Building a Healthier Future Together:

Addressing inequalities in Stockton-on-Tees

Director of Public Health Annual Report 2023/24

Stockton-on-Tees
BOROUGH COUNCIL

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Foreword

This year's Annual Report highlights the challenge of the health inequalities experienced by people in Stockton-on-Tees. We know our residents are experiencing even more challenges as a result of the cost-of-living situation and the ongoing impact of the Covid-19 pandemic. As I write, local authorities are also experiencing unprecedented financial pressures, making our responsibility even more pressing to drive better outcomes and make best use of our resources.

Fortunately, in Stockton-on-Tees we have excellent partnership working with other organisations and a strong voluntary and community sector. This helps us to be more innovative in our approach and to continue to make real sustainable impacts on health inequalities. We will need to work together ever more closely across partners. The voice of local people in all of this is also absolutely crucial and you will find some examples of the great work going on in our community, contained within this report. Also highlighted here are some actions we can take together across partners and communities in the borough to build on this work and go further and faster in improving outcomes and reducing inequality.

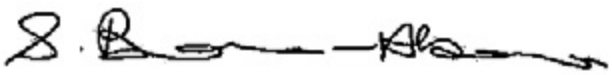
Councillor Steve Nelson
Cabinet Member for Health, Leisure and Culture

Introduction

There is much activity across the borough and nationally to address inequality in all its guises. The impact inequality and poor wellbeing have on the lives of local people is very real, unjust and often rooted in preventable causes. This said, I think we have a better opportunity than ever to address this in a meaningful way – there is a real will and passion to address inequality across our local health and wellbeing system and to work in partnership together with communities, who sit at the heart of all we do.

The good news is that we have really strong local building blocks, through the many strengths and work in our local communities and organisations. Secondly, we do have some evidence of what works in helping to improve outcomes and address inequality. The challenge is to apply this systematically across all partners in the borough and to commit to following this through despite wider changes and challenges, so that we can realise the impact. This report proposes an approach to help us, working across the local health and wellbeing system and agreeing a strategic approach and practical actions across civic, community and service areas.

I hope the report is useful in helping drive forward our collective activities to improve outcomes with, and for, local people.



Sarah Bowman-Abouna
Director of Public Health

Executive Summary

- Though much good work is underway, health inequalities still manifest themselves every day across our borough.
- A holistic and systematic approach is needed, to address health inequalities across the borough.
- There is clear evidence on how we could progress our local approach. Action must go beyond addressing poverty and deprivation (important though these are) to address the multiple factors that impact on people's lives and underpin inequality.
- Much local work is underway, within the local community, the Council and the wider system. Some examples are outlined in this report – it is crucial we collectively understand the impact we are having in seeking to address inequalities through both the stories of our local people and the data we collect.
- The Population Intervention Triangle (PIT) is proposed as a way of bringing this together and progressing work further.
- The PIT model focuses on action in civic society, the community and services; and also the interface between these and complements the Council's Powering our Future policy.
- To support this, a number of practical tools can be used to make sure the approach is embedded across the Council and wider local system. A self-assessment with partners is a helpful way of starting this process.
- The report makes some recommendations on the next steps we could take as a local system to go further, faster in addressing inequalities.

Our picture in Stockton-on-Tees

We have recently had the opportunity to review some of our key measures of health and wellbeing, as part of our local Health and Wellbeing Board developing its Strategy for the next few years. Across the population, life expectancy has increased for females from 81.4yrs to 82.1yrs (from 2011-15 to 2016-20). It has remained static for males at 78yrs (2011-15 to 2016-20). However, there is a wide discrepancy in life expectancy at ward level across the borough as shown in Figure 1 (more detail - Appendix 1). .

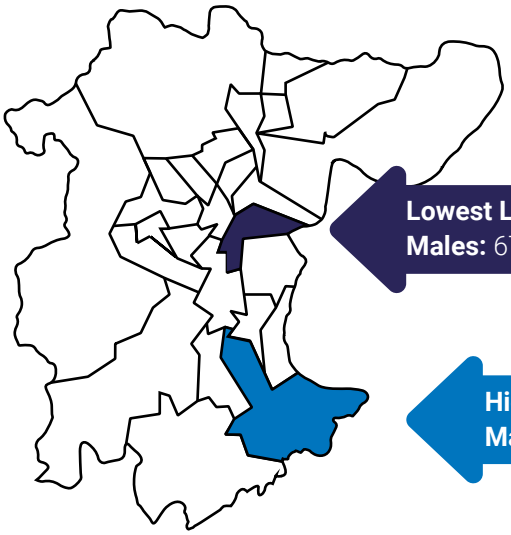
Figure 1: Inequality in life expectancy across Stockton-on-Tees

Life Expectancy (2016 - 2020)

Males
England:
79.5 Years
Stockton-on-Tees:
78.2 Years

Females
England:
83.2 Years
Stockton-on-Tees:
81.3 Years

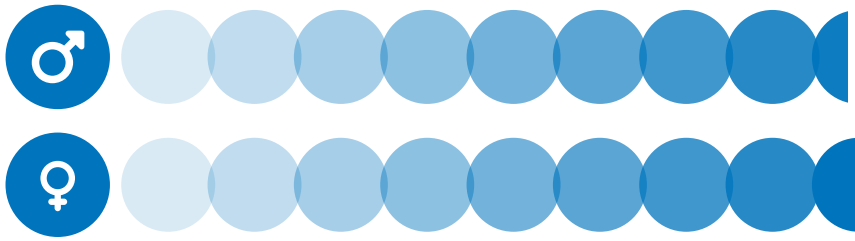
Variation in life expectancy across Stockton-on-Tees



Lowest Life Expectancy - Stockton Town Centre
Males: 67.4 Years **Females:** 71.8 Years

Highest Life Expectancy - Ingleby Barwick East
Males: 84.1 Years **Females:** 90.3 Years

Gap in Life expectancy between the higest and lowest wards



16.7 Years

18.5 Years

The gap between people living in the most deprived wards and those living in the most affluent wards is 16.7yrs for men and 18.5yrs for women. This gap in life expectancy is one of the widest gaps in the country and has been persistent for some years despite significant efforts across organisations. Though we have some examples of really good practice, it has proven challenging to put in place systematic action across all organisations in the local health and wellbeing system. Local statutory organisations will also need to work more closely together with communities, to understand how to make change happen together.

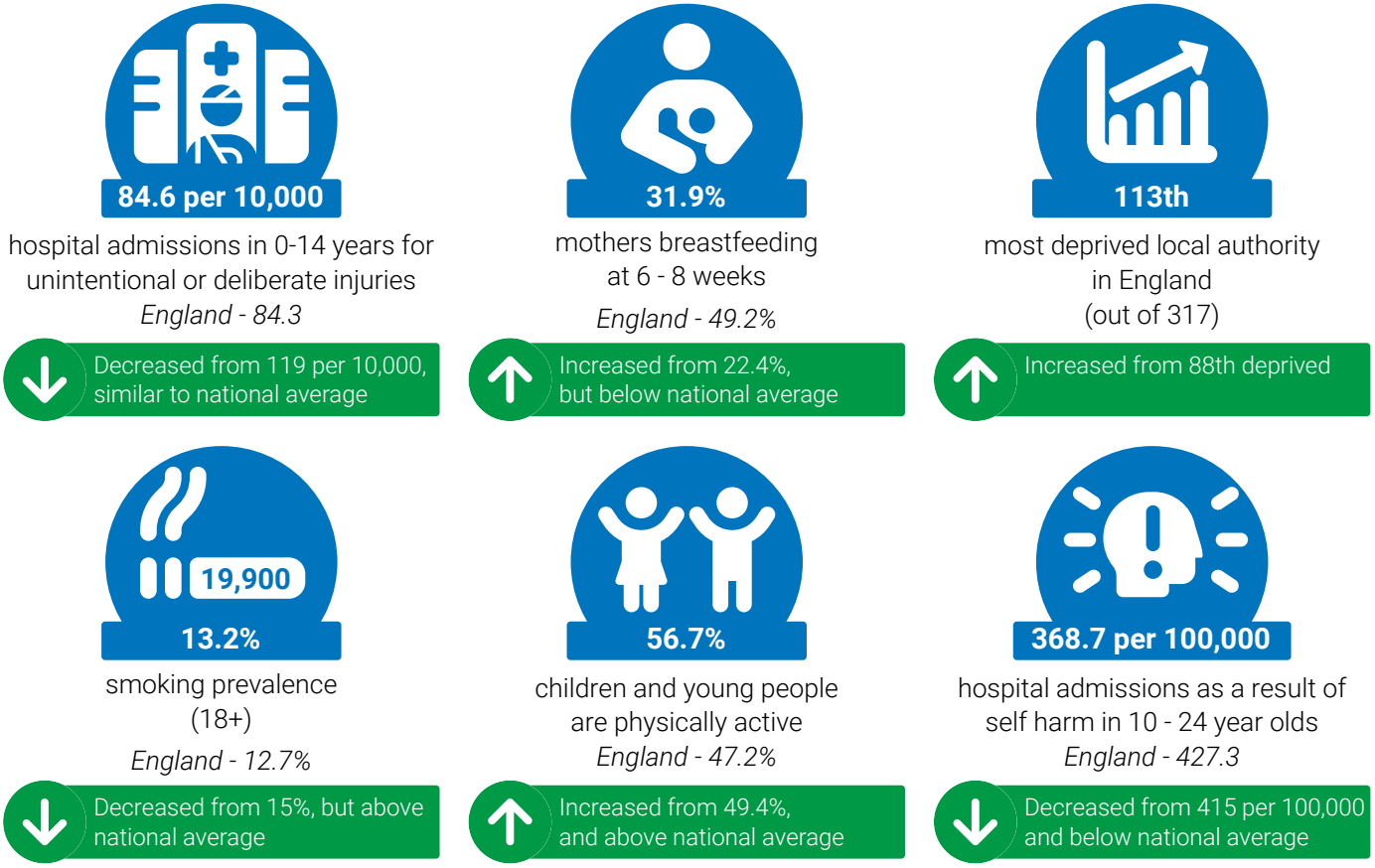
Inequality in life expectancy

- Inequality in life expectancy across different parts of the borough has increased for females between 2011-13 and 2018-20. All but two deciles have seen a decrease in life expectancy, and this decrease has been greatest in the most deprived areas. In particular, the gap between the most deprived and next most deprived decile has widened.
- For males, inequality in life expectancy seems to have reduced however this may be due to a reduction in life expectancy in some of the borough's affluent areas (Appendix 2). Particularly striking is that the 7yr gap between the most deprived decile and the next has not reduced.
- This picture for females and males emphasises the need for targeted action working with the most deprived communities as well as action across the whole population (the sliding scale or 'proportionate universalism' approach).

