



Tees, Esk and Wear Valleys
NHS Foundation Trust

Statement on information on health inequalities

2025/26



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Executive Summary

This report is Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) response to NHS England's refreshed expectations on reporting information about health inequalities for 2025/26. It brings together key information on who we serve, the main inequalities affecting our communities, what the trust has done during the year, and the areas we will focus on next.

- **Our population and geography:** TEWV serves around two million people across a large and diverse area including major towns and cities, rural and coastal communities, and prisons.
- **Deprivation and poverty:** parts of our footprint include some of the most deprived neighbourhoods in England. Poverty and financial hardship contribute to poorer mental and physical health and can make it harder for people to access care.
- **Ethnically minoritised and racialised communities:** our overall population is mainly White British, but some local areas have much higher proportions of ethnically minoritised and racialised communities. Local and national evidence shows different experiences and outcomes by ethnicity, so we need to respond at neighbourhood level in partnership with our communities.
- **Co-occurring needs:** many people face overlapping challenges (mental health, learning disability, neurodiversity, housing, employment, and social isolation). Co-occurring substance use and mental ill health is also a key concern, linked to avoidable harm and early death.
- **Physical health inequality:** people with serious mental illness and/or learning disability experience higher rates of long-term conditions and early death.

What TEWV has done in 2025/26

- **Improved how we use data:** we strengthened our population health analysis (including use of Fingertips and other sources) to inform planning, including work linked to our 5 year plan and community transformation.
- **Built capacity:** we secured three years of NHS England salary support for a Level 7 Health and Care Intelligence Specialist Apprenticeship to increase analytical capability.
- **Developed better dashboards:** we published our first Patient, Carer and Race Equality dataset and developed a new Equality, Diversity and Inclusion (EDI)

dashboard to help teams look at access, experience and outcomes by ethnicity and deprivation (and at trust, care group and team level).

- **Started stronger governance:** we developed measures aligned to our health inequalities plan (for example, reducing unknown ethnicity recording, understanding DNA/cancellations, and monitoring restrictive interventions, admissions and Mental Health Act use by ethnicity and deprivation).
- **Took action in services:** we progressed work on inclusive inpatient care through the Culture of Care programme; strengthened targeted approaches in Talking Therapies; continued community transformation work focused on groups and places at greatest need; progressed physical health improvement work (for example Making every contact count, screening pathways for longer-stay inpatients, and healthy weight approach in secure settings) and progressed our approach and partnership working for those experiencing drug and alcohol related harm.

Key challenges highlighted by the data

Persistent inequalities affect ethnically minoritised and racialised communities (including lower access in some services and higher levels of detention and inpatient care for some groups), alongside the continuing impact of deprivation, poverty, and substance-related harm. A specific operational challenge is that ethnicity recording has declined and is below the national mental health trust average, which limits how confidently we can understand and address inequalities.

Headline priorities for 2026/27

- **Build strong foundations (data and governance):** improve the quality of our data (especially ethnicity), publish simple dashboards for services, and set up regular reporting so teams can make better decisions and track progress.
- **Work in partnership on prevention:** agree our role with partners and focus on three prevention priorities in 2026/27: neighbourhood health and community transformation, suicide prevention, and dementia prevention.
- **Test and learn through three ‘pathfinder’ programmes:**
 - **Personalising care:** develop and test an approach to reduce Did Not Attend/Was Not Brought (DNA/WNB), focusing on our most deprived communities and people facing multiple disadvantage.
 - **Patient and Carer Race Equality Framework (PCREF):** build stronger relationships with community partners to learn from racialised communities, then use what we hear to adapt services, improve access and improve people’s experience.
 - **Culture of Care:** roll out Standard 5 “Equality” through innovation and learning hubs at inpatient sites, shaped by local drivers of inequality (including poor physical health, poverty, and drug and alcohol-related harm).

Overall, this report shows that inequalities in our population are real, local and overlapping; our focus is to use better data and lived experience insight to deliver practical improvements in access, experience and outcomes for the people most affected.

Introduction

On 19 November 2025 NHS England (NHSE) published an updated statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006). This outlined refreshed expectations on Trusts to Boards to identify key data and information on health inequalities and outline how they have responded to this information within or alongside their annual reports. This report forms Tees, Esk and Wear Valleys NHS Foundation Trust's response to this statement for the year 2005/26.

SECTION 1: Understanding Population Health Need

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) serves a population of two million people across County Durham, Darlington and North Yorkshire and are geographically one of the largest NHS Foundation Trusts in England.

The main communities we serve include:

- County Durham
- Darlington
- The Teesside boroughs of Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees
- City of York
- North Yorkshire – including Scarborough, Whitby, Ryedale, Hambleton and Richmondshire, Selby, Harrogate and Ripon
- The Pocklington area of East Yorkshire
- The Wetherby area of West Yorkshire
- Prisons located in the Northeast, Cumbria and parts of Lancashire.
- We are also a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the Northeast and North Cumbria.

The communities we serve are diverse. The area covered by TEWV contains an array of natural assets and vibrant communities. It also includes some of the most deprived neighbourhoods in England, and so has some of the country's poorest social, physical, and mental health outcomes. Deprivation creates additional stress and exacerbates any health condition (mental and physical), and our services therefore need to meet increased and more complex demand.

The things that drive inequality and poor health outcomes in our populations are complex and overlapping. People often face multiple challenges at one time across mental health, learning disability, neurodiversity, physical health, and social and economic circumstances.

Poverty and financial hardship are underpinning drivers of inequality which disproportionately impact people who use our services. Our “core 20” approach therefore needs to consider those living in our most deprived 20% of postcodes as well as wider consideration of social and economic exclusion including unemployment.

National evidence, combined with local data and insights has identified the following “plus” populations that require a more targeted approach to reduce health inequalities:

- Ethnically minoritised and racialised communities
- People experiencing physical ill health / at risk of multiple long-term conditions

- People with co-occurring substance use and mental ill health
- Rurality and isolation also contribute significantly for some of our communities.

The population data provided here gives a high-level overview of the communities we serve within TEWV. It provides a broad health and economic profile which influences how and when people present in service as well mental health indicators for our wider populations.

Links to all local authority joint strategic needs assessment are provided on trust intranet.

NB: Data at local authority level can mask ward and community level issues where pockets of deprivation and poor health outcomes exist alongside more affluent communities and vice versa. Neighbourhood and ward level data should be accessed to fully understand the health needs of the population. [Local health, public health data for small geographic areas | Fingertips | Department of Health and Social Care](#)

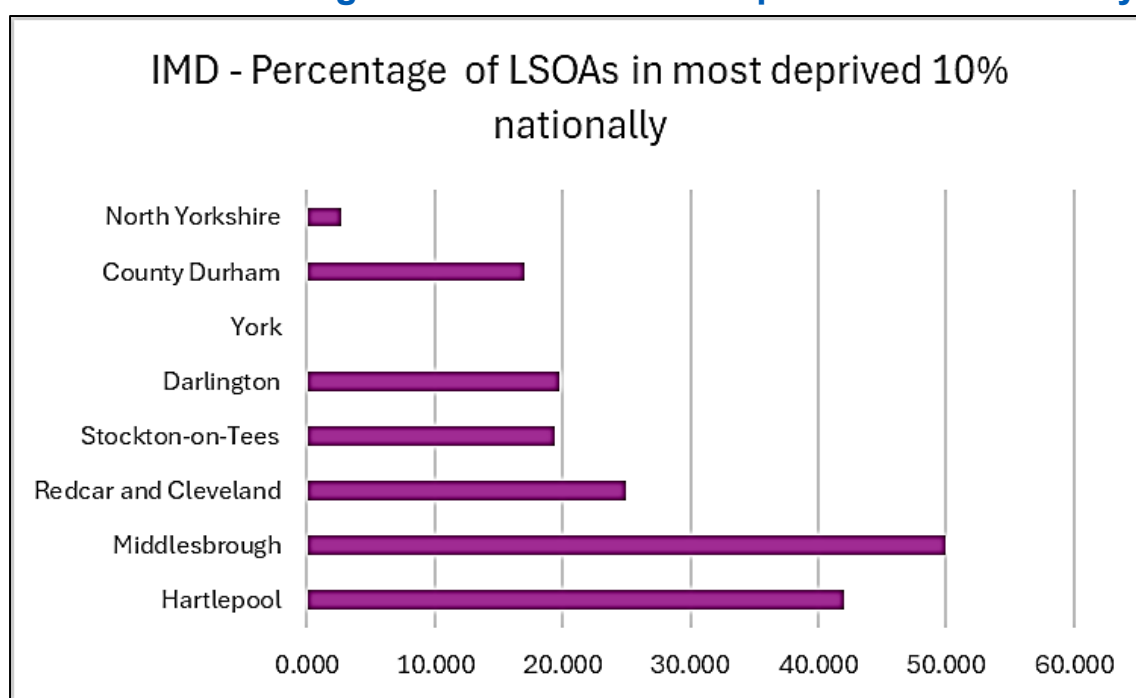
Ethnicity

The Trust serves a population which is 91.92% White British according to census figures. Whilst ethnically minoritised and racialised communities make up a smaller proportion of our overall population this varies significantly at place. National evidence and internal data also demonstrate differential outcomes for ethnically minoritised and racialised communities. It is important at a team and trust level to systematically built into planning and delivery an understanding of the local population. [This interactive map](#) enables exploration of ethnicity down to output area (the smallest geographic areas covered by the office for national statistics typically between 100-625 residents or 40-250 households): [Ethnic group - Census Maps, ONS](#). When viewed at this level, as an example, at output level in parts of Middlesbrough 74.7% of people identify as Asian, Asian British or Asian Welsh showing the importance of reviewing this data at a very local level.

Deprivation

According to [English indices of deprivation 2025](#), within the TEWV footprint, Middlesbrough and Hartlepool have the highest number of middle super output areas in the most deprived 10% nationally with almost half of the areas falling into this category.

Chart 1 – Percentage of LSOAs in most deprived 10% nationally

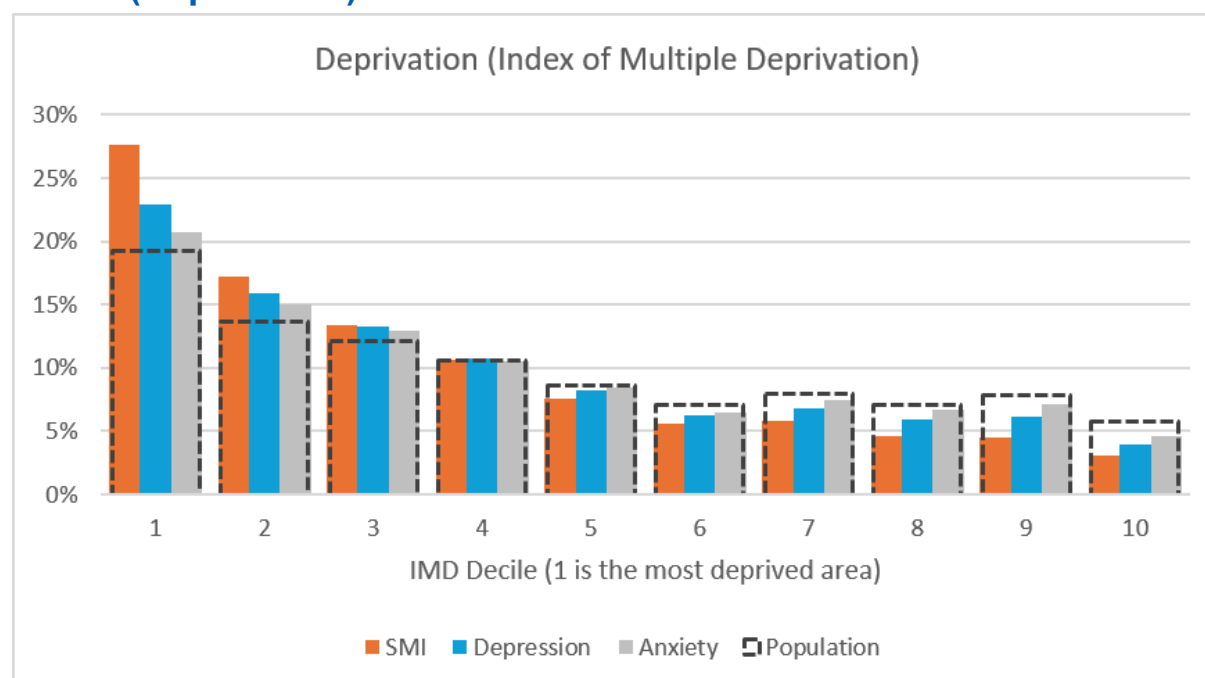


Poverty and Financial Exclusion

Poverty impacts high numbers of our communities. Around one in three children in Teesside were living relative low-income families in 2022/23. Within areas, however, this can vary significantly with statistics indicating over 50% of children living in poverty in parts of Middlesbrough for example (source [Joseph Rowntree Foundation](#)). Within North Yorkshire and York, the overall picture is less stark with proportion of children in relative low-income families between 11-12% of the population at County level in 2022/23. However, pockets of deprivation can be masked by higher levels of wider affluence, and its impact can be more acute when coupled with rurality and isolation. For example child poverty in some wards with in Scarborough is as high as 40% [Local health, public health data for small geographic areas - Data - OHID \(phe.org.uk\)](#)

The interconnectedness of poverty and mental ill health means that those using our services are disproportionately impacted by poverty. Primary care registration data shows higher levels of severe mental illness (SMI), anxiety and depression in the most deprived parts of the North East and North Cumbria.

Chart 2 –North East and North Cumbria (NENC) Integrated Care Board data– Patients with Anxiety, Depression or SMI Profile for NENC (Deprivation)



There are also high levels of economic inactivity across our geographies with people in the North East less likely to work if they have a long-term condition or disability than in other parts of the country.

