

Population Health & Healthcare Surveillance**Impact of COVID-19****Intelligence for the North East & North Cumbria AHSN****September 2020 Report 1****Report Content**

The NEQOS Population Health and Healthcare Surveillance report is produced annually. The aim of this report is to provide a single reference source containing a regional oversight of activity across all areas of health and healthcare, not solely limited to the AHSN work programmes, to assist users in identifying where there is wide variation across the North East and North Cumbria.

The COVID-19 pandemic has resulted in a major shock to health and social care services and some important trends are beginning to emerge, in both predictable and unexpected ways.

In early August 2020, implementation guidance was provided by NHS England and Improvement with regard to phase 3 of the NHS response to the COVID-19 pandemic. This was in support of the letter sent on 31st July to key figures across the NHS, local authorities and local resilience teams from Sir Simon Stevensⁱ. The guidance describes eight urgent actions to address inequalities in NHS provision and outcomes and asks for each of these to be delivered by specific dates, through local collaborative working, and by building upon regional and local work relating to inequalities that was already underway pre-COVID as well as recommendations from a number of more recent reviews.

This surveillance report focuses on a key set of metrics to support organisations by providing a better understanding of the impact of COVID-19 across the NENC region, reporting the strengths and challenges for the region, and identification of areas of unwarranted variation. It can be used to support planning of services and the programme to resume routine healthcare services as the pandemic evolves. It is important that these plans to reset the system are able to address existing inequalities to avoid any further exacerbation of these issues. Subsequent reports and updates will follow, as further information becomes available (see below for an outline of this).

The data included in the report are taken mainly from NHS Digital [digital.nhs.uk], NHS England [england.nhs.uk], and the government services and information website including Public Health England [gov.uk]. There are a substantial number of other information sources available containing data and resources relating to COVID-19, some of these are referenced within this report, and others include the Future NHS platform, the Health Foundation [health.org.uk], the WICH tool [PHE via gov.uk] and the Public Health North East regional platform C-WorkS: COVID-19 consequences.

NEQOS has provided some interpretation of the data presented in this report, with a high level summary on page 2 and a brief commentary under the heading of "what is the data telling us?" for each indicator. The methodology and approach to this work is described on page 4. Feedback from the AHSN and other stakeholders, on content and presentation, is welcomed.

i. <https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/>

Future reports planned

- Impact of COVID - Report 2 (due end Sept '20). Hospital activity-based information (A&E, outpatient and inpatient settings) presented using latest data available (at least to June '20).
- Ability to investigate data presented in Reports 1 and 2 in more detail, for specific indicators.
- Further reports to be produced relating to additional indicators once data is available or released.
- Refresh of indicators in existing reports (refresh period determined by data availability).

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The data presented in this report portrays health and healthcare in this region, for the time period before the COVID-19 pandemic, whilst lockdown measures were in place, and more recently as restrictions ease.

No.	Indicator	Key findings	Proposed updates	Further disaggregation or presentation
2.	COVID-19 reported cases	Latest reported number of cases (this is on the increase)	Latest figures to date will be reported in subsequent iterations of this report, taken directly from the UK coronavirus dashboard (updated daily).	Not required - there are already various regional and local dashboards being produced for users
3.	COVID-19 patients and healthcare	Latest reported number of admissions and admitted patients (these numbers are currently very low despite case numbers increasing)		
4.	Death registrations and those relating to COVID-19	Latest reported deaths are above the 5 year average but not driven by COVID-19. The majority of deaths took place in hospital in the latest week reported, with 26% taking place in a care home.	Latest figures to date will be reported in subsequent iterations of this report, taken directly from the ONS report (updated weekly).	Also available: COVID-19 deaths by local area and socioeconomic deprivation, or deaths in care homes, by occupation or ethnic group (England & Wales level)
5.	Hospital mortality monitoring	This indicator does not yet cover the COVID-19 impact period from Mar'20 onwards but the findings provide a useful baseline. The latest summary hospital-level mortality indicator (SHMI) value for all Trusts in England is shown, with County Durham and Darlington FT currently reporting a 'higher than expected' rate for the Jan-Dec '19 period.	Data for the period Apr '19-Mar '20 will be available at the end of Sept '20 , and updated further on a quarterly basis.	The NEQOS Hospital Mortality Report is already produced for all NENC Trusts, providing support and further details relating to hospital mortality.
6.	Estimated Diagnosis Rate for People 65+ years old with Dementia	Although the NENC CCGs has a higher diagnosis rate for dementia than England overall, this rate has dropped significantly since April '20 from a regional average of 73% to 67.1% in July 2020.	This data is available on a monthly basis and will be updated in future reports for further monitoring.	Comparison by CCG deprivation score is possible.
7.	Population vaccination coverage - Flu (aged 65+)	These indicators do not yet cover the COVID-19 impact period from Mar'20 onwards but the findings provide a useful baseline. For those aged 65+, although the NENC coverage rate is higher than England, there is variation at CCG level. Only 2 CCGs met the recommended rate of 75%.	Monthly updates may be available for inclusion in future reports, showing GP registered patients having the vaccine once the flu season is underway. These indicators are of particular importance at present, and also in light of the additional patients recommended to be part of the at-risk group in 2020/21.	Patients aged 65+, those <65 years and at risk, and children aged 2 and 3 years old is available.
8.	Population vaccination coverage - Flu (at risk individuals)	For at risk individuals, the coverage rate has decreased since 2017/18 and with no NENC CCGs reaching the recommended coverage rate of 55%.		
9a.	MMR vaccination coverage for children aged 2 years old (UK)	These indicators have just started to cover the COVID-19 impact period from Mar'20 onwards and the findings provide a useful baseline. The MMR and Dtap/IPV/Hib coverage rates for NENC CCGs are consistently higher than the England rate, but there is some variation within the NENC.	This data is available on a quarterly basis and will be updated in future reports for further monitoring. Q1 20/21 data should be available at the end of Sept '20.	Coverage at LA level is also available.
9b.	DTaP/IPV/Hib vaccination coverage for children aged 2 years old (UK)			
10.	Sickness absence - NHS sickness absence rates	This indicator has started to cover the COVID-19 impact period from Mar'20 onwards but more data is required to understand the extent of this in more detail. NENC NHS staff have a higher sickness absence rate than England overall. Since February '20 there has been a marked increase in the absence rate. National figures show variation in absence levels by staff group.	This data is available on a monthly basis and will be updated in future reports for further monitoring. May' 21 data should be available at the end of Sept '20.	Data relating to the specific reasons for sickness absence by staff group is available, but at England level only. Data can be presented by individual Trust if required.
11.	Excess weight in adults and children	These indicators do not yet cover the COVID-19 impact period from Mar'20 onwards but the findings provide a useful baseline, given the strong link between obesity and COVID-19. In adults, the rate of excess weight is higher than England overall, and this is significant in 4 LA areas in the NENC. There are 9 LAs in NENC with very high rates of excess weight in children in year 6.	This data is updated annually , and 2019/20 data (adults) will be published in May '21. Data relating to obesity in children (NCMP) may be available in Dec '20.	Additional ways of presenting this are subject to further discussion. Alternative and more timely data sources may also be available locally.
12.	Improving Access to Psychological Therapies (IAPT)	The number of referrals to talking therapies reduced substantially in April 2020 although numbers are again on the increase. More data is required to understand the full effect of the pandemic on these services and particularly on the outcome measures of finishing a course of treatment and the recovery rates, due to the time delay associated with these measures.	This data is available on a monthly basis and will be updated in future reports for further monitoring. July' 21 data should be available in Oct '20.	Additional key measures are available within the IAPT dataset and can be analysed and presented upon request. Further analysis to understand data quality issues and the extent of health inequalities is possible.

No.	Indicator	Key findings	Proposed updates	Further disaggregation or presentation
13.	NHS Stop Smoking Services in England	These indicators do not yet cover the COVID-19 impact period from Mar'20 onwards but the findings provide a useful baseline. The proportion of smokers setting a quit date is generally higher in the NE region than for England and the proportion of successful quitters is similar to the England rate.	This data collection has been paused by NHS Digital. Once reinstated this data is available on a quarterly basis by LA.	Further disaggregation to individual LA level trends is available.
14.	Breastfeeding statistics	These indicators do not yet cover the COVID-19 impact period from Mar'20 onwards but the findings provide a useful baseline. It is anticipated that breastfeeding rates may have increased during the lockdown period. This data is experimental, but does indicate that breastfeeding prevalence at 6-8 weeks is generally lower in the NENC than for England based on the latest data available.	This data collection has been paused and may be superceded by another reporting mechanism. If reinstated this data is available on a quarterly basis by LA.	Alternative and more timely data sources may also be available locally.
15.	Percentage of diabetes patients who have a record of retinal screening in the last 12 months	These indicators do not quite cover the COVID-19 impact period from Mar'20 onwards but the findings provide a useful baseline. The percentage of patients with diabetes with a record of retinal screening in the preceding 12 months is significantly higher in the NENC overall than for England in 2019/20. There is some geographical variation.	This data is updated annually and will be updated in future reports for further monitoring. 2020/21 data will be published in July '21.	Data is available at GP practice level upon request.
16a.	Referrals to cancer 2 week wait pathway - All Suspected Cancers	The number of patients seen by a specialist (all cancers, suspected breast cancer) dramatically reduced in April '20 but there is evidence that services have started to recover, and the number of patients seen is beginning to rise.	This data is updated monthly , and will be updated in future reports for further monitoring. Aug '21 data will be published in Oct '20.	Data is available at provider level upon request. Other cancer waiting times figures are also available and can be reported (e.g. 31 day, 62 day waits for first and subsequent treatment). Further analysis to understand the extent of health inequalities is possible.
16b.	Referrals to cancer 2 week wait pathway - Suspected Breast Cancer	The proportion of people seen within 14 days (both indicators) has also fallen in recent months. More data is required to understand the full effect of COVID-19 and the long term impact, particularly in light of the backlog of patients still waiting to be seen.		
17.	Diagnostics waiting times and activity	The percentage of patients waiting 6+ weeks for a diagnostic test increased dramatically from 3% in Feb '20 to over 60% in April '20, however this has now started to decline again. A similar but delayed pattern can be seen for those waiting 13+ weeks. More data is required to understand the full impact of COVID-19 on these measures.	This data is updated monthly , and will be updated in future reports for further monitoring. Aug '21 data will be published in Oct '20.	Data is available at provider level upon request. Data can be reported by individual diagnostic test (rather than all 15 together). Further analysis to understand the extent of health inequalities is possible.
18.	Percentage of the population aged 85 years & over	This data provides a useful population baseline position. In 2019, 2.48% of the North East population was aged 85 years or older, and this varies within the region with some areas having a considerably higher proportion of their residents in this age group. It is estimated that by 2039 there will be 100,000 people in the region in this age group (however the model does not account for the recent excess mortality rate in this age group due to COVID-19)	The population model is updated annually , but no specific date for this update is available.	Further analysis is available upon request of this and other population-related resources (such as POPPI and PANSI).
19a.	Appointments in general practice - appointments available and those with a GP	The number of appointments in general practice varies by CCG and over time. Following a reduction in appointments in April '20, the appointment rate is rising again. In April '20 there was an increase in the percentage of appointments with a GP but this has slowly reduced in the subsequent months.	This data is updated monthly , and will be updated in future reports for further monitoring. Aug '21 data will be published at the end of Sept '20.	Trends over time for appointment mode are possible, and waiting times are also available.
19b.	Appointments in general practice - appointment mode	The appointment mode has shifted from being 80% face to face pre-COVID-19 impact to around 50% (with the majority of the remainder being via telephone). The reported use of online/video consultations is currently very low (although this data collection is considered to be experimental). More data is required to understand the full impact of COVID-19 on these measures.		

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What does the Rating colour scheme mean ?

Values highlighted in GREEN and RED indicate when an area is statistically significantly better or worse than the England value for that particular indicator. AMBER indicates where an area's value is not significantly different to the England value.

For some indicators, where it is not straightforward to determine whether a high value is better or worse, or due to concerns with data quality, a different colour scheme is used – PALE BLUE and DARK BLUE to indicate values that are statistically significantly higher or lower than the England value. In cases where there are data quality concerns, this is noted in the text which accompanies the charts, and there is a need to interpret such indicators with caution.

Indicators that are shaded grey are presented in this way because they do not have confidence intervals with which to compare against the benchmark (i.e. England) value, and therefore it is not possible to determine whether a particular value is statistically significantly higher or lower than the benchmark.

Geography

Readers should note that it has not been possible to provide data that relates precisely to the geographical footprint of the AHSN, since the source data are published at region, local authority district, top tier local authority or CCG level only. Nevertheless, it is hoped that these data provide useful comparative information.

A geographical boundary change affects the comparability of some of the data over time. Cumbria CCG ceased to exist in April 2017, and North Cumbria CCG was created, which covers Allerdale, Carlisle, Copeland and Eden. South Lakes and Furness are now part of Morecambe Bay CCG.

On 1 April 2020 there were a number of changes (mergers) relating to CCGs within NENC.

Durham Dales, Easington and Sedgefield CCG and North Durham CCG merged to become NHS County Durham CCG; Darlington CCG, Hartlepool and Stockton on Tees CCG and South Tees CCG became NHS Tees Valley CCG; and Hambleton, Richmondshire and Whitby CCG became part of NHS North Yorkshire CCG.

