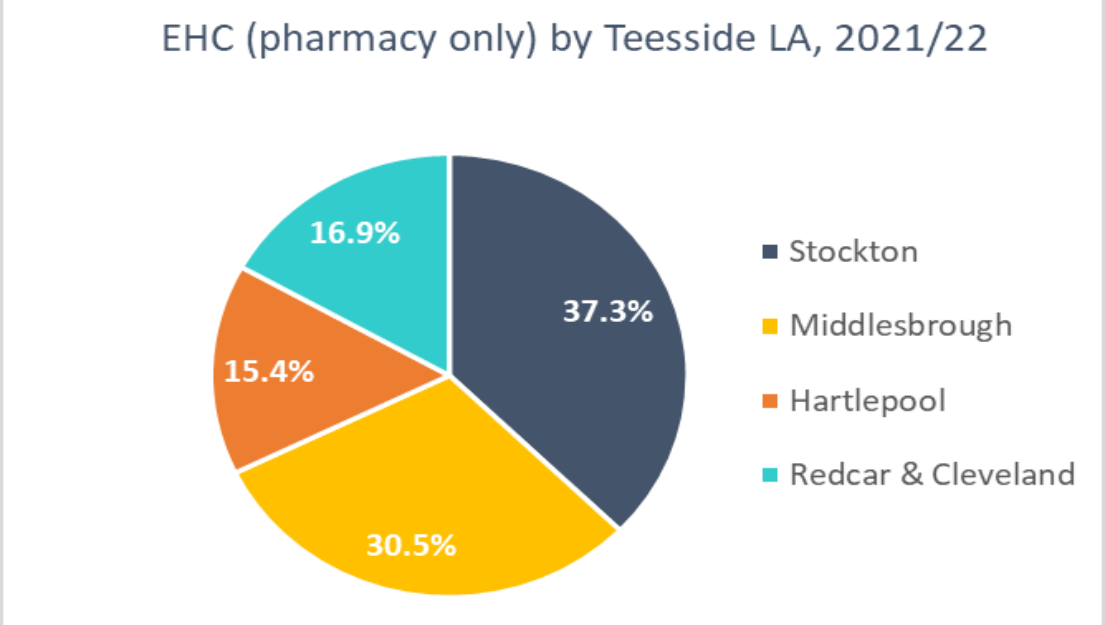
Source - Pharmacy data 2023

At sexual health clinics, 28.1% were dispensed in Middlesbrough and just 9.7% in Redcar & Cleveland. Across Tees, the majority of EHC in 2021/22 were among persons aged 20 years and over (77.8%), one in five (19.5%) aged 16-19 years and a very small number aged 13-15 years (<10).

With clinic data accounting for a small proportion of all EHC across Teesside, and only one year of data currently available, Figure 18 relates exclusively to EHC issued from pharmacies.

Overall, there were 6,243 EHC issued by Teesside pharmacies in 2019/20, 4,368 in 2020/21 and 5,783 in 2021/22. All areas experienced a reduction of EHC issued in 2020/21, due to the impact of COVID-19 but saw a significant increase in 2021/22 with higher than pre-pandemic numbers in Hartlepool and Redcar & Cleveland, whilst numbers in Middlesbrough and Stockton remained below pre-pandemic figures.