Importantly, we also have local inequality in healthy life expectancy. That is, there are big differences across our borough, in how long people are living in good health. Healthy life expectancy is 61.5yrs for females and 60.1yrs for males (compared to England figures of 63.9yrs for females and 63.1yrs for males – 2020 data). At the same time, retirement age and the cost of living have increased meaning more local people need to work while in poor health or are unable to work as long as they need to due to their health. This clearly means an impact on society, on individuals, families and community life, as well as the opportunity for some to contribute to the local economy.

Encouragingly, there has been some progress in outcomes since our last Health and Wellbeing Strategy was published in 2019 (compared with most recent data: Figure 2).

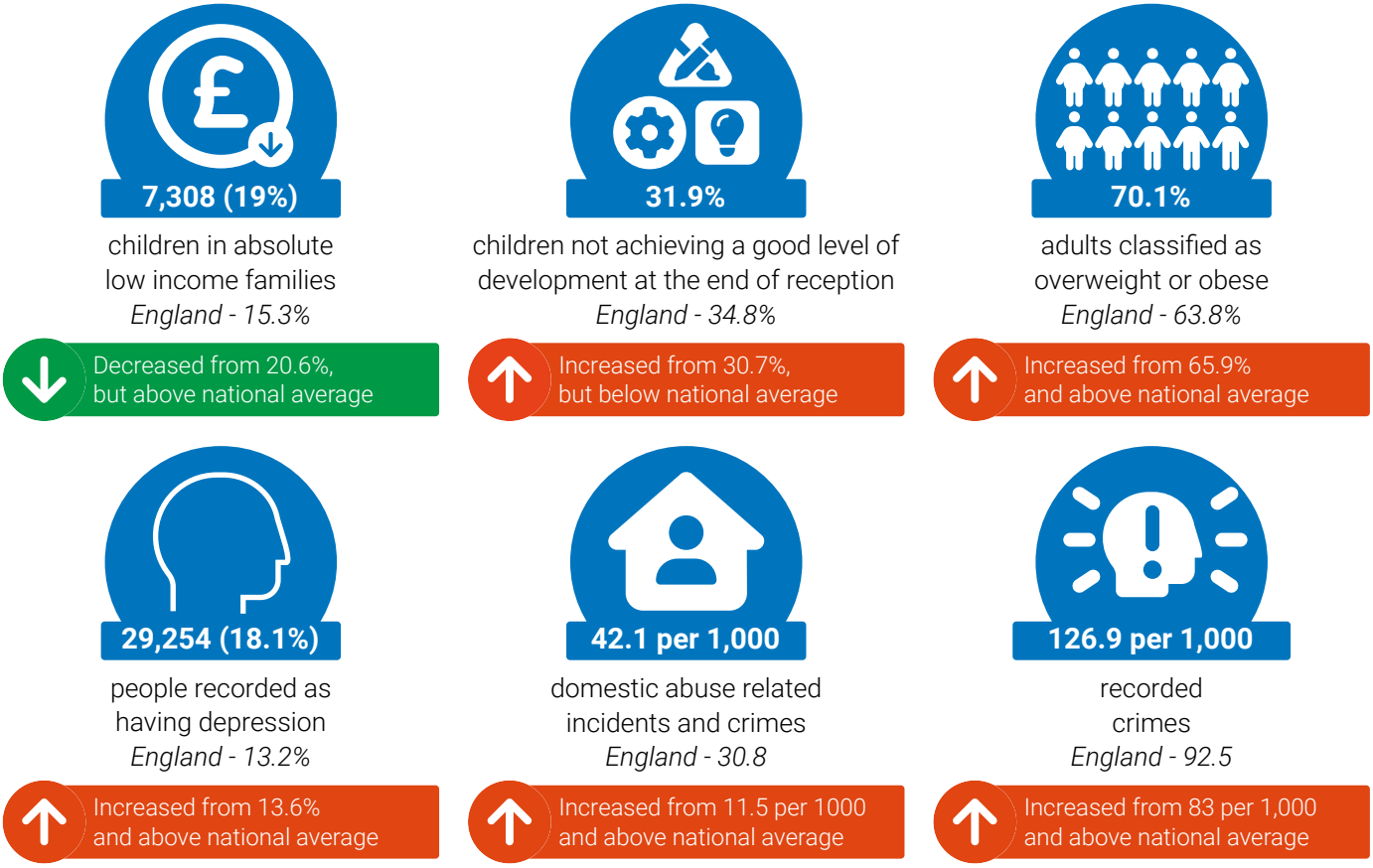
Figure 2: Improved outcomes (since 2019) - Examples



These improvements are positive news, though as the data above shows some outcomes that have improved remain worse than the national average. Figures for the whole borough also mask inequalities across different parts and communities of the borough. For example, there has been a drop in smoking across the population both nationally and locally in the last decade. Change in national policy (e.g. smoke free public places from 2017) has been a key factor in this change and has impacted the acceptability of smoking to the general public. At the same time, smoking remains the key preventable cause of premature illness and death. Smoking rates also remain highest (and higher than the national average) in some of the groups in our community that are susceptible to worse health outcomes, such as workers with routine and manual occupations, people with a mental illness and pregnant women. Inequalities therefore remain.

Equally, some of our population indicators illustrate the ongoing challenge in improving health and wellbeing in the borough (Figure 3).

Figure 3: Worsening outcomes or outcomes illustrating inequality (since 2019) – Examples



These figures also show that health remains poorer in some of our communities than others. These communities are more likely to experience poor health and the factors that lead to poorer health. Often, several factors combine to mean that some communities are disproportionately impacted and have disproportionately poorer outcomes. For example, communities who live in areas of greater deprivation, and some ethnic groups, are more likely to be overweight or obese. Some of the figures are root causes of poor outcomes and inequality. While less children are living in absolute poverty, almost 20% of our local children remain in families who are in absolute poverty and the impact this brings on health, wellbeing and overall life chances. Of course, there are always examples where people are able to overcome these disadvantages and inequality but at population level the evidence is clear that factors such as deprivation lead to poorer outcomes.

Perception and culture are also important. For example, where more recent local figures show that reported crime may be reducing, communities tell us that fear and perception of crime is a significant concern for residents and this will inevitably impact on other issues such as feelings of safety, mental wellbeing and how comfortable people feel to be active outdoors in their local neighbourhoods.

What do local people say?

Working with local communities in a different and more meaningful way is a priority for the Council and important to many local partners. The Council's Powering our Future programme gives focus to this, looking to understand and build on strengths and assets in communities and work closely with communities to shape our local priorities, to develop how we work together to deliver them and to understand whether we are collectively making a difference. This is a large programme of work but will be built on existing building blocks of good work in the community and in partner organisations. We are very fortunate to have a strong and vibrant voluntary, community and social enterprise sector in the borough as well as the many small and larger actions that people carry out in the neighbourhoods and communities every day to support each other. At the same time, it is important to acknowledge the impact that wider issues continue to have on local people, such as the cost of living and the ongoing impact of the Covid-19 pandemic.

The Council carried out a residents' survey in late 2023 which had 1,637 responses and provided a snapshot of the views of local people.

Residents' survey – some headlines

- 70% feel satisfied or very satisfied with life overall
- 16% felt very anxious, 16% anxious on the previous day
- 81% felt they can rely on people if they have a serious problem
- 7% always felt lonely and 40% some of the time or occasionally
- 40% had volunteered in the last 12 months
- 56% felt they belong to their neighbourhood
- 50% felt safe (walking alone after dark) in their neighbourhood

To build on this we need to forge closer links across our diverse communities in the borough to feel safe and connected and less anxious or lonely (63% of the residents survey were age 50yrs + and 92% were of white ethnicity). As well as many examples of good work across the local community, there are examples of the Council and partners reshaping our approach to working with communities which we can build on.

- The Powering our Future programme is focusing on supporting and empowering community capacity building and seeking to embed co-production and partnership with communities, learning from other areas
- A Making it Real Board has been established to provide a community view and voice on strategy and decision-making on health, wellbeing and adult services in the Council
- Co-design and co-production are taking place in a range of work areas including support for people caring for those with substance misuse issues; the new model for sexual health services; community-based interventions and support for healthy weight; and the design of the children and young people's health and wellbeing model, with children and families.

What works? Addressing health inequalities

Given the existing work underway, what more can be done to see a real shift in addressing health inequalities? The research evidence points to balancing action on where there is the most scope to improve health, cost effectiveness and fairness (focusing on the building blocks of health, which are not evenly distributed).

Robust research evidence on addressing health inequalities tells us to:

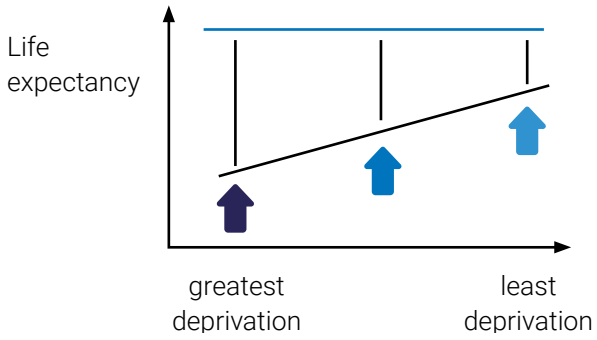
1. Provide **support across the population, according to level of need** - not just those in the most acute need or the areas of greatest deprivation. I.e. A mix of population interventions and high risk (targeted) approaches is needed
2. Understand and address the **relationship between** the many factors that drive inequality – rather than just a focus on poverty
3. Focus on **population and place**, not just individual behaviour to address the root causes of health inequality and build protective factors

1. The ‘sliding scale’ approach (proportionate universalism)

In his seminal research-based report Fair Society, Healthy Lives (2010), Prof. Sir Michael Marmot set out that to address health inequalities, it is important to provide support across the population, tailoring this to the level of need (a ‘proportionate universalism’ approach). This means a mix of population-wide approaches is needed, from universal through to early help and then to more targeted approaches working with communities at greatest risk. Though supporting local people with the greatest need is very important, focusing just on these communities will not improve overall population health and wellbeing; it will also lead to need escalating in groups of the population who previously needed less or minimal support. This feels particularly pertinent currently, when the cost-of-living situation means that people who were previously managing (or even managing well), are finding themselves in need of extra support.

To achieve this sliding scale approach (Figure 4), more ‘effort’ (resource, innovation) is needed to increase outcomes in areas and communities of greatest disadvantage, whilst maintaining support across the spectrum of the population:

Figure 4: Improving outcomes across the population



Maintaining this approach can be challenging in extremely resource-stretched times, however it should be seen as an investment to save opportunity with a focus on maximising existing resources and innovating to work in different ways rather than on a requirement for additional resource. That said, a period of transition from reactive-focused to more prevention-focused approaches will be needed. Strategic coordination and leadership across the local health and wellbeing system is key to successfully making this shift.

Marmot also described that deprivation is only one factor leading to inequality and that people experience inequality because of the interplay between various factors e.g. sex, race, disability.

2. Intersectionality
the relationship between drivers of inequality

Inequality is a complex issue – we cannot expect simple solutions to solve complex problems

- **'One size fits all'** approaches aimed at reducing inequality, **leave people behind**.
- **System-wide leadership** and working alongside **communities**, help shape approaches that promote equity and improve outcomes.