For those indicators in this report where the data is presented by CCG and where the available time period includes the period post-1st April 2020, this is reported for the current 8 CCGs that are currently part of the NENC area. Further disaggregation of the data by CCG (pre April 2020) and GP practice may be possible upon request.

Methodology and approach

1. An assessment of the 62 existing metrics from the March 2019 Population Surveillance report (<https://www.ahsn-nenc.org.uk/what-we-do/improving-population-health/measurement/>) was undertaken, with indicators categorised as short, medium or long term with regard to data availability and update frequency. The impact of COVID-19 on each metric was evaluated (direct / indirect / no link).

2. The content of scoping documents and impact assessments drafted by Public Health and NECS colleagues (included in the list below) were taken in account, in addition to a wealth of other information sources including recently published literature.

- The scope of broader impacts of COVID-19 and lockdown – unintended consequences (working draft shared by Helen Park, NECS, April 2020)

- The unintended consequences of the COVID-19 response – a rapid Health Inequalities Impact Assessment for the North East (draft shared by Claire Mathews, Public Health England, May 2020)

- Other sources include NHS Digital, ONS, Hospital Episode Statistics, PHE Fingertips tool, Gov.uk, IFS.org.uk, Health Foundation, CQC, King's Fund, NHS England/Improvement, Lancet, Centre for Mental Health, Ipsos MORI, and discussions from recent regional / national meetings relating to healthcare and data.

3. A matrix was produced containing a long list of COVID-19 relevant metrics, including new metrics and existing metrics where definitions have been revised appropriately.

The metrics were categorised by data availability (for the period February / March 2020 onwards), and information was included for each metric such as data source, organisational level available (CCG, LA, Trust, other), ability to analyse by deprivation, data update frequency, and relevance to COVID-19.

Metrics were prioritised in terms of data availability and relevance, and incorporated into a set of reports, of which this is the first.

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1. Background and introduction

The coronavirus pandemic represents an unprecedented challenge to health and care services, bringing radical changes to systems, organisation and to individual people.

A number of organisations have studied, assessed and reported on different perspectives of the impact of the pandemic and some of these are summarised below.

The public health, economic and social crisis

The Institute for Fiscal Studies (IFS) has described the COVID-19 crisis as affecting every part of the country. Whilst the virus itself is primarily a public health issue, the unprecedented responses it has necessitated mean it is also an economic and a social crisis, with variation by geography and people in terms of their degree of vulnerability to each of the three dimensions. Details on the health, economic and social costs of the pandemic by local area are provided in this IFS report, as well as a focus on those areas that are vulnerable on multiple dimensions. [ifs.org.uk The geography of the COVID-19 crisis in England, June 2020].

Although COVID-19 is a novel disease that has required exceptional measures to protect public health, the inequalities that the disease has highlighted are far from unprecedented. In the 2010 Marmot Review, Fair Society Healthy Lives [Institute of health equity.org], six priority objectives and recommendations for reducing health inequalities were set out. In February 2020 the Marmot Review 10 Years On [health.org.uk] an assessment of outcomes over the decade in five of these areas took place, noting that since 2010 there have been widespread and deep cuts in public spending, and these have been greatest in areas where need is highest. The key finding was that the last decade has been marked by deteriorating health and widening health inequalities. Life expectancy has stalled, with marked regional differences being observed.

A review into the disparities in the risk and outcomes from COVID-19 by Public Health England indicates that age was the largest disparity with those aged 80 or older being seventy times more likely to die than those under 40. Working age males diagnosed with COVID-19 were twice as likely to die as females and people who live in deprived areas had higher diagnosis rates and death rates than those living in less deprived areas. [Public Health England Disparities in the risk and outcomes of COVID-19, August 2020]

A report of the Social Metrics Commission in July 2020 contains a comprehensive account of poverty (collected between April 2018 and March 2019) and thus provides a baseline from which the impacts of COVID-19 on poverty can be judged in future years. The full scale of the economic and social impacts of the crisis cannot yet fully be measured. [Social Metrics Commission Measuring Poverty 2020: A report of the Social Metrics Commission, June 2020]

The link between health and income, in terms of recent economic shocks and the consequences these might have on people's health, is explored in an article from the Health Foundation [health.org.uk Living in poverty was bad for your health before COVID-19, July 2020]

The interaction of the pandemic with existing inequalities was investigated in a report by the IFS. The economic impact of the lockdown, including the shutdown of entire sectors such as retail and hospitality, school and nursery closures and widespread working from home, were not felt equally across the population and in many cases exacerbated existing inequalities. The health impacts of the virus are also not evenly spread, with higher death rates in certain occupations, ethnic minority groups and poorer localities. This report considers the implications for future inequalities. [ifs.org.uk COVID-19 and inequalities, June 2020].

Findings from the Opinions and Lifestyle Survey (latest published is August 2020) demonstrate the impact of the pandemic on people, households and communities. This includes adults leaving their homes (eating out, leisure, socialising, and travel to work), opinions on face coverings, going on holiday and on children returning to school. [Office for National Statistics Coronavirus and the social impacts on Great Britain: 21 August 2020].

Impact on health and social care services

A telephone survey conducted by Ipsos MORI on behalf of the Health Foundation (May 2020), reported findings which include that one-quarter of those surveyed had used a health service since lock-down, with a further 3% considering this but not doing so. Approximately 12% of respondents had a pre-arranged healthcare service cancelled [Health.org.uk The Health Foundation COVID-19 Survey, June 2020]

Since April 2020 there has been a drastic reduction in routine NHS care with millions of patients living with health problems (including cancer) being affected, and their treatment postponed or cancelled. Millions more patients have missed vital opportunities to receive initial assessment and diagnosis for health problems in the first place. [BMA The hidden impact of COVID-19 on patient care in the NHS in England, July 2020].

The results of a survey carried out with hospital Trust leads describes the different approaches that Trusts have put in place to continue caring for non-COVID patients and demonstrates the complexity of calculating what a sustainable level of service provision should be. This includes rapid innovation in service delivery, workforce support, and expressing concern about patients who have not accessed care during the lockdown period. Demand for physical health services dropped far more significantly than for mental health services during the pandemic [NHS Providers Recovery Position – What next for the NHS? June 2020]

At the start of the pandemic in April and May 2020, the NHS adapted at speed to redeploy staff, change estate configurations, reduce non-COVID-19 face to face appointments and redesign patient pathways. Royal College of Physicians' members think that it will take months to years to get back on an 'even keel' (to manage backlogs and stabilise services). The COVID-19 adaptations required at hospital specialty level have been described in terms of impact in this report. [Royal College of Physicians Returning the NHS to an even keel, July 2020].

Impact on health and social care services (cont'd)

The financial and performance issues facing the NHS are published each quarter by the King's Fund, usually based upon an analysis of national data and a regular survey of NHS Trust and commissioner finance directors [*King's Fund Quarterly monitoring report (QMR 29): How is the NHS performing? August 2020*]. The latest version focuses on data alone and looks at three areas of the NHS: revenue (day-to-day spending), capital (longer-term investment) and waiting time performance, in terms of where the NHS expected to be at the end of 2019/20, where it is in 2020/21 and what impact COVID-19 may have in the future. Early indications for 2020/21 are that the NHS has reported a year-to-date overspend of £2.6 billion.

A letter from NHS England to all GPs and their commissioners in July 2020 provided an update on their contractual requirements and encouraged practices to resume those services relating to the management of pre-existing conditions and urgent demand, including the delivery of face to face care, where clinically appropriate. Practices were asked to 'gear up' for a major expansion of the winter flu programme, focus on early cancer diagnosis and care of people with a learning disability, and to maintain disease registers, prescribing indicators and cervical screening indicators. The resumption of services such as new patient reviews, routine medication reviews, over-75 health checks and clinical reviews of frailty was expected from July 2020 [*NHS England Publications ref: 001559, July 2020*].

The COVID-19 pandemic has shone an uncompromising light on the social care sector, its staff and the people of all ages who use its services. A recent article from the King's Fund describes the key problems identified as facing social care (in 2019) and how COVID-19 has exacerbated these challenges, including quality of care and disjointed care [*King's Fund How COVID-19 has magnified some of social care's key problems, August 2020*].

A survey relating to the impact of COVID on the Care Home Nurse workforce in the UK was carried out in May and June 2020 (designed by the Queen's Nursing Institute, QNI). Findings confirm that the pandemic has been a very challenging and negative experience for the majority, and a stressful period for professionals working to care for and protect their residents. There were a small number of positive elements identified from responses, including good support from organisations (councils and private businesses) and from employers and colleagues, and that the experience improved relationships and team work. The findings provide information to support future planning [*qni.org.uk The experience of Care Home Staff during COVID-19, August 2020*].

The Health Foundation website is supporting the health and care system in the UK to deal with the current challenges by providing a wide range of evidence and resources in response to COVID-19 [<https://www.health.org.uk/what-we-do/responding-to-covid-19>].

The FutureNHS Collaboration Platform [future.nhs.uk] hosts a number of workspaces providing data and analytics support for COVID-19, containing a huge wealth of information and evidence to draw upon.

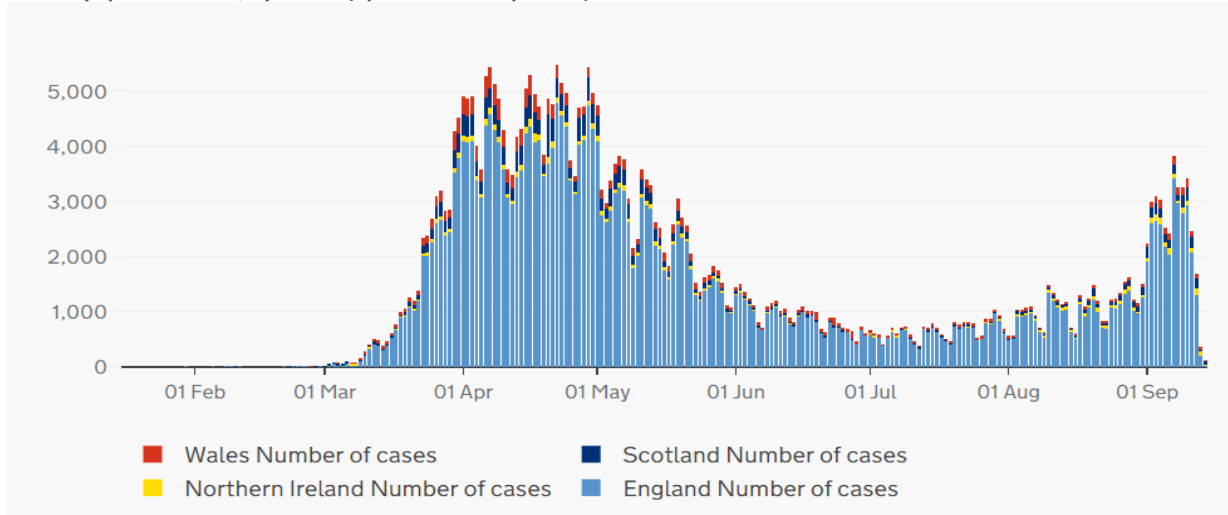
2. COVID-19 reported cases

The Coronavirus dashboard (coronavirus.data.gov.uk) provides the number of people who have tested positive for coronavirus on a daily basis. This is the number of people with at least one lab-confirmed positive COVID-19 test result, by specimen date or by date reported.

There are various regional and local dashboards and data presentations already in place, therefore the figure below simply shows the latest number of cases, by specimen date, by nation.

Note that this data included only pillar 1 tests (NHS / PHE labs in England) initially, but pillar 2 tests (commercial) have been included from varying dates between 15th June and 14th July, for each nation.

Cases by specimen date, by nation (updated 15th Sept 2020)

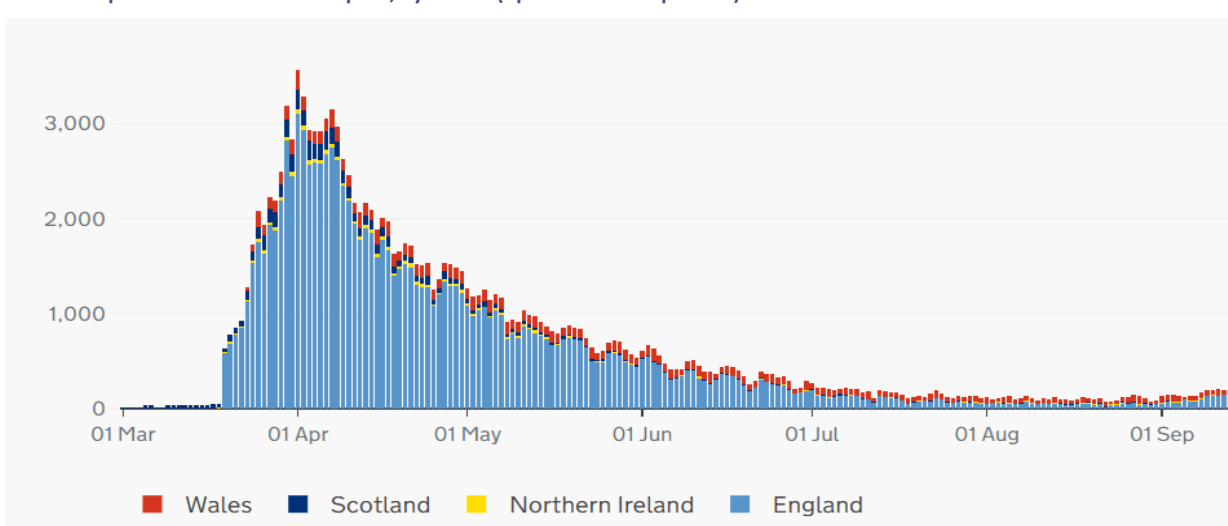


3. COVID-19 patients and healthcare

The coronavirus dashboard (coronavirus.data.gov.uk) also provides the number of COVID-19 patients admitted to hospital and the number of people in hospital at midnight the preceding night. Note that data are not updated every day for all four nations and the figures are not comparable as Wales include suspected COVID-19 patients while the other nations include only confirmed cases.

