LiveWell SOUTH TEES
HEALTH & WELLBEING BOARD

SOUTH TEES JSNA

Joint Strategic Needs Assessment

JUNE 2024

MISSION

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

GOAL

We want to improve outcomes for inclusion health groups.

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 the proportion of our families who are living in poverty, the second mission relates to creating places and systems that promote wellbeing, the third mission is to support people and communities to build better health and the fourth mission is to build an inclusive model of care for people suffering from multiple disadvantage across all partners.**

There are 11 goals. The second goal within the fourth mission is to understand and reduce the impact of parental substance misuse and trauma on children. See table below for all other goals and missions.

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 that promote wellbeing.	We want to create a housing stock that is of high quality, reflects the needs of the life course and is affordable to buy, rent and run.
		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 build an inclusive model of care for people suffering from multiple disadvantage across all partners.

Academic research posits that health inclusion groups are amongst those most negatively affected by the overall burden of disease and social need in the UK. This includes communicable diseases, mental health issues, physical health, criminal justice-related issues, accidental harms and the associated service pressures. Furthermore, multiple disadvantage is a complex issue that touches young people, adults, families, communities and society, affecting a range of health and social outcomes.

Dependency on and engagement with drugs and/or alcohol is a cross-cutting issue within inclusion health groups and can affect many aspects of an individual and community: relationships, meaningful activities and employment, family life, parenting, educational attainment, housing opportunities, criminal and anti-social behaviour, including increased likelihood of being a victim of violence.

Interventions to support people affected by multiple vulnerabilities and treatment leads to improved public health outcomes, benefitting the wider determinants of health, health improvement, health protection and preventing premature mortality.

There is a joint responsibility from a range of partners to reduce the harms associated with multiple vulnerabilities, which includes health and social care, housing services, employment support providers and criminal justice partners, for inclusion health groups.

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

3.1 We want to improve outcomes for inclusion health groups

Inclusion health is a 'catch-all' term used to describe people who are socially excluded. These people typically experience multiple overlapping risk factors for poor health (such as poverty, adverse childhood experiences, violence, substance use, mental illness and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases).

These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence issues. This leads to extremely poor health outcomes, often much worse than the general population, lower average age of death, contributing considerably to increasing health inequalities.

NHS England's National Framework states that inclusion health groups are relatively small but significant populations with high needs for healthcare, but who face a range of barriers in accessing healthcare services. Whilst numbers may be small, the cost is high to individuals and systems. By taking a strategic systems approach to inclusion health systems think about how to better utilise resources and work with partners to develop approaches that reduce pressure on the system, save lives and improve health life expectancy.

People in inclusion health groups are also more likely to experience range of morbidities particularly mental health problems and substance dependence, and often have untreated long-term conditions. The children of parents in inclusion health groups are more likely to have poor health across their life-course because of their extremely disadvantaged start in life. There is a risk that disadvantages in socially excluded groups flow from generation to generation – from parent, to child, to grandchildren.

Health across South Tees is generally worse than the England average; with health inequalities between most and least deprived wards being significant. Figure 1 below summaries some key headline data in relation to health.

Figure 1: Headline Health Data for Middlesbrough and Redcar & Cleveland

	Middlesbrough	**Redcar & Cleveland**
Overall health	Generally worse than the England average. Middlesbrough is one of the 20% most deprived districts/unitary authorities in England and about 31% (8,900) of children live in low-income families. Life expectancy for both men and women is lower than the England average.	Generally worse than the England average. Redcar and Cleveland is one of the 20% most deprived districts/unitary authorities in England and about 24% (5,800) of children live in low income families. Life expectancy for both men and women is lower than the England average.
Health Inequalities	Life expectancy is 12.5 years lower for men and 13.0 years lower for women in the most deprived areas of Middlesbrough than in the least deprived areas.	Life expectancy is 10.1 years lower for men and 7.0 years lower for women in the most deprived areas of Redcar and Cleveland than in the least deprived areas.
Child Health	In Year 6, 22.7% (401) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 25 per 100,000, worse than the average for England. This represents 25 stays over 3 years. Levels of teenage pregnancy, GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.	In Year 6, 21.0% (307) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is 43 per 100,000, worse than the average for England. This represents 35 stays over 3 years. Levels of teenage pregnancy, GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.
Adult Health	The rate of alcohol-related harm hospital stays is 819 per 100,000, worse than the average for England. This represents 1,091 stays per year. The rate of self-harm hospital stays is 209, worse than the average for England. This represents 310 stays per year. Estimated levels of adult smoking and physical inactivity are worse than the England average. The rate of hip fractures is worse than average. Rates of sexually transmitted infections and people killed and seriously injured on roads are better than average.	The rate of alcohol-related harm hospital stays is 762 per 100,000, worse than the average for England. This represents 1,048 stays per year. The rate of self-harm hospital stays is 246 per 100,000, worse than the average for England. This represents 310 stays per year. Estimated levels of adult excess weight are worse than the England average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average.

Source: Fingertips

There will be differences in needs within socially excluded groups (for example between men and women) and these differences must be understood and responded to appropriately using a pro-active and holistic approach.

The inclusion health groups identified in this report are people with drug and alcohol dependency; people with housing/homelessness/accommodation issues; Gypsy, Roma and Traveller community; people in contact with the justice system; sex workers; asylum seekers/migrants and refugees and victims of modern slavery. There are a range of issues for all of these groups, for example health literacy/language barriers, access to services, etc., which all fall under the banner of health inequalities.

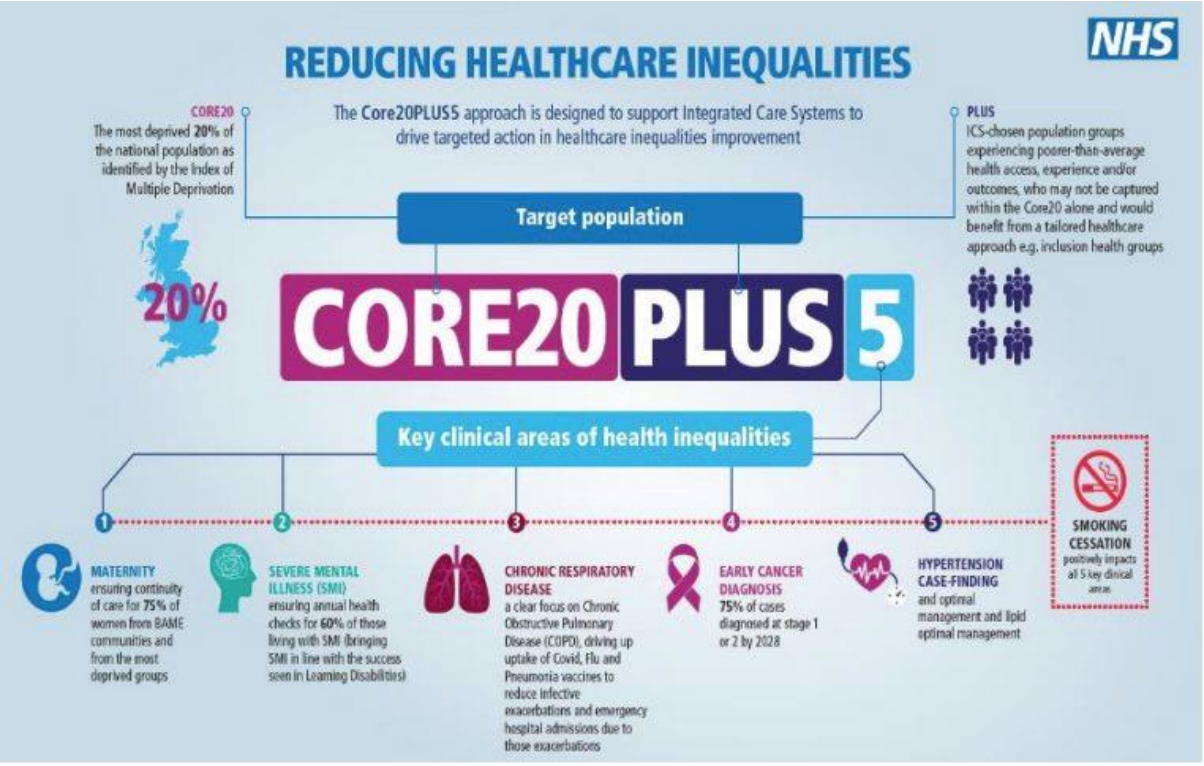
3.2 We want to reduce health inequalities

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

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

OGIM development has been focussed around areas identified through the Core20PLUS5 approach alongside local place-based need. Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach is shown in Figure 2 and it defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Figure 2: Core20PLUS5 Approach:



Source: NHS England

The 5-health inequality key priority areas (Maternity, Severe mental illness (SMI), Chronic respiratory disease, Early cancer diagnosis and Hypertension case-finding) are joined by a sixth priority: smoking cessation. This is also included at this level of Core20PLUS5 as a cross cutting theme because stopping smoking has a positive impact in all of the five clinical areas of focus.

All six of these priority areas are a consistent thread throughout all of the actions identified within each OGIM. The local OGIM approach is aimed at reducing the significant health inequalities in South Tees, including for the cohorts of people within inclusion health groups.

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

People belonging to inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities. Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered

The Tees Valley OGIMs include:

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

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

In order to ensure health inequalities are positively impacted across all services, it is imperative that we work collaboratively as a place-based system to agree a framework for action. This must be focused around the key priority groups, as above (people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery), and using intelligence from the Core20PLUS5 approach, plus building upon the information, support and intelligence flowing from the ICS Advisory Group. The framework should set out how partners will work together and utilise all available networks, resources and governance arrangements in place to improve prevention, access to care and wider societal determinants of health.

3.3 People with Drug and Alcohol Dependence

Our ultimate goal is to eradicate drug related deaths in South Tees. In order to achieve this, a system-wide approach is required in order to have a cumulative impact across specific priority areas including:

- Prevention – early intervention approaches and raising both education and awareness, especially with young people;
- Further improving treatment and recovery support – ensuring services are as open and accessible as possible, increasing capacity of detoxification and rehabilitation services, providing an integrated care approach to tackle multiple issues at the same time;
- Increasing harm reduction – further improving the multi-agency approaches and expanding outreach capacity to reach those most at risk, ensuring that needle exchange, reducing the spread of infectious diseases and Naloxone training/supply is continually delivered with the highest quality;
- Reducing demand and tackling supply – effective joint approaches with criminal justice agency partners to reduce availability of illicit drugs/alcohol, lobbying for improved legislation and supporting regulatory work;
- Challenging stigma – increasing the role that families and communities play in supporting people with drug and alcohol dependence – both directly and at community and strategic levels, using trauma-informed approaches and fostering supportive, non-judgmental communities/environments, building recovery capacity.