Figure 19: EHC issued by pharmacy location, Teesside local authorities 2021/22

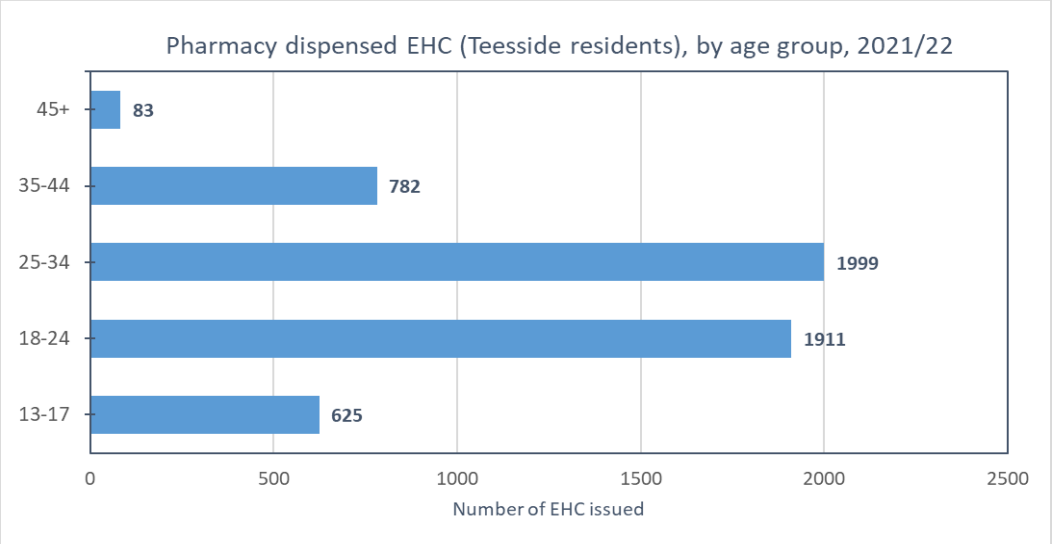


Source Pharmacy data 2023

Of the 5,783 EHC issued in pharmacies in 2021/22, 30.5% of distributions were from pharmacies located in Middlesbrough, with smaller distribution numbers in Redcar & Cleveland at 16.9%. This translates to a rate of 62.2 EHCs per 1,000 females in Middlesbrough, and 43.2 per 1,000 in Redcar & Cleveland.

The number of EHC dispenses for Middlesbrough and R&C from April 22 to March 23 was 1,467 for Middlesbrough and 868 for Redcar & Cleveland.

Figure 20: EHC issued to Teesside residents, by age band 2021/22



Source - Pharmacy data 2023

Almost three quarters (72.4%) Teesside residents accessing EHC in 2021/22 were aged 18-34 years, with slightly more in the 25-34 cohort (37%) than 18-24 (35.4%). A further 14.5% were aged 35-44 years, 11.6% in the youngest age band of 13-17 and a small number aged over 45 years (1.5%).

10.1.3 Sexually Transmitted Infections (STIs)

Figure 21 below shows a selection of sexual health indicators for Middlesbrough and Redcar & Cleveland for 2022. The table includes the numbers, rates, ranks against national local authorities and the England rate for comparison. 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. Case rates of Gonorrhoea are similar or lower locally compare to national rates.

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. HIV testing coverage is significantly better than the national average with 51% of eligible population attending sexual health services locally tested compared to 48.2% in England. This has increased significantly in recently with a rate of 15.2% in Middlesbrough and 11.9% in Redcar & Cleveland in 2020. Case rates of HIV are relatively low in South Tees and below the England average.

Figure 21: Sexual health indicators

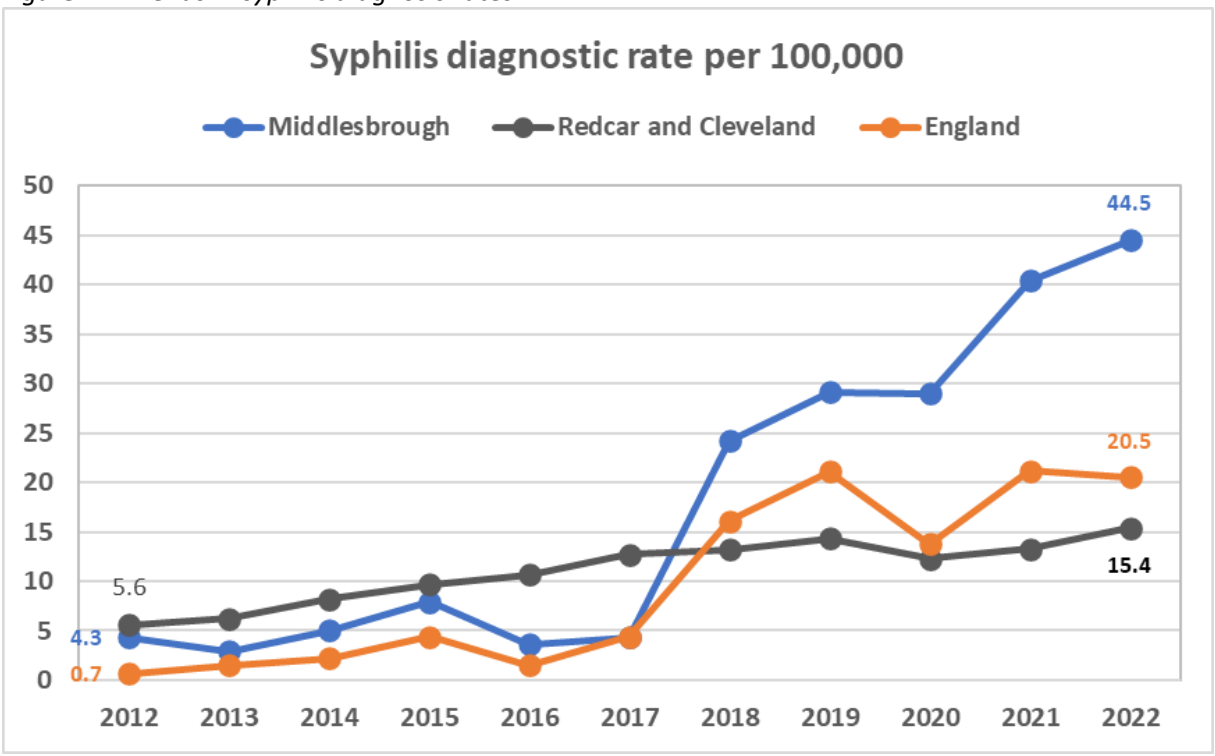
Indicator	Period	Middlesbrough			Redcar & Cleveland			England
		Number	*Value*	*Rank (LA)**	*Number*	*Value*	*Rank (LA)**	*Value*
Syphilis diagnostic rate per 100,000	*2022*	64	**45**	17/153	28	**21**	33/153	15
Gonorrhoea diagnostic rate per 100,000	*2022*	203	**141**	42/153	147	**108**	68/153	146
Chlamydia diagnostic rate per 100,000	*2022*	689	**479**	28/153	500	**366**	50/153	352
All new STI diagnoses rate per 100,000	*2022*	1,088	**757**	37/150	772	**565**	69/150	694
HIV testing coverage %	*2022*	2,489	**51.0%**	73/153	1,777	**51.9%**	67/153	48.2%
New HIV diagnosis rate per 100,000	*2022*	9	**6.3**	63/153	2	**1.5**	146/153	7