The total percentage of people in paid employment across our footprint varies between 61.6% in Middlesbrough to 80% in Darlington which in 23/24 had the highest employment rate in our footprint and along with North Yorkshire and York was higher than the England average. In terms of the gap in employment for those with a physical or mental long term health condition the gap was largest in Stockton at 25% followed by Darlington and York at 20% and 21%. It should be noted in some of our more deprived areas the size of the gap may be reduced by lower overall employment rate rather than being an indication those with long term conditions have more employment opportunities in these areas.

Age Profile and Population Projections

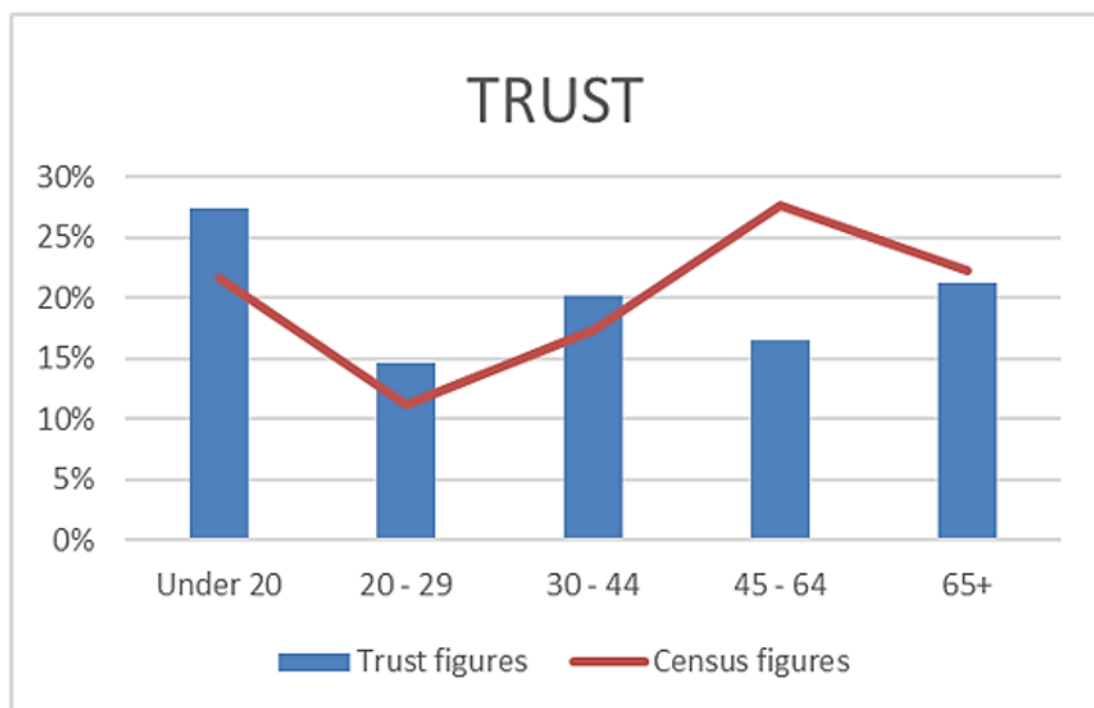
The UK population as a whole is aging with projections for aging in rural and coastal communities predicted to be more acute than in urban areas ([Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK](#)). Across the TEWV population over the next 20 years there is predicted to be a decline of 11-19% in 5–19-year-olds. An increase of 5-9% in 20–64-year-olds and an increase of 25-33% in those aged over 65. Planning assumptions needs to consider wider factors which influence demand including social and economic drivers of mental ill health such as those outlined in this report and in particular in children and young person services where the population projections do not reflect recent demand trends. However, planning must also be cognisant of greater proportions of the population in older adults including implications for our workforce.

Access data demonstrates higher levels of engagement in younger population in under 20's indicating a positive trend toward meeting increasing demand in this cohort with lower-than-expected levels of engagement in 45–64-year-olds. For those aged 65+ service access rates align with the current population.

Chart 3 – Age Groupings Access Rates

Age Grouping

Age grouping	Trust figures	Census figures
Under 20	27.36%	21.62%
20 - 29	14.68%	11.17%
30 - 44	20.13%	17.31%
45 - 64	16.53%	27.69%
65+	21.30%	22.21%



Drug and Alcohol Related Harm

It is common for people to experience problems with their mental health and alcohol/drug use at the same time, as there is often a common root cause in trauma. The latest National Confidential Enquiry into Suicide and Safety in mental Health ([NCISH | The University of Manchester](#) February 2025) indicated retained high levels of alcohol or drug use in suicides in people experiencing mental health problems. “Other evidence tells us that people with co-occurring conditions have a heightened risk of physical health problems and early death” ([Better care for people with co-occurring mental health, and alcohol and drug use conditions](#)) Substance misuse can be very common in socially marginalised communities (for example those involved in the criminal justice system), further adding to difficulties they have in

traditional services engaging with them. Drug and alcohol harm are commonly recorded within serious incidents and mortality reviews within the trust.

Drug related deaths are amongst the highest in the country in areas such as Middlesbrough with rates over 2x times higher than the national position. Data does indicate a narrowing of this gap in areas including Stockton and Hartlepool in the latest data (2022/23 [Fingertips | Department of Health and Social Care](#)). Although overall rates of drug related death in North Yorkshire are lower than Durham Tees Valley, and have seen a recent decline, the overall trends is one of significant increase over the last 20 years. Within York, historical highs in the last 10 years have seen a return to closer to the England average.

Chart 4 – Deaths from Drug Misuse (Persons) from Fingertips Site
Chart 5 and 6 – Deaths from Drug Misuse (York and North Yorkshire)

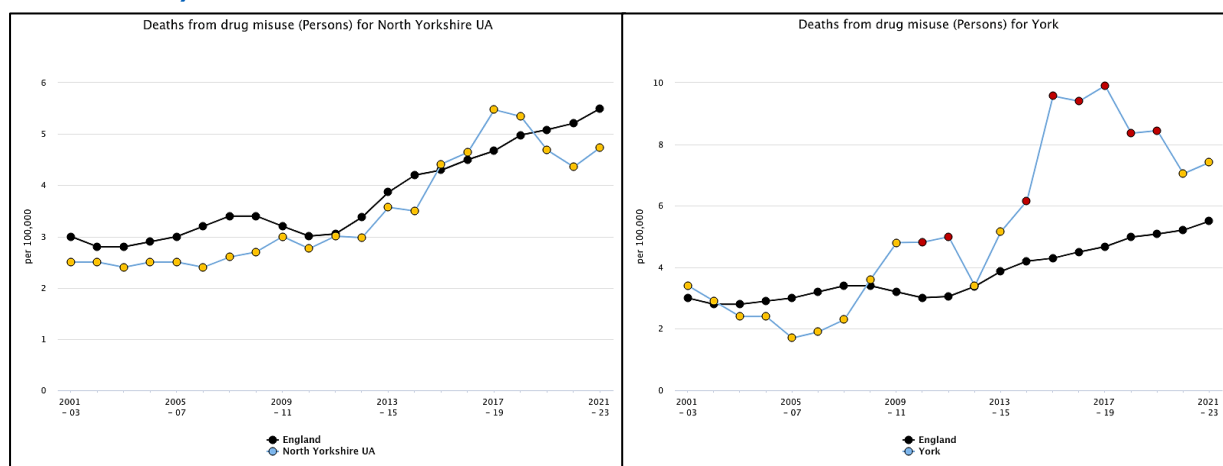
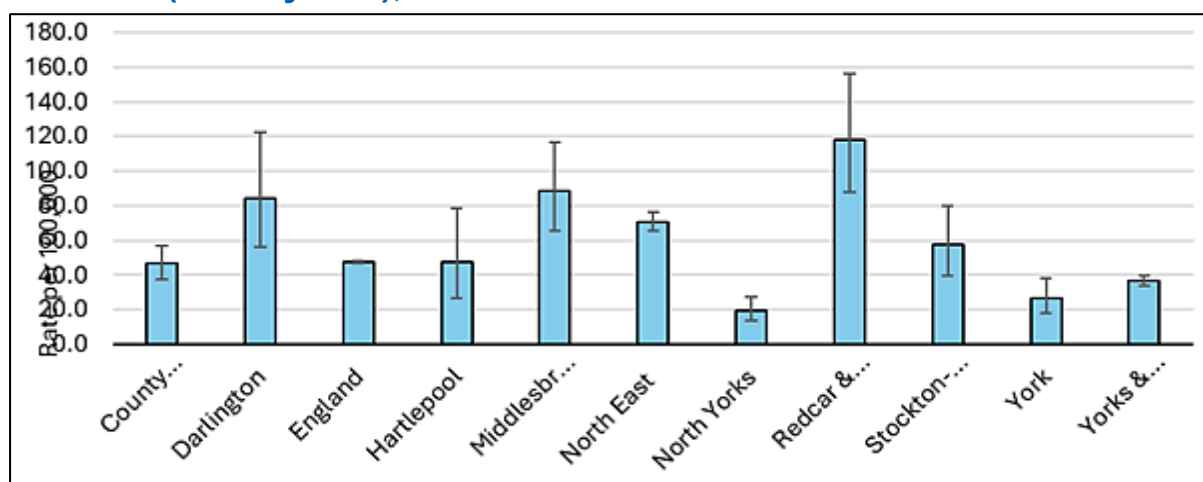


Chart 7 – Hospital Admissions due to Substance Misuse (15 to 24 years) TEWV Las, Northeast and Yorkshire and Humber Regions of England
Persons (15-24 years), 2021-22 – 23/24

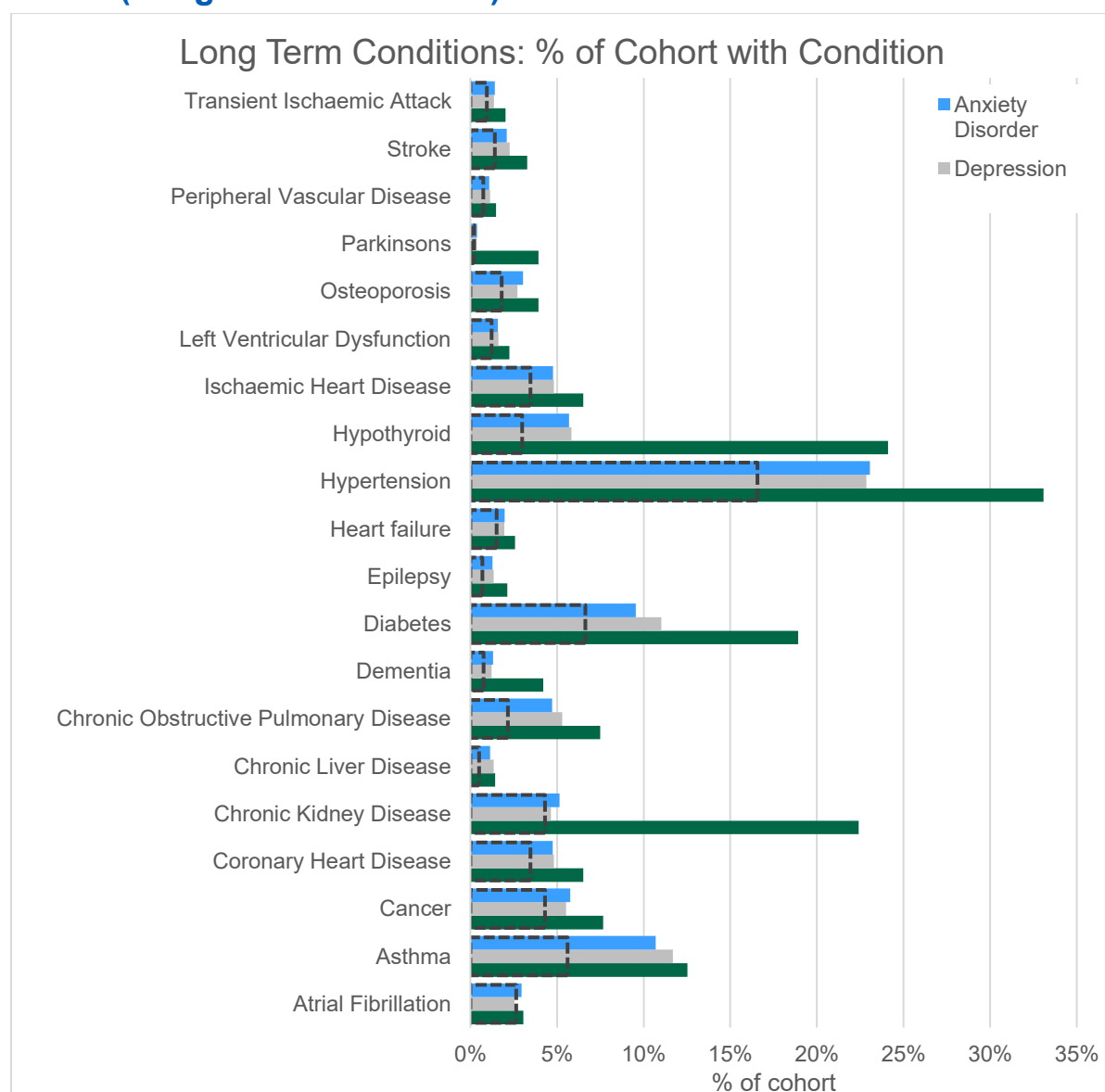


A number of areas across the TEVW footprint show significantly higher levels of hospital admission for substance misuse in 15–24-year-olds. With the rate in Middlesbrough almost twice that national rate and Redcar and levels higher still.

Physical Ill Health

There are high levels of physical ill health in the wider communities we serve which disproportionately impact on those with a serious mental illness (SMI) and or/ a learning disability. Across all long-term conditions registers in North East and North Cumbria those with an SMI, anxiety or depression were more likely to have the long-term condition. Multi morbidity is also the norm.