Only with effective local collaboration can these challenging issues be tackled effectively. It requires senior buy-in from all partners/stakeholders, a shared and thorough understanding of issues and prevalence, meaningful community engagement and lived experience involvement, and the use of targeted strategies to tackle issues and unmet/emerging needs.

3.4 People who Experience Homelessness

There are an increasing number of people with no suitable accommodation options available to them. The Department for Levelling Up, Homes and Communities (DLUHC) expect that there will need to be a 30% increase in available accommodation compared to current supported housing levels by 2030 to meet demand. We want to work collaboratively with key partners in South Tees to improve the access to decent accommodation options for inclusion health groups.

One of the main issues across the country and locally in the South Tees is the lack of stable move-on accommodation. Even with a good amount of commissioned and non-commissioned supported accommodation when there are very few options of accommodation to move people on into this becomes full very quickly. Coupled with very high rents in private sector and challenging lettings policies within the registered landlords sector, it makes attaining stable accommodation increasingly difficult, especially for those with multiple disadvantages.

One potential solution with a growing evidence base is to implement a Housing First-style approach. Central to the concept of Housing First is that stable housing is provided without unsurpassable tests of having to be 'housing ready'. Following that, any other support needs they might have, such as alcohol and drug dependency, physical and/or mental health problems, etc. are addressed through a tailored package of support. This will include those who are vulnerable, in crisis (such as those fleeing domestic violence and homeless people with unmet support needs) or need shorter-term help to

address immediate issues. The intended approach is to provide housing for those who, in normal circumstances, would most struggle to secure a roof over their heads. This shouldn't be in a setting that will, essentially, be setting them up to fail (i.e. areas where they will be surrounded by crime, ASB and other people exhibiting risky behaviours).

3.5 Vulnerable Migrants and Refugees

A key issue in accessing healthcare for asylum seekers and migrants is the presence of administrative barriers when attempting to register with a GP. This stems from confusion among administrative staff and doctors around who is eligible and what documents they need to register. This can often lead to them demanding proof of ID or address when individuals had expired ID documentation or were living in precarious accommodation (Source: BMA). The study found that 55% of doctors who work with refugees and asylum seekers were frequently or sometimes uncertain about their entitlement to care. This can therefore lead to asylum seekers and refugees being wrongly refused access to primary and secondary care, or being asked to pay upfront for assistance that is not urgent (Source: Refugee Council).

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

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

Research has found that refugees and asylum seekers often view the healthcare system as an extension of the Home Office and can refuse to engage out of fear of being charged, detained or deported. (Refugee Council).

Furthermore, a myriad of research has found that language can creative barriers to accessing healthcare due to the inability to speak English confidently and the need for interpreters, which is routinely refused. (Source: Refugee Council, DOTW).

3.6 Gypsy, Roma and Traveller Communities

Gypsy, Roma and Traveller (GRT) people in England have faced barriers to primary healthcare services. Between 2018 and 2019, Friends, Families and Travellers (FFT) mystery shopped 50 GPs in England and found that, despite no regulatory requirement to provide proof of address or identification in order to register, nearly half of all GP practices contacted refused registration on this basis. This issue similarly impacts other communities experiencing high levels of inequality, such as migrants in vulnerable circumstances and people experiencing homelessness.

Within the context of COVID-19, FFT's casework team identified that a notable shift towards digital-first processes for registration had resulted in additional barriers to care. People within Romany and Traveller communities are more likely to experience digital exclusion. Additionally, around 40% of

FFT's service users have low or no literacy as a result of educational inequalities, which also impacts digital access.

There is little specific data available, however, there is an indication from services supporting GRT populations in South Tees that they experience significant health inequalities compared to the general population. Chronic diseases, mental health issues, and maternal and child health concerns are prevalent.

3.7 Sex Workers

Sex work is strongly associated with poverty, drug addiction, social exclusion and problematic family backgrounds. Women are most affected by poverty and are also most likely to engage in sex work. It is estimated that 88% of sex workers in the UK are women. As poverty increases due to the cost of living crisis more women, particularly single mothers, turn to sex work to survive and feed their families. Focus groups conducted by the North East Sex Work forum (NESWF) indicated that local services were largely unaware of need and the changing face of the sex industry across Cleveland, so there is no accurate local data available.

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

The barriers faced by people experiencing multiple disadvantages to access support, in particular women, can be twofold, external/structural such as location, availability, suitability of programme, staff attitudes; or internal/individual such as feelings of inadequacy, mental/emotional stability, judgement and fear. Such challenges can be far reaching and permeate throughout people's lives particularly when a multi-agency approach is used, resulting in numerous appointments and goals to reach. In order to address some of this We Are With You are employing a one year fixed term post to work on an outreach basis, and within the Adults Access Team to focus on engaging vulnerable women in Redcar & Cleveland.

Health needs are unmet and need to be included in future commissioning including specific sexual health templates, direct reporting routes into police of specialist officers and informed mental health practitioners. Sexual health outreach clinics are being developed across South Tees, delivered from places that vulnerable people find safe and attend on a regular basis. These clinics will offer contraception as well as testing for sexually transmitted infections and signposting into other services.

3.8 Contact with Criminal Justice

There are often difficulties in obtaining healthcare appointments for prisoners, for example, due to limited prison staff available to escort prisoners to hospital, less urgent appointments may be cancelled or pushed back to allow staff free time to attend hospital appointments. There are often also delays in referrals or referral appointments are cancelled last minute. The effect of this is that prisoners often present at hospital later than they should, sometimes having harmful effects on their health.

South Tees, like many other areas, has examples of a lack of co-ordination amongst some of its services. Many individuals in contact with the criminal justice system face difficulties in navigating the complex web of health and social services locally. This lack of co-ordination can lead to gaps in care

and support, exacerbating health issues and hindering recovery from substance misuse issues, which are extremely prevalent amongst this cohort.

Stigma and discrimination associated with criminal records and substance misuse can deter individuals from seeking help and accessing services in South Tees (https://www.redcar-cleveland.gov.uk/community-support/south-tees-changing-futures-programme). Insufficient support for people transitioning out of custody can also be a challenge. Failing to ensure continuity of care for those transitioning from custody to community can often result in relapse and re-offending (https://www.middlesbrough.gov.uk/children-families-and-safeguarding/south-tees-youth-justice-service). Access to appropriate mental health care is also often limited locally, particularly for those with dual diagnoses of mental health issues and substance misuse (https://www.gov.uk/government/news/more-vulnerable-adults-supported-through-changing-futures-programme).

4. Key data and drivers for change?

This section summarises the key data that evidences the requirement to take action. It should be recognised that that there remain some gaps in accurate local data.

4.1 People with Drug and Alcohol Dependence

South Tees faces significant health inequalities and trends related to substance misuse (and drug and alcohol dependence). The area has one of the highest rates of substance misuse, related health problems and associated death rates in the country. This is driven by socioeconomic factors and underpinned by a high prevalence of mental health issues Our local substance misuse treatment and recovery services treat dependence for all drugs, including alcohol. Within the different cohorts heroin and crack users remain the groups with the most complex problems and the majority of those in treatment services in South Tees use heroin.

This cohort are an inclusion health group because of the significantly poorer life chances and outcomes that they face in comparison with people who do not use drugs and/or alcohol to harmful levels. These health inequalities include:

Life Expectancy:

- Life expectancy in South Tees is lower than the national average, with substance misuse contributing to this disparity;
- Men in South Tees have a life expectancy of approx. 76.2 years, compared to 79.6 years nationally. For women, it is approx. 80.8 years, compared to 83.2 years nationally.

Morbidity and Mortality:

- South Tees has a significantly higher rate of drug-related deaths (DRDs) than the national average;
- Deaths from drug misuse in Middlesbrough and Redcar & Cleveland are 14.1 (deaths per 100,000 population between 2020-22) and 8.5 respectively, compared to the national rate of 5.2 (Public Health Outcomes Framework - PHOF C19d).

Hospital Admissions:

- Alcohol-related hospital admissions in Middlesbrough are significantly higher than the national average;
- The rate of alcohol-related admissions is 1,027 per 100,000 population in South Tees, compared to the national rate of 648 per 100,000.

Understanding and preventing drug-related deaths (DRDs) is our primary aim. The key drivers for change are tackling the considerable deprivation, associated lower than average educational outcomes and consequent high unemployment in South Tees. Also, due to the high rate of co-morbidity between substance misuse and mental health disorders (approx. 40% of individuals in treatment for substance misuse also have a diagnosed mental health condition), improving access to support is the other essential element.

The Crime Survey for England and Wales provides information about illicit drug use from a national representative sample of 16-74-year-old residents in households. In the year ending 2020, 9.4% of adults aged 16-59 reported any drug use in the last year and 4.6% reported using drugs in the last month.

Treatment and recovery services provide a proven, protective factor for people that engage with them. There were 2,607 adults in treatment for drug misuse at year end of 2022/23 in South Tees. This was made of up 1,767 adults in Middlesbrough and 840 adults in Redcar & Cleveland. There were 1,028 new adults in drug treatment at the end of 2022/23 in South Tees, the highest rate since early 2020/21.

There were 708 adults in treatment for alcohol misuse at year end of 2022/23 in South Tees. This was made up of 382 adults in Middlesbrough and 326 adults from Redcar & Cleveland. There were 439 new adults (int alcohol treatment for the first time during 2022/23.

There were 214 young people in treatment for substance misuse at year end of 2022/23 in South Tees. This was made of up 92 young people in Middlesbrough and 122 young people in Redcar & Cleveland. The number of young people in treatment has been steadily increasing since 2020/21.

The health harms associated with alcohol consumption in England are widespread, with around 10.4 million adults (Health Survey for England 2019, NHS Digital) drinking at levels that pose some level of risk to their health; of these, around 1.8 million are higher risk drinkers. Alcohol-related deaths made up around 4% of all deaths in 2019 (ONS, 2021). Of these, about a quarter are alcohol-specific deaths – e.g. from alcohol poisoning, alcoholic liver disease, alcoholic pancreatitis. The remaining alcohol-related deaths are from conditions partially related to alcohol, roughly two thirds of which are from chronic conditions – e.g. cardiovascular diseases and cancers, with the remainder caused by acute consequences such as road traffic accidents or intentional self-harm.