'It's not just about lived experience but a critical reading of that lived experience that can shape policy-making. There is always a risk that it becomes just about people's experiences, not about the people that need to hear them.' (VCSE interviewee, IPPR)*

* https://www.ippr.org/articles/an-intersectional-approach-to-poverty-and-inequality-in-scotland

Intersectionality is 'A lens…for seeing the way in which various forms of inequality often operate together and exacerbate each other' Crenshaw (1989). It is crucial that we understand and address the relationship between the many factors that drive inequality. Poverty is very important but is only one of these factors. As well as being supported by the research evidence, this approach is used by a range of bodies including governments, the World Health Organisation and the World Economic Forum.

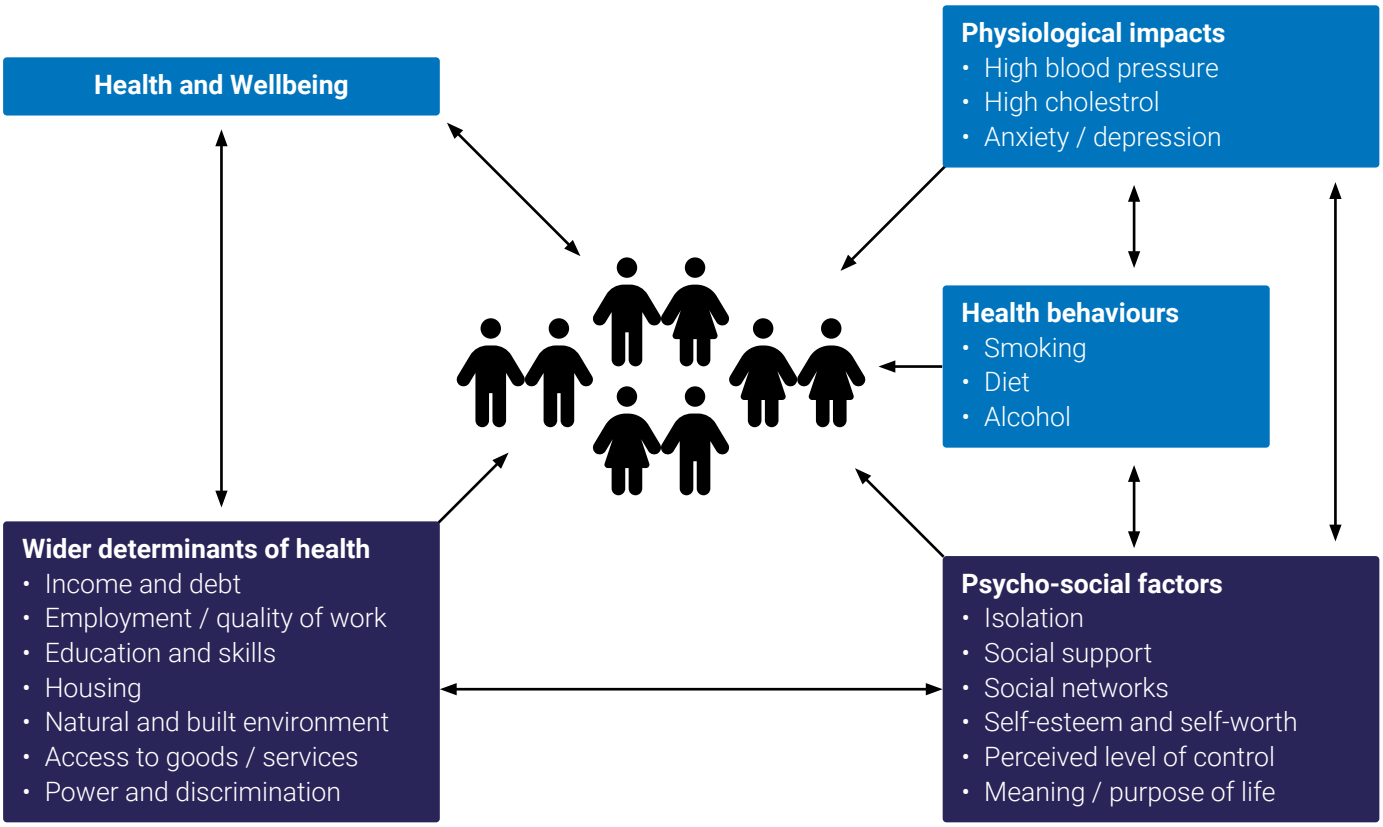
In 2021 an Institute for Public Policy Research (IPPR) report* in Scotland looked at research on policy, and on speaking to people with direct lived experience (Appendix 3). It recommended:

- Targeted approaches that focus on eradicating barriers to access experienced by specific groups.
- More democratic policy making, engaging with experts in intersecting inequalities and ensuring policy makers reflect the community.
- Embed partnership working with experts by experience, building long-term relationships with people with direct experience of poverty and / or other forms of inequality.
- Gather evidence and develop recommendations on how to address persistent gaps in understanding of e.g. BAME groups.
- Recognise that dismantling structural inequalities will take time, sustained work and appropriate resourcing.

3. Population and place focus

To effectively and sustainably address health inequalities and improve health and wellbeing, research evidence also highlights the importance of focusing on population and local place-level actions, rather than just on individual behaviour. Doing so helps not only address the root causes of health inequalities but also build protective factors such as resilience, healthy relationships and social connections, hope for the future and social and emotional development in children. A simplified system map of the causes of health inequalities is shown in Figure 5 below which is also supported by Marmot's work.

Figure 5: System map of the causes of health inequalities



(Adapted Labonte model, PHE 2021: https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report). The model is a simplification and there are many interactions between the different factors.

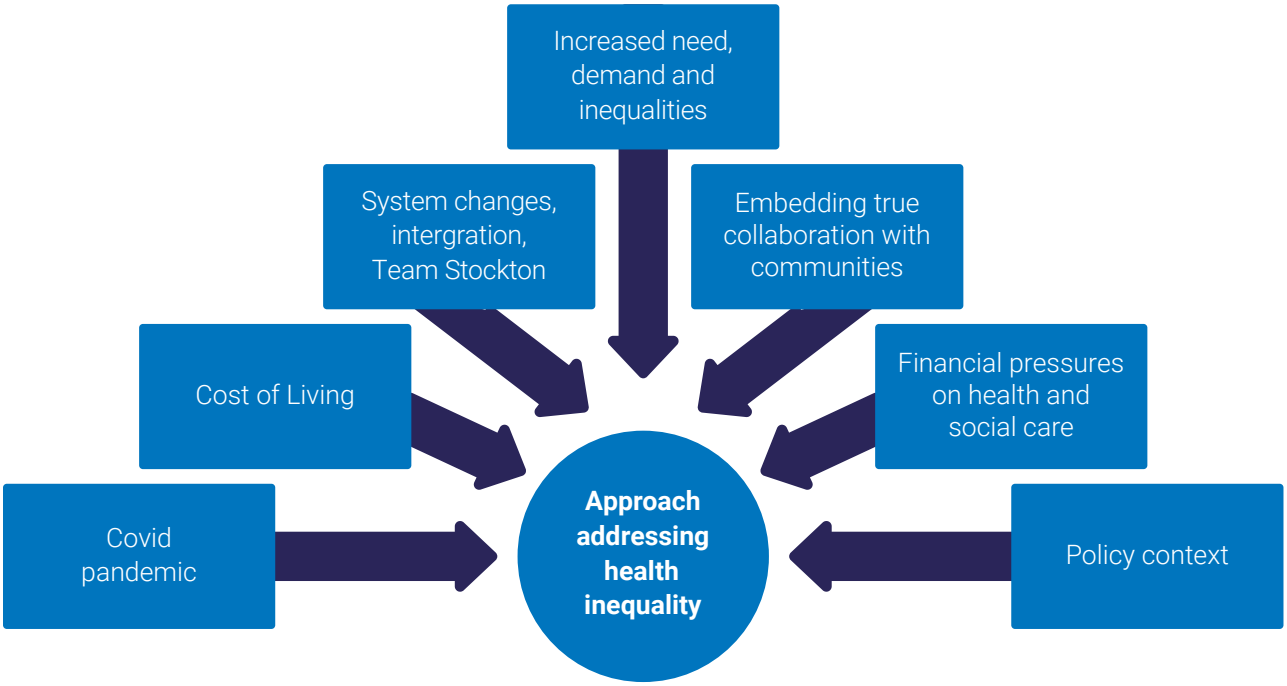
The learning from this approach shows:

- Health inequalities stem from variations in the wider determinants of health and whether people have access to psycho-social mediating and protective factors. This means that people do not have the same opportunities to be healthy.
- Given the range of causes, a joined-up, place-based approach is needed to tackle the complex causes of health inequalities.
- Interventions that solely rely on individual behaviour change are likely to widen inequalities given the complex pathways impacting on capability, opportunity and motivation to change.
- Action on behaviours and conditions need to be addressed within the context of their root causes (the wider determinants of health). For example, we know that a significant proportion of the gap in life expectancy in the borough is due to circulatory and respiratory diseases and cancer (Appendix 4), however addressing the wider causes such as access to green space and the impact of planning on health (not just lifestyle factors e.g. alcohol) will help to prevent these conditions and improve wider health outcomes.

There is a critical role for **local areas** to play in reducing health inequalities across the population, by taking a **joined-up place-based approach** - and utilising the **leadership**, **expertise** and **local levers** that are available to create **conditions that help people to be healthy**.

Current local context

While sadly inequalities in health and wellbeing have been a feature locally and nationally for some time, the context has changed in a way that now presents an opportunity to galvanise and drive forward local action in a way that has not been possible before. Some of the main factors affecting our collective approach to addressing health inequalities are summarised as follows:



Across the local health and wellbeing system there has been:

- A renewed focus on addressing health inequalities across the system, including the A Fairer Stockton-on-Tees framework to address inequalities being adopted with an initial focus on poverty. Also, a recognition of the need to look at the interface between geographical place and community characteristics (gender, race, experience, etc.) that impact on inequalities.
- The recent development of a Place Leadership Board for Stockton-on-Tees to lead joined up working across key partners, to develop a shared vision for the borough.
- The ongoing refresh of key strategic documents across partners including the corporate plan for the Council and the Health and Wellbeing Strategy.
- The evolution of the Integrated Care System (ICS) including the development of a 'place plan' for the Tees Valley and the regional ICB Strategy Better Health and Wellbeing for All.
- An increasing drive towards closer joint working and health and care integration.
- Development of the Council's Powering our Future programme which covers communities, partnerships, colleagues, transformation and regeneration. This programme is being implemented and includes cross-cutting work on the approach to early intervention and prevention.