Various figures are available relating to healthcare: there were 141 patients admitted (reported 02/09/20), a total of 972 patients in hospital (reported 13/09/20), and 106 patients on ventilation (reported 14/09/20).

COVID-19 patients admitted to hospital, by nation (updated 15th Sept 2020)



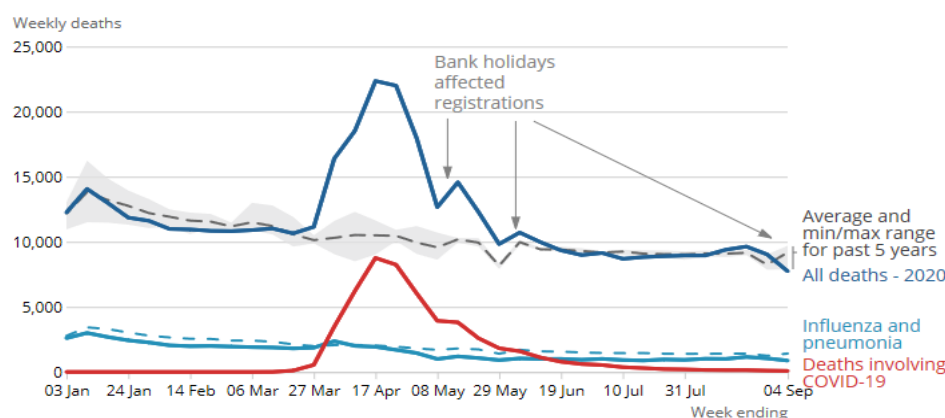
4. Death registrations and those relating to COVID-19

Number of deaths registered in England and Wales: this data is reported on a weekly basis by the Office for National Statistics and consists of provisional counts of the number of deaths registered in England and Wales, including deaths involving the coronavirus pandemic. The data is based on the date a death was registered rather than occurred.

Main points (latest available is Week 36):

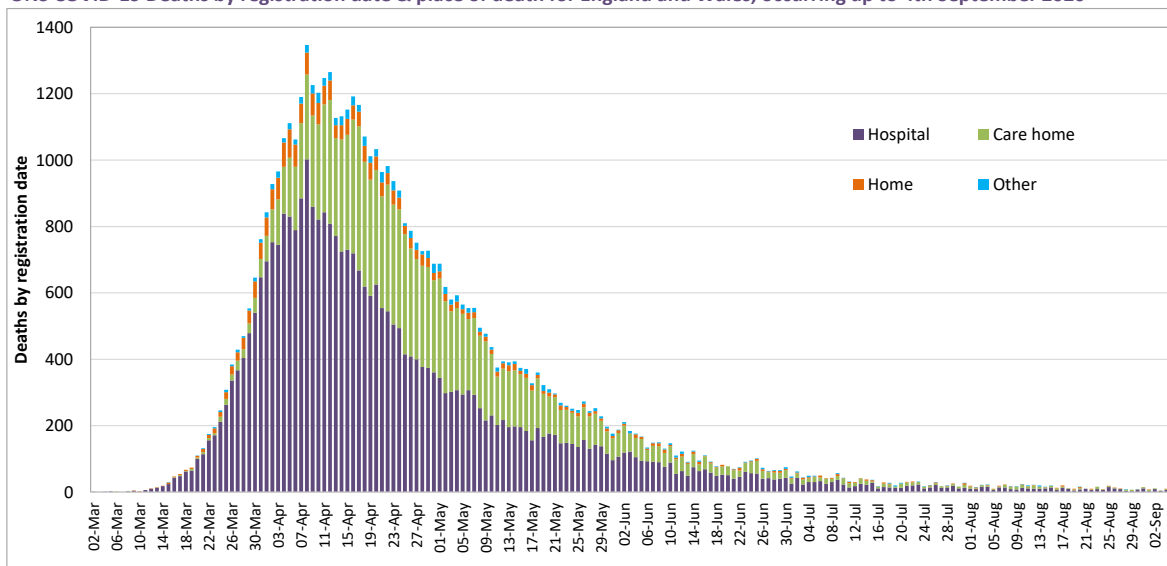
- In April and May there was very substantial excess mortality for England which relates to COVID-19 both directly and indirectly.
- The number of deaths registered in England and Wales in Week 36 was 7,739 (1,293 deaths fewer than in Week 35).
- The number of deaths registered in Week 36 was 15.7% below the 5 year average, and only 78 deaths mentioned 'novel coronavirus COVID-19'.
- COVID-19 has had a larger impact on those people who are most vulnerable and those at older ages. Some of these deaths would have likely occurred over the duration of the year but they have occurred earlier because of COVID-19.

Number of deaths registered by week, England and Wales (Office for National Statistics, data is provisional)



COVID-19 related mortality - deaths by place of occurrence: The daily death registrations for COVID-19 in England and Wales (produced by ONS, classed as provisional) show that the deaths peaked in the second week of April, and it also shows the split of deaths between hospitals and care homes. Sixty-five deaths were reported in the latest week available and of these 26% took place in a care home.

ONS COVID-19 Deaths by registration date & place of death for England and Wales, occurring up to 4th September 2020



Some population groups have a higher risk of dying from COVID-19 than others. Mortality rates are affected by age, gender, co-morbidities, deprivation, ethnicity, occupation and obesity. At the current time there is a steadily rising number of people who have tested positive for the disease since June, but death rates are not yet rising with the case numbers.

Public Health England has produced experimental statistics relating to Excess mortality in England

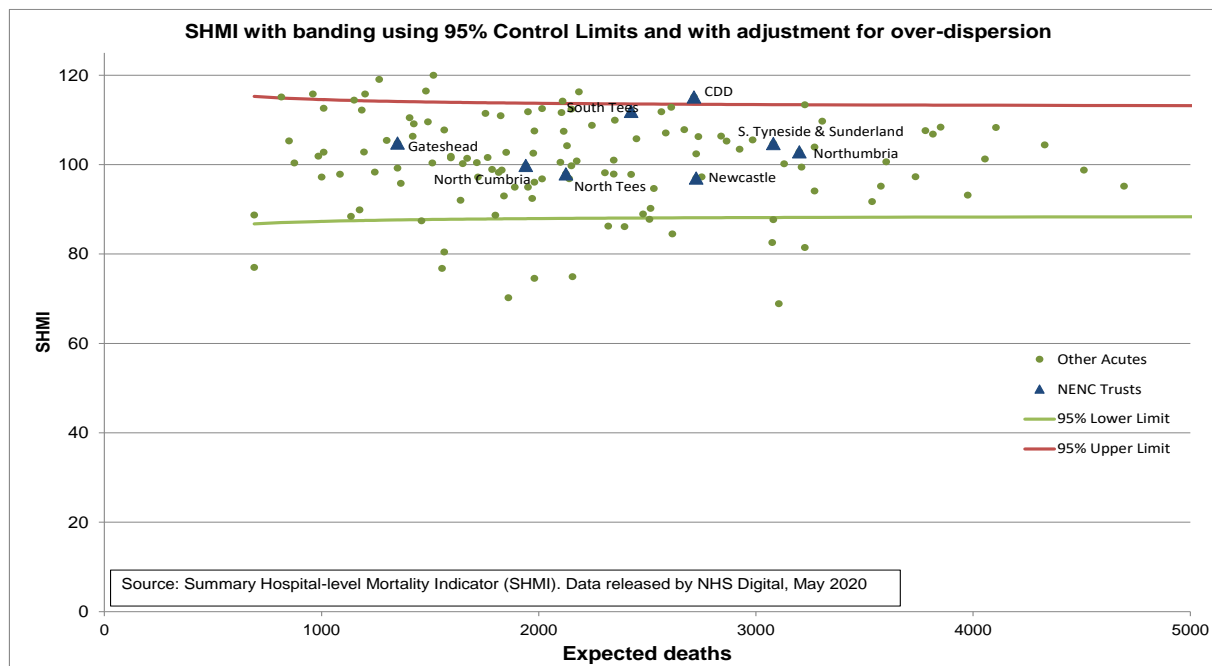
(<https://fingertips.phe.org.uk/static-reports/mortality-surveillance/excess-mortality-in-england-latest.html#introduction>).

The expected number of deaths is modelled using 5 years of data from preceding years to estimate the number of deaths we would expect on each day in 2020. Excess deaths are estimated by week and are presented by age, sex, region, ethnic group, level of deprivation, cause of death and place of death.

5. Hospital mortality monitoring

The monitoring of hospital mortality is a means of assuring the quality and safety of care provided by NHS trusts, and is also a potential way of informing improvement work, which is hugely important. Mortality indicators are a key element in the CQC's Insights reports.

SHMI funnel plot using 95% control limits and adjustments for over-dispersion (January to December 2019)



SHMI, total discharges, observed and expected deaths and banding, for the period January to December 2019

Provider	Discharges	Observed	Expected	SHMI	Category
County Durham and Darlington NHS FT	80970	3125	2715	115	Higher than expected
North Tees and Hartlepool NHS FT	60030	2085	2125	98	as expected
South Tees Hospitals NHS FT	86170	2715	2425	112	as expected
Gateshead Health NHS FT	32900	1415	1350	105	as expected
South Tyneside and Sunderland NHS FT	80425	3225	3080	105	as expected
The Newcastle Upon Tyne Hospitals NHS FT	113230	2640	2725	97	as expected
Northumbria Healthcare NHS FT	83040	3295	3200	103	as expected
North Cumbria Integrated Care NHS FT	47125	1935	1940	100	as expected

Data source(s): Taken from the NEQOS Hospital Mortality Quarterly Report (no. 45), and the original source is the Healthcare Evaluation Data (HED) system supplied by University Hospitals Birmingham NHS Foundation Trust.

Definitions / Notes

NEQOS produces a quarterly Hospital Mortality monitoring report for NHS organisations in the North East and North Cumbria. It aims to assist with mortality surveillance and assurance.

What is the data telling us?

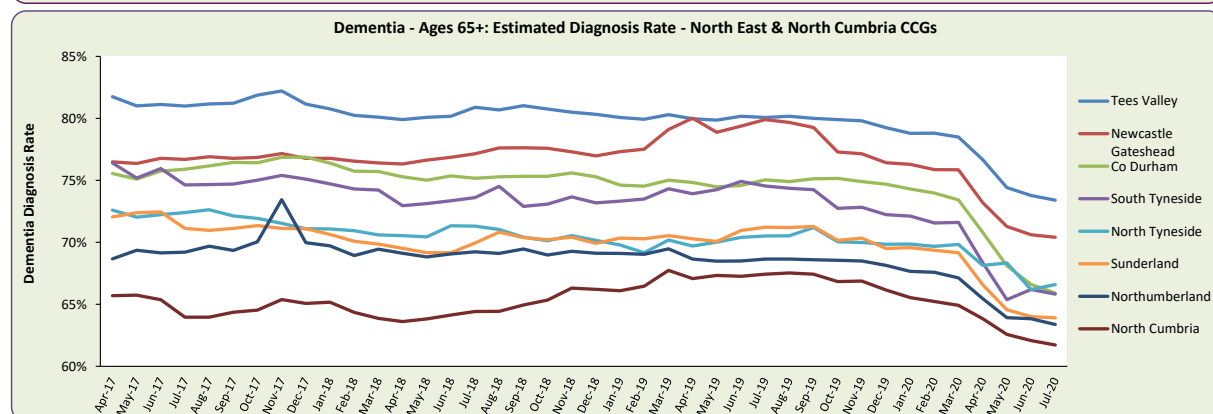
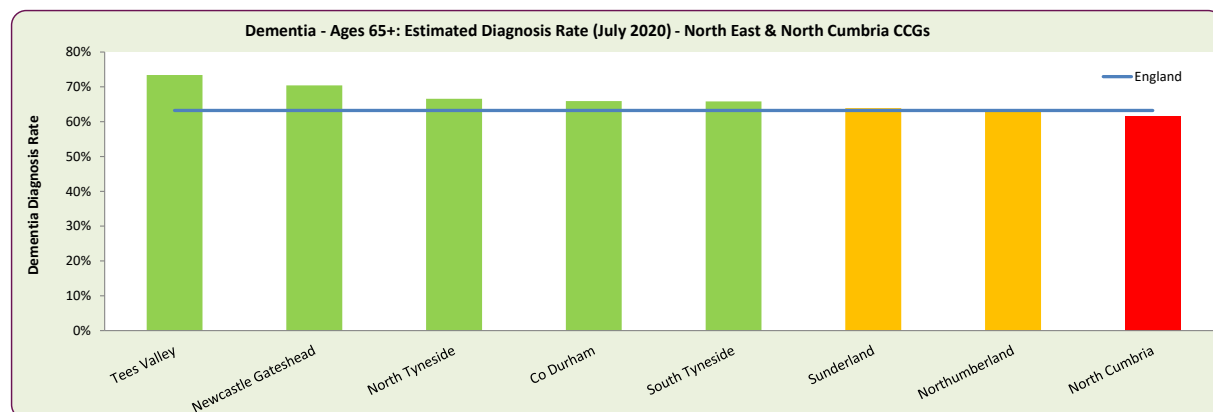
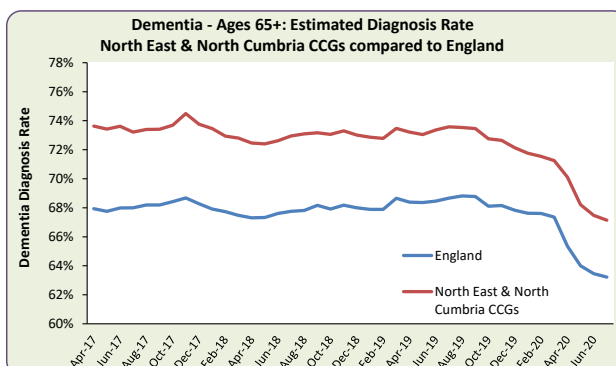
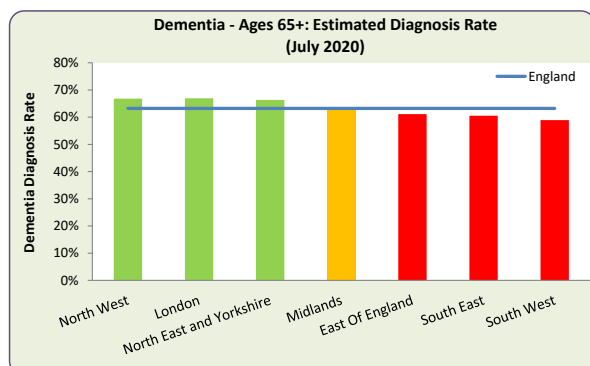
Report no. 45 covers the period January to December 2019 and relates to the pre-COVID period, however subsequent reports will also closely follow the national publications on COVID-19 as they emerge.