Compared against England
Significantly higher
Similar
Significantly lower

Source – Fingertips, OHID

Figure 22 below shows the trends in syphilis diagnostic rates over recent years. The North East is declared by OHID as currently in a syphilis outbreak. Rates have increased dramatically from 4.4 per 100,000 for both Middlesbrough and Redcar & Cleveland in 2014 to 44.5 per 100,000 in Middlesbrough and 20.5 per 100,000 in Redcar & Cleveland. This equates to an increase of 12 cases in 2014 to 92 cases in 2022.

Figure 22: Trends in syphilis diagnosis rates



Source – Fingertips, OHID

10.1.4 Teenage Conceptions

Teenage pregnancy is associated with poverty, low aspirations, and not being in education, employment, or training. Unintended pregnancies impact on women from all parts of society, with an estimated annual cost to the NHS in England of £817 million. **[Health, 2020. [Online] 2013]**

Figure 23 below confirms that in the under 18 year olds (2019-2021), Middlesbrough constantly has the highest number of conceptions (83, 71 and 83). In 2021, it also had the highest percentage of conceptions leading to abortion, at 48.2%, with Redcar & Cleveland at 45% above the national average of 53.4%.

Figure 23: Conception numbers and rates and the percentage of conceptions leading to abortion in Under 18s, 2019/20

	2019			2020			2021		
Under 18 years	Number of conceptions	Rate of conceptions (per 1,000)	% Conceptions leading to abortion	Number of conceptions	Rate of conceptions (per 1,000)	% Conceptions leading to abortion	Number of conceptions	Rate of conceptions (per 1,000)	% Conceptions leading to abortion
Hartlepool	40	27.0	57.5	32	20.4	46.9	34	19.9	44.1
Middlesbrough	83	37.1	39.8	71	30.4	40.8	83	31.5	48.2
Redcar & Cleveland	62	30.0	45.2	57	27.5	40.4	60	27.3	45.0
Stockton-on-Tees	70	22.0	42.9	73	22.0	41.1	61	17.4	39.3
North East	**872**	**21.8**	**47.2**	**766**	**18.6**	**40.3**	**840**	**19.8**	**45.0**
England	**14,019**	**15.7**	**54.7**	**11,878**	**13.0**	**53.0**	**12,361**	**13.1**	**53.4**

ONS Conception Statistics 2021

In 2021, Middlesbrough had the highest percentage of conceptions leading to abortion, at 32.8%, with Redcar & Cleveland at 28.5%, both above the North East (26.3%) and national average (26.5%) see figure 24.

Figure *24: Conception numbers, rates and the percentage of conceptions leading to abortion in all ages, 2019/20*

	2019			2020			2021		
All ages	Number of conceptions	Rate of conceptions (per 1,000)	% leading to abortion	Number of conceptions	Rate of conceptions (per 1,000)	% leading to abortion	Number of conceptions	Rate of conceptions (per 1,000)	% leading to abortion
Hartlepool	1,236	74.5	25.4	1234	74.1	25.2	1229	73	29.0
Middlesbrough	2,454	90.0	29.3	2435	89.0	30.5	2610	92.4	32.8
Redcar & Cleveland	1,633	71.8	25.4	1692	74.4	27.5	1788	78.9	28.5
Stockton-on-Tees	2,539	72.6	24.0	2528	72.9	27.5	2602	73.1	26.3
North East	**32,341**	**66.6**	**24.1**	**32664**	**66.8**	**24.4**	**33425**	**69.0**	**26.3**
England	**782,858**	**74.1**	**25.2**	**780013**	**73.7**	**25.3**	**785656**	**71.5**	**26.5**

ONS Conception Statistics 2021

Figure 25 below highlights that Middlesbrough is one of the most deprived local authorities in England and in 2021 had the highest conception rate in under 18s at 31.5 per 1,000 population followed by Redcar & Cleveland at 27.3 per 1,000 respectively. The under 18 conception rate remains higher in the North East at 19.8 compared to 13.1 per 1,000 nationally. In the last three years, the under 18 conception rate has reduced across all local authorities in Teesside.