High rates of alcohol-specific mortality and mortality from chronic liver disease are likely to indicate a significant population who have been drinking heavily and persistently over the past 10 - 30 years. The rate of alcohol-specific mortality in Middlesbrough is 19.4 deaths per 100,000 population, whilst in Redcar and Cleveland this rate is 14.4. Both of these areas are amongst the most deprived local authority areas in the country and are significantly higher than the England average: 10.9 deaths per 100,000 of the population (Source: LAPE, PHE).

4.2 People who Experience Homelessness

Figure 3 below shows the headline data across a range of homelessness measures (Department for Levelling Up, Housing and Communities – Official statistics for statutory homelessness).

Figure 3: Key Homelessness Data 2021/22

Indicator	Redcar & Cleveland		Middlesborough		Region	England
	No. of people	Rate per 100,000 population	No. of people	Rate per 100,000 population	No. of people	Rate per 100,000 population
Homelessness: households in temporary accommodation		0.4		*	0.5	4.0
Homelessness: households owed a duty under the Homelessness Reduction Act		8.4		22.2	13.6	11.7
Homelessness: households owed a duty under the Homelessness Reduction Act (main applicant 16-24yrs)	108	1.7	234	4.1	2.7	2.4
Homelessness: households owed a duty under the Homelessness Reduction Act (main applicant 55+ yrs)	58	1.8	86	3.3	2.5	2.8
Homelessness: households with dependent children owed a duty under the Homelessness Reduction Act	174	10.8	101	6.0	12.8	14.4

Source - Department for Levelling Up, Housing and Communities

Across almost all of the indicators, the values for Middlesbrough are higher than both the regional and national values. Homelessness indicators such as 'households in temporary accommodation' and 'households owed a duty under the Homelessness Reduction Act' show that issues of homelessness are significantly higher in Middlesbrough. The exception is 'households with dependent children owed a duty under the Homelessness Reduction Act, with Middlesbrough's value (6) being less than half of the regional (12.8) and national (14.4) rates per 100,000 population.

It can however be deduced from these comparisons that homelessness is a significant concern for Middlesbrough. For all indicators, the values for Redcar & Cleveland are lower than both the regional and national value.

4.3 Vulnerable Migrants and Refugees

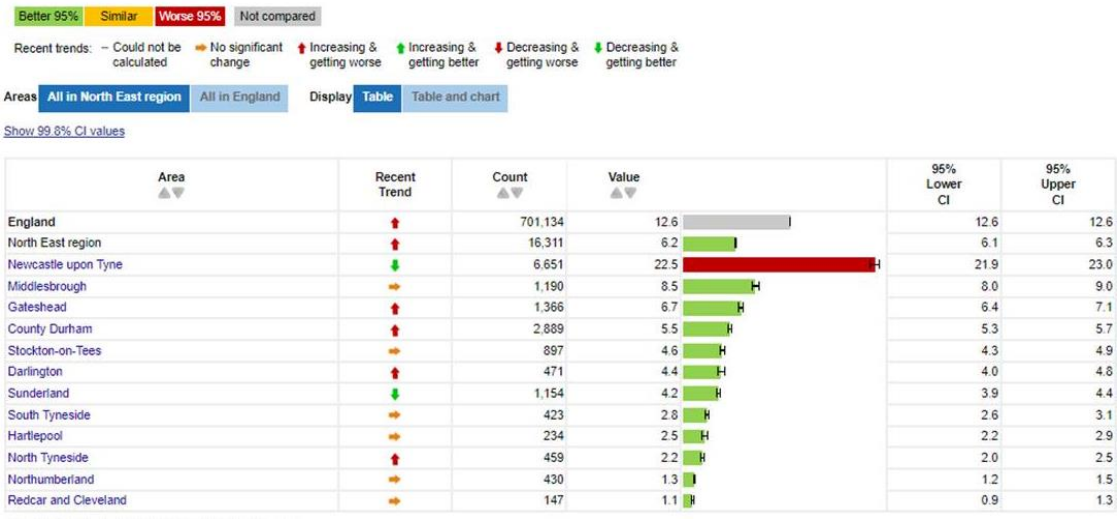
Asylum seekers are unequally distributed throughout the UK. Regionally, the North East hosts the most asylum seekers and resettled refugees out of all regions. In 2021 Middlesbrough had a higher proportion of migrants from outside of the UK that arrived in the country (1.6%) than England as a whole (0.9%). The number in Redcar & Cleveland was much lower (0.2%). The proportion of migrants that have resided in the UK for longer than a year is smaller in both Middlesbrough (8.8%) and Redcar & Cleveland (7.2%) than England (9.6%). This means that local services and migrants have many more challenges in terms of cultural and language barriers and the inability to provide proof of identification

and address, additional cost to services of migrants with health conditions, waiting times are longer and this impacts on the local population. There are concerns about migrants travelling to the UK to 'exploit' free healthcare, and often migrants mental health is very poor upon arrival in the UK due to the stress and trauma that their journey caused them.

Not By Choice - a publication by Doctors of the World (Oskrochi et al 2022) looking into migration and vulnerability during the pandemic highlighted clear barriers to wellbeing for asylum seekers and refugees. During the pandemic there was a 19% increase in inadequate housing (62.8%) compared to before the pandemic (44%). Inadequate housing conditions are known to have harmful effects on both physical and mental health. In total 26.6% reported bad or very bad general health and 15.28% were recommended to seek diagnosis for a mental health disorder based on their response to the survey.

Figure 4 below shows the number of new Flag 4 records added in the previous 12 months existing on the Patient Register at 31st July per thousand resident population. Flag 4s are codes within primary care systems which indicate that someone registered with a GP in England and Wales was previously living overseas.

Figure 4: GP Registrations from People Previously Living Overseas



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	701,134	12.6	12.6	12.6
North East region	↑	16,311	6.2	6.1	6.3
Newcastle upon Tyne	↓	6,651	22.5	21.9	23.0
Middlesbrough	→	1,190	8.5	8.0	9.0
Gateshead	↑	1,366	6.7	6.4	7.1
County Durham	↑	2,889	5.5	5.3	5.7
Stockton-on-Tees	→	897	4.6	4.3	4.9
Darlington	↑	471	4.4	4.0	4.8
Sunderland	↓	1,154	4.2	3.9	4.4
South Tyneside	→	423	2.8	2.6	3.1
Hartlepool	→	234	2.5	2.2	2.9
North Tyneside	↑	459	2.2	2.0	2.5
Northumberland	→	430	1.3	1.2	1.5
Redcar and Cleveland	→	147	1.1	0.9	1.3

Source – Fingertips, OHID

Middlesbrough recorded the second highest number of migrant GP registrations of all local authorities in the region. Data shows that there has been no significant change to the number of migrant registrations compared to previous years. Redcar & Cleveland had the lowest number of migrant GP registrations of all areas in the region, and trends indicate no significant change to the number compared to previous years.

Asylum seekers and refugees indicated poorer health (34.4%) than undocumented (24.4%) or 'other' (22.5%) service users. When looking at migrant health outcomes compared to the health outcomes of UK-born nationals, data from the Migrant Observatory (Centre on Migration, Policy and Society (COMPAS) at the University of Oxford) shows that foreign born UK residents have a lower prevalence of life-limiting health conditions (18%) than UK nationals (26%). However, data shows that as the migrant population spends more time in the UK their health outcomes decrease.

4.4 Gypsy, Roma and Traveller Communities

The Gypsy, Roma, and Traveller (GRT) communities in Middlesbrough and the North East of England face several key health issues and barriers. These issues are multifaceted, involving socio-economic, cultural, and systemic factors that affect their overall health and access to healthcare services.

Census data (ONS – UK Census 2021) shows that Gypsy & Irish Travellers have higher instances of self-reported poor health than their British counterparts. For example, 13% of Gypsy and Irish Travellers rated their health as 'bad' or 'very bad' compared to 6% of British people. Furthermore, people who identified as Gypsy or Irish Traveller had the highest proportion of disability, with 16% reporting being 'disabled: limited a lot' and a further 11% reporting being 'disabled: limited a little'.

In the South Tees area, GRT communities face specific health issues and barriers that reflect both regional characteristics and the unique challenges of these communities. There is a lack of robust data available specific to this cohort, so a key driver for change must include strategies to provide a better understanding of needs and barriers faced by GRT communities.

4.5 Sex Workers

There has been an increase in sex work in the UK as a consequence of rising poverty. Of the approximately 72,800 sex workers in the UK, 88% are women. Female sex workers who are street homeless are more prone to serious health problems, early mortality, violence, rape and mental illness. Up to 90% of sex workers were found to be using heroin, 60 % were using crack cocaine and many had a dual addiction. (source: BMC Health Services Research).

There is also a lack of specific data for this group, which must be addressed in order to tackle the challenges affecting them.

4.6 People in Contact with the Justice System

Data from Public Health England shows that:

- The mortality rate for prisoners is 50% higher than the rest of the population.
- People in and out of the criminal justice system are four times more likely to be smokers.
- 15% of prisoners had been homeless immediately prior to custody, compared to a lifetime experience of homelessness of 3.5% in the wider population.
- 42% of people in prison and 17.3% on probation suffered from depression, compared to just over 10% of the rest of the population.

The three most common diagnoses are anxiety, depression and personality disorder. 65% of the prison population is diagnosed with personality disorder and 50% of individuals on probation caseloads are found to be diagnosed with anxiety, depression and/or personality disorder.