Local action

Across the Council, community and partners a range of activity is already taking place to address inequality. A few examples are highlighted in this report followed by suggested next steps on how we build on these, make the approach more systematic across partners and respond to the evidence on addressing the complex causes of inequality and wider socio-economic determinants. The examples span targeted work with those in the community with the most complex needs; examples of a 'sliding scale' (proportionate universalism) approach according to level of need; and wider community and cost-of-living activity. In reality, there is often cross-over between these approaches.

1. Targeted support

Working with people with multiple needs

Across the borough there are many examples of working with some of the most vulnerable communities which we can learn from and build on, particularly with joined up approaches in mind that build on strengths and work with individuals and families

Stephen's story

Stephen (not his real name, 18yrs old) was referred to our local Individual Placement Support (IPS) service (Stockton Hartlepool Employment Connections, SHEC) in September 2023. He was using Cannabis daily and other drugs, including ketamine and crack cocaine weekly when he could afford to do so. Experiencing suicidal feelings, he was referred to CAMHS (Child and Adolescent Mental Health Service) in October 2023.

Our substance misuse provider Change Grow Live (CGL) and CAHMS worked closely together and with Stephen, with a clear reduction plan of his substance use and a package of psychosocial interventions. Stephen engaged well with this support and was motivated by his potential future and desire to work. He was then introduced to our local Individual Placement Support service by their key worker and though he was very motivated, Stephen struggled with low self-esteem and a previous apprenticeship that he had broken down due to a lack of understanding of his mental health needs and substance misuse. The IPS Employment Specialist worked with Steve to:

- Help him to produce a CV and applications
- Liaise with employers, training providers, and other agencies that fit his goal
- Work on a statement of disclosure, so Stephen could confidently be upfront about his journey
- Provide one-to-one support
- Allay his feelings of being overwhelmed
- Keep track of appointments, applications and interviews

Stephen has now been successful in securing a mechanics apprenticeship, is substance free and his mental health is stable. He is being supported to begin living independently. At his most recent interview, he spoke highly of the support he had received and how positive he felt about his future.

Latest figures show that 11 people from Stockton-on-Tees (who were in structured treatment for substance misuse) were supported into employment in the first year of the IPS programme - a real achievement with SHEC as a new provider having also built relationships with local businesses in that time. The service supports local people of different ages.

When I started the IPS Programme I was at the lowest point in my life. My marriage was finished, I was unemployed and heavily depressed. The IPS service is practical and uses common sense approaches not just tick box manipulations. This service I would strongly recommend, because it works. It worked for me. I now have a great job, looking forward to moving into a new flat with my daughter soon. Thank you so much, from the bottom of my heart.

(Local 55 year old male)

In addition, we are testing a new approach working with a range of partners for peer advocates to work alongside some of the individuals in the borough with the most complex needs, based on learning and approaches from elsewhere. The advocates will work with people who are often experiencing mental ill health, substance misuse, domestic abuse and housing needs to help identify what is important to them and how barriers to support available can be removed. Working alongside Teesside University we are looking forward to evaluating and learning from the programme, using peer research. The intention is to use this to inform our collective approach to working with communities with multiple needs, building on their strengths and helping us co-design models of support that will meet their needs.

Mobile vaccination clinics for homeless people

During the pandemic it became clear that people with pre-existing chronic conditions were at particular risk of harm from covid. Whilst many homeless people experience poor health uptake of covid vaccinations was low. The NHS, the council's housing and public health teams and local hostels worked closely to offer mobile vaccination clinics in accessible locations, at the right day and time for the target group and to complement the offer with food vouchers and further health and wellbeing support.

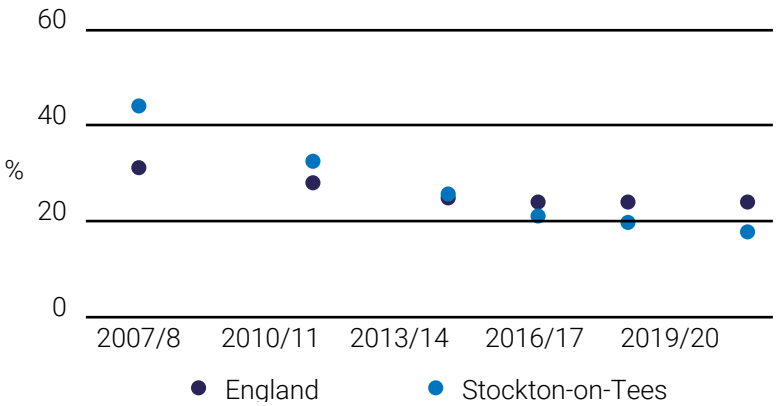
2. Tailoring support according to need

Oral health

Good oral health is an important part of health and wellbeing. Tooth extraction because of decay is the main reason for children needing a general anaesthetic. School absence, pain and impact on self-esteem are also associated with decay. In Stockton-on-Tees we have historically had a 'sliding scale' approach to support (universal through to targeted) which has helped improve outcomes.

Fluoride varnish is currently being reinstated following the impact of the Covid-19 pandemic. At the time of writing, the Bill introducing community water fluoridation is going through the parliamentary process. This will benefit the whole population with a particular benefit in areas of greatest deprivation. The local toothbrushing programme and fluoride varnish provision, have helped reduce dental decay in children over recent years, supported by population-wide health promotion work on reducing sugary diets which also help promote healthy weight. The borough's Community Wellbeing Champions (a network of 70+ individuals and voluntary and community organisations across the borough, funded through public health) have also helped distribute oral hygiene packs in the community.

Figure 6: Percentage of 5-year-olds with experience of visually obvious dental decay



Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children (Biennial publication - latest report 2022) https://www.gov.uk/government/collections/oral-health#surveys=and-intelligence:-children

Secondary school-age vaccinations

Historically, we have had good immunisation rates in our children and young people across the borough. However, this has changed locally and nationally and secondary school age vaccination uptake in Stockton-on-Tees has fallen significantly in the last two years to below the England average (including HPV vaccine for 12–13 year-olds, Meningococcal ACWY vaccine and Tetanus, Diphtheria and Polio for 14-15 year-olds). We know that vaccinations remain one of the best population-wide ways of protecting health.

In 2023, the Council's Public Health team used inequalities funding from the Integrated Care Board to work with a local behavioural insights organisation in carrying out research in local communities. The research focused on understanding attitudes and behaviours regarding the vaccinations among the young people, their parents and carers and professionals e.g. teachers. It was particularly focused on seeking views from communities in more deprived areas and young people identifying from BAME communities where it has previously been harder to hear the communities' views.

Surveys and focus groups at existing community group seetings working with community groups and VCSE Organisations

Views collated and analysed to understand more about motivators and barriers for vaccination to develop...

...new approach including vaccine champion coordinator role, work with schools and 0 - 19 public health school nurses and new tailored easy read information leaflets

NHS Health Check

Cardiovascular disease (CVD) can affect anyone but is more frequently found in people living in the poorest neighbourhoods. Cardiovascular events such as heart attack and stroke remain one of the biggest killers in England. The free NHS health check is promoted locally to assess the risk of CVD in anyone over 40 who has not yet been diagnosed with a chronic condition linked to CVD and to offer advice and support to make changes to live more healthily.

This free check is offered to all 40 - 74 year olds through their GP. It aims to detect risk of heart disease, diabetes, kidney disease & stroke and provide help to prevent these conditions. Locally public health works with GP practices and others such as community champions to successfully promote uptake of the check among communities in the most deprived areas, who are at a greater risk.

- 40% of local people taking up the Check are from the most deprived areas
- 1,024 people from these areas had their Check in the 12 months (2022/23 - 2023/24)

3. Cost of living and wider community support

The Council is committed to addressing poverty by providing Cost of Living support. This is supported by the current development of an anti-poverty strategy and the outstanding work of the Stockton Infinity Partnership and the local Welfare Support service, which supports residents to claim benefits to which they are entitled. The Infinity Partnership is recognised as the most effective Financial Inclusion Partnership in the country and ensures key partners work together to maximise income and assist those in debt.

Amazing work is done in the community in Stockton-on-Tees, through a range of groups and organisations. This work is the backbone of community resilience in the borough and a huge support to local people. A few case studies are highlighted here.

'Rosie'

Rosie (not her real name, >60yrs old) disclosed she is on medication to help with her mental health issues. Having previously been a school cook, she was glad to be invited to a cooking session where she received a slow cooker and casserole cookbook free of charge. Rosie believes this has saved her money on energy bills. Staff learnt she needed financial support and referred her to the Citizens Advice Bureau (CAB) who have assisted with her immediate and longer-term issues, going 'above and beyond' in her words. Rosie is regularly helped with emergency food parcels when the CAB are working on complex financial issues that can't be resolved overnight.

It came to light that some of Rosie's financial issues stemmed from supporting family members, who have since been offered support and referred to services such as the Stockton-on-Tees Active Travel Hub as they were eligible for a free bike. Rosie has also been helped by Thirteen's Hardship Fund. She said: 'This community pantry and lunch club really is a godsend; I don't know how I would manage without it most weeks.'

Sustrans Active Travel Hub, Stockton Town Centre

Community Pantry, Norton Community Centre

'Wayne' – Norton Community Pantry

Wayne is a single man in his 30s who depends on benefits and cares for his three children between Friday and Sunday each week, and regularly through school holidays. He lives in private rented accommodation which he struggles to afford and has severe mental health problems. Wayne has disclosed that he often does not eat for a few days to ensure he has enough food in stock for when his children visit over the weekend. He attends the pantry each week and regularly receives an emergency food parcel.

Staff have referred him to the CAB for financial support and advice. To aid his mental health, they have also facilitated access to training via Thirteen and volunteer sessions to improve green spaces at St Michael's Church in Norton. Wayne has also been referred to the Green Doctor to receive emergency funds to get his energy supply reinstated at home.

Wayne said: 'I've never received any support before and didn't know what help was out there, so I'm very grateful for the support that has been given to me.' The CAB are currently working towards a personal independence payment award for Wayne which would improve his situation, alongside seeking more affordable housing.

The PALS Hometown Project is an innovative approach to improving men's mental health awareness and well-being in Stockton-on-Tees, with a focus on the Town Centre wards. The project enables regular meetings that allow men of all ages to talk about their mental health, isolation and overall wellbeing in a safe, community space lead by peers. It connects people and signposts them to relevant services through initiatives like Infant Hercules Men's Choir (with 110 members) and community wellbeing walks.

Pals Project

Alan – community spaces

Community spaces started life as 'warm spaces' as the cost-of-living crisis began to take hold and sprung up across the borough in a range of venues. They have evolved to become wider community spaces welcoming people from the local community, running a range of activities and combatting loneliness and social isolation. Alan (70yrs old, Thornaby) offers invaluable support as a volunteer at one of the community spaces:

'Alan has been an absolute godsend in the success and sustainability of the Warm Welcome social drop in. He is full of the enthusiasm and just gets on with whatever needs doing, whether that is making drinks, welcoming people, calling bingo, tidying up or spreading the word about the group.