Figure *25: Under 18 conception rate and deprivation rank in Teesside*

2021 conception rate (U18s) and IMD 2019	**IMD (rank of average score)**	**Under 18 conception rate**
Middlesbrough	5	31.5
Redcar & Cleveland	31	27.3

ONS Conception Statistics and IMD 2019

Teenage pregnancy rates in Middlesbrough and Redcar & Cleveland are above the average when benchmarked against other local authorities with a similar level of deprivation. In 2021 Middlesbrough was the 5th most deprived area nationally and had the highest conception rate in England.

Although under 18 conceptions across Teesside have declined significantly over the last decade they remain consistently above the national average. In 2021 Middlesbrough had the highest under 18 conception rate in England (32.3).

10.1.5 Abortions

Abortion rates can be an indicator of the effective use and access to contraception in an area. The age-standardised abortion rate (ASR) in England and Wales has increased each year since 2016, to 18.6 per 1,000 women, the highest ASR since the Abortion Act was introduced in 1967. However, the abortion rate for women aged under 18 has continued to decrease from 15.0 in 2011 to 6.5 per 1,000 in 2021.

In 2021, there were 2,375 legal abortions in Teesside. The age-standardised abortion rate was higher in all Teesside local authorities than the North East, and England average. Middlesbrough has the highest rate in Teesside at 29 per 1,000 women, the fourth highest rate of all local authorities in England, as well as the highest national abortion rate in women aged under 18 years, at 14.6 per 1,000. ASR are highest in the 20-24 age group in all areas.

Figure 26: Age standardised abortion rate and crude abortion rates by age band, by local authority, Teesside 2021

		Crude rate per 1,000 women in age group					
Area of residence	ASR per 1,000 women (15 to 44)	Under 18	18 to 19	20 to 24	25 to 29	30 to 34	35 and over
Hartlepool	**20.0**	9.6	30.7	35.0	28.0	23.8	10.0
Middlesbrough	**29.0**	14.6	30.0	46.8	41.6	39.1	15.6
Redcar and Cleveland	**21.7**	12.0	35.2	43.9	28.1	24.8	8.8
Stockton-on-Tees	**20.0**	7.8	28.1	45.8	26.7	19.5	9.1
North East	**16.8**	8.5	22.1	28.5	24.2	19.5	8.7
England	**18.7**	6.5	22.4	30.9	27.3	22.5	10.7

Source - Abortion Statistics [revised tables 2023]

The earlier abortions are performed the lower the risk of complications. Figure 26 illustrates that in 2021, the majority of abortions carried out nationally were under 10 weeks, at 88.6% in England. The proportion of abortions carried out in this earlier gestation period has been increasing locally, regionally, and nationally in recent years. In 2021, Middlesbrough and Redcar & Cleveland authorities were similar to the national and above the regional average for abortions under 10 weeks gestation.

Figure 27: Percentage of abortion by gestation period, by local authority, 2021

	Abortion by gestation period (%)		
Area Name	**Under 10 weeks**	**10-12 weeks**	**13 weeks and over**
Middlesbrough	89.6	5.4	5.0
Redcar & Cleveland	89.7	4.8	5.5
North East	86.1	7.5	6.4
England	88.6	5.0	6.4

Abortion Statistics [revised tables 2023]

As per figure 28 below, in Middlesbrough the percentage of repeat abortions in all ages was higher (46.7) than regional (41.6) and national figures (42.6). In Redcar & Cleveland, the proportion of repeat abortions in all ages was lower (39.2) than regional (41.6) and national figures (42.6). In 2021, repeat abortions among women aged 25 and under were higher in both Middlesbrough (32.1) and Redcar & Cleveland (30.1) than regional (29.2) and national figures (29.7). Middlesbrough is considerably higher (55.3) that the regional (49.7) and national average (49.6) for repeat abortions in women aged over 25 years with Redcar & Cleveland (46.0) under the regional (49.7) and national average (49.6).

It is important to note that the numbers of repeat abortions particularly in women aged under 25 years are relatively small, a total of 291 repeat abortions in this age group across Teesside.