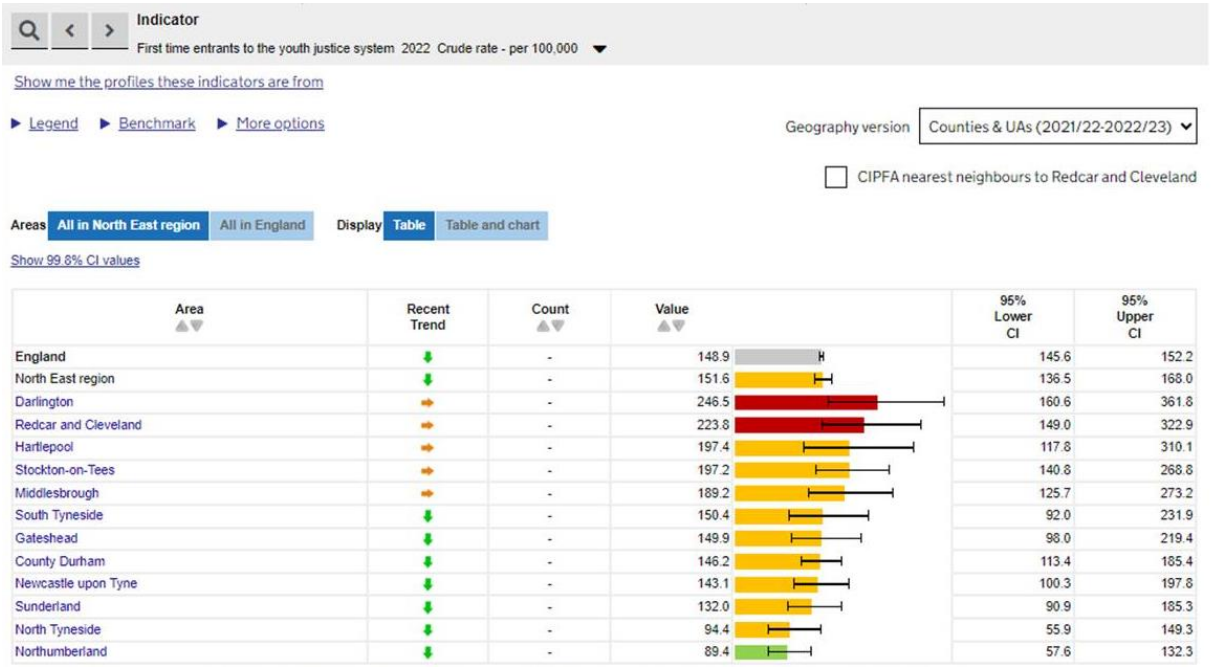
There is an approximate 25 years life expectancy gap between those in prison and the general population. This inclusion health group experience higher rates of cardiovascular disease with a third living with heart problems. More than 1 in 10 have lung problems like asthma and chronic respiratory diseases. Cancer is also prevalent, with those incarcerated and formerly incarcerated likely to have higher risk of deaths from cancer than the general population. This is due to multiple risk factors including delayed access to cancer screening programmes.

In the South Tees area, individuals in contact with the criminal justice system face several key health issues and barriers. The most significant issues reported by the South Tees Youth Justice system and those adults from this cohort who have been in contact with the South Tees Changing Futures programme are:

- Mental health problems;
- Substance misuse;
- Homelessness;
- Chronic physical health conditions;
- Barriers/limited access to key support services;
- Lack of co-ordination amongst local services;
- Stigma and discrimination (associated with having a criminal record and the co-morbidities);
- Insufficient support for those transitioning out of custody.

Figure 5 outlines how Middlesbrough and Redcar & Cleveland rank in comparison to the region in relation to first time entrants to the Youth Justice System.

Figure 5: First Time Entrants to Youth Justice System (Ministry of Justice):



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	148.9	145.6	152.2
North East region	↓	-	151.6	136.5	168.0
Darlington	→	-	246.5	160.6	361.8
Redcar and Cleveland	→	-	223.8	149.0	322.9
Hartlepool	→	-	197.4	117.8	310.1
Stockton-on-Tees	→	-	197.2	140.8	268.8
Middlesbrough	→	-	189.2	125.7	273.2
South Tyneside	↓	-	150.4	92.0	231.9
Gateshead	↓	-	149.9	98.0	219.4
County Durham	↓	-	146.2	113.4	185.4
Newcastle upon Tyne	↓	-	143.1	100.3	197.8
Sunderland	↓	-	132.0	90.9	185.3
North Tyneside	↓	-	94.4	55.9	149.3
Northumberland	↓	-	89.4	57.6	132.3

Source – Fingertips, OHID

Redcar & Cleveland have the second highest number of first time entrants into the youth justice system, with a rate of 246.5 per 100,000 population. This is significantly higher than the national value (148.9) and the regional value (151.6). Middlesbrough has the fifth highest prevalence, with a value of 189.2. Whilst this is lower than that of Redcar & Cleveland, this still remains higher than the national and regional values. Data therefore indicates that first time entrants to the youth justice system are significantly higher in both Middlesbrough and Redcar & Cleveland. Trend data signifies that for both areas, there has been no significant change in prevalence compared to previous years.

Multiple sources of evidence (e.g. Understanding the most serious violence among young people in London, Greater London Authority's City Intelligence Unit: https://data.london.gov.uk/dataset/serious-youth-violence) suggest that this high level is linked to deprivation, poor educational attainment and the multiple risk factors listed above.

5. What are we doing already in relation to this goal?

This section summarises some of the services, programmes and projects responding to the health inclusion agenda.

5.1 We want to improve outcomes for inclusion health groups

Understanding the System and Identifying what needs to improve
Work commenced in March 2023 with Policy Lab on mapping the range of services, projects and programmes currently operating across South Tees to support people experiencing homelessness; substance misuse; mental health issues; domestic abuse and contact with the criminal justice system. The outcome demonstrated the significant scale of support with overlapping objectives. There is scope to improve the coordination of services, projects and programmes through improved communication, early planning and more collaborative commissioning.

There is a wide range of local, system-level developmental work ongoing in South Tees. This includes public sector, VCS and wider stakeholders, some of which is detailed below. There is an acknowledgement of a genuine local commitment towards improving the offer and outcomes for inclusion health groups. This will require a collaborative effort to reduce barriers and adopt a multi-faceted approach to addressing all aspects of vulnerability faced by these groups. It is essential to promote inclusivity, cultural competence, and equity in healthcare access and delivery, whilst continuously improving the quality of support available.

Across South Tees a number of organisations are structured around being led by the voice of people who use their services. This engagement of people with lived experience is a crucial element of improving the local offer. Recovery Connections, a local, peer-led registered charity, are especially effective in this area and the Thrive Partnership also has a team of Ambassadors providing the lived experience voice. The Community Transformation Programme led by TEWV is locally recognised as a good example of co-production and there is scope for other services to learn from this.

In November 2022 a Lived Experience Coordinator was employed via MVDA. Lived Experience Ambassadors were identified through a range of activities, including the Lived Experience through Art Project and engagement with Holme House Prison. The aim is to develop Ambassadors to a stage where they are capable of influencing and co-producing services.

The following service models and programmes provide an overview of the South Tees system but are not intended to be an exhaustive list. It is also acknowledged that, due to the level of funding available, substance misuse and mental health support is more widely available than services for the other inclusion health groups.

ACT Middlesbrough (Accessing Change Together)
Commissioned in April 2021 ACT Middlesbrough is an integrated partnership with internal council services and external commissioned services to support those in Middlesbrough with housing, substance use and domestic abuse issues. The services include, internally, Housing Solutions, Community Interventions & Recovery Connections. Externally they include, My Sisters Place, Home Group, Thirteen, Changing Lives, Harbour, North Star, Recovery Connections and Riverside. The services range from community-based support to accommodation-based services. ACT Middlesbrough aims to:

- Enable a person's story to grow with them to stop them having to tell their story more than once.
- Use a trauma informed approach in all services.

- Enable better information sharing between services.
- Understand that people have different needs, so the support offered depends on individual circumstances.

Thrive Partnership

In April 2022 the Thrive Partnership, the integrated drug, alcohol and domestic abuse service, commenced in Redcar & Cleveland. We Are With You are the lead provider who provide the core substance misuse service, Harbour provide the core domestic abuse service and Intuitive Thinking Skills provide a recovery based programme. The Thrive Partnership:

- Provides personalised support, putting people at the centre of their own plans.
- Enables people to realise their true potential, encouraging change, hope and a plan for the future.
- Supports people to make positive and long-lasting contributions to their community.
- Reconnects people with family members and friends and be confident to celebrate successes.
- Delivers services in community settings, schools, colleges, and youth clubs – anywhere people would like to be seen.

South Tees Changing Futures Programme

South Tees was awarded £3.1m for the South Tees Changing Futures (STCF) programme in 2021. This programme supports adults experiencing multiple disadvantages in both Middlesbrough Council and Redcar & Cleveland Borough Council areas. The original programme was due to cease on 31st March 2024, but DLUHC/National Lottery Community Fund agreed that the original funding (£3.1m) could be extended over a longer period, to 31st March 2025.Following a competitive bidding process, a further £850,000 of funding was secured for 2024/25.

Changing Futures is funding a team of 17 Key Workers and five Enhanced Caseload Workers to 31st March 2024. From 1st April 2024, funding has been secured from the ICB Health Inequalities funding for a further 12 months. To October 2023, over 800 adults across the South Tees area have been engaged in support – everything from support to access housing, applying for benefits, arranging medical and other appointments including substance misuse services and generally just being a trusted advocate. They have workers based in the Emergency Department of South Tees Hospital Trust and Cleveland Police Custody Suite increasing the opportunity of engaging the most vulnerable. This cohort are invariably those most prone to health inequalities and the resultant higher risk of clinical issues.

Making Every Adult Matter (MEAM)

The MEAM Approach is embedded within all South Tees services, helping local areas design and deliver better coordinated services for people experiencing multiple disadvantages. It's currently being used by partnerships of statutory and voluntary agencies in 42 local areas across England. The MEAM Approach areas consider seven principles, which they adapt to local needs and circumstances. Most of the teams within South Tees including substance misuse, domestic abuse have received training and hands on support to embed this approach. Specialist services are also supported, such as The Guiding Light project supports a small group of women who are affected by violence and multiple disadvantage.

Embedding a Trauma Informed Approach

Changing Futures has funded a Trauma Informed lead and funding for training to improve practice across South Tees. The support has been well received and is making an impact. Over 400 staff have benefitted from training and 16 staff from a range of partners trained as Trauma Informed Champions in 2023, ensuring that effective practice is considered in their host organisation. These partners

include local authority teams, substance misuse services and voluntary and community organisations. A further 21 people have been identified as Round Two champions, including eight staff from Cleveland Police.

Housing
At the Changing Futures Programme Board meeting in February 2023, it was agreed that funding be allocated to trial a Housing First-Style model. Housing First-Style Sub-Group has been established to develop the project. In total, £560,000 of funding has been allocated to support delivery. Beyond Housing is working with RCBC to identify five properties and a draft specification, building on the Key Worker model.

Recovery Connections and Building Recovery In Middlesbrough (BRIM)
Recovery Connections is a peer-led, substance use recovery organisation based in Middlesbrough. Originally Hope Northeast, they were founded in 2008 by members of the local recovery community. Their Middlesbrough-based rehab is rated outstanding by the CQC.

In Summer 2022, Recovery Connections launched BRIM. Through the activities and collaboration involved in BRIM, their aim is to bring recovery, what it stands for, and its immense social value to the forefront of people's minds. BRIM also aims to:

- Challenge stigma and creating a positive frame for recovery.
- Create a coherent and town-wide approach to addiction.
- Match recovery goals to sustainable development goals set by UN.
- Re-develop under-privileged communities.
- Gain insight into what works in communities.
- Create contagious cascades of recovery and hope in the community.
- Create champions that visibly support prevention and early intervention.