Chart 8 - North East and North Cumbria (NENC) Integrated Care Board data– Patients with Anxiety, Depression or SMI Profile for NENC (Long term Conditions)



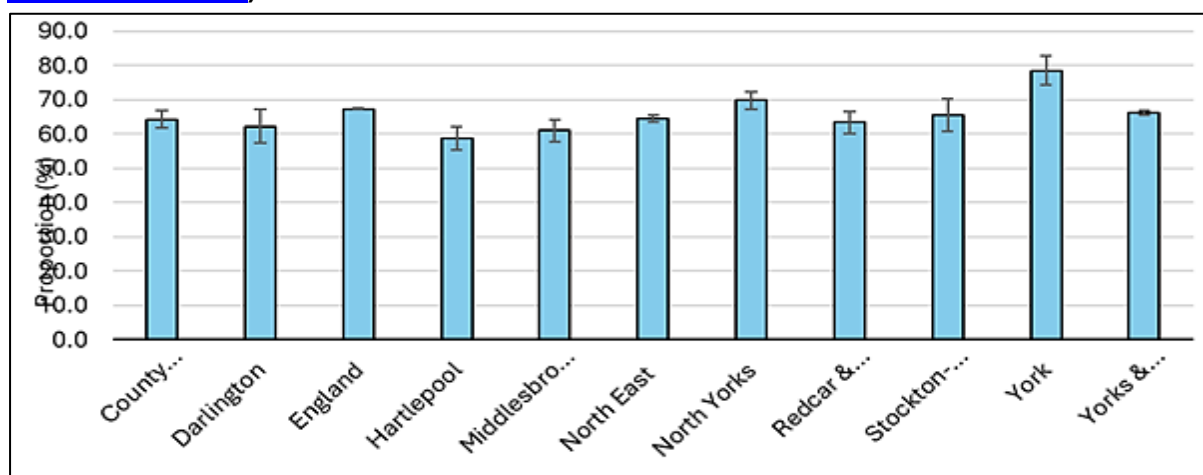
Comparable data for North Yorkshire is in development. Although overall life expectancy in North Yorkshire and York is higher than or similar to the England average there are disparities across this geography with stark differences at ward level with almost 15 year difference in male life expectancy between some of the most and least deprived communities. [Local health, public health data for small geographic areas - Data | Fingertips | Department of Health and Social Care.](#)

Chart 9 – Life Expectancy for North Yorkshire and York from Fingertips

Indicator	Period	North Yorkshire			England			Range	Best
		Recent Trend	Count	Value	Value	Worst			
Healthy life expectancy at birth (Male)	2021 - 23	–	–	63.8	61.5	51.8			69.7
Healthy life expectancy at birth (Female)	2021 - 23	–	–	64.6	61.9	52.6			70.8
Life expectancy at birth (Male, 1 year range)	2023	–	–	80.2	79.3	73.4			82.7
Life expectancy at birth (Male, 3 year range)	2021 - 23	–	–	80.3	79.1	73.1			82.5
Life expectancy at birth (Female, 1 year range)	2023	–	–	83.8	83.2	78.2			86.8
Life expectancy at birth (Female, 3 year range)	2021 - 23	–	–	84.0	83.1	78.9			86.5

Indicator	Period	York			England			Range	Best
		Recent Trend	Count	Value	Value	Worst			
Healthy life expectancy at birth (Male)	2021 - 23	–	–	62.0	61.5	51.8			69.7
Healthy life expectancy at birth (Female)	2021 - 23	–	–	62.7	61.9	52.6			70.8
Life expectancy at birth (Male, 1 year range)	2023	–	–	80.2	79.3	73.4			82.7
Life expectancy at birth (Male, 3 year range)	2021 - 23	–	–	79.8	79.1	73.1			82.5
Life expectancy at birth (Female, 1 year range)	2023	–	–	83.9	83.2	78.2			86.8
Life expectancy at birth (Female, 3 year range)	2021 - 23	–	–	83.6	83.1	78.9			86.5

Chart 10 – Percentage of Physically Active Adults TEWV LAs, Northeast and Yorkshire and Humber Regions and England Persons (19+ years), 2023/24 (Data Source: [Fingertips | Department of Health and Social Care](#))

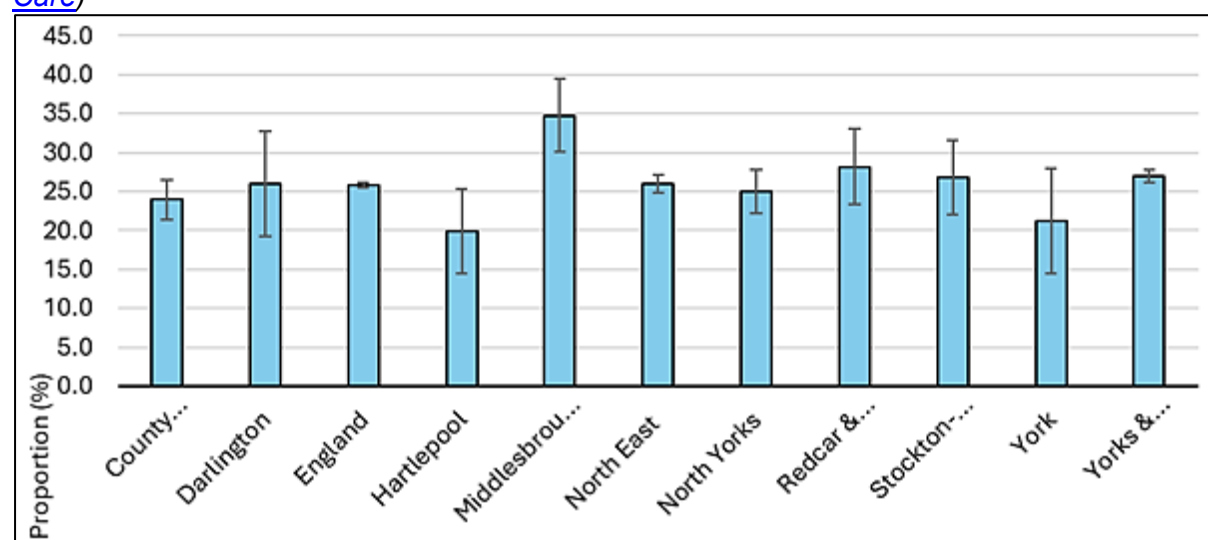


Physical activity is evidenced to be effective in the promotion of good physical and mental health. Our most physically active local authorities are in York with 78.8% of adults accounted as physically active and North Yorkshire at 69.9%. In Hartlepool the rate of physically active adults is 58.7% and across County Durham and Tees Valley less people are active than the England average.

Chart 11 – Smoking Prevalence in Adults with Anxiety or Depression (aged 18 and over) – Current Smokers (GPPS)

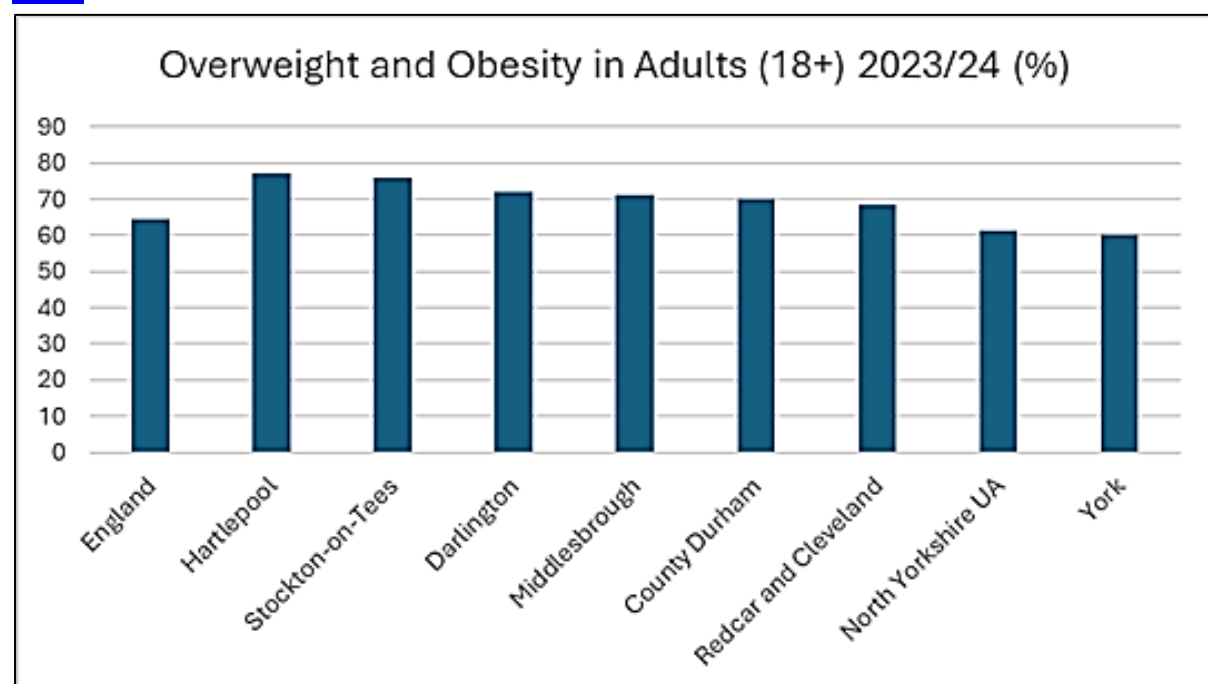
TEWV LAs, Northeast and Yorkshire and Humber Regions in England

Persons (18+ years), 2016/17 (Data Source: [Fingertips](#) | [Department of Health and Social Care](#))



Smoking rates in those with Anxiety and depression are consistently higher than at population level. Where the percentage of people smoking in the wider population varies in the TEWV footprint between 18.3% in Hartlepool and 11.4% in York (of 22/23), in people with anxiety and depression this is as high as 34.8% in Middlesbrough.

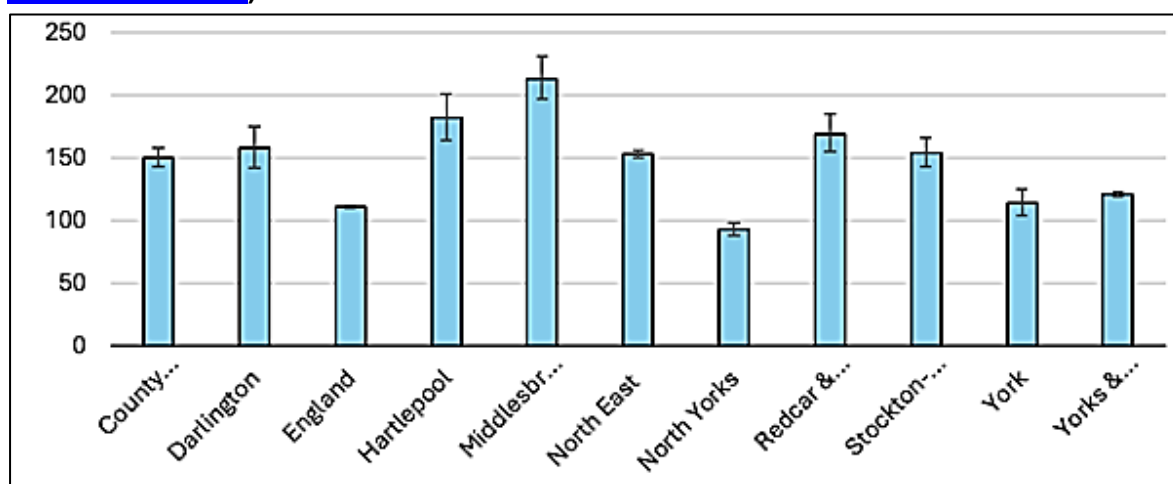
Chart 12 – Percentage of Overweight and Obesity in Adults (18+ years), 2023/24 Data Source: [Fingertips](#) | [Department of Health and Social Care](#)



Levels of overweight and obesity are high across the country with over 60% of adults nationally falling into this category which is associated with multiple health harms. Whilst North Yorkshire and York rates are slightly below the England average this still accounts for most of the adult population in these areas. All other areas are over the England average with the highest rates in Hartlepool and Stockton at 77.2% and 76.1%. Local intelligence suggests this is higher in our patient population with particularly high rates in our secure in-patient services.

Chart 13 – Premature Mortality in Adults with Severe Mental Illness (SMI) TEWV LAs, Northeast and Yorkshire and Humber Regions and England

Persons (18-74 years), 2021-23 (Data Source: [Fingertips | Department of Health and Social Care](#))



Local intelligence also highlights higher proportions of health risk behaviour and long-term conditions in people with serious mental illness. The culmination of social, health and economic inequality show in premature mortality rates which see people with serious mental illness dying early across all our localities with significantly higher rates in the Durham Tees Valley areas.

SECTION 2: Improving Data Use Quality, Collection and Analysis

Action to improve data use, quality collection and analysis this year has included:

TEWV footprint analysis has been undertaken on a range of relevant population health indicators on the fingertips profile. This helped to form a community profile as part of this year's 5-year plan submission and is being developed as part of a "planning pack" to increase use and accessibility of population health data in routine planning across the Trust. This will inform our ongoing community transformation and neighbourhood health partnerships as well as work on race equality and inclusivity for core 20+ populations. In 2026/27 we aim to improve the use and accessibility population data through trialling accessible placed based profiles.

Population health need has informed targeted work on core 20+ population groups in areas including addressing physical health inequality, Drug and alcohol related harm, race equality and poverty (see section 4: Using information to take action on health inequalities)

A successful application to NHS England for 3 years salary support for a L7 Health and Care Intelligence Specialist Apprenticeship which commenced in December 2025. This post will provide much needed dedicated capacity and capability for population health analytics within the Trust.

Publication of our first Patient, Care and Race equality data set. This was supported by a series of webinars and leadership "time outs" and a team template to promote the importance and use of ethnicity recording as part of delivering accessible and inclusive care.

The development of a new equality, diversity and inclusion dashboard which enables segmentation of data on access, engagement, restrictive practice, length of stay and mental health act use. Segmentation is by ethnicity and deprivation and can be analysed at trust, care group and team level.

The development of a new governance framework for scrutiny of select health inequalities measures aligned to our health inequalities plan. This includes routine consideration at board level, quality committee and care group board for 26/27.