Alan is so cheerful and the group love him. He is very approachable and has been a real hit with his sense of humour. Alan has donated prizes himself to the bingo games played at each session and has even asked a local business to donate prizes too. It is such a relief to be able to leave the group in Alan's capable hands when regular staff cannot lead the sessions. He is not fazed by this and seems to enjoy the responsibility. He is full of energy and keen to think of new ways to expand the group and add extra activities that people will enjoy.

Alan is a real community star!'

(Community spaces staff member)

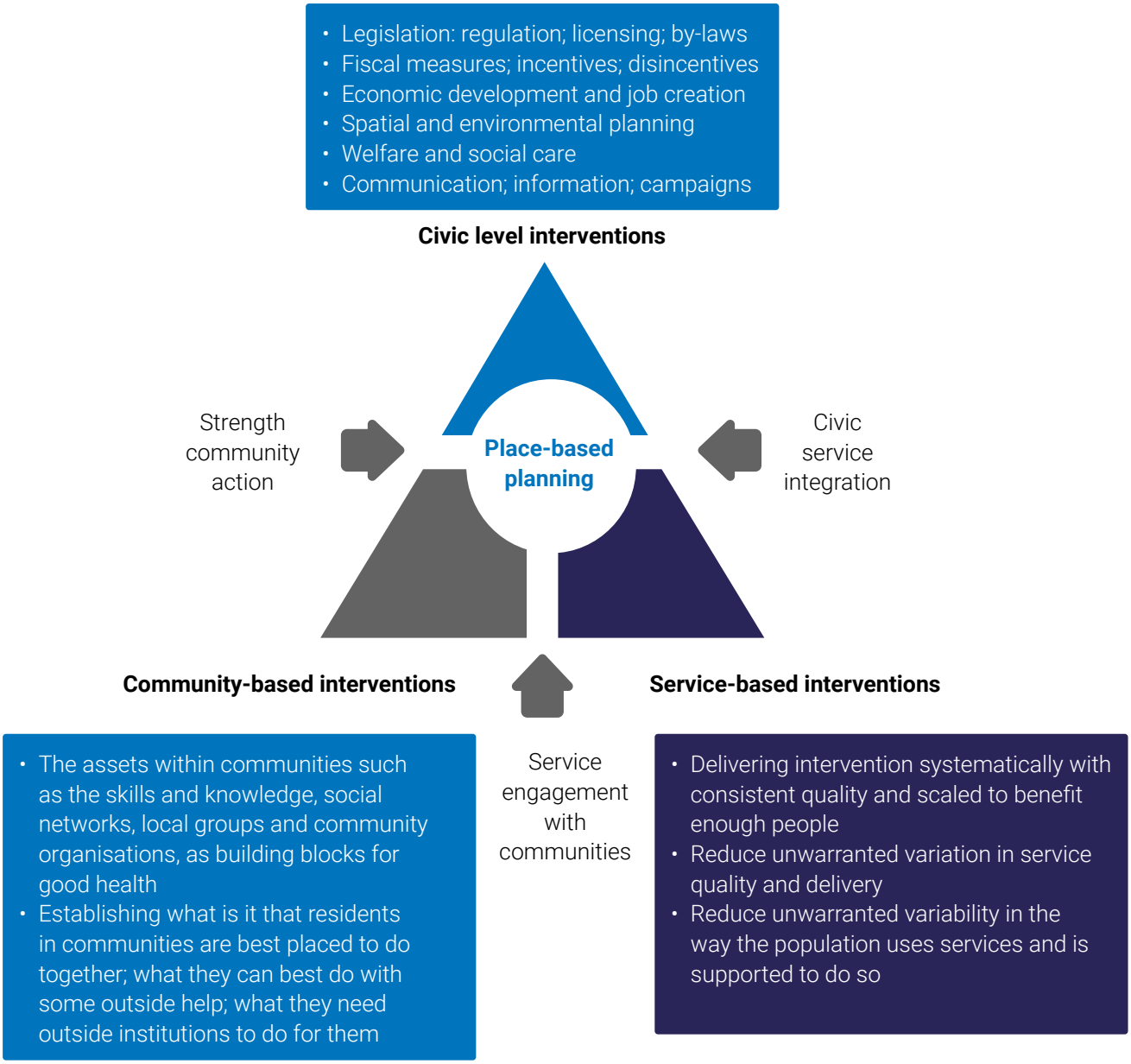
Alan volunteering at one of the borough's community spaces

Approach

What next in Stockton-on-Tees?

As addressing health inequalities is complex, it is helpful to coordinate and plan our activity through a single evidence-based approach, which will help the partners across the borough to act in a systematic and structured way, focusing on local place.

The Population Intervention Triangle (PIT)



https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report

The Population Intervention Triangle (PIT) model sets out that to be effective, system leadership and planning is needed to implement action on civic, service and community interventions. The elements in the model have the potential to reduce inequalities at population scale.

- **Civic** interventions have the greatest reach of any intervention. Local authorities are a driving force as leaders of place and are well-placed to act on many drivers of inequality. There are tools available to help implement healthy public policy on the following, which both impact on health and wellbeing and address inequality e.g. economic development, spatial planning, welfare, community safety and impact as a major local employer.
- **Services** can achieve significant outcomes due to their direct impact with individuals but must be delivered with system, scale and sustainably - and deliver further and faster to the most disadvantaged communities.
- **Community** - it is important that all partners and communities understand the value of community assets in reducing health inequalities (e.g. skills and knowledge, social networks, local groups and community organisations, as building blocks for good health). Community-centred approaches focus on changing the conditions that drive poor health alongside individual factors. They aim to increase people's control over their health and lives.
- Particular focus on **joint working across the interfaces** between the civic, service and community sectors will enable the whole to become more than the sum of its parts.

The model is accompanied by a range of practical tools and more detail on specific actions that can support its delivery to produce measurable population level change. It is based on focusing on place and not just individual problems or issues and was developed through practical experience, including addressing health inequalities between and within local geographies.

The PIT model can be used at a variety of levels:

- To support **cross-organisational working** at the strategic place-based level, including with population health management.
- At a **topic or condition level**, it can (for example) support whole system approaches to main elements of health inequalities and prevention (aimed at wider determinants, behaviours or health conditions).
- By **individual partners** (for example primary care; voluntary, community and social enterprise (VCSE) sector) as a framework to easily see how their contributions fit on a place basis.

The PIT approach: What is our current position?

A self-assessment, co-produced across partners and the community, would support shared strategic direction and action across the system and is recommended as a next step. However, an overview of some key points is captured here. Strategic bodies such as the Place Leadership Board and Health and Wellbeing Board support work across the interface between civic, community and service activity.

Civic intervention

Key strategies and policies are in place and leaders across the local system have identified addressing inequality and improving health and wellbeing as priorities. There is the opportunity to embed addressing inequality and equity impact assessment and to join up across the system further through identifying shared strategic outcomes. Also to acknowledge and implement the intersectionality approach and glean learning from other areas that have taken a 'Marmot places' approach.

There are pockets of good practice in relation to designing approaches and models of support and in commissioning e.g. work to build social value in contracts. The Council is continuing to develop further as a lead employer in the borough and to embed addressing inequality specifically throughout commissioning processes. Much work is underway on practice and workforce e.g. development of welfare support and the employment hub, with the opportunity to employ a 'Making Every Contact Count' approach.

It is important to embed into our monitoring frameworks: measuring impact on the gaps between worst and best outcomes in our communities; and community voices and the outcome of community conversations. The indicators set out in Marmot's review provide an evidence-based starting point for measuring whether we are addressing the root causes of inequality.

Service-based intervention

Currently we have some services and models that are based on the best available evidence and are tailored according to need. However, this is not consistently the case across the health and wellbeing system – this approach is needed at scale to have a meaningful and sustainable impact and to go further and faster where there is the greatest need. Embedding equity impact assessment will also support this.

Starting from the experience and journey of communities and individuals (rather than services) will help in designing more joined up approaches and support. To design models that are tailored according to need, a more nuanced understanding is needed of the many inter-related factors leading to inequality in communities, with services responding to these and not focused on individual issues where this is over-simplistic.

Community-based intervention

Focused work is under way in the Council to better understand the strengths and assets in communities, as well as community views. This is being developed focusing on supporting community development and community engagement, and learning from other areas across the UK who are further along in establishing a new partnership with local people. Working with the National Development Team for Inclusion (NDTI) we are embarking on a self-assessment process to help us determine our readiness and next steps in this work. There is the opportunity to then join this up with strategic partners to identify a common approach and next steps. We know that there are groups in our local population who we need to work more closely with to understand their strengths and needs so we can agree together a coherent approach to working together.

The work with communities will have implications for how we work as statutory organisations in the future, including how we shape and support our workforce. There are some good examples of working closely with communities on specific issues and agendas and there is the opportunity to broaden this and embed into strategy and policy. We also need to ensure commissioning processes allow co-production and support to small community organisations who may be best placed to deliver on particular issues.

Lastly our impact monitoring approaches can be developed to capture the experience of our local communities and sit these alongside quantitative data to inform collective evaluation, planning and decision-making.

In summary, a huge amount of work is going on in the community and across organisations to address inequalities and their causes. We can build on this by **agreeing a shared approach** across partners in the borough that is rooted in research evidence and addresses the **complex relationships** between the causes of inequality. The **PIT approach** brings together civic, service and community action to do this. A self-assessment will highlight gaps in our current work and identify next steps and how we work together. There are some starting points in systematically embedding addressing inequality into all our key **policies, approaches and services**, working across **partners** and **communities**.

Next steps

Key message: To help address inequalities and improve health and wellbeing, we need a systematic, evidence-based approach agreed and implemented across partners and communities and embedded in strategy, policy, design, action, monitoring and evaluation.

A co-produced self-assessment will identify actions across partners and the community. To continue to drive forward addressing inequalities, our current position in the borough points to some initial next steps.

1. **Adopt the Population Intervention Triangle (PIT) approach,** working with partners and communities to embed this, driven by strategic leadership across the borough and the local health and wellbeing system e.g. Health and Wellbeing Board, Place Leadership Board. The strategic approach will help define how we work together as a health and wellbeing system and out of this will fall programmes and activities in-line with the evidence base.
2. It is proposed the PIT is used to **support** the implementation of the ***A Fairer Stockton-on-Tees framework*** with a focus on the wider determinants of health to support addressing inequalities in general (beyond specifically health inequalities). The approach will provide next steps beyond the initial focus on poverty, proposing how to address the complex inter-related causes of inequality through both a strategic approach and practical tools.
3. Work across local partners and the community to **co-produce a self-assessment** (particularly in relation to the civic and service aspects) on our current position and generate recommendations and actions. The recommendations can be linked with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy as they are updated and will help to highlight initial areas of focus and short and longer-term actions.
4. **Consider** adopting a **'Marmot place' approach** or using the learning from Marmot place sites.
5. Explore **LGA support** for the self-assessment process and / or bespoke LGA support programmes to embed addressing inequality across the Council and local system e.g. policy and leadership support.
6. **Adopt** and embed an **equity impact assessment** approach across all Council strategies, policies and programmes of work, engaging experts in intersecting inequalities e.g. Office for Health Improvement and Disparities, LGA, Health Foundation, Association of Directors of Public Health, National Development Team for Inclusion.
7. **Adopt** more **sustainable approaches** to creating the conditions for maximising health and wellbeing and addressing inequality e.g. taking the next step from providing shorter-term crisis food provision, to a strategic approach to the local food environment.
8. Continue to focus on **supporting community building,** focusing on assets and strengths.
9. Continue to move towards **embedding working with the community** in developing policy, designing approaches to issues and models of support / services, commissioning processes and understanding impact on outcomes.
10. Explore opportunities to embed the approach to addressing inequalities across the collective workforce, such as **adopting a Making Every Contact Count approach** focusing on advice and brief interventions on a small number of consistent key issues.