Reconnect
RECONNECT is a care after custody service that seeks to improve the continuity of care of people leaving prison or an immigration removal centre (IRC) with an identified health need. This involves working with them before they leave to support their transition to community-based services, thereby safeguarding health gains made whilst in prison or an IRC. Whilst not a clinical service, RECONNECT offers liaison, advocacy, signposting, and support to facilitate engagement with community-based health and support services.

Cleveland Sex Work Strategy
The North East Sex Work Forum (NESWF) has developed a Cleveland Sex Work Strategy with the aim of a consistent harm reduction approach to the sex industry across Cleveland funded by the PCC office. This has included focus groups with frontline practitioners to assess knowledge gaps, consultation with the sex work community to assess unmet health needs and a local upcoming event which will host speakers from the sex industry and workshops to help improve local services going forward, specific training for local police is also in development alongside the NESWF.

6. What are the key issues?

6.1 Common issues for inclusion health groups

Inclusion health groups in South Tees, face a range of common issues and barriers – this is similar on both regional and national levels. Here are the key themes and barriers they encounter:

Key Issues and Barriers for Inclusion Health Groups

1. **Health Inequalities**:
    - **Access to Healthcare**: Inclusion health groups often struggle to access mainstream health/support services. Barriers include lack of identification, bureaucratic hurdles, and discrimination, often due to stigma associated with those with multiple and complex vulnerabilities.
    - **Chronic Health Conditions**: Higher prevalence of chronic diseases like COPD, HIV, hepatitis, tuberculosis, mental health disorders, and substance use disorders.
    - **Poor Health Outcomes**: These groups often experience worse health outcomes, with higher morbidity and mortality rates compared to the general population.
2. **Mental Health**:
    - **High Prevalence of Mental Health Disorders**: Mental health issues are significantly more common among inclusion health groups. Factors contributing to this include trauma, substance misuse, and lack of social support.
    - **Stigma and Discrimination**: Mental health issues are often exacerbated by stigma and discrimination, making it difficult for individuals to seek help.
3. **Substance Misuse**:
    - **High Rates of Drug and Alcohol Dependence**: Substance misuse is a major issue, particularly among homeless populations and those with unstable housing.
    - **Access to Treatment and Recovery**: Limited access to effective treatment options for substance misuse, often due to lack of resources and services tailored to the needs of these populations.
4. **Housing and Homelessness**:
    - **Unstable Housing**: Homelessness and unstable housing conditions significantly impact physical and mental health. This is a critical issue in areas like South Tees.
    - **Temporary Accommodation**: Many individuals in these groups rely on temporary accommodations, which often do not provide a stable environment conducive to good health.
5. **Social Exclusion and Isolation**:
    - **Lack of Social Support**: Social isolation and lack of supportive networks are common, contributing to poor mental health and limited access to services.

- **Discrimination**: Experiences of discrimination and stigma further isolate these individuals from mainstream society and services.

Data Specific to the South Tees Area.

1. **Middlesbrough and Redcar & Cleveland**:
    - **Health Outcomes**: Data from Public Health England and local health profiles indicate that Middlesbrough and Redcar and Cleveland have some of the highest levels of health deprivation in England.
    - **Homelessness**: Reports from local councils highlight significant issues with homelessness. Middlesbrough has a particularly high rate of rough sleeping and use of temporary accommodation.
    - **Substance Misuse**: Local data shows higher rates of drug-related deaths in Middlesbrough compared to the national average. The area also reports high levels of alcohol dependence.
    - **Mental Health**: The South Tees area has higher rates of mental health issues, with local health services under significant pressure to meet demand.

Data Sources:

1. **Office for Health Improvement and Disparities (OHID), formerly Public Health England (PHE)**:
    - OHID provides detailed health profiles for local authorities, including data on health inequalities, substance misuse, mental health, and other relevant indicators.
    - Public Health Profiles provide specific data for Middlesbrough and Redcar and Cleveland.
2. **Local Authority Reports**:
    - Annual public health reports from Middlesbrough and Redcar and Cleveland councils offer insights into local health challenges and service provision.
    - Middlesbrough Council Public Health Report
    - Redcar and Cleveland Council Public Health Report
3. **Office for National Statistics (ONS)**:
    - ONS provides demographic data and statistics related to health, housing, and social determinants of health.
    - ONS Website

Evidence for what will have a positive impact in terms of addressing the issues:

Efforts to address these issues in the South Tees area should focus on:

1. **Integrated Care Models**: Developing integrated care pathways that address physical health, mental health, and social care needs.
2. **Community Outreach**: Enhancing outreach services to engage with hard-to-reach groups, ensuring they can access health services.

3. **Housing Support**: Increasing the availability of stable and supportive housing options.
4. **Substance Misuse Services**: Expanding and improving substance misuse treatment services.
5. **Anti-Stigma Campaigns**: Running campaigns to reduce stigma and discrimination against socially excluded groups.

By tackling these barriers, it is possible to improve the health and wellbeing of inclusion health groups in South Tees.

6.2 Health Literacy / Language Barriers

Due to the aforementioned affects of deprivation on inclusion health groups, there is an increased likelihood of poor educational attainment amongst these population cohorts. Low health literacy has harmful effects on overall physical and mental health (Source: PHE/UCL Improving health literacy to reduce health inequalities Practice resource summary: September 2015). This is because people with low health literacy, compared with the general population:

- are x1.5 to x3 times more likely to experience increased hospitalisation or death and are more likely to have depression.
- are more likely to struggle with managing their and their family's health and wellbeing and are thus at increased risk of developing multiple health problems.
- use fewer preventative and health promotion services, such as cancer screening and flu vaccinations, and have less recall and adherence to medical instructions and healthcare regimes.
- find it more difficult to access appropriate health services, make greater use of accident and emergency services and have longer in-patient stays.
- have less effective communication with health and social care practitioners and are less likely to engage in active discussions about their health options, potentially leading to their health needs being hidden.

6.3 Access to Services

There are clear opportunities for stakeholders to continue developing relationships across the system. Feedback from Changing Futures Key Workers has identified that services that already exist aren't being used as they probably should and some services are not publicised sufficiently. Some services are often not prepared to deal with the complexity of problems that socially excluded people face, or they don't have sufficient resource to support to the extent required. Some services, for example housing, have Government directed policies and practices that explicitly exclude people.

There is evidence of good practice. The weekly Virtual Hubs established by TEWV are highly regarded in enabling frontline staff to discuss particular barriers faced with partners from a range of organisations.

At the Changing Futures Conference in September 2023 it was recognised, based on the direct experience of people accessing services, that the services themselves too often worked in silos. There remains a need for commissioners to act flexibly around the way they structure contracts and measure key performance indicators. At a local level there is a broad acceptance that the approach needs to

change, but it not always easy to implement this. Processes set by funders in regard to achievement of key performance targets, audit requirements and data management can limit creativity or a 'common sense' approach. Other factors impacting delivery include the culture of providers and the recruitment, retention and ongoing training of staff.

Some services operate overly rigid working processes that are not tailored to helping each individual benefit as they should. Too often services were perceived as being inflexible and uncaring. They often did not recognise how difficult it is for some people to manage through any day. As a system, too often we make the individual the problem. Their personal situation, health condition, history of engagement and approach to embracing support too often need to align with service requirements and preferences of staff. There is a case of bringing services to where people are, negating the need for an appointment-based system. The other alternative is to provide spaces where people feel comfortable, where they are welcomed and feel valued.

Trust with services is hard to achieve but easy to lose. Services therefore need to be consistent, delivery in a way that encourages people to remain engaged. The importance of services being trauma-informed when supporting vulnerable people cannot be overstated. Trauma-informed care (TIC) is an approach that acknowledges the widespread impact of trauma and understands potential paths for recovery. It recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures, and practices. The key benefits and importance of trauma-informed services are as follows:

1. **Creating a Safe Environment**: Trauma-informed services prioritise creating a safe physical and emotional environment for clients. This helps vulnerable individuals feel secure, reducing anxiety and fostering a sense of trust.
2. **Promoting Empowerment and Autonomy**: Trauma-informed care emphasises the importance of empowering individuals and fostering their autonomy. This approach helps clients feel more in control of their lives and decisions, which is crucial for their recovery and well-being.
3. **Understanding Trauma's Impact**: Recognising that trauma can have profound effects on an individual's behaviour, mental health, and ability to engage with services allows providers to tailor their approaches accordingly. This understanding helps in avoiding re-traumatisation and in providing more effective support.
4. **Building Trusting Relationships**: Trauma-informed care focuses on building strong, trusting relationships between service providers and clients. Trust is essential for vulnerable individuals to feel comfortable sharing their experiences and engaging fully with the support offered.
5. **Improving Engagement and Retention**: When services are trauma-informed, clients are more likely to engage with and remain in the services provided. This can lead to better outcomes, as continuous support and consistent engagement are critical for vulnerable individuals' progress.
6. **Reducing Re-traumatisation**: A trauma-informed approach aims to avoid practices that may inadvertently re-traumatise individuals. This involves being mindful of triggers and stressors and ensuring that interactions and interventions are sensitive and respectful.
7. **Holistic Support**: Trauma-informed care often involves a holistic approach, addressing not just the immediate issues but also the underlying trauma and its long-term effects. This can lead to more comprehensive and sustainable support and recovery.
8. **Cultural Competence**: Trauma-informed services are often more culturally competent, recognising and respecting the diverse backgrounds and experiences of individuals. This is crucial in providing relevant and effective support.

9. **Staff Wellbeing and Development/Training**: Trauma-informed care includes ensuring that staff are well-trained in understanding trauma and its effects. It also emphasises the importance of staff well-being, as supporting vulnerable individuals can be challenging and emotionally taxing.
10. **Enhanced Outcomes**: Ultimately, trauma-informed services can lead to better outcomes for individuals. By addressing the root causes of their issues and providing empathetic, effective support, individuals are more likely to experience recovery and improved quality of life.

Incorporating a highly developed, trauma-informed approach is essential for our local services to support health inclusion groups more effectively. It ensures that the care provided is empathetic, comprehensive, and tailored to the unique needs of those who have experienced trauma.

It can be confusing for people as to what support they can receive. It is frustrating when people know about a service but are assessed as not being suitable to access the service as their situation/condition does not meet narrow criteria. Organisations need to take a more flexible approach to risk. Too often data protection is cited as a reason but there are examples from elsewhere where data agreements have been implemented to remove barriers.

There is evidence of good practice. The provision of three dual diagnosis nurses by TEWV is regarded as a significant step forward in responding to the needs of people experiencing issues with substance misuse and poor mental health.