Measures include:

- Percentage (%) of those accessing services by ethnicity – with a focus on reducing % of unknown as part of trust inequalities plan delivery
- 'Did not attend' (DNA) and cancellations- reduction in gap for core 20+ populations (ethnicity and deprivation to start with)
- Restrictive interventions by ethnicity and deprivation (monitoring only initially)
- Admissions by ethnicity and deprivation (monitoring only initially)
- Mental health act (MHA) use by ethnicity and deprivation (monitoring only initially)

- Partnerships with community volunteer services (CVS) organisations supporting racialised communities (process measure – map, increase and insights)
- Use of population health data (process measure)

In addition, a selection of performance indicators will be reported by ethnicity and deprivation.

SECTION 3: Understanding Healthcare Access, Experience and Outcomes

Note - for the period of April 1st, 2024 - March 31st, 2025, unless otherwise stated

Inequalities in Recovery Rate for Talking Therapies (Source: local service records)

Ethnicity

The recovery rate for people accessing talking therapies services varies by place and ethnicity. Overall recovery rates are highest in York and Selby ranging between 50-67%. The highest recovery rates are in Black / Black British people in all localities. The lowest recovery rate was amongst Asian or Asian British people in the Durham and Darlington locality at 36%, however in North Yorkshire rates for Asian or Asian British people were higher at 63% and 59%.

Age

Recovery rates by age show rates were highest for those aged 65+ in all localities ranging from 66-71% compared to 42-48% in those aged under 25 and 49-57% in those aged 25-64.

Gender

Recovery rates by gender were lower in those identifying as non-binary in all localities. Rates of recovery in males were slightly higher than females in all localities.

Table 1 – Recovery Rates by Ethnicity, Age, Gender and Locality

	North Yorkshire		Durham & Darlington		York & Selby	
Ethnicity	Number of Patients	Recovery Rate	Number of Patients	Recovery Rate	Number of Patients	Recovery Rate
Asian or Asian British	43	63.41%	127	36.21%	82	53.85%
Black or Black British	32	66.67%	43	51.43%	27	66.67%
Mixed	58	48.21%	113	44.76%	70	58.21%
Not known	55	49.06%	33	29.03%	85	50.00%
Not stated	29	50.00%	70	40.91%	54	62.26%
Other ethnic groups	30	44.83%	69	40.00%	44	52.27%
White	5400	52.89%	8448	49.42%	3714	55.35%
Blank		N/A	2	0.00%		N/A
Total	5647	52.90%	8905	48.97%	4076	55.40%

Age	Number of Patients	Recovery Rate	Number of Patients	Recovery Rate	Number of Patients	Recovery Rate
		N/A	348 (18 and under)	36.34%		N/A
Under 25	821	41.54%	1271 (19-24)	45.08%	1049	48.29%
25 - 64	4289	53.58%	6719	49.11%	2795	56.87%
65+	537	65.90%	567	66.09%	232	70.83%
Total	5647	52.90%	8905	48.97%	4076	55.40%

Gender	Number of Patient	Recovery Rate	Number of Patients	Recovery Rate	Number of Patientes	Recovery Rate
Female (including trans woman)	3896	52.08%	6031	47.94%	2767	54.53%
Male (including trans man)	1719	54.97%	2808	51.58%	1232	57.56%
Non-binary	19	36.84%	48	40.00%	51	49.02%
Not Known (not recorded)	0	N/A	<5	0.00%	<5	50.00%
Not Stated (person asked but declined to provide a response)	5	50.00%	4	66.67%	13	76.92%
Other (not listed)	8	50.00%	9	0.00%	9	33.33%
blank		N/A	<5	0.00%		N/A
Total	5647	52.90%	8900	48.97%	4076	55.40%

Inequalities in the Use of the Mental Health Act

Ethnicity

Information has been produced by calculating the expected rates of detention by gender and ethnicity for the trust based on standardised rates of detention per 100,000 population. The trust's anticipated rates are based on the 2021 census for ethnicity, sex, age and gender. These have been compared to the trust's detention rates and NHS Digital rates for 2024/25.

Compared to the national rates of detention per 100,000 population the trust detains more White, Asian/ Asian British and Other Ethnicities than the national rates, fewer Mixed people and the same number of Black/ Black British people. It should be noted that national rates of detention have fallen and that the trust's rates of detention have also decreased but are still higher than national rates for some groups of people.

Table 2 - Actual Detention rates per 100,000 population compared with anticipated detention rates and compared with national rates (2024)

COMPARISON TO NATIONAL RATES OF DETENTION					
Ethnicity	National rates of detention per 100,000 population	Anticipated numbers of detentions in TEWV based on national rates	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	Relative rate between TEWV detention figures and National Figures
White	66.9	1278	2405	125.8	1.88
Mixed	122	30	22	89.9	0.74
Asian/Asian British	85.7	46	63	117.4	1.37
Black/Black British	256.7	33	33	254.7	0.99
Other Ethnicities	140.8	20	41	292.4	2.08
Unknown	-	-	309	-	-

Table 2 shows that per 100,000 population those who identify as Black/Black British are detained 2.03 times more than White People, compared to 2.61 times in 2023/24 and Other Ethnicities are detained 2.33 times more than White people, compared to 1.32 times in 2023/24. Asian/Asian British, which is the same as 2023/24, and Mixed people are less likely to be detained than White people compared to 1.32 times more likely to be detained in 2023/24.

Table 3 - Relative Ratios of TEWV detention rates by ethnicity (1 April 2024 – 31 March 2025)

Ethnicity	White	Mixed	Asian/Asian British	Black/Black British	Other Ethnicities
White		1.40	1.07	0.49	0.43
Mixed	0.71		0.77	0.35	0.31
Asian/Asian British	0.93	1.31		0.46	0.40

Black/Black British	2.03	2.83	2.17		0.87
Other Ethnicities	2.33	3.25	2.49	1.15	

The rates are calculated against the row labels so if the figure is greater than one the characteristic in the row label shows a higher detention rate than the comparator in the column label, if the figure is less than one, they show a lower rate of detention.

An example of interpretation would be 'per 100,000 population Black/ Black British people are detained 2.03 times more than White people.'

Table 4 – Rates of Detention by Sex

Sex	Female	Male
Female		1.01
Male	0.99	

Further analysis of relative rates of detention by ethnicity and gender per 100,000 population show that compared to White women, Black/Black British women are detained 2.24 times more, compared to 3.39 times more in 2023/24, and are detained at higher rates than any other female ethnic group. Black/Black British men are 1.65 times more likely to be detained than White men, compared to 1.94 times in 2023/24. Women from other ethnicities are 1.85 times more likely to be detained compared to White women, compared to 0.85 times less likely in 2023/24. Men from other ethnicities are 2.36 times more likely to be detained compared to White men, compared to 1.77 in 2023/24.

Age

Rates of detention were similar in 20-29, 30-44 and 65+ with a lower rate amongst 45–65-year-olds. The under 20s rate is expected to be lower given the age range.

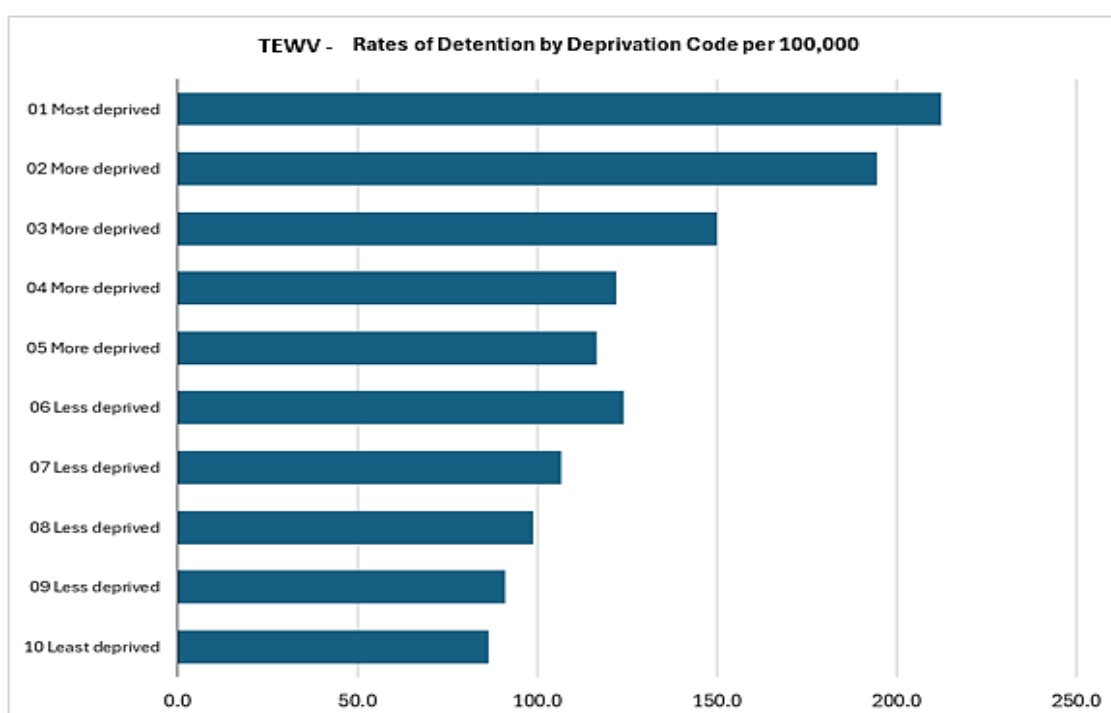
Table 5 – Rates of Detention by Age

Age group	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population
Under 20	101.0	22.9
(20-29)	465.0	201.0
(30-44)	700.0	198.2
(45-64)	704.0	127.0
(65+)	895.0	204.5

Deprivation

Rates of detention for the most deprived deciles are significantly higher at trust level in our most deprived communities with more than twice the rate of detention in our most deprived decile than our least deprived decile overall. Within care groups there is significant differences which reflect the makeup of the population. In numerical terms this results in seven times as many detentions in the most deprived decile in Durham tees valley than in the least deprived decile. Within North Yorkshire, York and Selby the actual number detentions are not socially profiled with slightly more detentions from the least deprived deciles than the most deprived deciles. This is a reflection of the different population make up in the two care groups and demonstrates the need to interrogate this data at place level and in the context of the communities served.

Chart 14 – Rates of Detention by Deprivation Code per 100,000 (TEWV)



Inequalities in Service Access and Hospital Admissions

Ethnicity

Access data shows that many racialised communities are underrepresented in services overall. Data also demonstrates a decline in ethnicity recording which has fallen to 68% which is lower than the national average for mental health trusts and significantly below target.

Table 6 – Access to Services by Ethnicity (TEWV v Census)

Ethnicity	Trust Figures	Census Figures
Asian/Asian British Bangladesh	0.05%	0.15%
Asian/Asian British Chinese	0.08%	0.47%
Asian/Asian British Indian	0.12%	0.61%
Asian/Asian British Other	0.14%	0.59%
Asian/Asian British Pakistani	0.23%	0.84%
Black/Black British African	0.16%	0.49%
Black/Black British Caribbean	0.05%	0.08%
Black/Black British Other	0.06%	0.08%
Decline To Disclose	0.12%	
Gypsy/Romany	0.00%	0.07%
Mixed-Other	0.32%	0.31%
Mixed-White And Asian	0.17%	0.47%
Mixed-White/Black African	0.11%	0.20%
Mixed-White/Black Caribbean	0.11%	0.24%
Not Stated	31.84%	
Other Ethnic Group-Any Other	0.36%	0.45%
Other Ethnic Group-Arab	0.10%	0.24%
White-British	64.97%	91.92%
White-Gypsy	0.06%	0.13%
White-Irish	0.19%	0.36%
White - Other	0.77%	2.32%

When comparing overall admissions and access to services by ethnicity there is an inverse relationship between proportion of people accessing overall support and those groups more likely to require admission. Local data also indicates longer lengths of stay for Black/Black British people with an average length of stay over twice that of white people. Lengths of stay for “other Ethnicities” are similar to white people. Although Asian/Asian British people have similar rates of detention to white people they are much more likely to spend time in hospital and have significantly lower level of overall access to services.