Summary Hospital-level Mortality Indicator (SHMI) is the indicator which reports all deaths in hospital and all deaths that occur within 30 days of discharge from hospital across the NHS in England, comparing the observed number of deaths with the number expected (calculated from a statistical model). The funnel plot shows the SHMI for all Trusts in England (Jan - Dec 2019), and in the NENC the rate is 'higher than expected' for County Durham and Darlington FT for this period. The related data is shown in the table above.

6. Estimated Diagnosis Rate for People 65+ years old with Dementia

The rate of those aged 65+ with a recorded diagnosis of dementia in the general practice record per person estimated to have dementia based on the CFAS II model

North East & North Cumbria CCGs	England
67.1%	63.2%



Data source: NHS Digital (<https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses>) Copyright © 2020 Health and Social Care Information Centre

Definitions / Notes

The cover page of this report contains an explanation of the organisational mergers that have taken place recently.

For this indicator NENC CCGs relates to 8 CCGs (previously 11 CCGs, excluding Hambleton, Richmondshire & Whitby).

Not everyone with dementia has a formal diagnosis. This indicator reports the rate of persons aged 65 years and over with a recorded diagnosis of dementia per person estimated to have dementia (given the characteristics of the population and the age and sex specific prevalence rates derived from the Cognitive Function and Ageing Study II¹ expressed as a percentage. Dementia has been identified as a priority area for improvement in the NHS Long Term Plan².

What is the data telling us?

The dementia diagnosis rate (of those estimated to have dementia) for the NENC CCGs combined is consistently much higher than the England rate, although, since April 2020 there has been a marked drop in the dementia diagnosis rate across England and this decline is noticeable in the NENC from Q3 2019/20.

At CCG level there is significant variation, with estimated dementia diagnoses rates in July 2020 ranging from 61.7% in North Cumbria CCG to 73.4% in Tees Valley CCG.

This data can also be reported by CCG deprivation score.

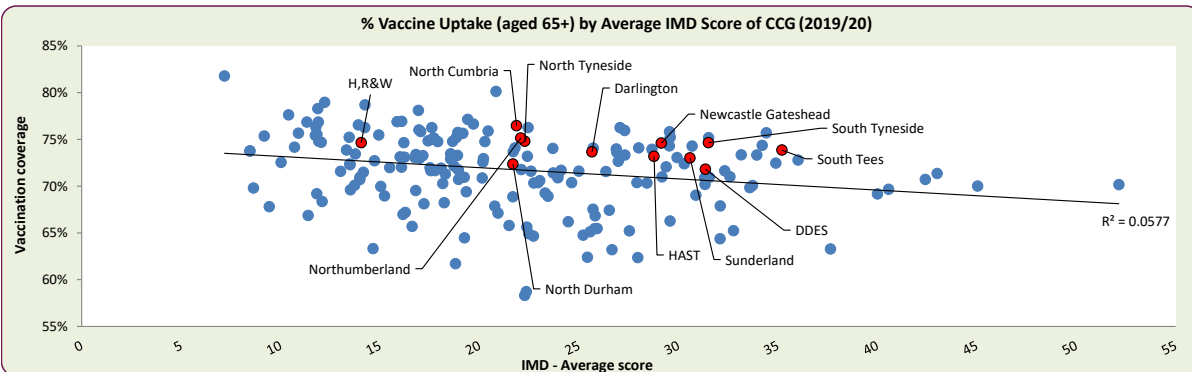
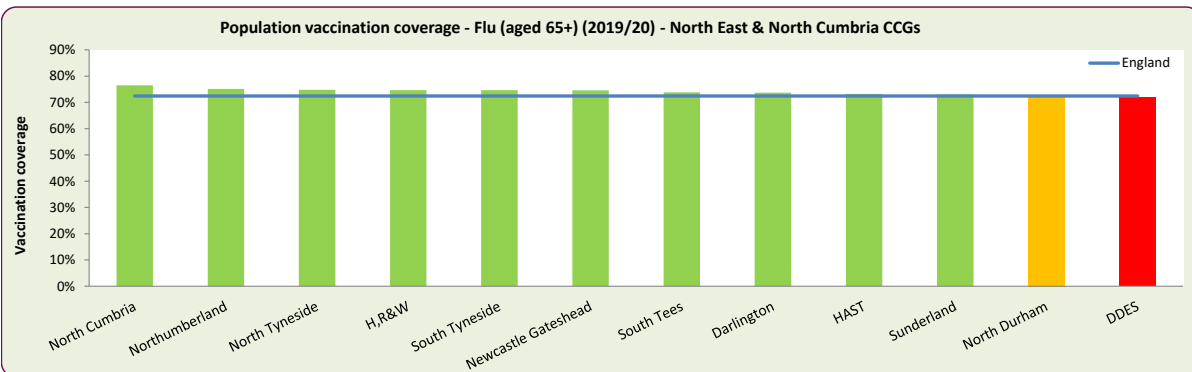
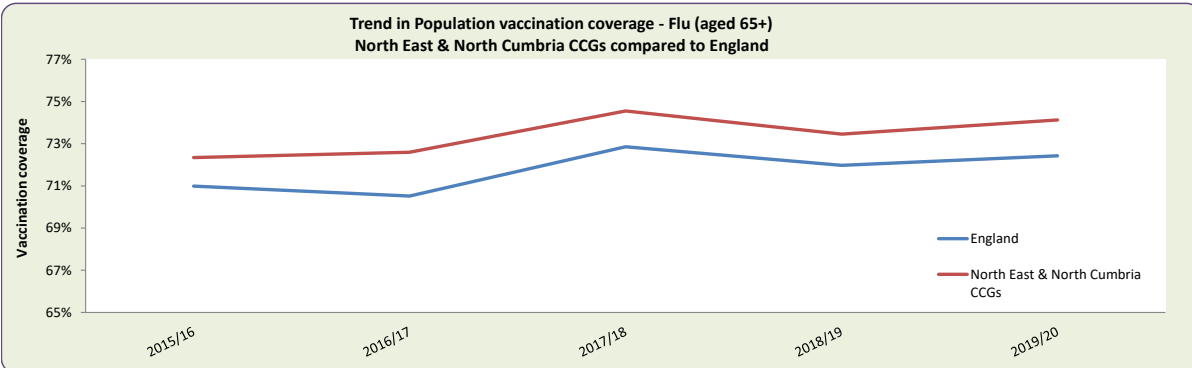
Due to the impact of COVID-19, caution is urged in drawing any conclusions from these data.

1. <http://www.cfes.ac.uk/cfas-ii/> 2. <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

7. Population vaccination coverage - Flu (aged 65+)

Flu vaccine uptake (%) in adults aged 65 and over, who received the flu vaccination between 1st Sept 2019 and 29th Feb 2020.

North West	North East & Yorkshire	South West	South East	Midlands	East of England	London	England
74.0%	73.8%	73.7%	73.1%	72.5%	71.9%	66.2%	72.4%



Data source: Public Health England (<https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2019-to-2020>)

Definitions / Notes

The cover page of this report contains an explanation of the organisational mergers that have taken place recently.

For this indicator NENC CCGs relates to 12 CCGs, including Hambleton, Richmondshire & Whitby. Over time the reporting period has changed from September to end January, to September to end February (from 2017/18 onwards).

Immunisation is one of the most effective healthcare interventions available and flu vaccines can prevent illness and hospital admissions among those aged 65 years and above. Coverage is closely related to levels of disease and monitoring coverage identifies possible drops in immunity before levels of disease rise. The flu vaccination is offered to people in at-risk groups such as pregnant women and elderly people, who are at greater risk of developing serious complications, such as bronchitis and pneumonia if they catch flu.

In this report the vaccination coverage is reported using statistical significance calculations (as described in the introduction to this report). However, this data is also presented in the Fingertips tool as benchmarked against the coverage goal ($\geq 75\%$), which may result in a slightly different Red / Amber / Green rating for some organisations.

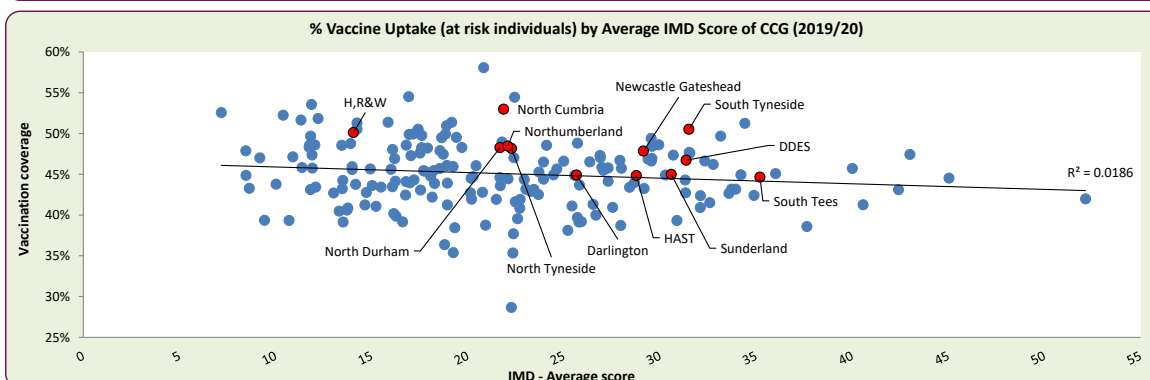
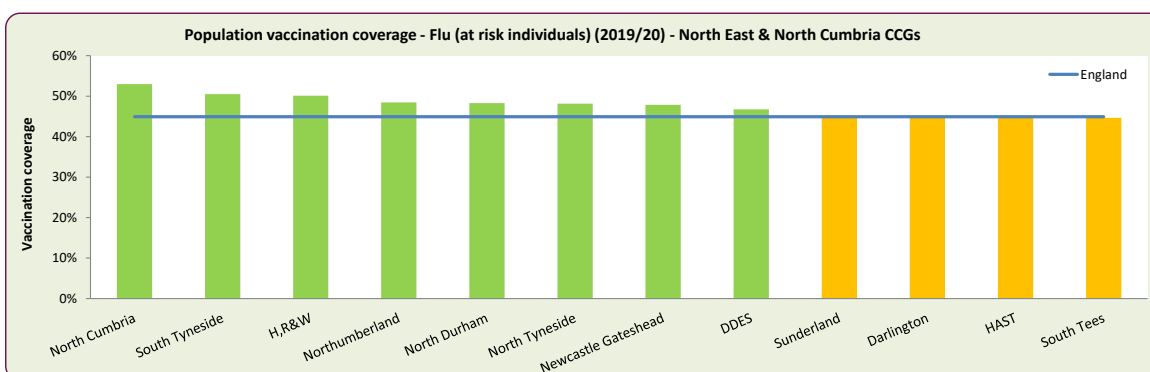
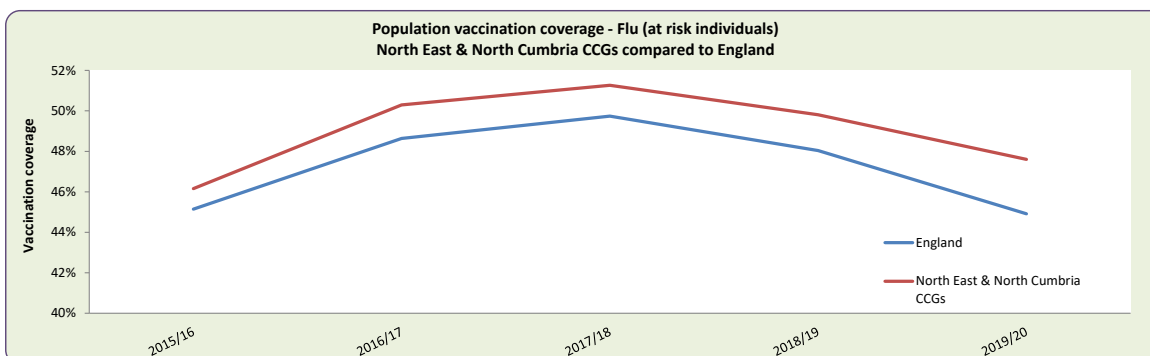
What is the data telling us?