11. Embed the model in the Council's transformation agenda (Powering our Future) – for example

    a. Communities: Through supporting **a better understanding of communities** where there is currently a gap in our knowledge and our joint working e.g. some BAME communities. Working with communities to address inequality and build protective factors through the PIT approach, will also support the move to **earlier intervention and prevention.**

    b. Transformation: Through **informing our approach** to design of models of support and services. The approach will promote **early prevention** through focusing on wider socio-economic determinants of health, balancing targeted and universal activity and providing a structure to help address the complex interactions between factors that lead to inequality, beyond deprivation.

    c. Partnerships: Through providing a **structured approach** to determining priorities and approach across strategic partners; and aligning activity and systematically monitor impact.

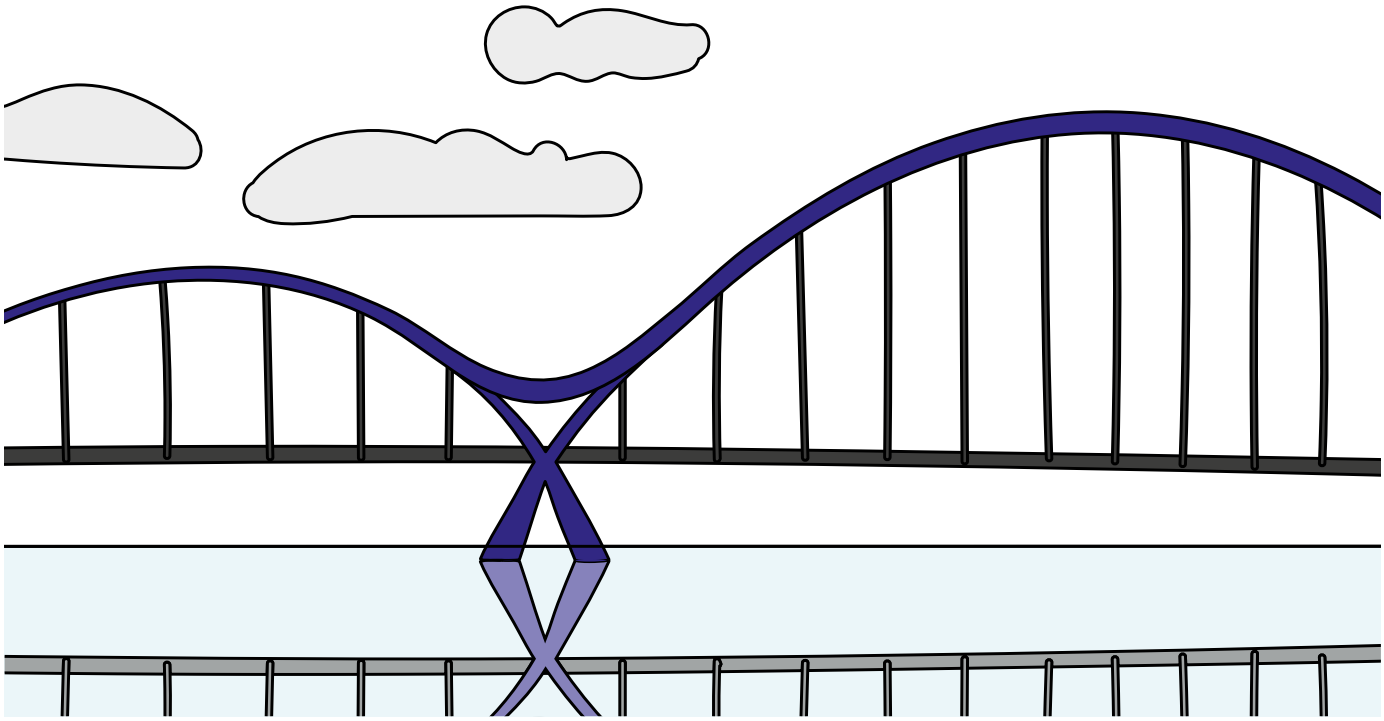
    d. Regeneration: Through helping to embed addressing **wider socio-economic determinants** of inequalities and health and wellbeing through policy and practical action.

    e. Colleagues: Through embedding an approach to prevention and addressing inequality in our **workforce planning**; and embedding e.g. Making Every Contact count across our current workforce to **maximise their impact**.

12. Identify and **address gaps in our understanding of local communities**, through work with the community, local intelligence and research evidence. For example, the experience of people in varying ethnic groups and the LGBTI community.

13. **Ensure** local strategic outcomes / **impact monitoring approaches explicitly capture impact in inequalities,** using the Marmot indicators as a basis. A logic model approach can lend itself well to clearly linking actions and measures to strategic outcomes and

14. will be used to monitor the new Joint Health and Wellbeing Strategy.



Appendices

Appendix 1: Life expectancy

Life expectancy across the population for females (2011-15) was 81.4 years.

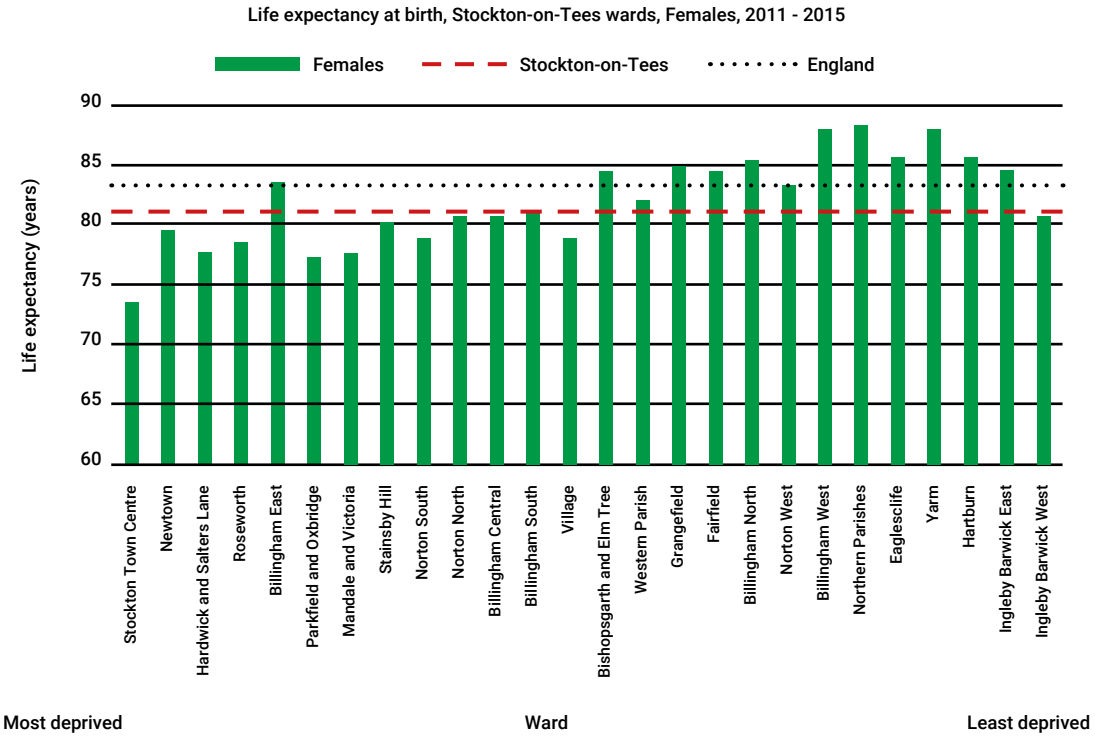


Figure 1 Life expectancy at birth, Stockton-on-Tees wards, females 2011-15

Life expectancy across the population for females (2016-20) was 82.1 years.

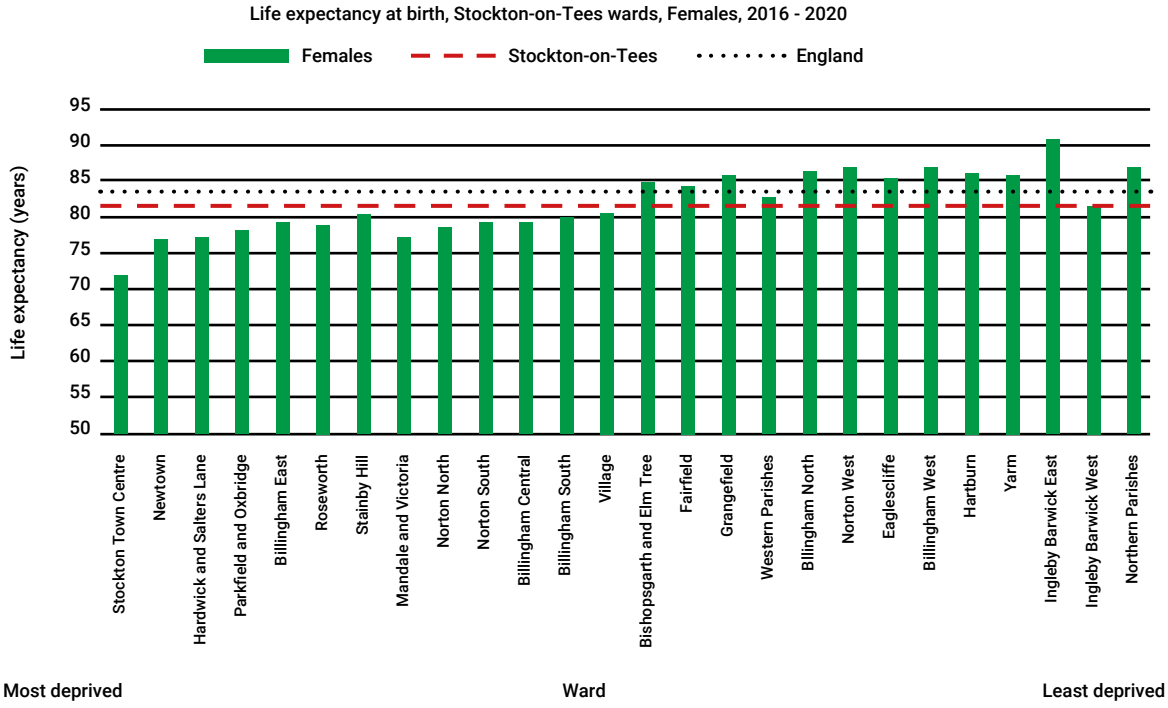


Figure 2 Life expectancy at birth, Stockton-on-Tees wards, females 2016-20

Life expectancy across the population for males (2011-15) was 78 years.