Chart 15 – Number of people Accessing Services per 100,000 of the Population (trust)

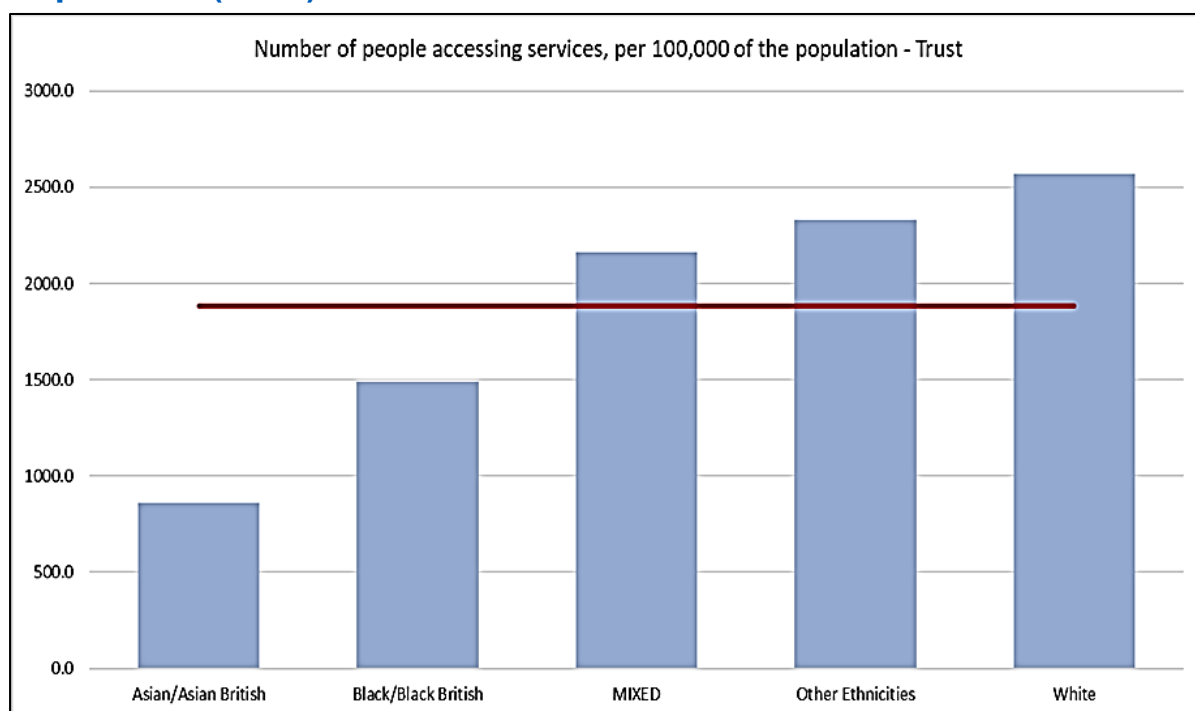
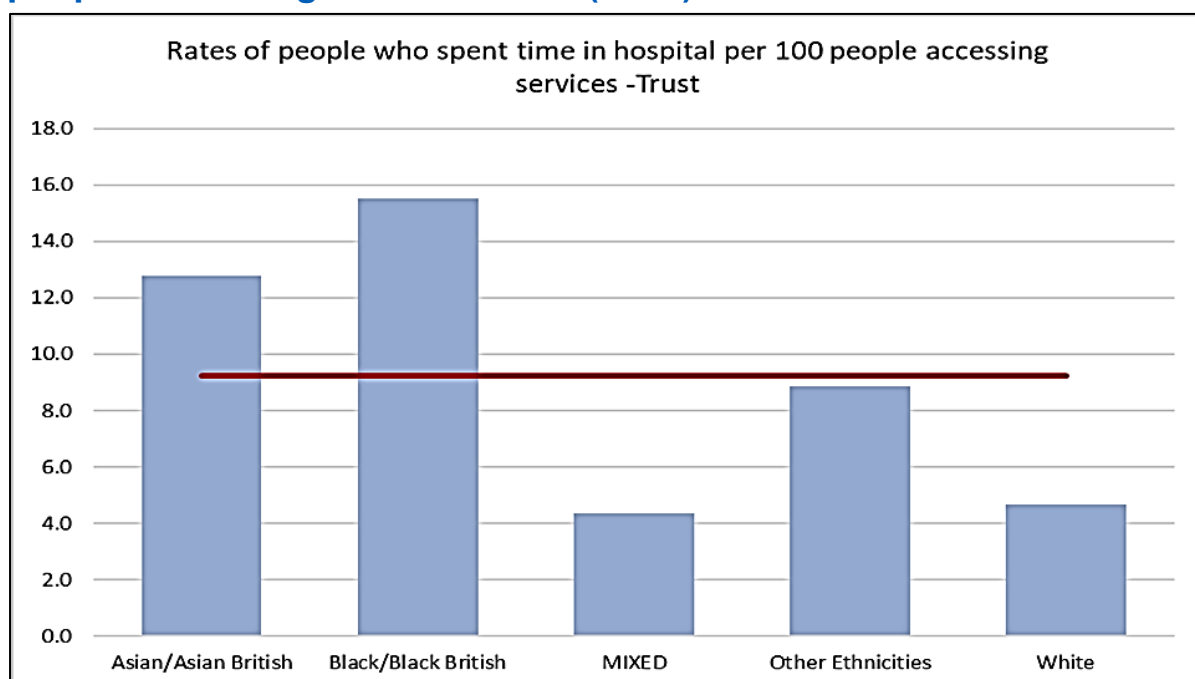


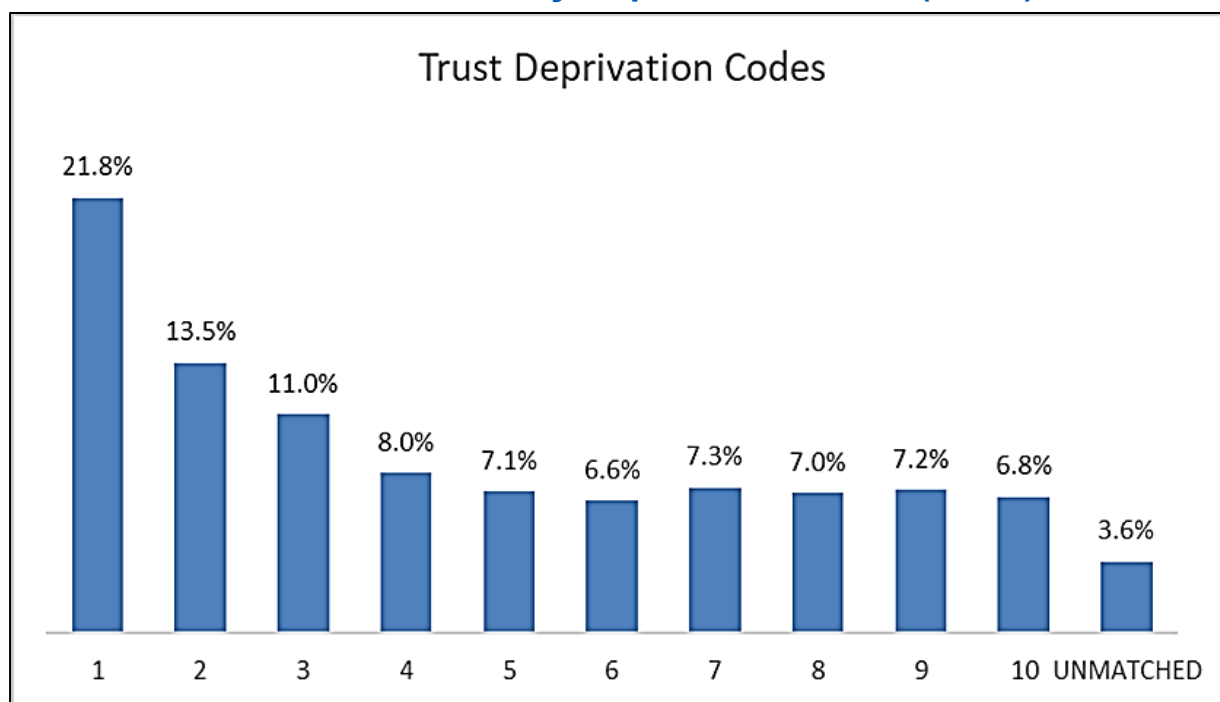
Chart 16 – Rates of People who spent time in Hospital per 100,000 people accessing trust Services (trust)



Deprivation

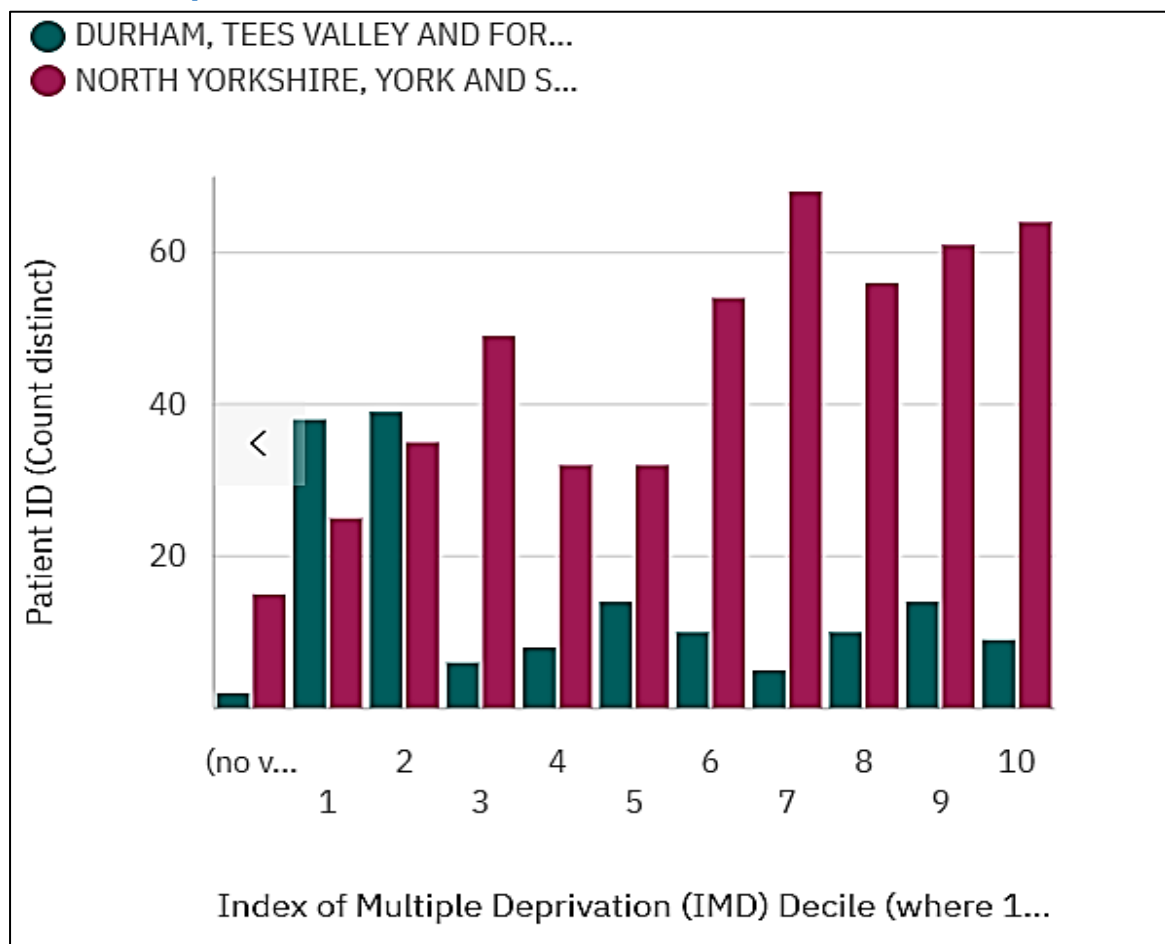
The interconnectedness of poverty and mental ill health means that those using our services are disproportionately impacted by financial hardship. 21.8% of people accessing trust services come from the 10% most deprived postcodes nationally.

Chart 17 – Access to Service by Deprivation Decile (Code) – trust



Significantly higher levels of hospital admissions can be seen in deciles 1 and 2 in Durham Tees Valley. This pattern does not follow in North Yorkshire, York and Selby where the admission rate are flatter and reflective of overall population structure.

Chart 18 – Hospital Admissions by Deprivation Decile (Code) – trust Care Groups

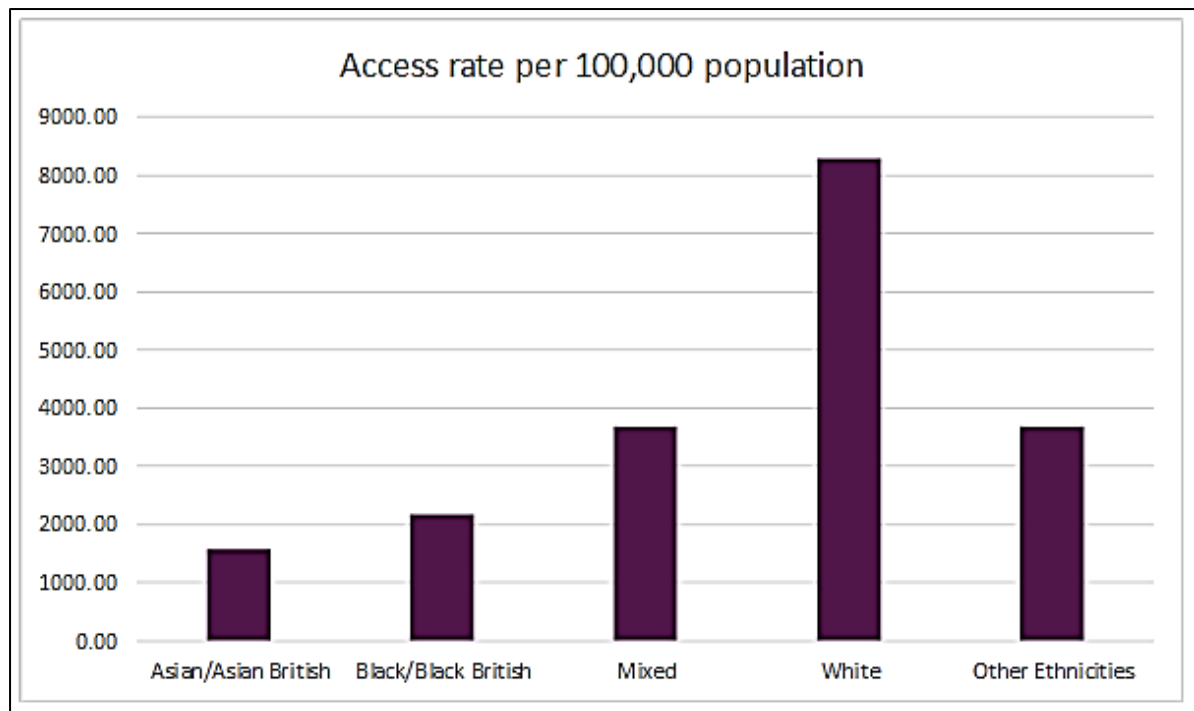


Inequalities in Rates of Access to Mental Health Services (0-17 Years)

Ethnicity

This data shows the rates of access by ethnicity for children and young people aged under 18 who have received at least one contact with TEWV services between 1 April 2024 and the 31 March 2025. This shows significantly lower levels of services access in ethnically minoritised and racialised communities with five times higher rate of access for white communities than Asian/Asian British communities and four times higher rate for white communities than those identified as Black/Black British. 3,279 children and young people had unknown ethnicity during this period, this represents 85% ethnicity recording rate which is higher than the overall trust average of 68%.