The flu vaccination coverage rate for older people in the NENC region increased slightly in the latest time period, and was the second highest of all the English regions in 2019/20 at 73.8% compared with an England average rate of 72.4%. However, only North Cumbria and Northumberland CCGs achieved the 75% government recommended coverage rate. DDES CCG had the lowest coverage at 71.8%. There seems to be no particular association between vaccination coverage and CCG deprivation score (higher IMD score indicates more deprived).

8. Population vaccination coverage - Flu (at risk individuals)

Flu vaccine uptake (%) in at risk individuals aged over 6 months to under 65 years (excluding pregnant women), who received the flu vaccination between 1st Sept 2019 and 29th Feb 2020.

North West	South East	South West	North East & Yorkshire	Midlands	East of England	London	England
47.6%	46.2%	45.9%	45.8%	44.8%	42.5%	41.8%	44.9%



Data source: Public Health England (<https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2019-to-2020>)

Definitions / Notes

Vaccination against seasonal influenza targets those people who are at greatest risk of developing serious complications such as pneumonia. The at-risk groups in this metric are those aged under 65 years, pregnant women, children and adults with long term health conditions or poor immunity, and those living or working in environments which place them at greater risk. PHE produces a National Influenza Report once a fortnight which provides a summary of influenza and other seasonal respiratory illnesses³. In 2020/21 it is proposed that additional cohorts of patients are also vaccinated, including household contacts of those on the NHS shielded patient list or of immunocompromised patients, those delivering domiciliary care and potentially also those aged 50-64 year olds later in the season, depending on vaccine availability.

In this report the vaccination coverage is reported using statistical significance calculations (as described in the introduction to this report). However, this data is also presented by PHE within the indicator portal as benchmarked against the coverage goal ($\geq 55\%$), which may result in a slightly different Red / Amber / Green rating for some organisations.

What is the data telling us?

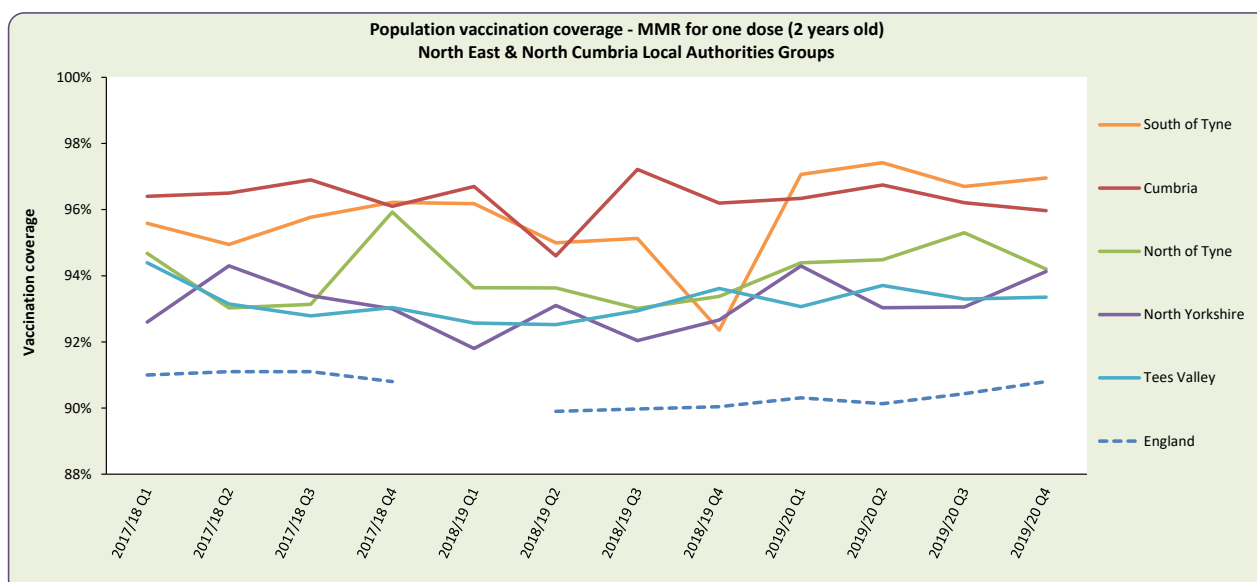
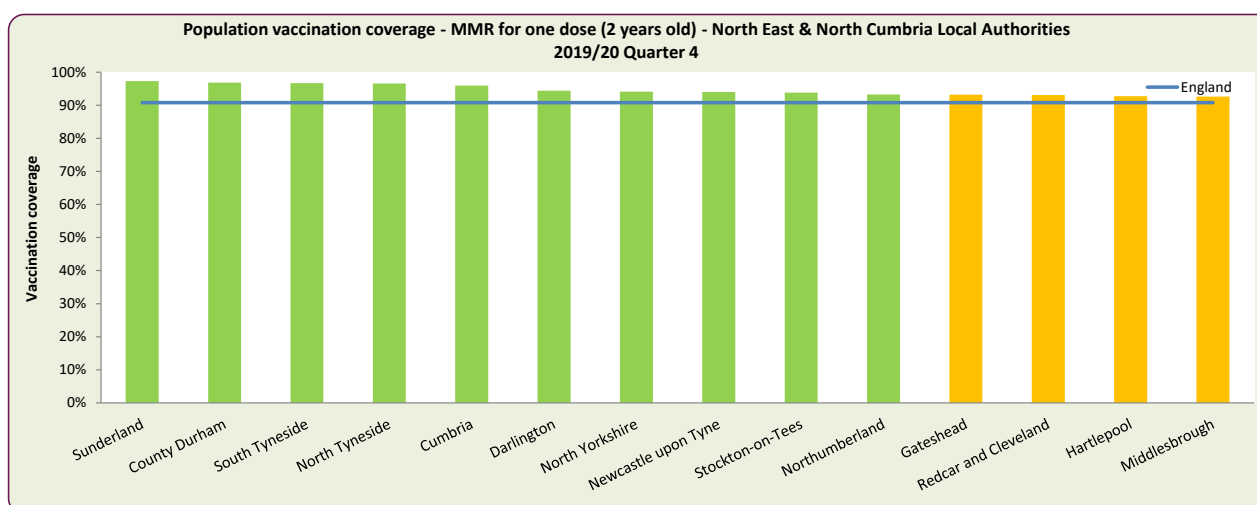
The flu vaccination coverage rate for at-risk individuals in the NENC region has decreased both regionally and nationally since 2017/18. In 2019/20, the North East and Yorkshire region rate was 45.8% compared with an England average rate of 44.9%. In the latest financial year there were no NENC CCGs that achieved the 55% government recommended coverage rate. Four CCGs, South Tees, HAST, Darlington and Sunderland all only achieved 45% coverage or lower.

As with the 65+ years flu group, there is no correlation between vaccination coverage and CCG deprivation score.

3. <https://www.gov.uk/government/statistics/weekly-national-flu-reports-2019-to-2020-season>

9a. MMR vaccination coverage statistics for children aged 2 years old (UK) - COVER programme

UK quarterly vaccine coverage data for MMR for one dose for children reaching their second birthday during the evaluation quarter



Data source: Public Health England (<https://www.gov.uk/government/collections/vaccine-uptake#cover-of-vaccination-evaluated-rapidly-programme>). This data is classed as provisional.

Definitions / Notes

MMR is the combined vaccine that protects against measles, mumps and rubella. These are highly infectious, common conditions that can have serious complications. Vaccine coverage is closely correlated with levels of disease and monitoring coverage identifies possible drops in immunity before levels of disease rise. This indicator reports those children who received one dose of MMR on or after their first birthday and at any time up to their second birthday, as a percentage of all children whose second birthday falls within the time period. As the latest available report (Q4, 2019/20) largely reflects vaccines administered prior to March and therefore does not reflect impact of the COVID-19 pandemic on the UK immunisation programme. A research paper describing data analysis of the early impact of COVID-19 on routine childhood vaccinations (to April 2020) indicates that vaccination counts fell from February 2020, but did improve by mid-April⁴.

What is the data telling us?

The MMR coverage for the latest period (2019/20, Q4) varies across the local authorities in the region from 97.3% in Sunderland to 92.7% in Middlesbrough, compared to the England coverage of 90.8% for the same period.

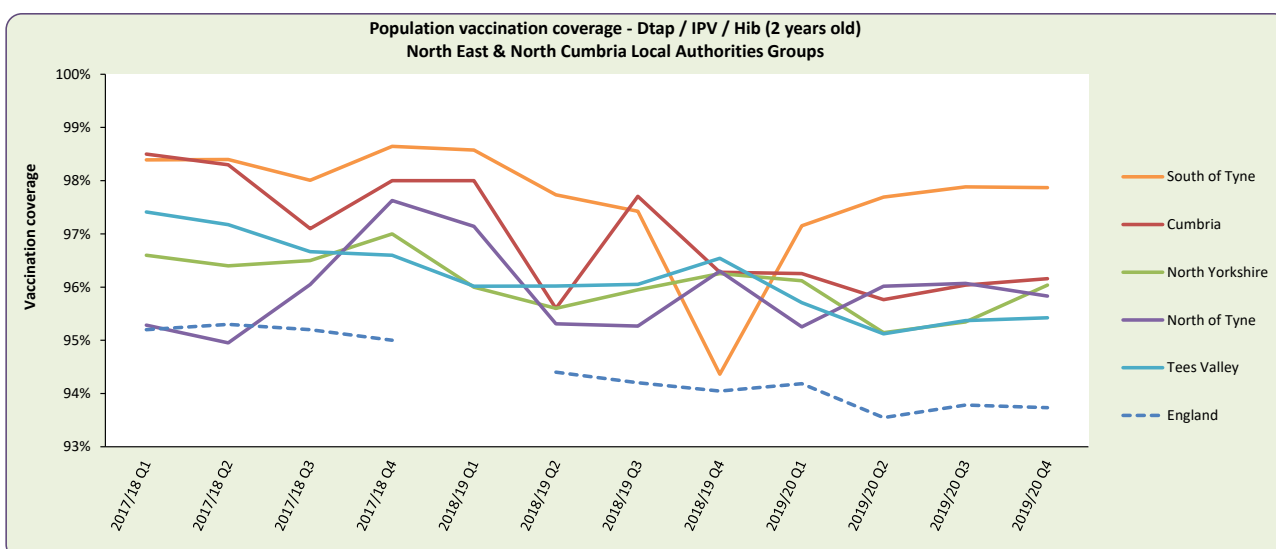
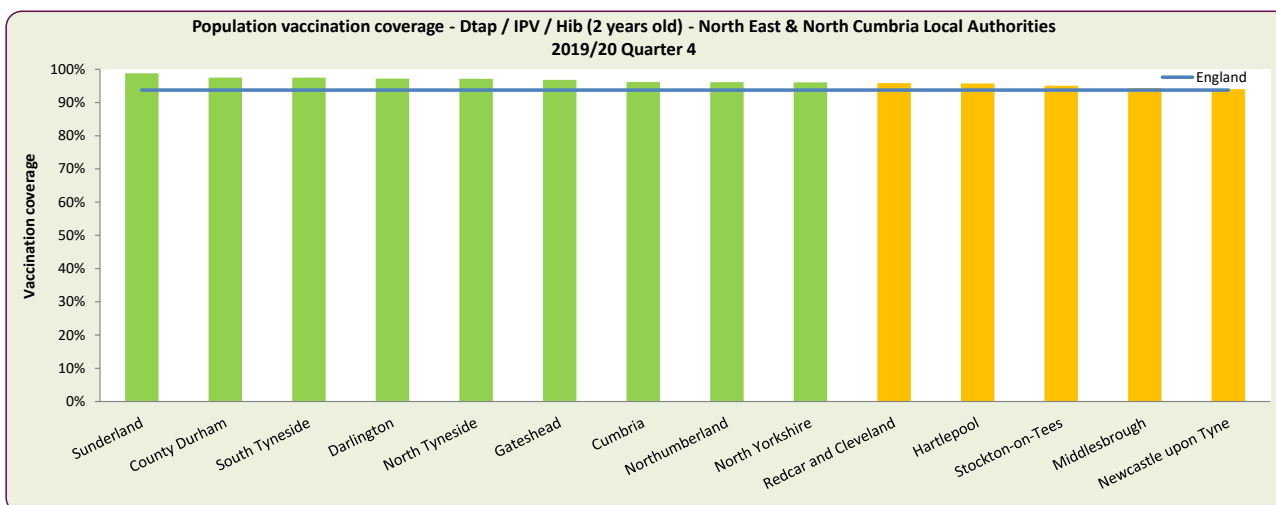
Coverage trends over time are shown for local authority groups but can be reported separately upon request. Issues with a London-based data migration taking place in 2018/19 Q1 have resulted in no England level data for this quarter being available.

The south of Tyne LAs (County Durham, Sunderland and South Tyneside) and Cumbria LA consistently have the highest coverage rates over time, however all LAs in the region have higher rates than England.