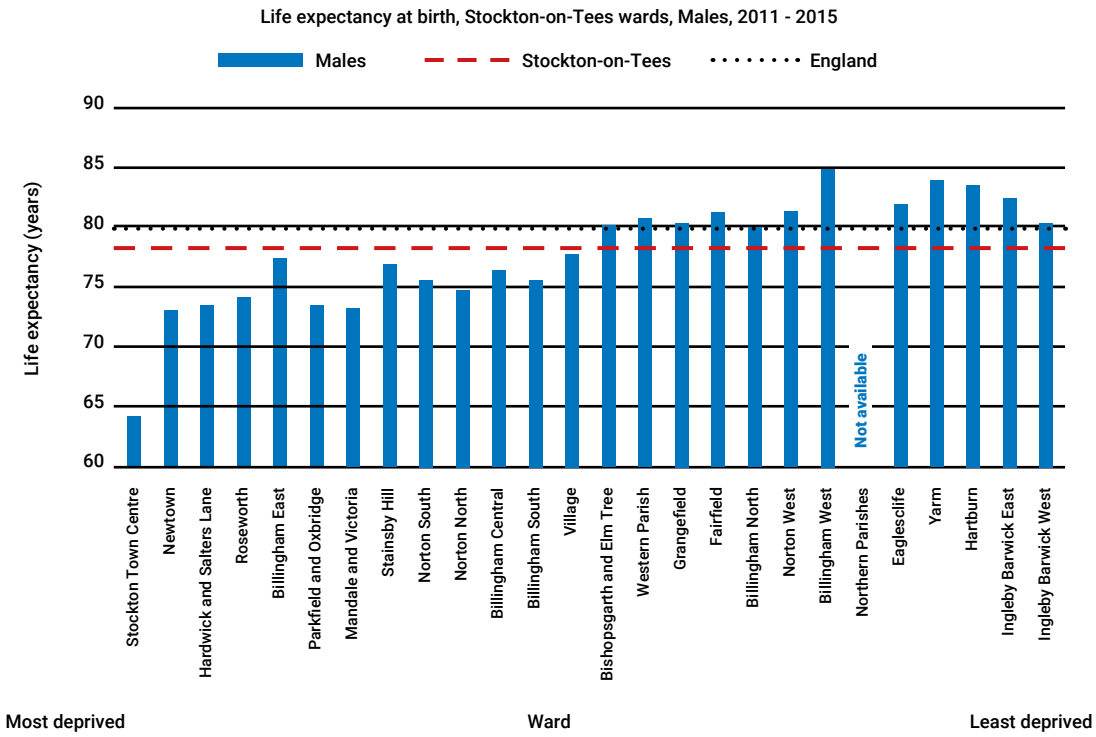


Figure 3 Life expectancy at birth, Stockton-on-Tees wards, males 2011-15

Life expectancy across the population for males (2016-20) was 78 years.

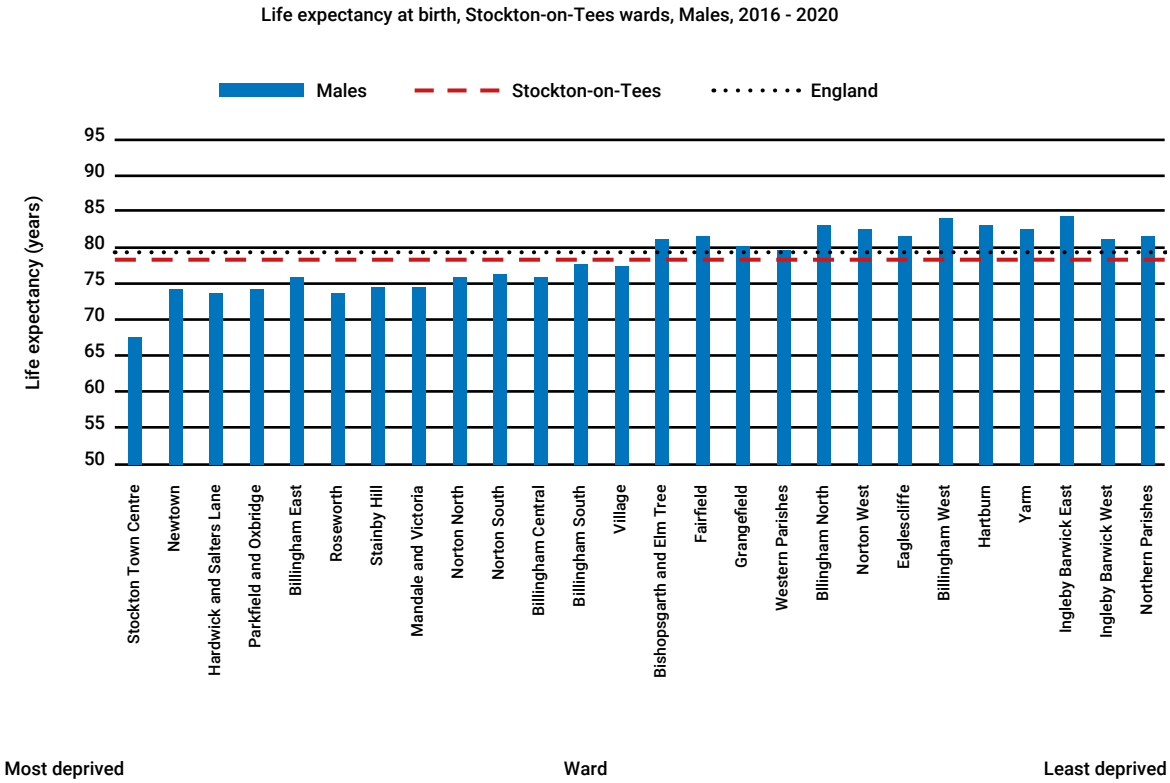


Figure 4 Life expectancy at birth, Stockton-on-Tees wards, males 2016-20

Appendix 2: Inequality in life expectancy

Females

For females there has been an increase in the slope of inequality from 11.4 years to 13.9 years. The gap in LE from decile 1 to decile 2 in 2011-2013 was approximately 1.8 years, this increased to 4 years in 2018-2020. Life expectancy for females has decreased in all deciles except decile 6 and decile 8 where there has been a small increase (0.1 years). The most significant decrease is in decile 3 which has seen the greatest decrease (3.9 years).

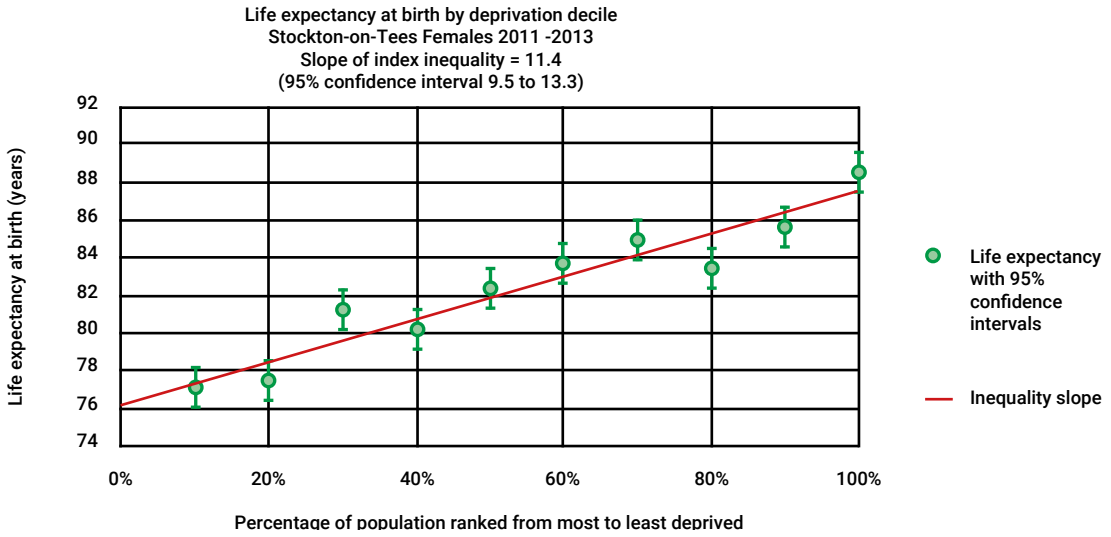


Figure 5 Life expectancy at birth by deprivation decile, Stockton-on-Tees, females, 2011-13

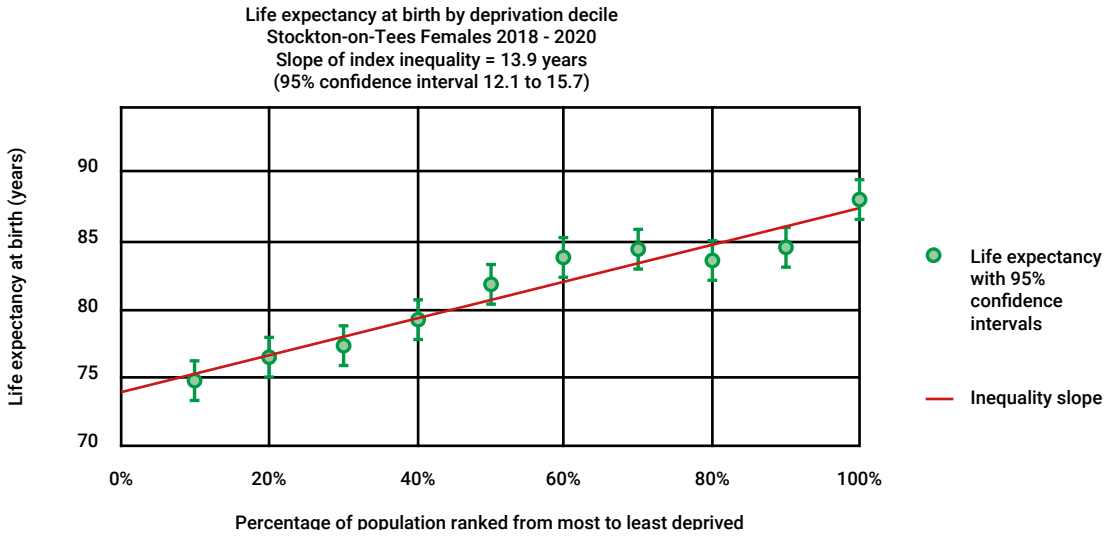


Figure 6 Life expectancy at birth by deprivation decile, Stockton-on-Tees, females, 2018-20

Males

For males the slope index of inequality reduced from 17.3 in 2011-13 to 14.5 in 2018-20. The explanation is not clear, but the 2011-13 data may well have been skewed by the 3rd least deprived decile, which has 'pulled the line upwards' at the right-hand end, whereas the line for 2018-20 is not influenced by such extremes and so may be 'flatter' as a result.