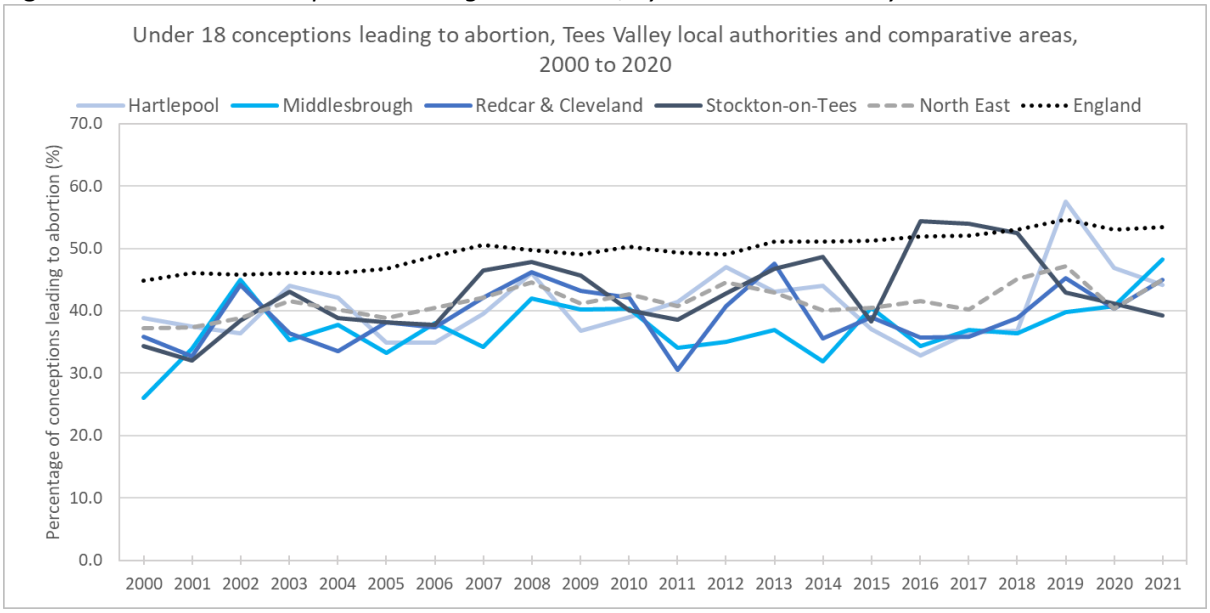
Figure *28: Percentage of repeat abortion, by local authority, 2021*

	Repeat Abortions (%)		
Area of residence	**All ages**	**25 years and under**	**Over 25 years**
Middlesbrough	46.7	32.1	55.3
Redcar & Cleveland	39.2	30.1	46.0
North East	41.6	29.2	49.7
England	42.6	29.7	49.6

Abortion Statistics [revised tables 2023]

A significant proportion of conceptions in the under 18 age group lead to abortion. Nationally, more than half of conceptions (53.4%) led to abortion in 2021. Middlesbrough has the highest proportion leading to abortions in Teesside, at 48.2% with Redcar & Cleveland at 45%. Figure 28 below indicates the percentage of conceptions leading to abortion in under 18s is rising for both Middlesbrough and Redcar & Cleveland.

Figure *29: Under 18 conceptions leading to abortion, by Tees local authority 2000-2020*



Source - ONS Conception Statistics

Figure 30 Conception numbers, rates and percentage of conceptions leading to abortion in Teesside, 2019-2021

	2019			2020			2021		
All ages	Number of conceptions	Rate of conceptions (per 1,000)	% leading to abortion	Number of conceptions	Rate of conceptions (per 1,000)	% leading to abortion	Number of conceptions	Rate of conceptions (per 1,000)	% leading to abortion
Hartlepool	1,236	74.5	25.4	1234	74.1	25.2	1229	73	29.0
Middlesbrough	2,454	90.0	29.3	2435	89.0	30.5	2610	92.4	32.8
Redcar & Cleveland	1,633	71.8	25.4	1692	74.4	27.5	1788	78.9	28.5
Stockton-on-Tees	2,539	72.6	24.0	2528	72.9	27.5	2602	73.1	26.3
North East	**32,341**	**66.6**	**24.1**	**32664**	**66.8**	**24.4**	**33425**	**69.0**	**26.3**
England	**782,858**	**74.1**	**25.2**	**780013**	**73.7**	**25.3**	**785656**	**71.5**	**26.5**

Source ONS Conception Statistics 2021

In 2021, of the Teesside local authorities, Middlesbrough had the highest proportion of conceptions leading to abortion, at 32.8%, with Redcar & Cleveland ate 28.5%. Middlesbrough (29.3) and Redcar & Cleveland (25.4) have a higher percentage of conceptions leading to abortion than the North East (24.1) and national average (25.2).