4. https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.19.2000848#abstract_content

9b. DTaP/IPV/Hib vaccination coverage statistics for children aged 2 years old (UK) - COVER programme

UK quarterly vaccine coverage data for Dtap/IPV/Hib for children reaching their second birthday during the evaluation quarter



Data source: Public Health England (<https://www.gov.uk/government/collections/vaccine-uptake#cover-of-vaccination-evaluated-rapidly-programme>). This data is classed as provisional.

Definitions / Notes

The combined DTaP/IPV/Hib is the first in a course of vaccinations offered to babies to protect them against diphtheria, pertussis (whooping cough), tetanus, polio and Haemophilus influenzae type b. The vaccine is offered when babies are 2, 3 and 4 months old. This indicator reflects the number of children who received 3 doses of DTaP/IPV/Hib vaccine at any time by their second birthday as a percentage of all children whose second birthday falls within the time period.

As the latest available report (Q4, 2019/20) largely reflects vaccines administered prior to March it therefore does not reflect impact of the COVID-19 pandemic on the UK immunisation programme.

What is the data telling us?

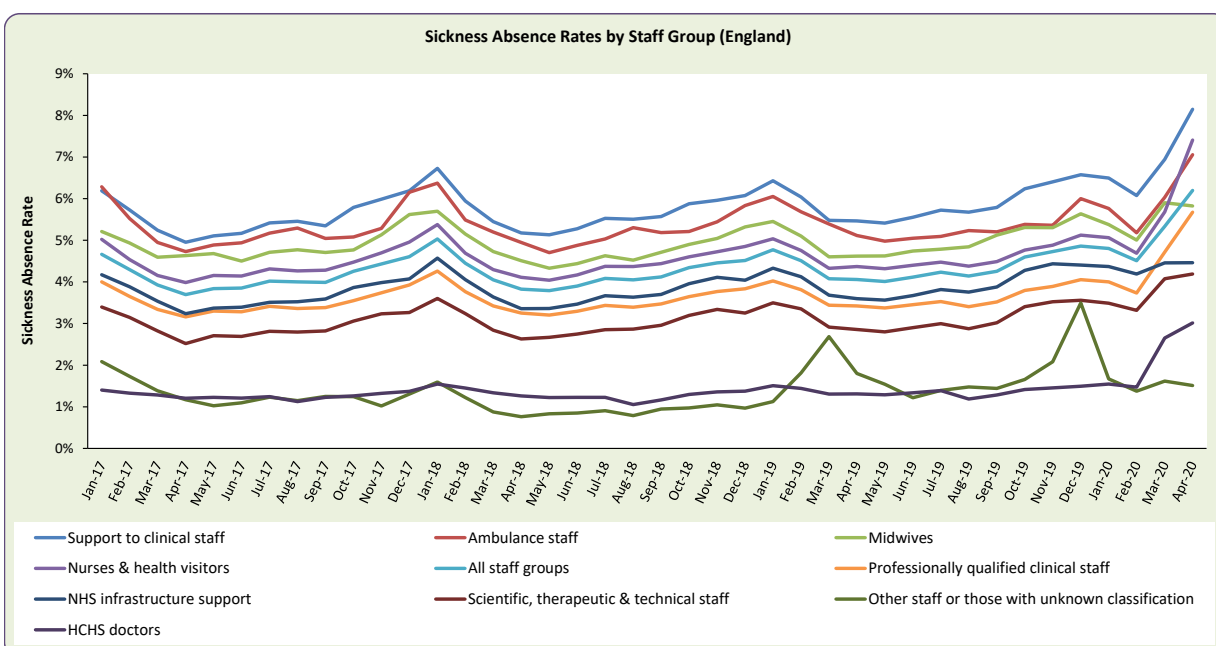
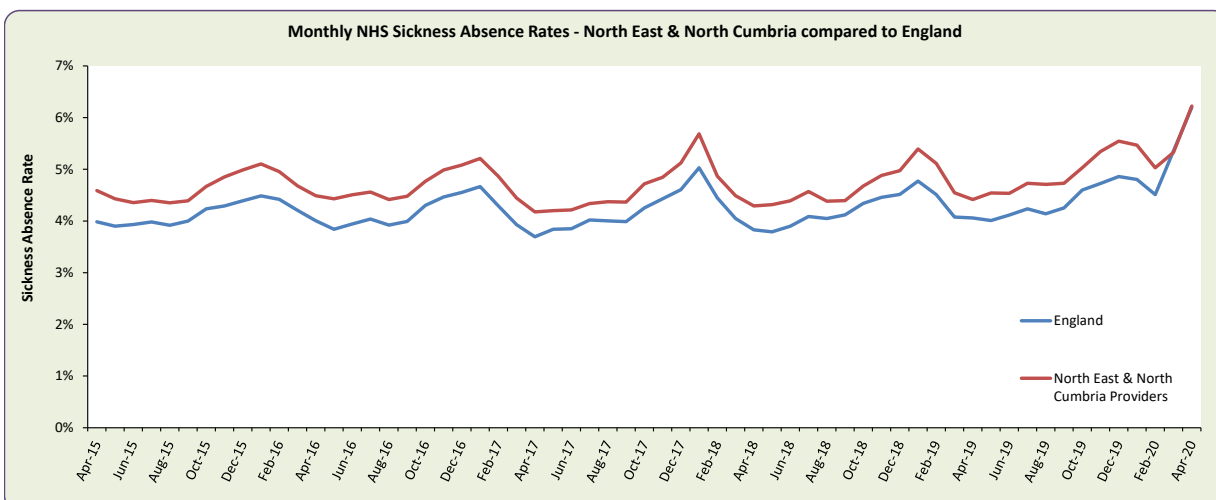
The DTaP/IPV/Hib coverage for the latest period (2019/20, Q4) varies across the local authorities in the region from 98.8% in Sunderland to 94.0% in Newcastle upon Tyne, compared to the England coverage of 93.7% for the same period.

Coverage trends over time are shown for local authority groups but can be reported separately upon request. Issues with a London-based data migration taking place in 2018/19 Q1 have resulted in no England level data for this quarter being available.

There is quarterly variation in the coverage rates for each LA, however for almost the entire period reported above, all LAs in the region have higher rates than England. For all four quarters of 2019/20, the South of Tyne LA group (County Durham, Sunderland and South Tyneside) has the highest coverage.

10. Sickness absence - NHS sickness absence rates

Sickness absence rates for NHS staff, calculated from the Electronic Staff Record (ESR)



Preventable Suffering

Data source: NHS Digital (<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>). This data is classed as provisional.

Definitions / Notes

NHS sickness absence statistics are compiled from data recorded on the Electronic Staff Record (ESR) system as part of the day to day activities in running NHS organisations. They provide details by staff group, type of organisation and sickness absence reason. The NHS workforce is extremely diverse in terms of occupations and skills compared to many other public sector employers, and NHS work is often physically and psychologically demanding which increases the risk of illness and injury.

Sickness absence rates for English NHS staff are calculated by dividing the 'Full Time Equivalent number of days sick' by the 'FTE number of days available' for each month.

What is the data telling us?

The North East and North Cumbria providers line in the first chart above contains data relating to staff employed at the NENC hospital Trusts (including two mental health Trusts) in the region, and also includes NEAS staff. This information can be produced at separate organisational level on request.

Monthly sickness absence rates for England overall and the Trusts in the region show seasonal variation, with higher absence rates in winter than summer. Since February 2020 there has been a marked increase in the absence rate, most likely due to COVID-19, and the regional and England rates for April 2020 are 6.22% and 6.20% respectively however additional data is required to understand the extent and duration of this additional absence.

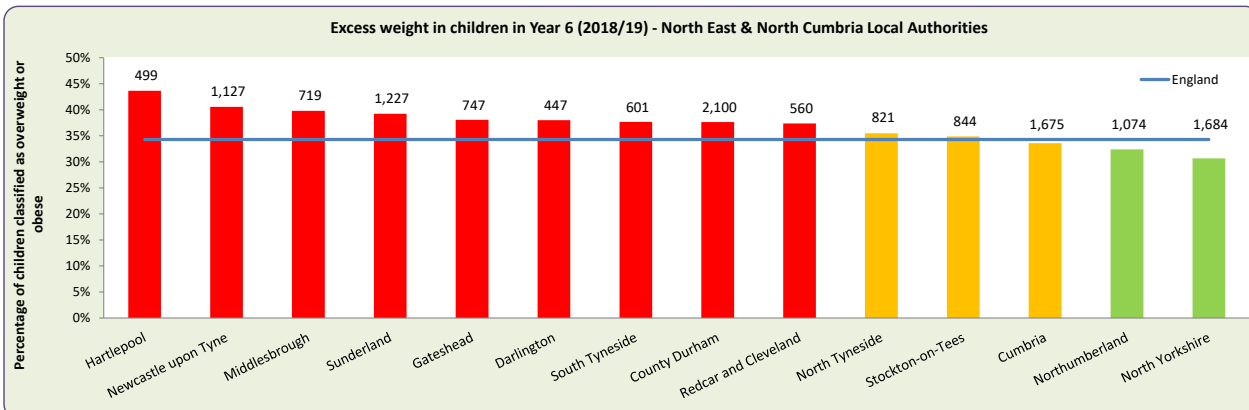
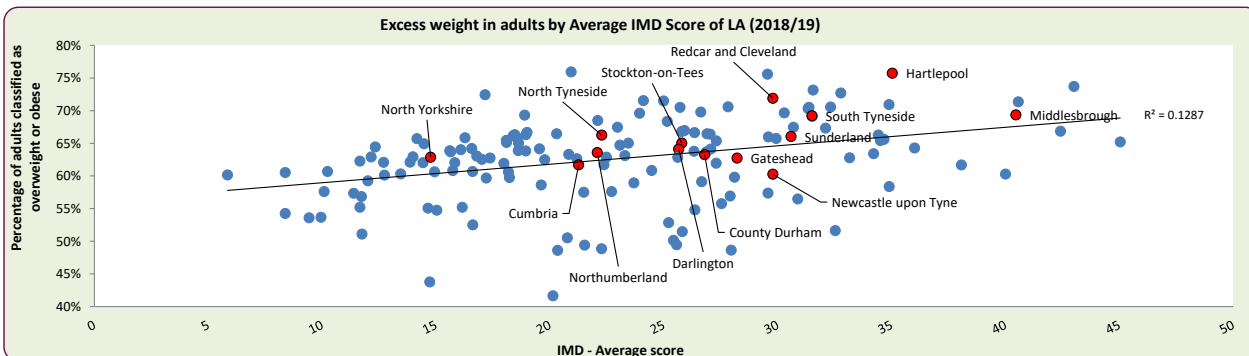
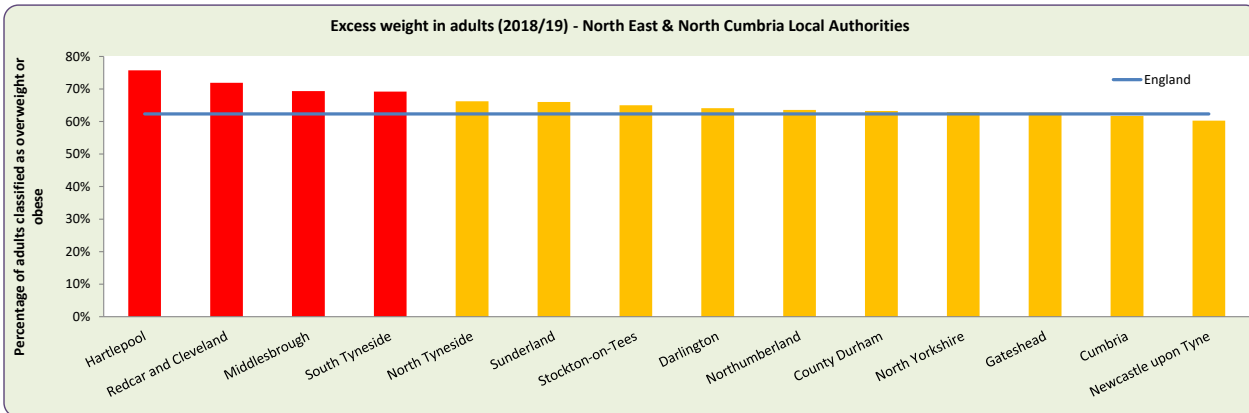
Sickness absence rates by Staff Group are also available, but only at England level, as shown in the second chart. Staff groups with the highest absence rates since February 2020 are those classed as 'support to clinical staff', 'ambulance staff' and 'nurses and health visitors'. Other staff groups with relatively lower absence levels have shown substantial increases in the latter period, such as HCHS doctors (Hospital and Community Health Services).

Additional data is available, at England level, which shows the reasons for sickness absence by staff group (25 reasons available). The main reason for absence is currently due to anxiety/stress/depression/other psychiatric illnesses (20.9%) however it is anticipated that a change in the main reasons for absence will be reported in the coming months due to the pandemic.