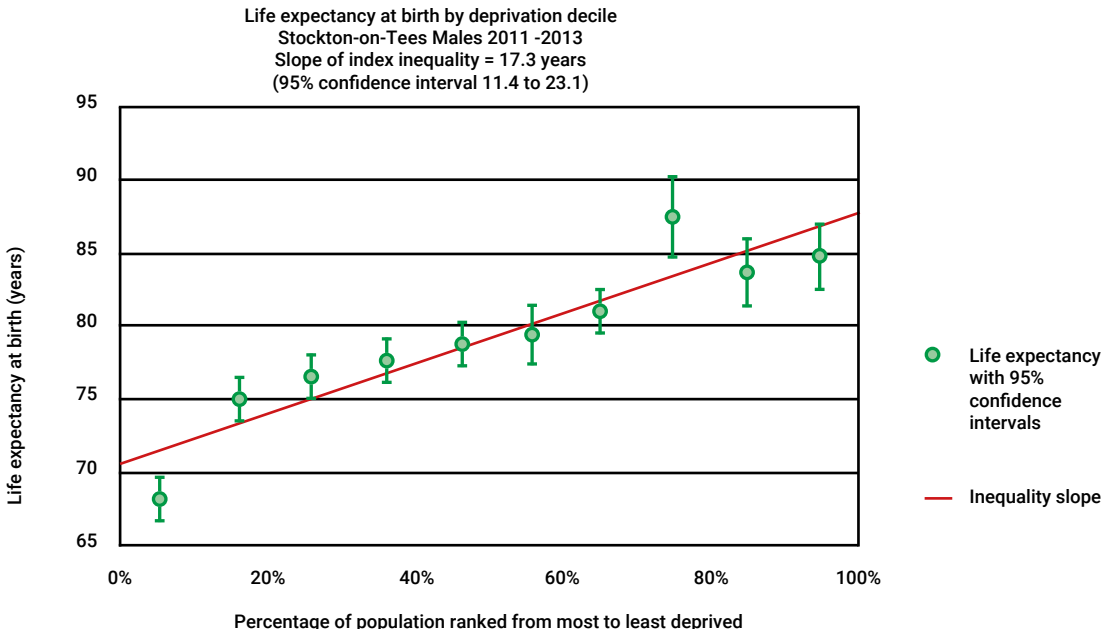


Figure 7 Life expectancy at birth by deprivation decile, Stockton-on-Tees, males, 2011-13

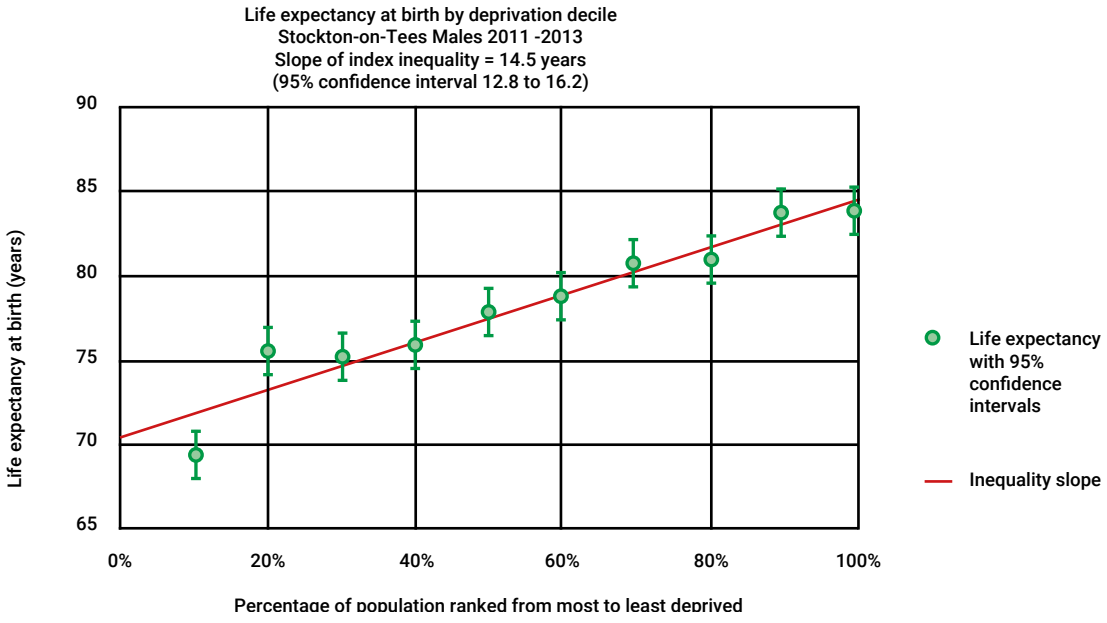


Figure 8 Life expectancy at birth by deprivation decile, Stockton-on-Tees, males, 2018-20

Appendix 3: Intersectionality

The IPPR report Intersectionality: Revealing the realities of poverty and inequality in Scotland (2021) (https://www.ippr.org/articles/an-intersectional-approach-to-poverty-and-inequality-in-scotland) made recommendations for Scotland's Poverty and Inequality Commission based on existing research on policy, and on speaking to people with direct experience of living with multiple factors impacting their wellbeing and access to services. It looked at access to public services such as housing and healthcare, to digital access, the reliability of social security, food insecurity, no recourse to public funds status and barriers to employment.

The Scottish government's diversity wheel illustrating intersectionality, showing how personal characteristics intersect with systems and structures to shape a person's experience (https://www.gov.scot/publications/using-intersectionality-understand-structural-inequality-scotland-evidence-synthesis/pages/3/).

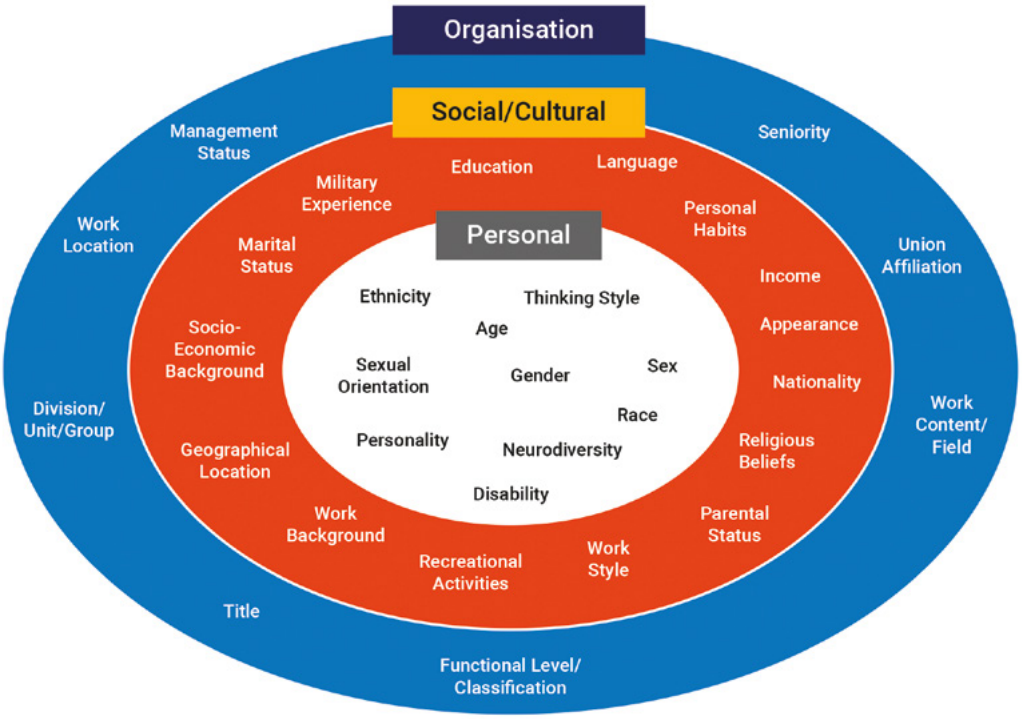


Figure 9 Diversity wheel. Scottish government 2022

Appendix 4: Breakdown of the life expectancy gap between the most and least deprived quintiles of Stockton-on-Tees by cause of death, 2020 to 2021

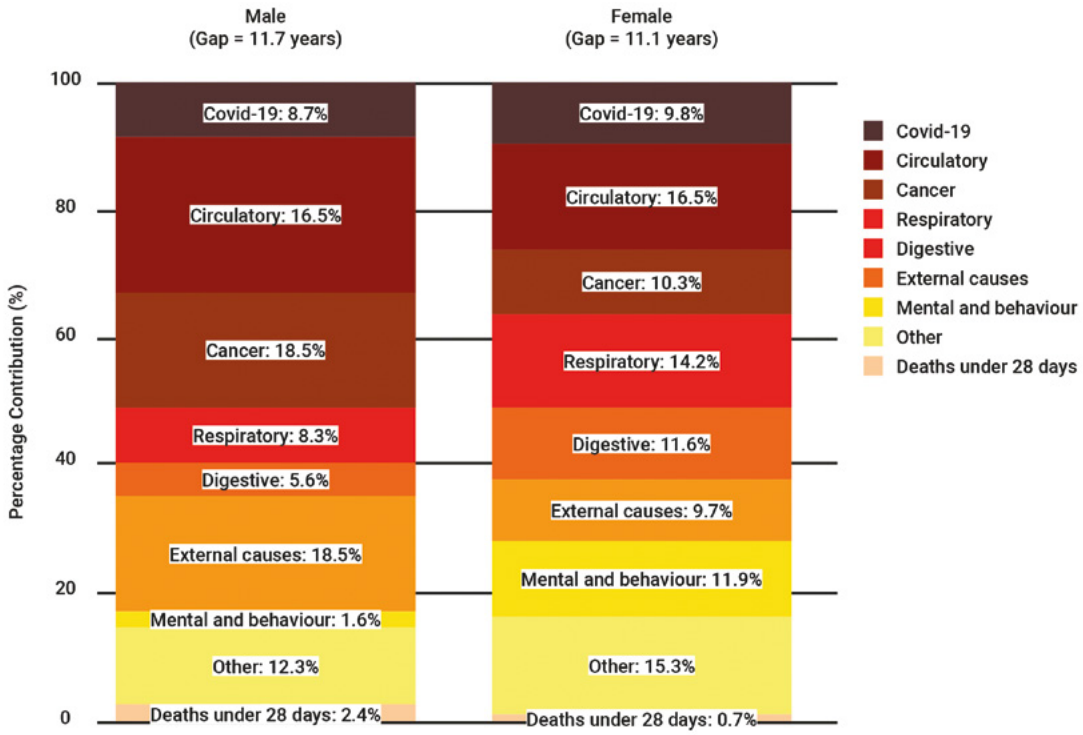


Figure 10 Life expectancy gap between most and least deprived population quintiles by cause of death. Stockton-on-Tees. 2020-21


Stockton-on-Tees
BOROUGH COUNCIL