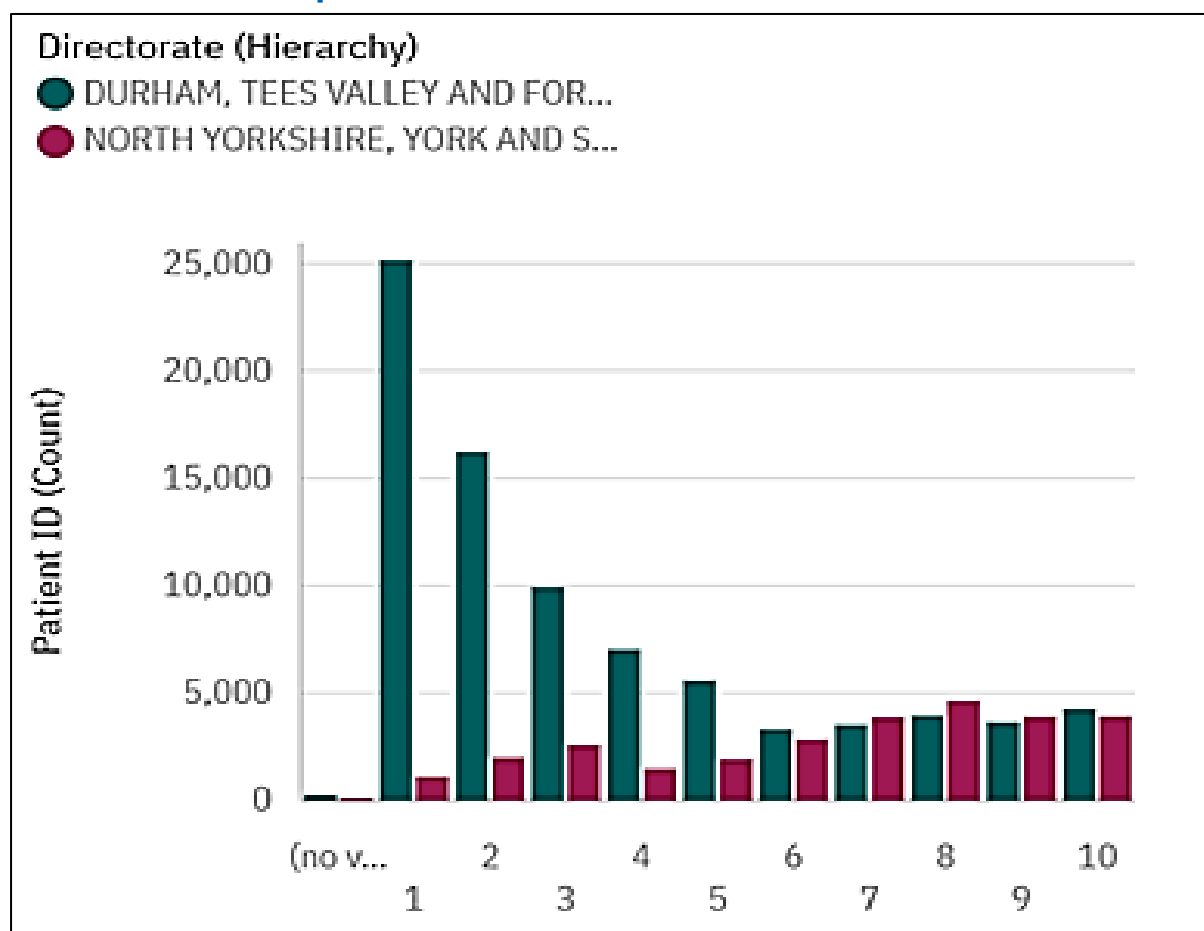
Chart 19 – Access Rates per 100,000 Population by Ethnicity



Deprivation

Developmental data from the test version of our new equality, diversity and inclusion (EDI) dashboard on 2 February 2026 indicates significantly larger number of children accessing service in Durham Tees Valley from the 20% most deprived postcodes. Within North Yorkshire, York and Seby, higher numbers of children and young people from the least deprived 20% of the population access services which is reflective of the overall population make up on the geography.

Chart 20 – Access Rates by Deprivation Decile (Code) for Children – trust Care Groups



Sex

Rates of children and young people accessing services by sex indicate slightly higher rates of access for males.

Table 7 – Children and Young People Accessing Services by Sex

Sex	Number of Patients	Population	Access rate per 100,000 population
Female (Including Trans Woman)	13718	191648	7157.91
Male (Including Trans Man)	15876	201984	7860.03
Non-Binary / Gender Neutral	60		
Other (Not Listed)	11		
Unknown	224		

Age

Rates of access for children and young people are around 1.5 times higher in the 17-18 age group than the 5-15 age group in both care groups.

Inequalities in Rates of Restrictive Interventions in Inpatient Services for the period of 1 April 2024, to 31 March 2025

Initial analysis suggests that women are more likely to physically restrained, chemically restrained and be in seclusion compared to men, whereas in 2023/24 men were more likely to be in seclusion. Men are more likely to be mechanically restrained compared to women, but the numbers are very small so caution must be shown in drawing any conclusions from this. Physical interventions are significantly higher for those aged 18–29 than for any other age group as was the case in 2023/24. Mechanical restraint is low across the board but there appears to be an outlier in the 30–44 age group as there was in 2023/24.

Analysis was done which included comparing restrictive intervention data to the number of ward stays. For this, patients were only counted once in the numerator (number of restrictive interventions) and once in the denominator (number of ward stays within the time frame) regardless of how many ward stays or restrictive interventions they may have had.

The analysis showed the following:

- Women are slightly more likely (22.7%) to be subject to restrictive interventions compared to men (19.4%).
- Restrictive interventions were used on 23.3% of 18-29 year olds who had a ward stay. The two numerators (the number of interventions) added together divided by the two denominators (the number of ward stays) have been used to reach this figure.
- All ethnicities, except for Mixed, experienced higher levels of restrictive interventions compared to White people. However, it needs to be noted that for 45.3% of restrictive interventions ethnicity is unknown and therefore the figures need to be treated with caution.

Deprivation

Within the national dashboard, information on restrictive intervention is not segmented by IMD (Indices of Multiple Deprivation), we are unable currently to identify any potential inequalities by deprivation locally. However, work is planned to address this locally.

Proportion of Adult Acute Inpatient Settings Offering Smoking Cessation Services

All inpatient settings are offered tobacco dependency support through a dedicated specialist team.

Adult Mental Health Inpatient Rates for People with a Learning Disability

A “tabletop” exercise was undertaken at the end of 2023 which showed that around 2% of all admissions had a learning disability which is in line with population expectations. Two thirds of those admitted with a learning disability were already receiving the support of our community teams. There was no overall marked difference in number or lengths of admissions between those with a learning disability and without with the exception of a small number of complex cases. There is no current real time system to flag when an individual with a learning disability is admitted though the reasonable adjustment flag should support this going forward. A 12-point discharge plan forms part of the assuring transformation national data collection for people with a learning disability and autistic people.

Both Care Group Adult Learning Disability Delivery Groups monitor admissions of people with learning disabilities on their community team caseloads to adult and older adult inpatient services, which they term ‘greenlight admissions’. This ensures that appropriate support, consultation and joint working is offered, as well as facilitating well supported discharges. We’ve not seen a marked increase in the rates of admission of people with learning disabilities but often their care needs have been more complex, and lengths of stay can be impacted.

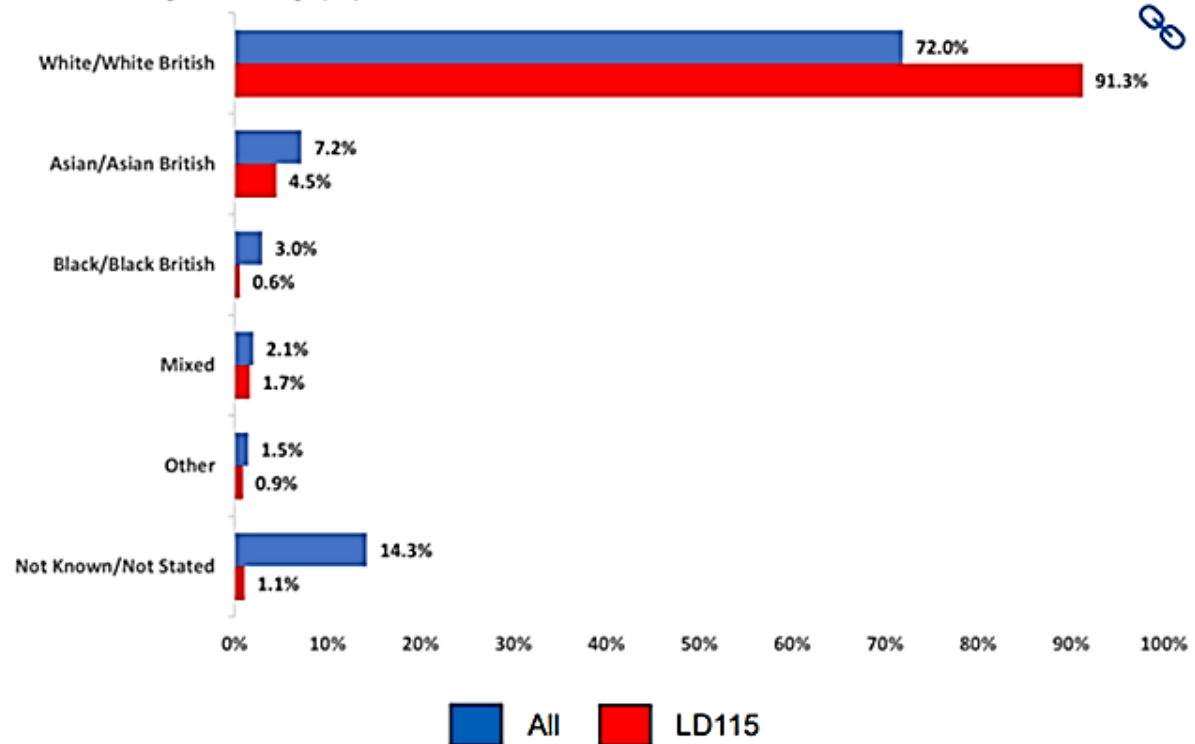
The trust has initiated ‘Intensive Support Teams’, wrapping support around the person at times of crisis with the objective of working with those most at risk of an inappropriate admission.

Access to Learning Disability Services by Ethnicity

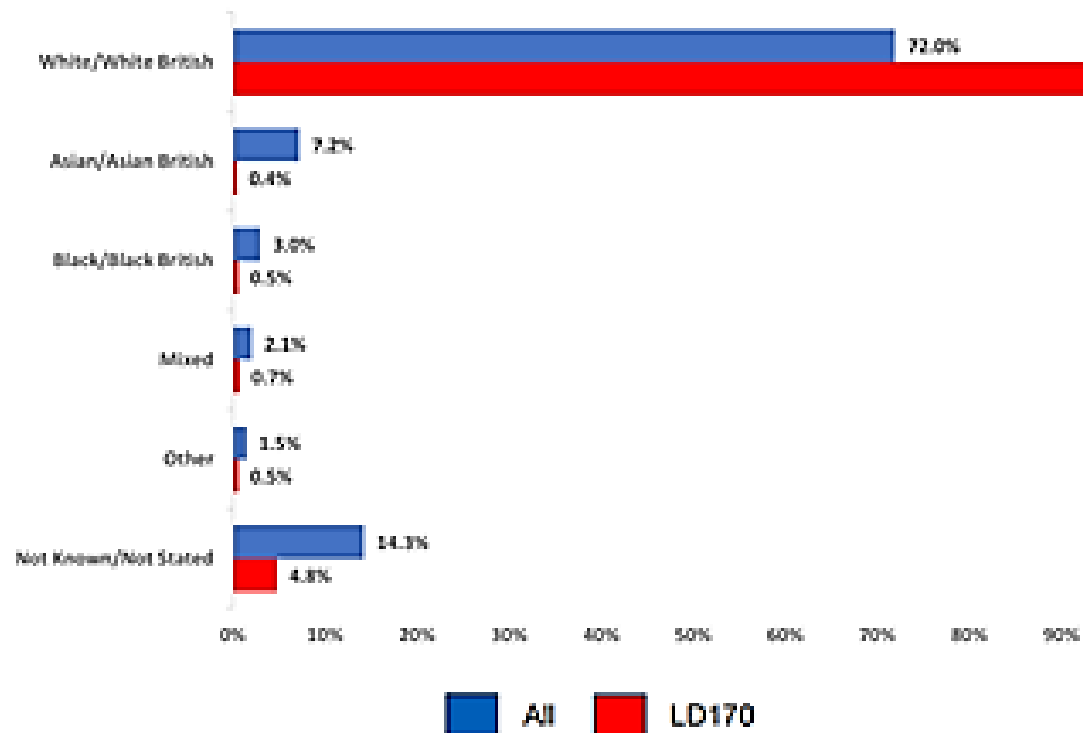
National benchmarking data for both care group’s community learning disability teams (LD115 Durham Tees Valley and LD170 North Yorkshire, York and Selby) shows lower than national engagement from racialised communities. Whilst this will be partially attributable to our population make up it also resonates with trust level data showing underrepresentation of many racialised communities in our access data. Ethnicity recording within learning disability service is however higher than the trust average at 97% in Durham Tees Valley and over 92% in North Yorkshire York and Selby. There will be learning for the wider trust on how this has been achieved.

Chart 21 and 22 – Caseload Percentage by Ethnicity (2023/24) – LD115 and LD170

Caseload by ethnicity (%) - 2023/24



Caseload by ethnicity (%) - 2023/24



Learning from Learning from Lives and Deaths (LeDeR) [LeDeR - Resources](#)

The 2023 Learning from Lives and Deaths (LeDeR) report highlights persistent and significant health inequalities experienced by people with learning disabilities.

People with a learning disability continue to die substantially younger than the general population, with a median age at death of around 62 years – approximately 20 years earlier than people without a learning disability. Around 39% of deaths reviewed in the LeDeR programme were classified as avoidable, almost double the rate seen in the general population. Treatable deaths, where timely and effective healthcare could have altered outcomes, remain particularly high, indicating ongoing barriers to accessing quality care.