11. Excess weight in adults and children

Percentage of adults (aged 18+) and percentage of children classified as overweight or obese

West Midlands	Yorkshire and the Humber	North East	North West	East Midlands	East of England	South West	South East	London	England
65.6%	65.4%	64.9%	64.9%	64.2%	63.3%	61.3%	60.9%	55.9%	62.3%



Data sources: Public Health England (based on Active Lives survey, Sport England) presented in *Fingertips.phe.org.uk*. NHS Digital (<https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme>) Copyright © 2020 Health and Social Care Information Centre

Definitions / Notes

Excess weight in adults is associated with a wide range of health problems and is a big health crisis in England. The urgency of tackling this has been brought to the fore by evidence of the link to an increased risk from COVID-19⁵ and the government has set out a package of measures to address this⁶. Population-level interventions that are targeted at the circumstances in which people live are required⁷. Note that as the data relating to adults is self-reported it is likely to be an under-estimation of the prevalence of excess weight in adults.

What is the data telling us?

For the period 2018/19 (latest available) the observed rate of excess weight in adults is higher in the North East Region than England overall. At regional level, the prevalence of excess weight in adults was significantly higher than the national average in four of the NENC AHSN region constituent local authorities and the highest rate was observed in Hartlepool (75.7%). There is an association between obesity and deprivation. The final chart relates to data taken from the National Child Measurement Programme (NCMP) and this data demonstrates that 9 local authorities in the region have very high rates of excess weight in children in Year 6 (absolute numbers are above the bars).

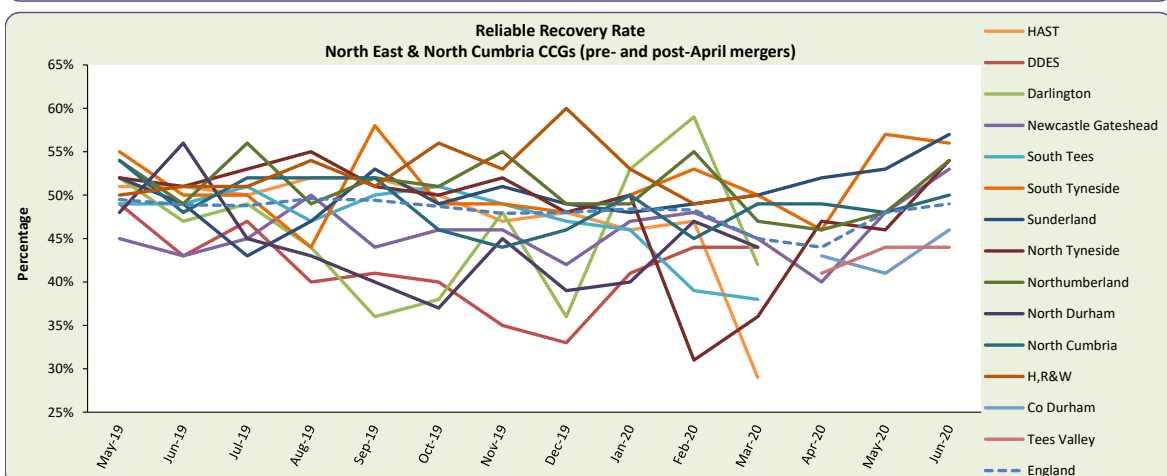
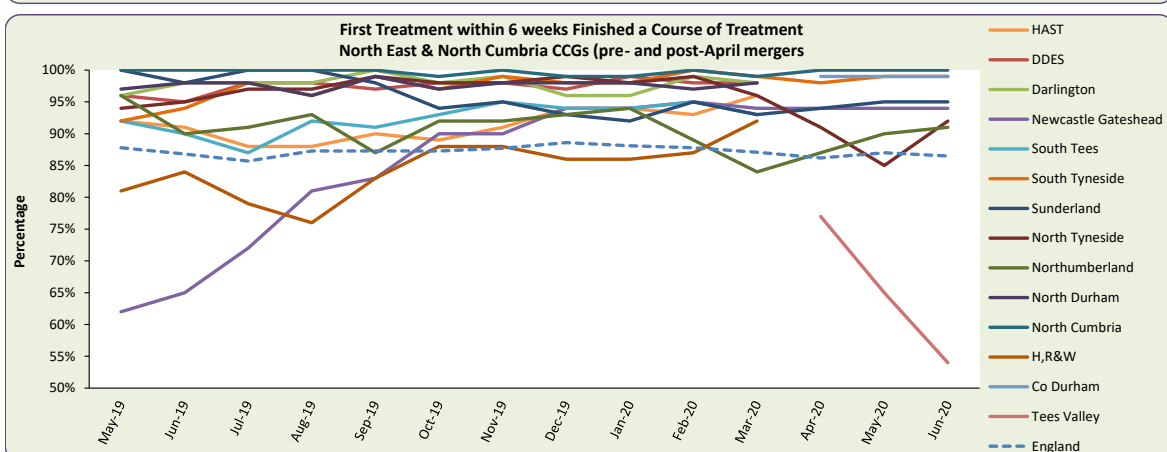
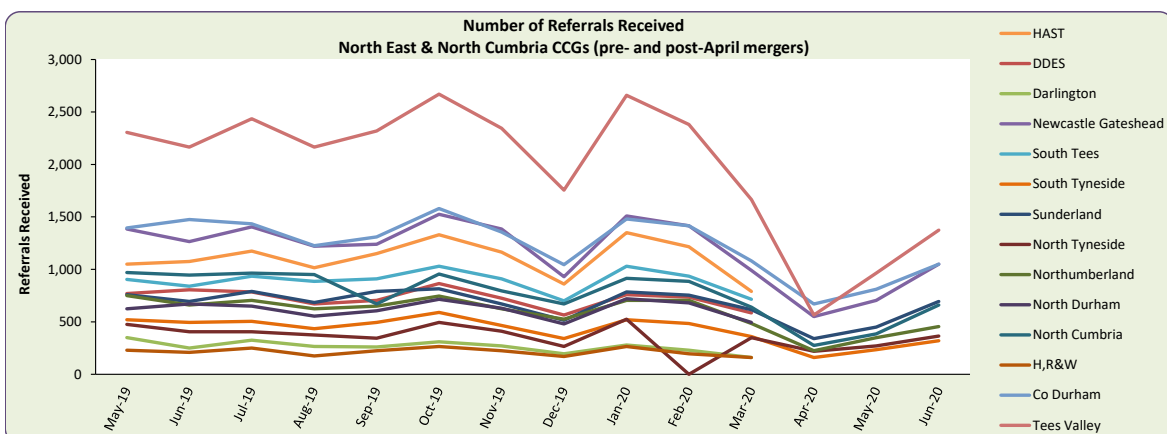
5. <https://www.gov.uk/government/publications/excess-weight-and-covid-19-insights-from-new-evidence>

6. <https://www.gov.uk/government/publications/tackling-obesity-government-strategy/tackling-obesity-empowering-adults-and-children-to-live-healthier-lives>

7. <https://www.health.org.uk/news-and-comment/charts-and-infographics/what-can-former-red-wall-areas-tell-us-about-food-environments-and-obesity>

12. Improving Access to Psychological Therapies (IAPT)

Trends in referrals to IAPT, proportion of people completing a course of treatment, and recovery rates



Data source: NHS Digital (<https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services>) Copyright © 2020 Health and Social Care Information Centre

Definitions / Notes

IAPT is run by the NHS in England and offers NICE-approved therapies for treating people with depression or anxiety. The pandemic will have had profound effects on the public's mental health.

Information is released each month relating to activity, waiting times and outcomes such as recovery. The charts above aim to demonstrate activity relating to three of the key measures in IAPT services. As the time period shown contains a point at which a number of NENC CCGs merged, activity for the two new CCGs (Tees Valley and County Durham) has also been calculated back in time. Disruption to submissions during the COVID-19 period means that this data should be interpreted with care.

What is the data telling us?

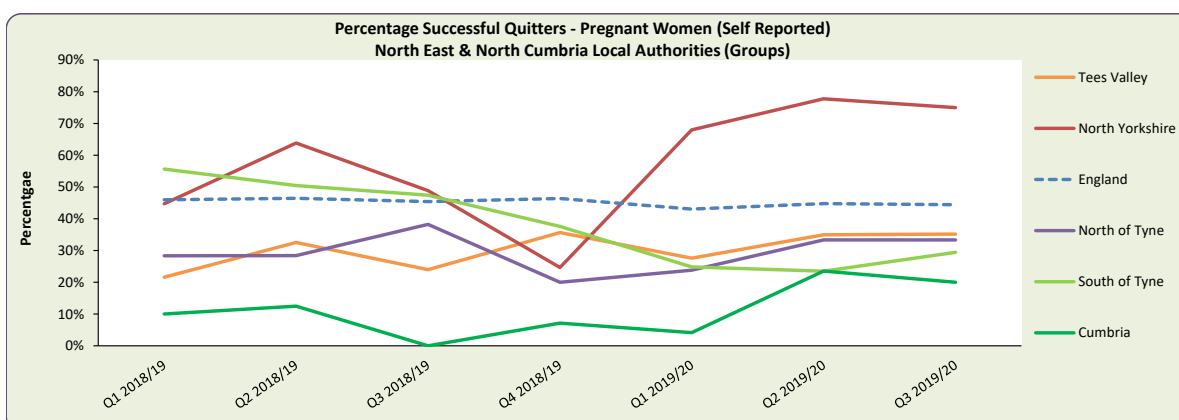
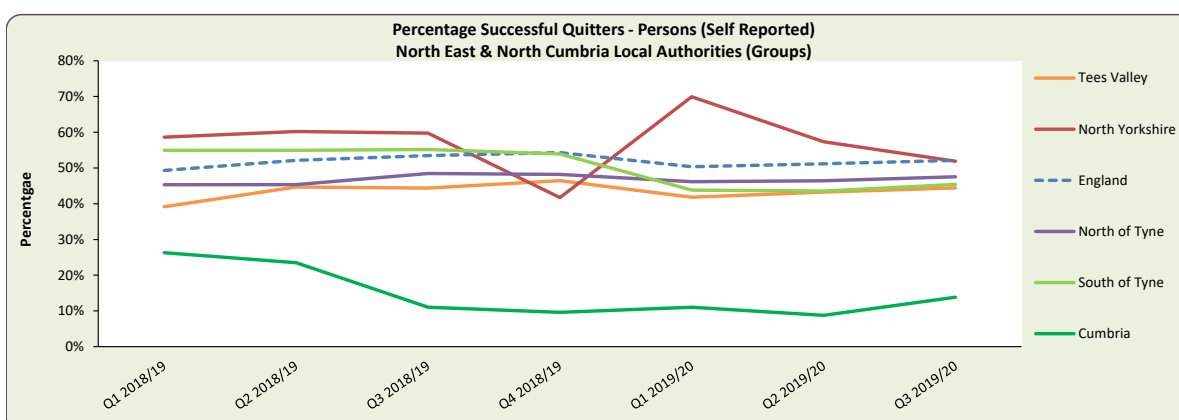
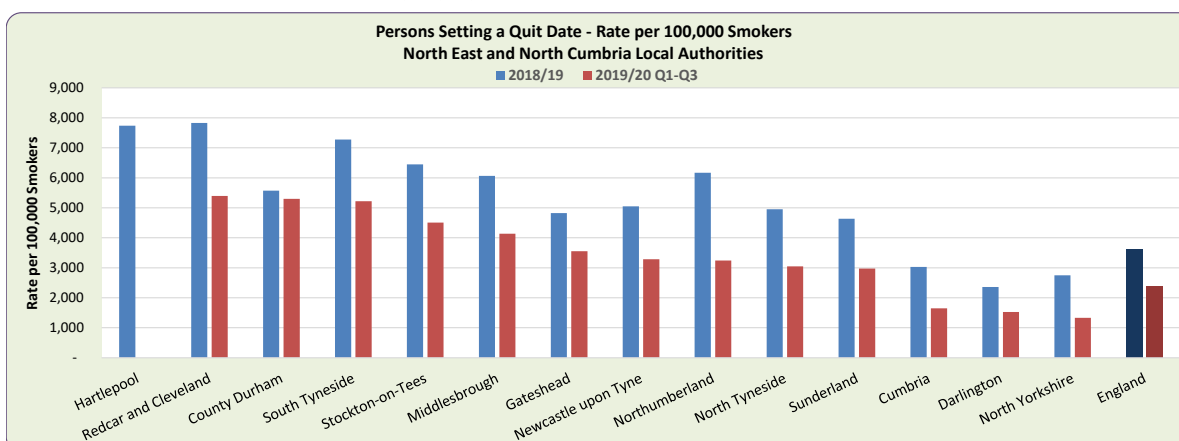
The number of referrals to talking therapies reduced substantially in April 2020 although referral numbers are on the increase again. More data is required to ensure numbers return to pre-COVID levels over time. Note that this chart contains absolute numbers rather than rates.

Since October 2019 almost all CCGs have maintained a high achievement rate for the percentage finishing a course of treatment where their first treatment was within 6 weeks. The exception is Tees Valley CCG where the rate is steadily reducing, however further investigation is required to understand the reasons behind this.

The recovery rate (expressed as those who showed 'reliable improvement') for NENC CCGs in June '20 varies from 44% in Tees Valley to 57% in Sunderland, compared to the England rate of 49%.

13. NHS Stop Smoking Services in England

Results from the monitoring of the NHS Stop Smoking Services in England, including those setting a quit date and the proportion that were successful, and the latest results relating to pregnant women.



Data source: NHS Digital (<https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england>) Copyright © 2020 Health and Social Care Information Centre

Definitions / Notes

Due to COVID-19 the collection of this data was paused in May therefore the latest publication available is for Q3 2019/20. The data includes the number of people who smoke, and women who are pregnant who smoke, who set a quit date, and the outcome of this (defined as 'successful quitter'), which is collected each quarter.