The South Tees Changing Futures Programme has been able to support many people with a replacement birth certificate. This is important in being able to open a bank account and access Universal Credit, PIP and bid for a house on Tees Valley Homefinder. For a relatively modest financial cost, the impact can be transformational. Once people have an address, they are then able, in principle, to register for other services e.g. GP and dentist.

There is an expectation that for many services people are expected to interact digitally via a smart device. For many people, this simply is not possible, and they therefore are not accessing services that they require. They may not read or write very well, there may be language barriers, or they may have suffered being stigmatised in the past and so have no confidence to access service again.

6.4 Sources of Evidence

The information provided within this section is based on a range of data and insights from several reliable sources focused on public health and social issues in England, particularly in the South Tees area. The following list comprises the main sources referenced:

- **Office for Health Improvement and Disparities (OHID), formerly Public Health England (PHE)**:
    - **Public Health Profiles**: Detailed health profiles for local authorities, which include data on health inequalities, substance misuse, mental health, and other relevant indicators.
    - Source: Public Health Profiles
- **Local Authority Reports**:
    - **Middlesbrough Council Public Health Report**: Annual reports providing insights into local health challenges and service provision in Middlesbrough.
    - **Redcar and Cleveland Council Public Health Report**: Annual reports from Redcar and Cleveland council detailing public health issues and strategies.
- **Office for National Statistics (ONS)**:
    - **ONS Website**: Provides demographic data and statistics related to health, housing, and social determinants of health.

    - Source: ONS Website
- **NHS Digital**:
    - **Statistics on Drug Misuse and Mental Health**: Comprehensive data on the prevalence of drug misuse and mental health issues.
    - Source: NHS Digital
- **Homeless Link**:
    - **Annual Review of Single Homelessness Support**: Reports on the state of homelessness and support services in England.
    - Source: Homeless Link
- **Local Data and Reports**:
    - Specific studies and reports commissioned by local health authorities and councils in Middlesbrough and Redcar and Cleveland.
- **Research Articles and Policy Papers**:
    - Various academic and policy papers focusing on health inequalities, social determinants of health, and inclusion health.
    - Systematic reviews, which provide a broader understanding of findings from multiple studies.
    - Specific studies:
        - **Cognitive Behavioral Therapy**: McGuire, J. (2008). A review of effective interventions for reducing aggression and violence. *Philosophical Transactions of the Royal Society B: Biological Sciences*.
        - **CBT for Anger Management**: Howells, K., & Day, A. (2003). Readiness for anger management: Clinical and theoretical issues. *Clinical Psychology Review*.
        - **Educational and Vocational Training**: Davis, L. M., Bozick, R., Steele, J. L., Saunders, J., & Miles, J. N. V. (2013). Evaluating the Effectiveness of Correctional Education. *RAND Corporation*.
        - **Substance Abuse Programs**: Mitchell, O., Wilson, D. B., & MacKenzie, D. L. (2012). The effectiveness of incarceration-based drug treatment on criminal behavior. *Campbell Systematic Reviews*.
        - **Restorative Justice**: Sherman, L. W., & Strang, H. (2007). Restorative Justice: The Evidence. *Smith Institute*.
        - **Victim Satisfaction**: Latimer, J., Dowden, C., & Muise, D. (2005). The effectiveness of restorative justice practices: A meta-analysis. *The Prison Journal*.
        - **Mentorship Programs**: Jolliffe, D., & Farrington, D. P. (2007). A rapid evidence assessment of the impact of mentoring on re-offending. *Home Office Online Report*.
        - **Probation Services**: National Probation Service. (2019). *Probation Reform Programme*.
        - **Diversion Programs**: Petrosino, A., Turpin-Petrosino, C., & Guckenburg, S. (2010). Formal System Processing of Juveniles: Effects on Delinquency. *Campbell Systematic Reviews*.
        - **Family Therapy**: Henggeler, S. W., & Schoenwald, S. K. (2011). Evidence-Based Interventions for Juvenile Offenders and Juvenile Justice Policies that Support Them. *Social Policy Report*.
        - **Mental Health Courts**: Honegger, L. (2015). Does the evidence support the case for mental health courts? A review of the literature. *Law and Human Behavior*.
        - **Reduction in Recidivism**: Aos, S., Miller, M., & Drake, E. (2006). Evidence-Based Adult Corrections Programs: What Works and What Does Not. *Washington State Institute for Public Policy*.
        - **Reoffending Rates**: Ministry of Justice. (2013). *Compendium of reoffending statistics and analysis*.

- **Rehabilitation Outcomes**: Visher, C. A., Winterfield, L., & Coggeshall, M. B. (2005). Ex-offender employment programs and recidivism: A meta-analysis. *Journal of Experimental Criminology*.
- **Enhanced Victim Satisfaction**: Umbreit, M. S., Coates, R. B., & Vos, B. (2004). Victim satisfaction with mediated dialogue with offenders: The impact of victim-offender mediation. *International Review of Victimology*.
- **Cost-Effectiveness**: Drake, E. K., Aos, S., & Miller, M. G. (2009). Evidence-Based Public Policy Options to Reduce Crime and Criminal Justice Costs: Implications in Washington State. *Victims & Offenders*.
- **Humanizing the Justice Process**: Maruna, S., & LeBel, T. P. (2003). Welcome home? Examining the reentry court concept from a strengths-based perspective. *Western Criminology Review*.

These sources collectively provide a comprehensive view of the issues faced by inclusion health groups, offering both quantitative data and qualitative insights into the barriers and challenges they encounter.

7. What is the current evidence base?

7.1 People with Drug and Alcohol Dependence

The government strategy - From harm to hope: A 10-year drugs plan to cut crime and save lives - was published in 2021. The main aim of this strategy is to reduce drug use, reduce drug-related crime and reduce drug-related deaths and harm. By the end of 2024/25, the strategy sets ambitions to have:

- Prevented 1,000 deaths, reversing the upward trend in drug deaths for the first time in a decade.
- Delivered a phased expansion of treatment capacity with at least 54,500 new high quality treatment places – an increase of 20% – including 21,000 new places for people who use opiates and/or crack cocaine, meaning that 53% of opiate and crack users will be in treatment; and at least 7,500 more treatment places for people who are either rough sleeping or at immediate risk of rough sleeping.
- Contributed to the prevention of 750,000 crimes including 140,000 neighbourhood crimes through the increases in drug treatment.
- Closed over 2,000 more county lines through relentless and robust action to break the model and bring down the gangs running these illegal lines.
- Delivered 6,400 major and moderate disruptions – a 20% increase – of activities of organised criminals, including arresting influential suppliers, targeting their finances and dismantling supply chains.
- Significantly increased removal of criminal assets, taking cash, crypto-currency and other assets from the hands of criminals involved in drug trafficking and supply.

Local government and its partners are outlined as crucial to the successful delivery of this strategy. Every local area was required to establish a Combating Drugs Partnership by the end of 2022. Whilst the new drugs plan focuses on the use and supply of illegal drugs, it states that local partnerships should ensure plans sufficiently address alcohol dependence and wider alcohol-related harms.

Every local authority area has a substance misuse treatment and recovery service model for their local population. These services are recognised as protective factors for individuals who misuse substances via ubiquitous evidence:

1. **Reduction in Substance Use**: Treatment programs have been shown to significantly reduce substance use. Studies demonstrate that individuals who engage in drug and alcohol services often experience a decrease in the frequency and quantity of their substance use.
2. **Improved Health Outcomes**: Access to these services is associated with better physical and mental health outcomes. Clients often see improvements in chronic health conditions, mental health disorders, and overall quality of life.
3. **Decreased Criminal Activity**: Participation in substance misuse programs is linked to a reduction in criminal behaviour. Many individuals receiving treatment show lower rates of arrest and incarceration.
4. **Enhanced Social Functioning**: Drug and alcohol services help improve social relationships and employment status. Clients often report better family relationships, increased social stability, and higher rates of employment or engagement in educational programs.
5. **Harm Reduction**: These services provide harm reduction strategies, such as needle exchange programs and safe consumption spaces, which reduce the risks associated with substance misuse, including the transmission of infectious diseases and overdose deaths.

6. **Support and Relapse Prevention**: Ongoing support from these services helps prevent relapse. Regular follow-ups, counselling, and support groups provide the necessary structure and encouragement to maintain sobriety.

Overall, the evidence indicates that drug and alcohol services are crucial in mitigating the negative consequences of substance misuse and promoting long-term recovery and stability.

7.2 People who Experience Homelessness

Housing and homelessness are significant issues impacting upon the health and wellbeing of too many people across South Tees. The Lived Experience Network Meeting in October identified supply and demand issues based on current real life situations. It was the impetus for the Housing Summit in May 2023 attended by 57 people from 23 separate organisations. On the basis of the discussions, the Housing Emerging Issues Report (July 2023) report was prepared that summarised the main issues faced by people experiencing multiple disadvantages in accessing and retaining housing, and by those services and organisations with a role in responding to demand.

The report included a number of recommendations in relation to gathering data to better understand supply, demand across the system. The report was considered by the Live Well South Tees Board in July 2023 and an Action Plan produced to drive the key recommendations. Additional focus was upon reviewing data on the number of impending/overdue Section 21 and Section 8 notices; and considering of physical health (in addition to mental health) in relation to finding suitable accommodation to free up bed space. Delivery of the action plan is to be a focus for early 2024.

7.3 Vulnerable Migrants and Refugees

Government policy allows asylum seekers and refugees to access GP and nurse consultations in primary care, treatment provided by a GP and other primary care services for free. However, secondary care services are residence based and are therefore inaccessible to asylum seekers until they are granted refugee status. The measure of residence that the UK uses to determine whether someone is entitled to free NHS healthcare is known as 'ordinary residence'. To be ordinarily resident in the UK, people from countries outside the European Economic Area (EEA) who are subject to immigration control need to also have the immigration status of 'indefinite leave to remain'.

Hospital treatment is free of charge for people who are ordinarily resident in the UK. This does not depend on nationality, payment of UK taxes, National Insurance contributions, being registered with a GP, having an NHS number, or owning property in the UK. To be considered ordinarily resident, you must be living in the UK on a lawful and properly settled basis for the time being. Since 6 April 2015, non-EEA nationals who are subject to immigration control must have the immigration status of indefinite leave to remain at the time of treatment and be properly settled, to be considered ordinarily resident.