10.2 What are we doing already in relation to this goal?

10.2.1 Condoms

From April 2023 C-Card provision has been commissioned directly by south Tees' local authorities and delivered by Brook who are the country's leading charity for sexual health services for young people aged 13 – 25 yrs. Brook deliver education and training to a wide number of organisations that work with young people including , schools, colleges, youth services, school nurses and health visitors.

In the first year of the contract (April 2023 to March 2024)

- 83 RSE sessions were delivered (digital and F2F) in mainstream schools for years 10-11 (14-15 year olds).
- 58 RSE sessions were delivered (digital and F2F) to FE colleges for years 12-13 (16-17 years).
- Digital and in person C-Card registrations in South Tees was 1,122 (against a target of 1,200).
- Repeat condom distributions South Tees was 432.

Across Tees, Local authorities are engaging with a behavioural insight company to attempt to change behaviours in the 16-34 age group. The aim is to encourage this cohort to use condoms more frequently to reduce the onwards transmission of STIS and help reduce unwanted pregnancies and repeat abortions.

10.2.2 Syphilis and Gonorrhoea

A syphilis and gonorrhoea action plan is being implemented across Tees, with the aim of reducing the prevalence of syphilis and gonorrhoea. The plan will focus on:

- Increased testing across Tees targeting groups most affected i.e., 18-34 years old.
- Develop joint pathways between Sexual Health services, maternity services and infectious disease department with clear lines of contact and responsibility.
    - Develop a pathway and referral process with maternity services
    - Develop a programme of targeted screening to all antenatal patients and re screen if anyone is at risk at 28/36-weeks.
- Work with partners to promote STI awareness and testing options.
    - South Tees PH organised 3 training webinars to raise awareness for midwives (and community midwives) school nursing and health visiting.
- Develop a multiagency syphilis communications group to develop and implement broad community media/promotional campaigns with PH teams and comms departments.

- Increase social media output to keep awareness and testing options high.
- Develop and implement targeted information campaign to local partners - GP practices, pharmacy, allied health partners.
- Develop clear guidelines re stages of syphilis discussed and adhered to by all Clinicians with limited possibility of different interpretations.
- Ensure timely access to treatment to prevent onwards transmission.
- Ensure robust partner notifications protocols are adhered to.
- Review recall system to ensure 6/12 follow up is acted upon and conduct interim audits.
- Increase walk-in clinics thus reducing express home postal testing resulting in more viable samples being taken in clinics.

10.2.3 Teenage Conceptions

- Increase the number of long-acting reversible contraception (LARC) clinics.
- South Tees Public Health has established and chair a multiagency South Tees Teenage Conception Strategic Partnership Group. This group meets quarterly and is developing an action plan for all partner agencies to drive forward key workstreams including:
    - C-Card scheme
    - Sexual Health Service offer to young women
    - Prevention
    - Communication Strategy
    - Data and mapping

10.3 What are the key issues?

- Rates of new STI diagnoses in Middlesbrough (688 per 100,000) are higher than England (551 per 100,000)
- STI testing rates (excluding chlamydia aged under 25) per 100,000 crude rates are significantly less in the NE (2052.7 per100,000) when compared to England (3422.4)
- Syphilis rate in Middlesbrough has increased for the 4th year in a row and is sig higher than England at 41.1 per 100,000 compared to NE (9.4) and England (13.3 per 100,000)
- HIV Testing coverage in all of Teesside is significantly lower than England (45.8) and NE (44.1) with all 4 Teesside LAs reporting less than 30% of those eligible HIV test at GU Clinic
- Middlesbrough has higher than England rates of U18 conceptions.
- LARC – significant waiting times for IUD.

10.4 What is the current evidence base in relation to this goal?

The below evidence base was collated by Teesside University as part of the Health Determinants Research Collaborative (HDRC):

- Although the rate of under 18 conceptions continues to decrease for the Tees area, the rate remains significantly higher than the national average, and the reduction not continuing at the same pace as the national average. Abortions rates for the under 18 age group highlight some significant differences between areas of Tees, with Hartlepool, Middlesbrough and Redcar & Cleveland has been lower than the national average, while in Stockton the proportion of teenage pregnancy leading to abortion is higher than the national average (Tees Sexual Health Commissioners, 2020)

- The quality of reproductive health education has long-term health consequences, for both individuals and future generations. Preconception health issues in adults can significantly impact the health of their children (Stephenson *et al.*, 2019)
- Significant variation and gaps in the current UK science and biology curricula for 14–18 year-olds as they relate to sexual and reproductive health. At the same time, substantial numbers of young people are leaving school with inadequate understanding of concepts that have important implications for their sexual and reproductive health (Maslowski *et al.*, 2023)

The main recommendations put forward by the above papers include:

- A commitment to work towards a specialist integrated sexual health service – to provide users with open access to confidential, non-judgemental services including sexual transmitted infections and blood borne viruses testing, treatment and management; HIV prevention (including pre-exposure prophylaxis and post-exposure); the full range of contraceptive provision; health promotion and prevention (including relevant vaccination) – this should be supported by remote and online provision.
- Promoting good sexual health through primary prevention activities including condom use, vaccination, the sexual health aspects of psychosexual counselling, HIV PrEP, behaviour change and those which aim to reduce the stigma associated with STIs, HIV and unplanned pregnancy.
- Providing rapid and easy access to open access STI and BBV testing, treatment and management services through a variety of mechanisms which should include remote and online services; providing rapid and easy access to open access reproductive health services including the full range of contraceptive services; supported referral to NHS funded abortion services (based on up-to-date knowledge of local contractual arrangements for abortion services including late gestations and those with comorbidities); and support in planning for a healthy pregnancy; through a variety of mechanisms which should include remote and online services.

10.5 What do local people say?

Tees valley Sexual Health Consultation carried out during 2023 highlighted the following:

- Embarrassment and stigma are key barriers to seeking sexual health services.
- Need to increase provision of sexual health services in rural areas.
- Increase testing opportunities for syphilis.
- Expand training opportunities, e.g., covering C-Card, on STI screenings.
- Need to increase accessibility to community groups, specifically seldom heard communities.
- Improve referral pathways.
- Main barriers for vulnerable groups not accessing sexual health services are location, cost of transport, stigma, and lack of trust in professionals.
- Confusing online booking system for booking SH appointments.
- Had difficulty understanding the instructions and using the home testing kits.
- Raise awareness of the different sexual health services across Teesside - many professionals across Teesside organisations and services do not have up to date information or know where to refer.
- Increase provision and awareness of C-Card Service.
- Improve accessibility - Need to increase provision of sexual health services in rural areas.
- Pharmacies not offering EHC, STI testing, C-Card, pregnancy testing.
- Extend availability and choice - Review contraception assistance via GP practices as in some cases members are struggling to get contraception from GPs instead being referred to sexual health services.

10.6 What are the key actions in relation to sexual health?

- Address the sexual health needs with a focus on reducing inequalities, improving contraceptive care for young people and young adults, and improving STI prevention, testing and further transmission.
- Reduce sexual health inequalities by understanding the drivers for poorer sexual health in the most deprived areas, in young people and at-risk groups. Develop and Implement evidence-based and co-produced interventions including condom distribution schemes, walk-in clinics, targeted clinics and good information and access to contraceptive care at local level and through trusted organisations.
- Continue to improve overall service utilisation rates and review the utilisation of online and virtual sexual health services in the light of learning from the pandemic and ongoing changing needs and demand. Ensure that residents are aware of local services and that young people, at risk groups and those who are digitally excluded have good access to face-to-face services.
- Work with partners to improve access, capacity and delivery of contraceptive care starting from user depended to long-acting methods to reduce reliance on emergency contraception and unwanted pregnancies.
- Review utilisation emergency contraception pathways to ensure appropriate and timely access to EHC in service and pharmacies.
- Strengthen the prevention of STIs and unwanted pregnancies through improved information and locally accessible condom distribution schemes for young people and at-risk groups.
- Continue to improve access to STI services with in-service and online/ home-testing STI testing, treatment and partners notification to detect and treat disease, reduce unmet need and reduce onward transmission in response to the increase of syphilis and gonorrhoea cases.
- Conduct further in-depth analysis to understand the reasons for the continued decline in cervical screening, vasectomy, psychosexual counselling provided by the sexual health service.
- Collaborate with system partners to improve the sexual health and productive care of the local population and prevent and respond to sexual health needs and challenges such as the STI outbreaks, high abortion and repeat abortion rates and sexual health violence.
- Establish systems to involve local communities, especially those who are at highest risk, to co-design and develop pathways and service improvements to increase local access and equality, e.g. review of translation services.
- Improve data systems and reporting of key information to monitor and benchmark sexual health needs and service provision at local level.

11. Recommendations

1. Establish the governance for the Ill health prevention programme, including wider partnership meetings, internal team meetings and a multi-agency action plan that delivers the key actions in relation to each topic.
2. Implement a Health Equity Audit process across all screening and diagnostic services to ensure that resources are fairly distributed and health inequalities are not being widened particularly among our CORE20PLUS groups.
3. Ensure the use of population health data to review and recommission high quality joined up diagnostic / screening services (ie NHS Health checks, cancer screening) that meet the needs of service users, improve access, experience and outcomes, and reduces inequalities.
4. Development and delivery of a robust primary prevention offer which includes raising awareness of health status and risk, through a communications plan that utilises local, regional and national campaigns / resources.
5. Workforce training for adult social care, children services, front line services, health care, education, in relation to MECC, brief intervention, and promotion of diagnostic / screening services (like targeted lung health check) and referrals to appropriate services (like stop smoking service).
6. Consultation and community engagement to inform the codesign and quality improvement of how existing commissioned services can better meet the needs of local people.
7. Take an integrated approach to the delivery of diagnostic and screening services across primary care, secondary care, voluntary sector, public health and communities to promote and increase uptake of treatment and referral to ill health prevention services.