The report highlights that people with learning disabilities from minority ethnic backgrounds die at a younger age than their white counterparts, with the median age of death among Asian and British Asian learning-disabled people reported as 43.2 years. This demonstrates the compounding impact of ethnicity and disability on health outcomes. Many people who died lived in areas of high socioeconomic deprivation, reinforcing the importance of addressing wider determinants of health alongside service level factors. These issues are especially pertinent within the TEWV footprint, where deprivation levels vary significantly across localities.

Around one third of deaths involved delays in care or unmet clinical guidelines. Diagnostic overshadowing remains a significant concern, with physical health symptoms sometimes attributed to a person's learning disability or mental health condition, leading to missed or late diagnoses.

The LeDeR 2023 findings demonstrate entrenched health inequalities that require sustained, system-wide action. For TEWV, this includes strengthening our recording and reporting systems, implementation of the reasonable adjustments flag, improving access to physical healthcare, reducing diagnostic overshadowing, ensuring staff are equipped to recognise and respond to physical health deterioration and ensuring our PCREF (Patient and Carer Race Equality Framework) plans are inclusive of our learning disability services and all communities

Health Checks

Health checks are delivered in primary care therefore the trust does not hold this data for our specific footprint. As such the latest ICB level data is included for reference.

Learning Disability Health Checks

Proportion of Learning Disability patients receiving a health check in the last 12 months

	July 2024	December 2024	Trend
NENC ICB position	63%	61%	↓
Most deprived communities	64.3%	60.5%	↓
Least deprived communities	66.2%	58%	↓
White communities	65.3%	61.6%	↓
Non-white communities	44.2%	38%	↓

Figure 1 – Learning disability annual health checks by Ethnicity

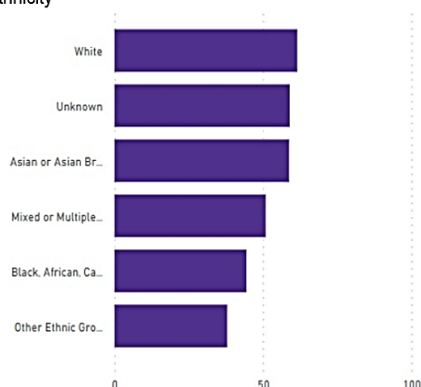
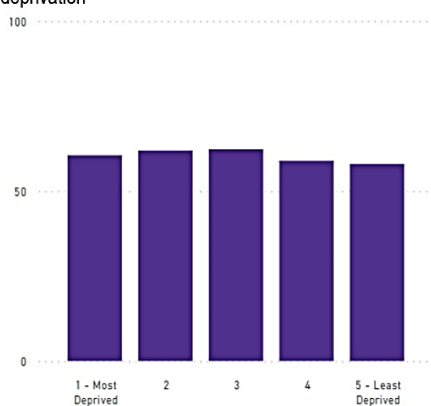


Figure 2 – Learning disability annual health checks by deprivation



Data Source: NENC Primary Care data via the Healthier and Fairer Insight Dashboard
Reporting Period: January 2023 – December 2024 (12 month rolling period)

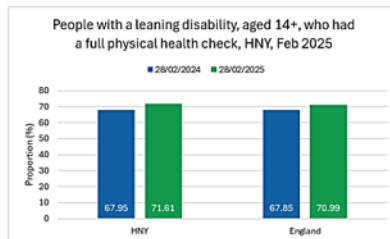
The data has been taken from NENC Healthier and Fairer dashboard, derived from NENC Primary Care data. It reflects the proportion of people with a diagnosis of Learning disability who have a recorded health check in the previous 12 -month period.

A greater proportion of individuals from the 20% most deprived communities (60.5%) are shown as having received their health check in the last 12 months compared with the least deprived (58%), although both have experienced a reduction compared with the previous reporting period. The reduction may be aligned to the change in method for identifying when health checks are due, changing the due date to the month of an individual's birthday. If this is the case, the percentage will increase again in the next two reporting periods.

There is an inequality gap by ethnicity with a smaller proportion of those from ethnic communities with a learning disability, in particular those of mixed or multiple ethnic groups, receiving their annual health check compared with those of white ethnicity

Primary ICB Outcome	Fairer Outcomes for all
National guidance	Core 20 plus 5
Lead Team	Learning Disability Network

Annual Health Checks- Learning Disability



The national target is for 70% of people aged 14+ with a learning disability to have a physical health check. At the end of February 2025, nearly 7,300 residents in HNY had completed their health check, 71.6% of those eligible. This is an increase on the proportion at the same date in 2024 and remains slightly higher than the England average. An additional 467 physical health checks have been delivered in 2024/25 compared with the same stage in 2024/24.

Key Messages from Lived Experience Engagement and Poverty Proofing Themes

Engagement with racialised and ethnically minoritised communities locally has provided insights including:

- Lack of comparative language to describe western mental health diagnoses
- Stigma associated with accessing services
- Cultural beliefs about the manifestation of symptoms of mental illness
- Fear of accessing service and being asked about ethnicity in particular related to asylum status
- Cultural expectations regarding the role of family vs state in caring for loved ones
- The natural aging process and symptoms of mental ill health
- Differential perceptions of the role of medication in particular relating to long term use
- Lack of culturally informed resources and limited accessibility due to language barriers, for example Culturally Sensitive Translatable Information.
- Mental health literacy challenges, complexities with the system pathways, and lack of knowledge about local service offer.
- Need for staff cultural competency training to highlight the lived experience in racialised communities, unpacking diversity and challenging stereotypes. Examining post-migration realities such as unfamiliar systems, language barriers, trauma histories, and daily stressors such as discrimination/Hate Crime.

Our lived experience engagement group for health inequalities “sharing the pen” have been active for approximately three years and have undertaken a range of work to highlight key message to staff about the impact of and how to take action on health inequalities. A poem and visual were developed and shared to depict some of these messages which centred around the need to:

- Listen
- Build real understanding of what’s happening outside of services
- Acknowledge and disrupt the power imbalance between services and individuals/communities

- Make reasonable adjustments to improve access, outcomes and experience
- To look to create a sense of welcome and belonging within services
- To challenge “othering”
- For staff to feel able to bring their authentic selves into the patient relationship
- To use creative approaches to support engagement, build trust and understanding

A cocreated training resource is currently under development.

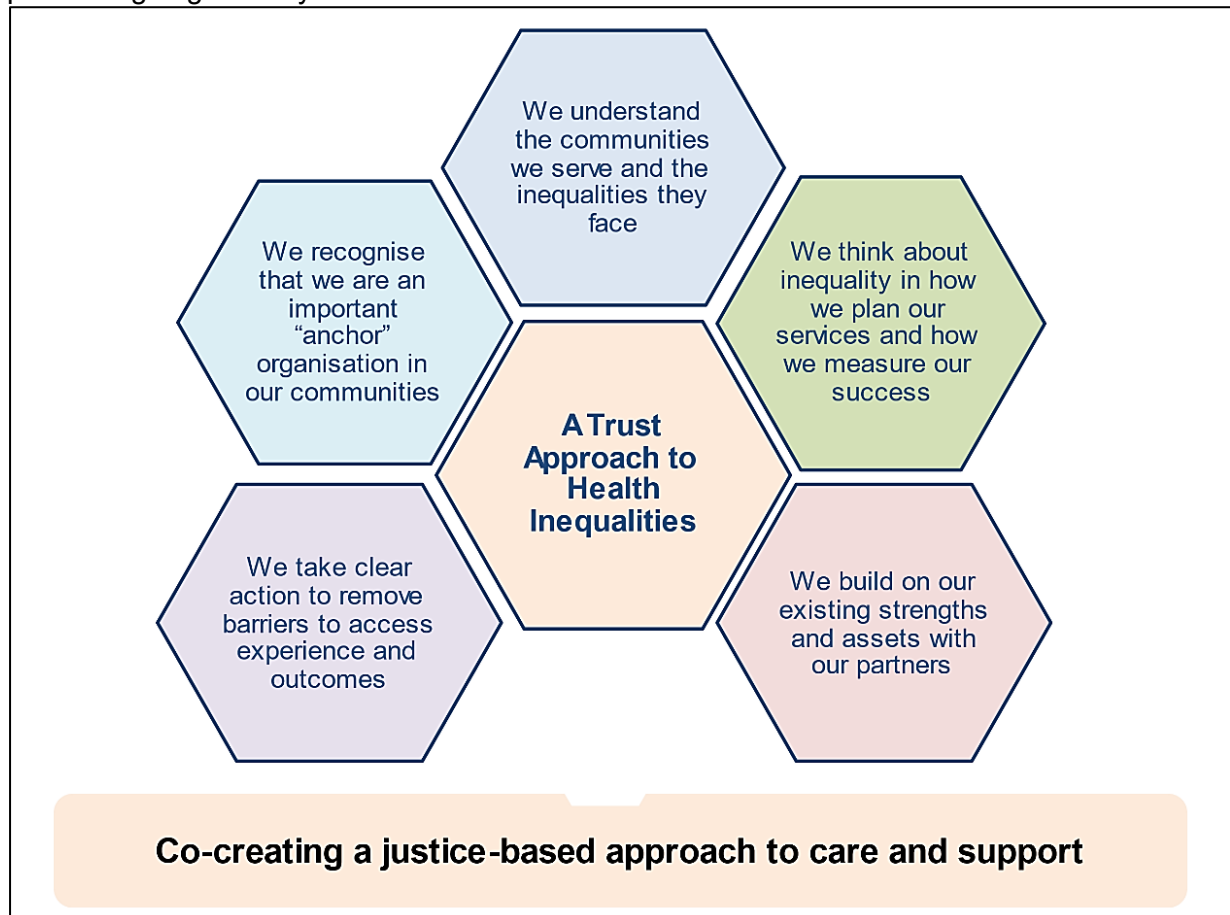
As part of a programme of “poverty proofing” © in partnership with Children’s Northeast during 2022/23 families engaged in our services and staff shared the following message about the impact of financial hardship on access and benefitting from services.

- **Travel**
 - *“She’s missed loads of appointments, not because she wants to…….but she really, really can’t afford to take him all the way up there.”*
- **Other Costs**
 - *“Every now and then we have a family who can’t answer a call because they don’t have credit on their phone or they don’t have a phone, they end up getting discharged because we send them a letter to say they need to call in but they don’t have a phone or credit to do it.”*
- **Financial Awareness**
 - *“It was only when we thought to dig a bit deeper that they told us, it would have been easy to think, they’re just not bothering, but actually when we asked it was because of the costs.”*
- **Referral Processes**
 - *“A barrier in the first place is having to get referred into them, I don’t know what’s available and I have to get referred in”*
- **Treatment**
 - *“We get plenty of notice for appointments, sometimes we get plenty of appointments in advance so you can plan out your diary, you’ll get so many appointments for three months in advance.”*
- **Communication**
 - *“He said something about neuro something, I didn’t know what that was either, so I’ve obviously had to google it.”*
- **Flexibility**
 - *“I do appointments in schools, that’s easier for parents who can’t get out of work or who can’t get to the Ridings.”*

Action on Health Inequalities

Overall Approach

Since 2023/24 TEWV have adopted a coproduced approach to tackling health inequalities within the trust based around the following of commitments. Lived experience engagement was central to the development and initial implementation of this approach and forms a core part of ongoing delivery.



Areas of progress in meeting these commitments in since the publication of our last statement are outlined below.

A [co-creation video on health inequalities](#) has been completed and shared at this link: [NHS Health Inequalities video](#).

A reflective session was held for staff who attended a patient safety summit on health inequalities in 2023/24 and a TEWV health inequalities "Team Challenge" was launched.

The challenge saw over 30 teams take on work to address health inequalities and share existing good practice. A cocreated showcase event was held in March 2025 where teams presented their learning and practice. These presentations covered a wider range of inequalities. Event evaluations showed that all respondents learned something new about health inequalities and would take learning back into their teams.

A benchmarking exercise has been completed using the NHS Providers Health Inequalities Self-Assessment Tool and Reducing Inequalities: A Guide for Trust Board Members. The maturity matrix scored the trust as “Maturing” across all four domains of practice and the outputs were used to inform executive level objectives for 2025/26.

- Domain 1. Building public health capacity and capability - Maturing (50%)
- Domain 2. Data, insight, evidence, and evaluation - Maturing (50%)
- Domain 3: Strategic leadership and accountability - Maturing (61%)
- Domain 4: System Partnerships - Maturing (60%)

To support this a new business assurance risk on health inequalities has been developed to enable routine scrutiny of the contributing factors to reduce inequality across the trust at board level.

The trust co-authored the development of a national toolkit in partnership with the Public Mental Health Implementation Centre and Royal Collage of Psychiatrists to outline the practical action clinicians can take to address inequalities in everyday practice. This was launched in summer 2025 ([Health Inequalities Briefing Pack](#)). A blog was co-created with local lived experience engagement members to promote to resource ([Health Inequalities Briefing Pack: What is it and how should we use it?](#))

Our updated Equality Impact Assessment policy now includes requirement to consider health inequalities/inclusion health.

Recovery College Online

Our online recovery collage has commenced work to:

- Use plain English to make information more accessible.
- Analyse our evaluation data by deprivation

Autism

We continue work to make our clinical environments more accessible to autistic people including initial environmental audits in adult mental health wards and are rolling out mandatory Autism training and online Oliver McGowan training.

Culture of Care

Since July 2024, the trust has implemented the nationally co-produced Culture of Care programme across inpatient mental health and learning disability services, embedding action on health inequalities into ward-level improvement activity. The programme is grounded in standards developed with lived experience leaders and people who experience inequality, with a specific focus on anti-racism, trauma-informed care, autism-informed care, and co-production. Delivery to date has prioritised wards where inequalities in safety, dignity, and involvement are most evident. This has included targeted action to improve sexual safety for women, introduce reasonable adjustments for autistic people, and strengthen choice, privacy, and access to information for inpatients. Improvement activity is co-produced with

patients and staff and tested using quality improvement methods. Early learning indicates improved patient-reported experiences of safety and involvement, reductions in specific harms in some areas, and increased staff confidence in delivering more equitable, personalised inpatient care. This learning is informing wider scale-up across the trust.