Studies have shown that refugees and asylum seekers often face unique health challenges that differ from those born in the UK such as untreated communicable diseases, poorly controlled chronic conditions, maternity care and mental health and specialist support needs (BMA, 2023). This can include poorly managed hypertension, diabetes, epilepsy, and badly healed injuries as well as parasitic infections and missing vaccinations (BMA, 2023). Furthermore, refugees and asylum seekers often have complex mental health needs, facing a myriad of issues such as depression, isolation and PTSD as a result of torture, sexual or gender-based violence. This can lead to misunderstandings, missed health conditions and a lack of suitable treatment from the UK due to the unique health needs of

asylum seekers and refugees. This therefore causes poor health outcomes.

Research has found that children and families seeking asylum in the UK face harmful and unsuitable living conditions in temporary accommodation, which has negative effects on their health and well-being (Human Rights Watch, 2022). Accommodation is often inadequate as a result of funding cuts, meaning that asylum seekers living in government-provided housing often face issues such as mold or rodent infestations (Human Rights Watch, 2022). These issues can cause serious health issues such as infection and respiratory conditions, contributing to the poor health outcomes for these groups. Furthermore, asylum seekers and refugees are often given cheaper and poorer quality housing in historically deprived areas (British Red Cross, 2023). This has been found to have harmful effects on mental and physical health, with research reporting a lack of privacy (Bakker et al., 2016), disturbed sleep due to noise (Gewalt et al., 2018) and the fear of harassment and discrimination (Gewalt et al., 2018). These issues are shown to negatively impact the mental health of asylum seekers and refugees, causing stress and anxiety (Brown, Gill & Halsall, 2022).

7.4 Gypsy, Roma and Traveller Communities

Individuals with the highest rates of self-reported bad, very bad or poor health (both physical and mental) predominantly lived on unauthorised tolerated and roadside sites, local authority sites and in housing. Even where their planning status was precarious, residents at private sites (generally with long-term residents and on-going neighbourhood contact in school and community settings) were more likely to report good or fair health compared to those at local authority or unauthorised tolerated/roadside sites. Those at private sites with planning permission were most likely to report good or very good health as well as higher levels of satisfaction with their surroundings.

Gypsy, Roma and Traveller communities face chronic exclusion across all wider social determinants, facing difficulties such as deprivation, inadequate accommodation and barriers to employment. For example, data shows 10,000 Gypsies and Travellers have no place to stay as a result of chronic national shortages of sites, and that 3,000 families are without a permitted stopping place and therefore have no access to basic water or sanitation. This inevitably has negative effects on health outcomes for these groups, due to lack of water and sanitation causing infections, dehydration and malnutrition.

Accommodation insecurity negatively impacts on Gypsies and Travellers physical and mental health. Effectively addressing accommodation insecurity/provision of sites will have a direct and positive ‘knock-on’ effect not just on community members’ health, but also on the wider social determinants that impact on their intergenerational health and wellbeing (education, employment etc). Unauthorised and authorised sites for Gypsies and Travellers (including local authority owned and run) are all too often situated in environments which promote poor health (busy roads, beside heavy industry etc). Improving the environmental health factors of existing sites and promoting appropriate future development of Traveller sites will improve health outcomes in the long-term. Such measures are also likely to prove cost-effective in terms of reduced ill-health and disability as well as increased mental health.

7.5 Sex Workers

Research has found that street sex workers often experience multiple health and social problems, leading to extreme health and social inequality. Sex workers often see high rates of chronic disease, reproductive health need, respiratory disease and health problems related to substance misuse. Furthermore, street sex workers often have extensive trauma as a result of adverse childhood experiences, leading to poor mental health and a high prevalence of issues such as anxiety, depression, isolation, PTSD and self-harm (Potter, Horwood & Feder, 2022). This often exacerbated by physical,

verbal, and sexual violence faced during their work from intimate partners, perpetrators posing as clients and the police. As a result of trauma, many sex workers engage in substance misuse, which has additional harmful effect on physical and mental health (Potter, Horwood and Feder, 2022). There are often complex needs underlying their health issues, such as homelessness and insecure housing, unemployment, poverty and criminalisation (Johnson et al., 2023).

Despite the prevalence of poor health outcomes among sex workers, there is a strong evidence base to suggest a lack of adequate services, and the inaccessibility of existing services. For example, research has stated that sex workers face large barriers to accessing health and social care as a result of a lack of specialist services and mainstream services being inadequate to address the complex needs of sex workers (Johnson et al., 2023). It has been stated that despite the prevalence of a range of health conditions, health clinics for sex workers persistently focus solely on sexual health (Potter, Horwood & Feder, 2022).

7.6 People in Contact with the Justice System

Evidence of support approaches within the English criminal justice system generally focuses on various interventions and programs designed to aid offenders and those at risk of offending. These approaches aim to reduce recidivism, support rehabilitation, and promote social reintegration. Here is a brief summary of the key approaches and their impacts, along with supporting sources:

1. **Rehabilitation Programs**:
    - **Cognitive Behavioral Therapy (CBT)**: CBT-based programs aim to change offenders' thinking patterns and behaviors. Evidence shows these programs can reduce reoffending by addressing underlying issues such as anger management, problem-solving, and substance abuse .
    - **Educational and Vocational Training**: Providing education and job skills training to offenders has been shown to reduce recidivism by improving employability and helping individuals build productive lives post-release .
    - **Substance Abuse Programs**: These programs target offenders with drug and alcohol problems. Successful completion often leads to reduced reoffending rates as substance abuse is a significant factor in criminal behavior.
2. **Restorative Justice**:
    - **Victim-Offender Mediation**: This approach involves facilitated meetings between victims and offenders to discuss the harm caused and agree on steps to make amends. Evidence suggests restorative justice can lead to high victim satisfaction and lower reoffending rates due to increased offender accountability.
3. **Mentorship and Support Networks**:
    - **Mentorship Programs**: Pairing offenders with mentors who provide guidance and support can help in the reintegration process. Studies indicate that mentorship can enhance social support networks, reduce feelings of isolation, and decrease the likelihood of reoffending.
4. **Community-Based Programs**:
    - **Probation Services**: Intensive supervision and support provided by probation officers can help manage offenders in the community, reducing the need for incarceration and promoting rehabilitation.
    - **Diversion Programs**: Programs that divert offenders from the traditional criminal justice process into treatment or community service can prevent the negative effects of imprisonment and reduce future criminal behaviour.
5. **Family and Relationship Interventions**:
    - **Family Therapy**: Interventions aimed at improving family relationships and dynamics can be particularly effective for young offenders. Positive family support is crucial in preventing reoffending and aiding rehabilitation.

6. **Mental Health Interventions**:
    - **Mental Health Courts and Specialised Services**: For offenders with mental health issues, tailored mental health interventions and specialised courts that focus on treatment rather than punishment have been effective in reducing reoffending and improving mental health outcomes.
7. **Impact on Offenders and the System**
    - **Reduction in Recidivism**: Many of these support approaches have been shown to reduce reoffending rates, which is a primary goal of the criminal justice system.
    - **Improved Rehabilitation and Reintegration**: Programs that focus on education, skills training, and therapy help offenders reintegrate into society as productive members.
    - **Enhanced Victim Satisfaction**: Restorative justice approaches often result in high levels of victim satisfaction and a sense of justice being served.
    - **Cost-Effectiveness**: Community-based programs and diversion initiatives can be more cost-effective than imprisonment, reducing the overall burden on the criminal justice system.
    - **Humanising the Justice Process**: Support approaches emphasise rehabilitation and support over punishment, promoting a more humane and effective criminal justice system.

In summary, evidence-based support approaches within the English criminal justice system have demonstrated positive impacts on reducing reoffending, improving rehabilitation outcomes, enhancing victim satisfaction, and promoting a more cost-effective and humane justice process.

8. What do local people say?

8.1 Inclusion Health Groups Accessing Health Services

Street sex work is active across Middlesbrough in some of the most deprived areas, with drug dealing, criminal exploitation, sexual exploitation, trafficking, poverty, drug related crime, homelessness, substance misuse, other criminal activities.

Issues with services include:

- Lack of out of hours/weekend services.
- Unable to receive specific services (i.e. triple swab). People often lie to health services regarding occupation.
- Some organisations consistently changing support workers, this has an impact on building trusted relationships.
- Rigid appointment times and 'three strikes' approach to missing appointments. Being labelled as a problematic client.
- Lack of coordination of appointments, requiring travelling between areas that can be difficult given public transport limitations and cost.
- Difficulties accessing health appointments, and often having to repeat their story that can be retraumatising.
- Often feel judged from people delivering services. There is a stigma attached to be being labelled as a sex worker. Worry of being considered an unfit parent.
- Difficulty accessing housing. Often placed in hostels which are mainly mixed, amongst individuals who have been perpetrators of abuse/violence.

Challenges for services in supporting sex workers include: being unaware of client need; not being able to offer appropriate service especially in aftermath of violence/abuse; confusing laws which could result in reluctance to engage with sex work community; unaware of scale of need regarding mental health/physical needs.

Research with VCS organisations and people who access their services has been coordinated through the South Tees Changing Futures Programme. Primary research in 2023 identified evidence of the situation experienced by people from a range of backgrounds.

In terms of mental health, people who feel on crisis are often deemed insufficiently in crisis for a mental health service intervention and are left without any recourse to alternative support. People called the crisis number out of desperation – having knowledge of other statutory or non-statutory support could prevent reaching that point.

Unaddressed trauma experienced by refugees/asylum seekers is seen as a root cause of mental ill-health which, undiagnosed and untreated, can lead to other vulnerabilities. Gaps in support provision were identified by the refugee community with issues deemed too severe for one service but too mild for another, leaving so many people 'falling through the net' - resulting in further deterioration of their mental health.

Migrants and asylum seekers receiving healthcare services felt they didn't fully understand their diagnosis and, if prescribed, their medication and its overall effect and could often benefit from 'just having someone to talk to' – to someone who had the skills to advise knowledgeably.

Health and support services may be available, but some BAME communities are unaware of their existence as they are not promoted in the right way or at the places where communities attend to access other support e.g. food banks, immigration advice, places of worship etc. Not all health services, including dentists, provide an interpreting service. An example was given of refugee families from Kuwait (Arabic speakers) who desperately and urgently need to register with a dentist. Telephone consultations can present a language barrier.

9. What are the recommendations?

9.1 Recommendations Overview

The following five guiding principles are not mutually exclusive, but should work together in a long-term way across national, regional, and local systems:

Healthy-by-default and easy to use initiatives – Initiatives that make healthy choices the default and services easy to use tend to be 'upstream interventions' that target structural factors and do not require much agency to improve health (i.e. individuals do not need to invest much of their own resources or effort to benefit). On the other hand, high agency interventions tend to increase inequalities. Case study examples include Stockton-on-Tees which has made a range of changes to the town to help economic recovery and promote physical activity, and the Pupil Premium, additional funding provided direct to schools based on the number of pupils receiving free school meals or who are classified as looked-after.