12. References

Ahmad, M., Reading, K., & Gannon, M. X. (2021). Improving Abdominal Aortic Aneurysm (AAA) Screening Uptake through Patient Engagement—Analysis and Outcomes of Strategies to Improve Uptake at a Regional Program Level. *Annals of vascular surgery, 72*, 488-497.

Bowe, F., Paul, I., Ferguson, J., Dunning, J., & Harrison, S. (2020). High intensity inspiratory muscle training (HI-IMT) in individuals referred for lung resection surgery. *Physiotherapy, 107*, e33-e34.

Burkert, J., Jarman, R., & Deol, P. (2023). Evolution of Lung Abnormalities on Lung Ultrasound in Recovery From COVID-19 Disease—A Prospective, Longitudinal Observational Cohort Study. *Journal of Ultrasound in Medicine, 42*(1), 147-159.

Byrnes, K., Hamilton, S., McGeechan, G. J., O'Malley, C., Mankelow, J., & Giles, E. L. (2020). Attitudes and perceptions of people with a learning disability, family carers, and paid care workers towards cancer screening programmes in the United Kingdom: A qualitative systematic review and meta-aggregation. *Psycho-Oncology, 29*(3), 475-484.

Cancer Research UK (2024) About Cervical Screening | Cancer Research UK

Fingertips Cancer Screening (2024) Fingertips

Harte, E., MacLure, C., Martin, A., Saunders, C. L., Meads, C., Walter, F. M., Usher-Smith, J. A. (2018). Reasons why people do not attend NHS Health Checks: a systematic review and qualitative synthesis. *British Journal of General Practice, 68*(666), e28-e35.

Kelly, C., Emery, P., & Dieudé, P. (2021). Current issues in rheumatoid arthritis-associated interstitial lung disease. *The Lancet Rheumatology, 3*(11), e798-e807.

Maslowski, K., Reiss, M. J., Biswakarma, R., & Harper, J. (2023). Reproductive health education in the schools of the four UK nations: is it falling through the gap? *Human Fertility*, 1-13.

McGeechan, G., Burke, S., Bussey, L., & Slater, S. (2020). Final report of Public Health South Tees Cancer Screening Awareness Evaluation.

NHS Bowel Screening (2024) https://www.nhs.uk/conditions/bowel-cancer-screening/

Patel, R., Barnard, S., Lagord, C., Thompson, K., Hughes, A., Fox, S., Nuttall, M. (2021). Addressing Health Inequalities Through the NHS Health Check Programme in England.

Prothero, L., Lorencatto, F., Cartwright, M., Burr, J. M., Gardner, P., Anderson, J., Lawrenson, J. G. (2021). Perceived barriers and enablers to the provision of diabetic retinopathy screening for young adults: a cross-sectional survey of healthcare professionals working in the UK National Diabetic Eye Screening Programme. *BMJ Open Diabetes Research and Care, 9*(2), e002436.

Quinn, L. M., Shukla, D., Greenfield, S. M., Barrett, T., Garstang, J., Boardman, F., Connop, C. (2022). EarLy Surveillance for Autoimmune diabetes: protocol for a qualitative study of general population and stakeholder perspectives on screening for type 1 diabetes in the UK (ELSA 1). *BMJ Open Diabetes Research and Care, 10*(2), e002750.

Richards, M. (2019). Independent review of national cancer screening programmes in England. *Interim report of emerging findings*.

Stephenson, J., Vogel, C., Hall, J., Hutchinson, J., Mann, S., Duncan, H., Cade, J. (2019). Preconception health in England: a proposal for annual reporting with core metrics. *The Lancet, 393*(10187), 2262-2271.

Sweeting, M. J., Marshall, J., Glover, M., Nasim, A., & Bown, M. J. (2021). Evaluating the cost-effectiveness of changes to the surveillance intervals in the uk abdominal aortic aneurysm screening programme. *Value in Health, 24*(3), 369-376.

Sykes, K., Tuschick, E., Giles, E. L., Kanmodi, K. K., & Barker, J. (2022). A protocol to identify the barriers and facilitators for people with severe mental illness and/or learning disabilities for PErson Centred Cancer Screening Services (PECCS). *PLOS ONE, 17*(11), e0278238.

Tees Sexual Health Commissioners. (2020). Sexual Health Needs Assessment Teesside. Retrieved from https://www.redcar-cleveland.gov.uk/sites/default/files/2022-05/Sexual%20Health%20JSNA.pdf