Improving Access to Talking Therapies

Across North Yorkshire, York and Selby (NYYS) and Durham and Darlington, Talking Therapies services have established targeted pathways and “champion” roles to improve access, experience and outcomes for priority groups, including older adults, veterans, students, perinatal individuals, ethnically and culturally diverse communities, and people living with long-term health conditions or disabilities.

In NYYS, champion groups drive service improvements, community outreach and integrated working with physical health and veterans’ services. A national Digital Trailblazer project improved older adults’ engagement and recovery rates in digital therapies, with learning now embedded into routine practice. Both services prioritise ongoing staff training to strengthen support for people with long-term conditions.

In Durham and Darlington, dedicated pathways provide tailored support for students, veterans, perinatal individuals and those with long-term health conditions. Outreach work, strong partnerships with education, public health and physical health services, and collaboration with community organisations help reduce barriers and improve equity of access and outcomes.

Learning Disabilities

Within learning disabilities services, we have improved our evidence base by:

- Alongside Primary Care Network Colleagues, producing easy read and accessible resources to support with menopause. These resources have been adopted for use by NENC ICB as part of their regional pack.
- Developing an ‘End of Life’ Resource pack, to support our staff when they are involved in the care of someone who has reached the end of their life. This pack has been adopted for use across the specialty.

Community Transformation

An inequalities approach has been central to our work on Community Transformation and neighbourhood health, for example:

- Focused work has progressed in East Durham and Durham Dales to improve support for people with dual mental health and substance use needs. This has included addressing unconscious stigma in service providers, improving referral pathways and developing creative ways of better supporting people with alcohol issues
- Teams in Durham Dales have been working very closely with farming communities to better understand the specific challenges and health inequalities they face. This has included a focused ‘deep dive’ led by a lived experience lead, targeted work with one GP practice and development of more flexible and proactive ways to reach farming communities

- Working closely with partners in the local authority, provided targeted support to Gypsy Roma and Traveller communities
- Recognising that older people do not always access or receive the same support as working age adults for mental health needs, we have worked closely in partnership with Age UK, Alzheimer's Society and primary care to improve identification of mental health needs in older people (including older carers) and improved pathways to access timely support
- We have used population health data to begin to better target interventions, resources and partnership approaches in the areas of greatest need to try to narrow the inequality gap

Digital Exclusion

Three laptops have been sourced and placed in trusts libraries for people applying for paid roles to help with digital exclusion.

Trans Reference Group

The Trans Reference group continues to be a supportive resource for staff who are supporting Trans patients to improve patient experience and access to health services.

Child and Adolescent Mental Health Services

In partnership with the Northeast and North Cumbria (NENC) provider collaborative young person's admissions and access by inequality are being examined.

Allied Health Professionals (AHPs)

In September 2025 we held a development session on the refreshed public health framework for allied health professionals (AHP). This is resulting in the development of an action plan outlining the invaluable contributions AHP workforce have to public health in the organisation. This will align to the trustwide health inequalities and prevention plan in the coming year.

Action on our Key Challenges

Inequalities for Ethnically minoritised and racialised communities

The trust's Business Intelligence Team has developed an Equality, Diversity and Inclusion (EDI) dashboard to support monitoring and reporting against the Patient and Carer Race Equality Framework (PCREF). The dashboard enables analysis of patient data, including intersectional factors such as deprivation to better understand health inequalities. Ethnicity data quality remains a national challenge. The trust's current ethnicity recording rate (68.2%) is below the national mental health average (74.6%) and has declined. Key barriers include staff confidence in collecting data and patient concerns about how information will be used. Improving ethnicity recording and building understanding among both staff and patients will be a priority for the coming year.

A temporary Band 7 EDI Officer (0.4 WTE) has been appointed to support PCREF implementation. The role is being evaluated to determine its long-term structure and impact.

The trust has developed a template to help teams understand PCREF, access local data, identify related targets, and evidence anti-racist practice. This has been shared widely across networks and forums to increase awareness and uptake.

Data shows lower-than-expected service access among Gypsy and Traveller communities. In response, the trust has partnered with a Nurse Specialist and community members to deliver staff training on cultural awareness and barriers to care. The trust is also working with the University of York on an engagement project to strengthen co-production with Gypsy and Traveller communities. Further research findings community experiences of mental health care across Yorkshire and the Northeast were shared in early 2026. A Good Practice Guide has been developed and shared across staff networks.

To promote earlier access and reduce crisis escalation, the trust undertook targeted community engagement, including outreach at the Middlesbrough Mela, sharing translated information about local mental health services.

A Black and Ethnic Minorities Communities Link Worker is in post in the Tees area and had contributes to activity including:

- Middlesbrough Mental Health Collective – A partnership with voluntary sector organisations and Teesside Mind to deliver culturally informed training and upskill frontline staff and volunteers.
- Community Conversations (“Looking After Your Head”) – Monthly community sessions throughout 2026 to increase awareness of mental health pathways and introduce PCREF (Patient and Carer Race Equality Framework) to local communities.
- Cultural Competency Training – Ongoing sessions for staff and partners focusing on cultural humility, trauma-informed practice, reasonable adjustments, working with interpreters, and understanding racism and migration. Additional training is being delivered in inpatient services at Roseberry Park (2026–2027), alongside patient engagement sessions. Evaluations will be undertaken in 2026.

A service evaluation within Early Intervention in Psychosis (EIP) services found that people from ethnically minoritised and racialised communities are over-represented in EIP services compared to their proportion in the general population. A higher proportion of service users from ethnically minoritised and racialised communities’ access EIP through compulsory or hospital admission compared to white service users. The evaluation includes interviews with service users and engagement with local organisations to improve accessibility, information resources, and equity of care. This work will continue as an ongoing programme of improvement.

Older People’s Mental Health Services in Teesside are working to improve access for South Asian communities who are under-represented in community services. Actions include auditing dementia pathway standards, promoting culturally appropriate assessment tools, increasing interpreter use, and improving ethnicity recording accuracy.

The trust has strengthened partnerships with advocacy providers, including Cloverleaf in Durham and North Yorkshire. Awareness sessions for staff and service users have increased referrals to advocacy services, with emerging themes reviewed to inform service improvements. An advocacy and patients' rights network was launched in December 2025. Advocacy providers now contribute to trust governance groups, including the Mental Health Legislation operational group. A new patient survey has been developed to capture experiences of detention and access to Independent Mental Health Advocates as part of the 'I Want Great Care' initiative.

During 2024–2025, the trust delivered a programme of anti-racism and inclusion training, including 'Show Racism the Red Card', 'Upstander' training, and 'Compassion, Respect, Responsibility and Race', supporting staff to challenge discrimination and promote inclusive practice.

Inequalities for People Experiencing Physical Ill Health / At Risk of Multiple Long Term Conditions

The role of the trust in addressing physical health inequalities is well recognised and a more strategic approach to this agenda has been developed in response. This has included a refresh of the trustwide governance arrangements for physical health and the development of a trustwide Physical Health Plan underpinned by clinical advisory groups in key areas of practice including public health. In 2025/26 the Public Health Clinical Advisory Group have focussed on "Making Every Contact Count (MECC)" and screening and immunisation.

MECC training has been promoted through online training and preceptorship and international nurses training events. A video to promote access to the training and share the basics of MECC has been developed and internal trainers trained to reach those who might not have access to online training.

The Bowel and Breast screening pathways are now in place for all eligible inpatients with stays of over 6 months and will be rolled out across other national screening pathways where possible.

A flu campaign was delivered throughout the autumn/winter period.

To ensure parity across the care group, the adult learning disability Tees Enhanced Physical Health Team has been reconfigured to become the Durham, Tees Valley and Forensic (DTVf) Physical Health Team, meaning that we're now able to offer support to all our primary care practices located in that care group.

Secure inpatient services dietetic team have led obesogenic environments project which has included action on

- Group psychoeducation sessions
- Healthy weight clinic alongside physical health team
- Healthier vending machines

- Healthier and culturally appropriate options in the onsite shop to meet previous quality improvement targets and to support self-catering
- One person portion cookbook- healthier alternatives, diabetes friendly meals
- Implementation of “fakeaways” on wards and the cocreation of a takeaway policy
- Developed proposal to expand access to GLP1s including an onsite wrap around offer

Between March 2024 and March 2025, the service has seen Overweight and Obesity levels reduce from 93% to 84% of patients, between March and October the numbers had reduced from 84-73.3% overweight and obesity levels.

Throughout 2025 we have collaborated with Cumbria Northumberland Tyne and Wear NHS foundation trust (CNTW), Northeast Together, Northeast and North Cumbria Integrated Care Board (NENC ICB), and The Office for Health Improvement and Disparities (OHID) to review and update “A Weight Off Your Mind”, the regional framework to support people with lived experience of mental health conditions and/or learning disabilities to achieve/maintain a healthy weight. We are developing a local plan in response with a focus on equitable access to weight management support and healthy food environments

A specialist diabetes nurse in partnership with our acute partners in CDDFT was recruited for six months in 2024/25 and resulted in:

- A marked increase in staff knowledge and confidence after training
- Improved collaborative working between the acute diabetes team, mental health in-patient and community teams, social services, patients, and carers.
- Updated policy and procedures
- Anecdotal reports of reduction in acute admissions for diabetes and improvement to the stability of diabetic patient in the pilot wards

Poverty and Financial Exclusion

The learning from a programme of Poverty Proofing undertaken in partnership with Children Northeast within our CAMHS service in South Tees continues to be rolled out through clinical networks. Our CAMHS team have developed a video resource to share their approach to working with families experiencing socioeconomic challenge and the changes we can make as a service.

The Did not attend/Was not brought (DNA/WNB) policy has been updated and reflects the impact of economic and wider inequality on engagement with services.

Drug and Alcohol Related Harm

A strategic approach to dual diagnosis began development in 2024/25. This focusses on workforce skills and competency and policy and pathway adherence including routine screening and partnership working.

A new model of specialist substance use inpatient in-reach is now in place in Durham and Darlington. The service has received over 362 referrals and is showing positive results in terms of partnership working and individual outcomes.

Specialist nurse roles across Teesside continue to provide enhanced support and facilitate partnership working and funding has been secure for enhanced roles linked to primary care as part of Durham community transformation.

Recovery connections provide in-reach to Roseberry Park, and the services are exploring expansion of this to include wider specialist substance use service in-reach.

A social determinants key worker funded by a local public health partnership is attached to the crisis suite at Roseberry Park to support those experiencing multiple disadvantage including substance use with promising outcomes in terms of engagement and reducing repeat attendance.

All areas are now covered by dual diagnosis networks to facilitate partnership working, relationship building and share learning and development.

The North Yorkshire "Drink and Drug Hub" [Providing Information & Support for Drink & Drugs - Drink Drug Hub](#) is being promoted as a model to support workforce competency and development across the trust and will form part of enhanced training to support the established of dual diagnosis advocate embedded within teams. Basic dual diagnosis e-learning has been refreshed and made available to all staff.

As part of harm minimisation our approach to naloxone training and carrying in teams has been tested, evaluated and is being rolled out. Our ambition is to embed training as core part of basic life support mandatory training.

Our Plans for 2026/27

A high-level plan has been developed to street trust level activity on health inequalities and prevention during 2026/27 and beyond.

Initial priorities and measures are outlined below along with the range of supporting workstreams and interdependencies that contribute to this. Health inequalities governance will be strengthened in 26/27 through alignment with integrated performance and governance of the 10 year plan.

Year 1-2

- **1. Building Strong Foundations through data and governance** – benchmark and improve our data collection to enable analysis, provide health inequalities dashboards by service, establish routine reporting which enables data driven decision-making, develop a population informed “planning pack” to support quality and inequality impact assessment in key decisions, build dedicated analytical capability for population health.
- **2. Modelling the approach** through 3 pathfinder programmes delivering locally informed responses to national priorities:
 - **Personalising care** - Develop and trial a model for DNA/WNB reduction for our most deprived communities and those experiencing multiple disadvantage including “poverty proofing” service pathways and adopting latest evidence for effective engagement.
 - **Patient and Carer Race Equality Framework** – Establish relationships with our community sector partners to grow insights from racialised communities. Undertake a detailed exploration into the drivers of mental health act use for ethnically minoritised and racialised communities. Use these insights to model service adaptations, increase community reach and improve accessibility and responsiveness of services.
 - **Culture of Care work programme** – Roll out Standard 5 “Equality” through innovation and learning hubs at all inpatient sites informed by local drivers of inequality (including poor physical health, poverty and drug and alcohol related harm)
- **3. Defining our role and contribution in partnership aligned to the following prevention ambitions for 26/27:**
 - Maximising the prevention opportunity of neighbourhood health and community transformation
 - Suicide prevention
 - Dementia prevention
- **Our measures:** 10% year in year increase in ethnicity recording to target of 90%. Percent reduction in the gap in was not brought/did not attend for core 20+ populations in pilot teams. Increase in access to and use of population health data at team level. Establish and test governance and reporting flows. Benchmark and Increase partnerships with community sector organisations supporting core 20+ populations including racialised communities. Develop segmented staff data set.

Interdependencies and contributing workstreams

Physical health plan (screening, immunisation, making every contact count, training and education, holistic care)	Mental health research leadership award and academic partnerships	Suicide prevention organisational priorities and partnerships
Equality, diversity and human rights groups	Health literacy and accessible communication	Better health at work award
Staff networks	Equality and diversity lunch and learn webinars	Co-occurring Substance use and mental health (dual diagnosis) partnerships
Health inequalities benchmarking tool	Business assurance risk framework	Executive objectives
Lived experience engagement and “sharing the pen”	Staff training offer	Facilities and estates plan
A dedicated link worker for asylum seeker and refugee communities	Publication of statement of information on health inequalities	Equality and diversity dashboard
Health inequality impact assessment	Recovery College online	Population health data platforms
Allied health professionals' public health implementation plan	Strategic approach to co-occurring substance use and mental ill health (Dual Diagnosis)	Anchor institution work