Long-term, multi-sector, multi-component action – Health inequalities are driven by an unequal distribution of the wider determinants of health. Any programme of levelling up health needs actions across multiple sectors and which are cross-government to address this unequal balance of the wider determinants of health. Case study examples include the Preston model which involved the city council leading a multi-sector approach to build community wealth, and Healthy New Towns an initiative led by NHS England in partnership with 10 housing development sites across England and a range of different local organisations to design and shape new places so that they promote health and wellbeing.

Locally designed focus – Services and programmes need to be designed around the specific needs of places and communities, especially in disadvantaged or ethnically diverse areas. Evidence suggests that programmes with good community engagement are more likely to be effective.

Targeting disadvantaged communities – Disadvantaged areas and communities need bespoke interventions above and beyond what is provided to the rest of the population. Case study examples include the New Deal for Communities which targeted 39 deprived neighbourhoods in England focusing on crime, community, housing, education, health, and worklessness, and the Wirral Council programme on helping people who were out of work back into employment.

Matching of resources to need – More resources should be given to those with more need to enable the extra support they need to enjoy good health.

Specific policy recommendations include:

1. Levelling up health should be a core part of the cross-government levelling up activity.
2. A long-term, cross-government Levelling Up for Health or Health Inequalities Strategy is needed to drive national, regional and local action.
3. A clear vision for levelling up health and what success would look like is needed informed and supported by an agreed set of metrics.
4. National and local policies to level up should be informed and checked against the evidence based principles outlined above.
5. Local areas supporting the levelling up agenda need the adequate resources to effect change, working closely with local communities.
6. A prioritisation process should be undertaken to identify a set of cross-government priority domains and actions (e.g. housing, education, or welfare) which are likely to have the greatest impact on levelling up health. This may include a combination of stakeholder engagement,

literature review and data analysis to identify those domains which are likely to have the biggest impact in the short, medium and long term.

7. Allocating resources in proportion to need should be used for distribution of public funds rather than competitive bidding.
8. There is a need to broaden the public narrative on health outcome disparities from being perceived as a predominantly health service issue (dealing with the impact) to a social/structural issue that everyone needs to invest in. This could be a facilitated through a public conversation on levelling up health.

9.2 Specific Local Recommendations

Recommendation – Review Substance Misuse Services and Plan for Different Funding Scenarios
Funding for substance misuse services has been supplemented by significant, additional grant funding since 2020. At present (early 2024), this is all due to end by 31/3/2025, subject to review by the Government following the July 2024 election. We will review our South Tees substance misuse service models and plan for scenarios for 2025/26 onwards, based on different funding levels.

Recommendation – Improved Housing
To improve the outcomes of asylum seekers and refugees, local authority strategies should focus on improving the social determinants of health that affect health and wellbeing. Inadequate housing provision including issues such as mould, infestation and overcrowding are key issues. There should be a focus on improving housing support for these groups, including assessments on the suitability of accommodation, an increase in services to resolve disputes and a focus on long-term investment for historically deprived neighbourhoods, to increase physical and mental wellbeing among residents.

Recommendation – Pilot a Housing First-style Approach
A large-scale fully-fledged Housing First model would require £millions of investment, along with significant amounts of both housing and staffing capacity. Unfortunately, we are not in a position to deliver that for South Tees at this stage so we have a vision to start with a small-scale Housing First model which could be scaled up if we are successful in gaining further investment. To provide some mitigation to the local issues, we have £560,000 as one-off grant funding, into developing a Housing First approach. Provision will be commissioned at a local level, funded through combined Changing Futures and TEWV Community Transformation.

Recommendation – Healthy Literacy for Aslyum Seekers/Refugees
Healthcare resources from local GP and other primary care centres should be made available in other languages as standard practice, to resolve language barriers to accessing healthcare for refugees and asylum seekers. There should also be a focus on ensuring interpretation is readily available where needed. Furthermore, training and education for administrative staff and doctors working in local practices should be encouraged and implemented, to ensure understanding of the process for registering local refugees and asylum seekers within their practices. Local services offering psychological services for refugees and asylum seekers should be clearly communicated to those groups living in the local area.

Recommendation – Improved Accommodation (GRT Sites)
Local Authorities and Health and Wellbeing Boards should collaboratively address the negative impact accommodation insecurity has on Gypsies' and Travellers' physical and mental health. Effective joint working at the local level represents the most effective way of reducing health inequalities resulting from poor and insecure accommodation.

Recommendation – Flexible, trauma informed service delivery
Services to be more flexible and trauma informed in their service provision, recognising that potentially vulnerable women may have specific needs to be considered regarding timings of appointments alongside the consideration of an increase in out of hours support.

Recommendation – Women who experience multiple disadvantage
Commissioners, stakeholders and policy makers to develop a greater understanding of and to give consideration to the multiple needs of women in inclusion health groups. There should be a particular focus on those who are involved in or exploited through the sex industry and/or involved in the criminal justice service, within a health and safety model of service provision. This should enable the development of a tailored, local action plan.

Recommendation - Women who experience multiple disadvantage
Improved reporting routes to police with specific points of contact for women who experience multiple disadvantages such as the development of non-uniform, non-enforcing officers who are specifically trained to offer an enhanced response.

Recommendation Women who experience multiple disadvantage
More effective collaboration to be developed amongst frontline services, both public and voluntary to ensure sustained appropriate services for women experiencing multiple disadvantages.

Recommendation – Criminal Justice (or women who experience multiple disadvantage?)
Improvement of through the gate support from custody to community including the provision of suitable housing, particularly for women at this vulnerable stage. Consistent informed support is considered vital to decrease the chance of recidivism.

Recommendation – Criminal Justice
Early interventions to prevent a custodial sentence and therefore to prevent health and wellbeing needs escalating. This should include a focus on preventing children and young people coming into contact with the criminal justice system, but also intervening earlier to improve the health and wellbeing of people already in the criminal justice system.

Recommendation – Health Literacy
To promote health literacy and reduce inequalities in health, local areas should:

- Adopt an early intervention approach to health literacy – ensuring that promoting health literacy is fully integrated into early years and school curriculums.
- Consider the integration of health literacy promotion into other local policy and strategy which promote literacy, language, numeracy and ICT skills, for example.
- Ensure that all health and social care information services are clear and accessible to all, regardless of individual ability.
- As part of a broader strategy, improve the economic and social conditions for at risk groups (the social determinants of health), as these are known to impact on literacy, health literacy, health outcomes and health inequalities.
- Develop awareness and empower health and social care professionals through training to improve health literacy by strengthening public–professional communications.
- Invest, develop, evaluate and share good practice in relation to health literacy Improving health literacy to reduce health inequalities 48 initiatives which improve health and reduce health inequalities.
- Use local knowledge and skills by investing in effective and sustainable community-led approaches, such as ‘health literacy champions’ and using social networks to distribute good health literacy.

- Develop awareness and empower health and social care professionals (across all tiers of an organisation) to improve health literacy and health inequalities by strengthening public–professional communications. This can be achieved through training, continued education and inter-disciplinary initiative.

Recommendation – Develop Local Inclusion Health Research Projects
Our research recommendations are:

- Research studies should routinely examine the distribution of impacts of interventions across socio-economically disadvantaged areas and groups;
- Health inequalities programmes need robust evaluation;
- There needs to be more research into multiple disadvantage and intersectionality;
- A Health Equity Evidence Centre is needed to develop the evidence of what works to address inequalities. More support is needed to help local systems translate research evidence into practice – this can be more effectively achieved via further development of our links with South Tees HDRC.

10 References

The impact of housing on refugees: an evidence synthesis (tandfonline.com)

Asylum seekers: are they living on easy street? (redcross.org.uk)

Unique health challenges for refugees and asylum seekers - Refugee and asylum seeker patient health toolkit - BMA

lay-summary-asif2022.pdf (kcl.ac.uk)

Healthcare for refugees: Where are the gaps and how do we help? - Refugee Council

Overcoming barriers - Refugee and asylum seeker patient health toolkit - BMA

*Barriers-to-wellbeing-09.21.pdf (doctorsoftheworld.org.uk)

The health of migrants in the UK - Migration Observatory - The Migration Observatory (ox.ac.uk)

Where do migrants live in the UK? - Migration Observatory - The Migration Observatory (ox.ac.uk)

Impact of insecure accommodation and the living environment on Gypsies' and Travellers' health (publishing.service.gov.uk)

Ethnic group differences in health, employment, education and housing shown in England and Wales' Census 2021 - Office for National Statistics (ons.gov.uk)

Briefing_Health-inequalities-experienced-by-Gypsies-and-Travellers-in-England.pdf (gypsy-traveller.org)

Traveller caravan count: January 2019 - GOV.UK (www.gov.uk)

Access to healthcare for street sex workers in the UK: perspectives and best practice guidance from a national cross-sectional survey of frontline workers | BMC Health Services Research | Full Text (biomedcentral.com)

English_CollectiveofProstitutes.pdf (ohchr.org)

*Interventions to improve health and the determinants of health among sex workers in high-income countries: a systematic review (sciencedirectassets.com)

Redcar and Cleveland Crime | Crime Stats & Graphs (varbes.com)

Review of NHS Healthcare in Prisons (publishing.service.gov.uk)

Behind bars: the poor health of the prison community | RCP London

New advice on reducing health inequalities in the criminal justice system - GOV.UK (www.gov.uk)

Healthcare for offenders - GOV.UK (www.gov.uk)

Public health in prisons and secure settings - GOV.UK (www.gov.uk)

Health disparities and health inequalities: applying All Our Health - GOV.UK (www.gov.uk)

New national strategy to tackle Gypsy, Roma and Traveller inequalities - GOV.UK (www.gov.uk)

NHS entitlements: migrant health guide - GOV.UK (www.gov.uk)

CORE20PPLUS5 FE (tghn.org)

4a_Health_Literacy-Full.pdf (publishing.service.gov.uk)

Health literacy and patient information | Knowledge and Library Services (hee.nhs.uk)

All Our Health: about the framework - GOV.UK (www.gov.uk)

The MEAM Approach - MEAM

The Teesside Charity - Bridging the Gap

Functional health literacy and health-promoting behaviour in a national sample of British adults - PMC (nih.gov)

Changing Futures Women Experiencing Multiple Disadvantages Report.pdf

NHS commissioning » RECONNECT (england.nhs.uk)

Building an Inclusive Recovery City in Middlesbrough - recoveryconnections.org.uk

Building Recovery in Middlesbrough - (recoveryconnections.org.uk)