As smoking impairs lung function it is possible that smokers could be at higher risk of developing severe illness and a poorer outcome if infected by COVID-19.

This indicator links to smoking prevalence, which is collected but is mainly reported via surveys (available via [Fingertips.phe.org.uk](https://fingertips.phe.org.uk)).

What is the data telling us?

The proportion of smokers setting a quit date is generally higher in the North East region than for England.

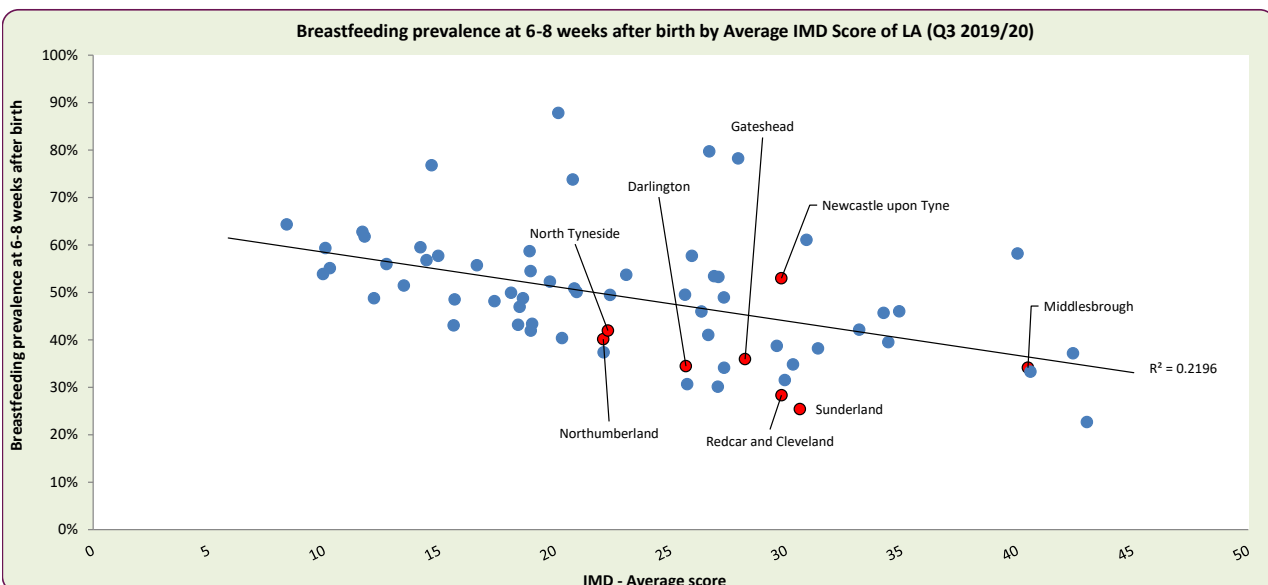
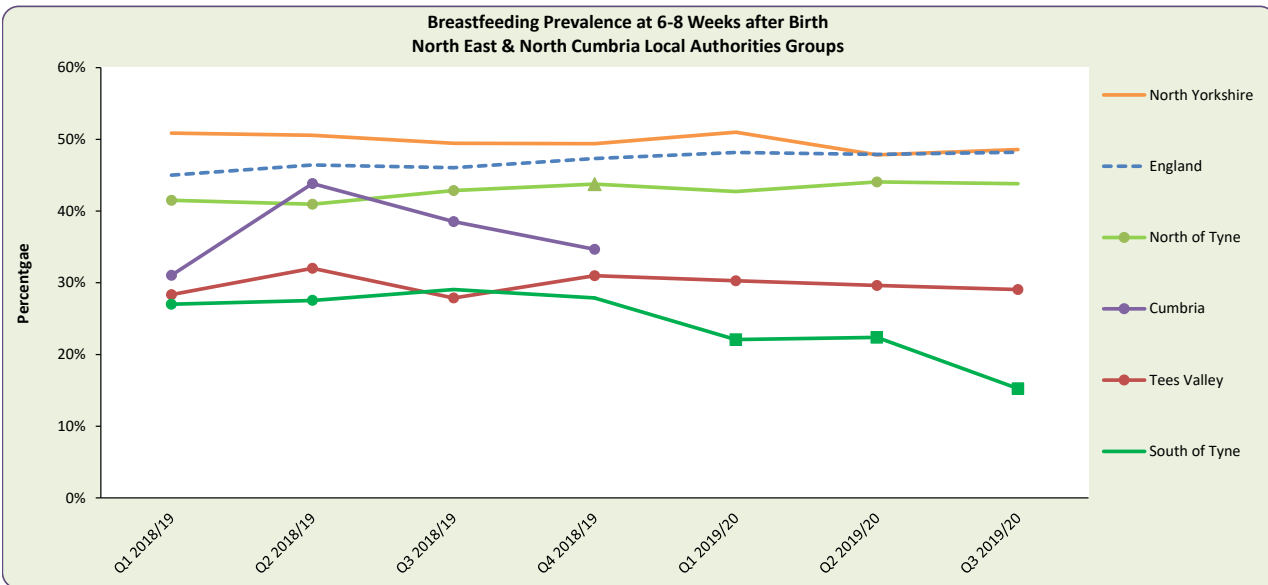
No data is available for Hartlepool LA in 2019/20.

The proportion of successful quitters across the NENC is similar to, but generally slightly lower than, the England rate, which is just over 52%. The figures for Cumbria are very low, and this is due to a large number of people being lost to follow up or the outcome being unknown.

With regard to the subgroup of pregnant women, in 2019/20 to date all LA groups within the NENC area had a lower quit rate than England. North Yorkshire had a much higher quit rate. Information is available at specific local authority level in order to understand more detail relating to these indicators. The figures for Cumbria also include a large proportion of people where no outcome from the Stop Smoking service has been reported.

14. Breastfeeding statistics

Breastfeeding prevalence at 6-8 weeks after birth



Data source(s): Public Health England Breastfeeding statistics (<https://www.gov.uk/government/collections/breastfeeding-statistics>)
Used under the terms of the Open Government Licence v3.0. Classed as experimental statistics.

Definitions / Notes

This data is taken from an interim reporting system to collate breastfeeding information. Local authorities have been asked to report a number of metrics at a resident population level, including the number of infants due 6-8 week reviews per quarter, and those being totally, partially and not at all breastfed. Caution should be exercised when interpreting the figures as there is not full coverage. The symbols in the first chart indicate the extent of robustness of the data (circle = 1 or more Trusts did not pass validation, square = 1 or more trusts did not submit data, triangle = both validation and submission issues are possible). There are no submissions from Cumbria in 2019/20.

In the second chart, only local authority areas where data has passed all validation checks for Q3 2019/20 have been included.

What is the data telling us?

The breastfeeding prevalence rates in NENC based on this reporting system indicate that the rates are lower for all local authority areas when compared to the England rate. It must be noted that the numerator data (number of infants breastfed) is missing from South Tyneside LA in all available quarters of 2019/20 which has resulted in the reported rate reducing over time.

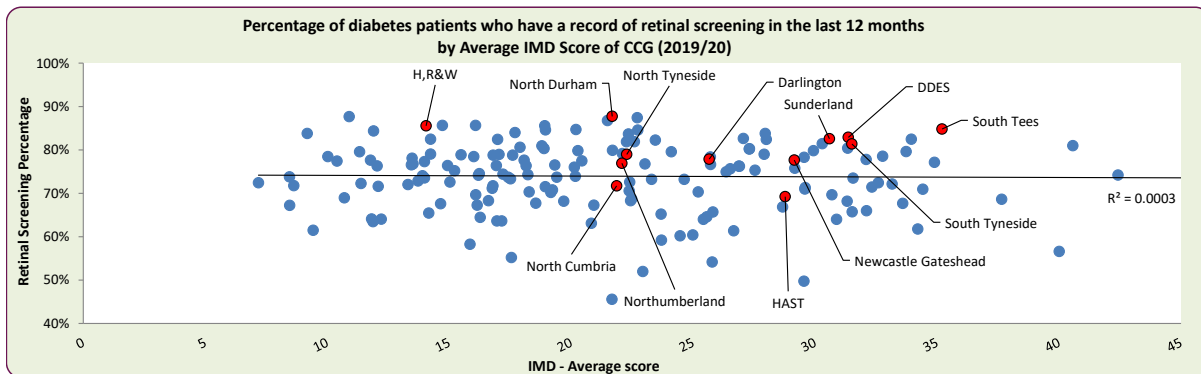
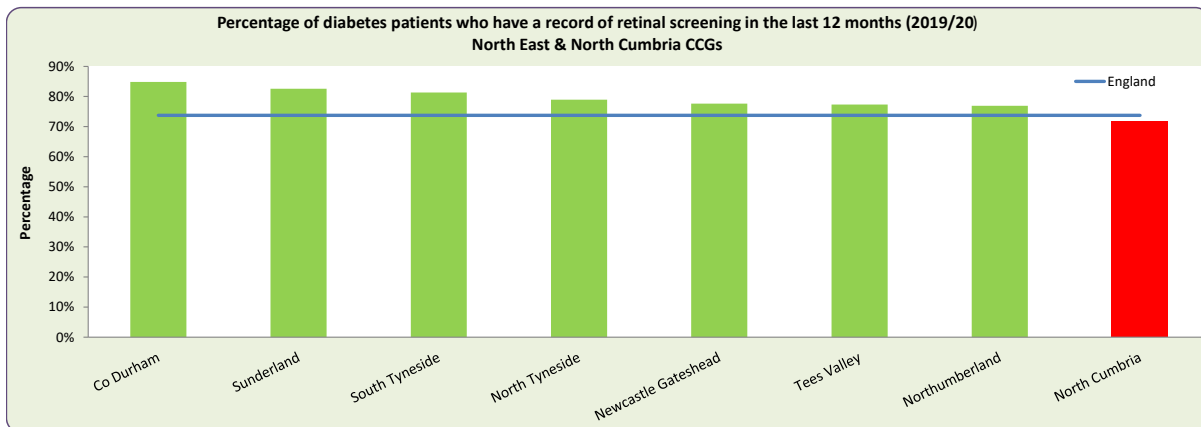
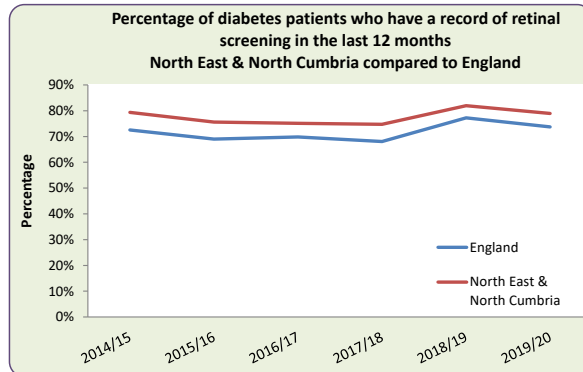
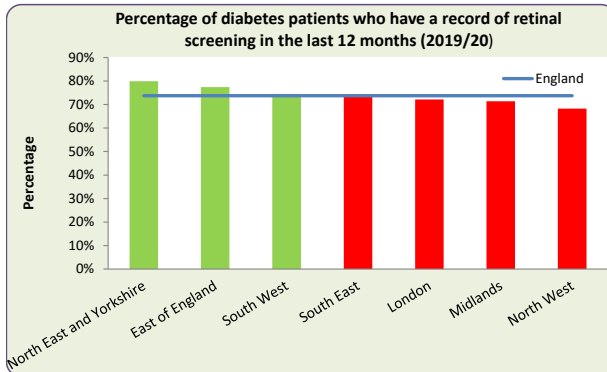
The scatter plot shows the breastfeeding rate expressed by IMD score of the LA area (limited to only those LA areas with fully valid data). Although there is substantial variation, there is an association between breastfeeding rates and level of deprivation. In the NENC, Newcastle LA has the highest rate at 53.0%.

15. Percentage of diabetes patients who have a record of retinal screening in the last 12 months

The percentage of patients with diabetes, on GP practice registers, who have a record of retinal screening in the preceding 12 months

For 2019/20

North East & North Cumbria CCGs	England
78.9%	73.7%



Data source: NHS Digital. Indicators no longer in QOF (INLIQ). Copyright © 2020 Health and Social Care Information Centre.

Definitions / Notes

Diabetic retinopathy is one of the most common causes of blindness in the UK. Regular screening allows prompt identification and effective treatment, if necessary, of sight threatening diabetic retinopathy.

This indicator measures coverage (the proportion of eligible patients with diabetes who have been screened). The information presented above has been derived from indicators that have been removed from the Quality and Outcomes Framework (QOF), a system of financial incentives for improving quality of primary care within the contract for GP services. However, the data are still collected and published.

What is the data telling us?

The percentage of patients with diabetes, on GP practice registers, who have a record of retinal screening in the preceding 12 months was significantly higher in the NENC AHSN area in 2019/20 than in the country as a whole (78.9% compared to 73.7%).

Within the region, all of the CCGs had rates which are significantly better than the national average in 2019/20 except for North Cumbria CCG.

There is no relationship between retinal screening rates and deprivation, based on the scatter chart shown above, which is based on data from 2019/20.

NHS and Public Health organisations are currently working to support the safe restoration of NHS diabetic eye screening services that have been impacted by the pandemic.

16a. Referrals to cancer 2 week wait pathway - All Suspected Cancers

Two week wait from GP urgent referral to first outpatient appointment for all suspected cancers.

For latest month

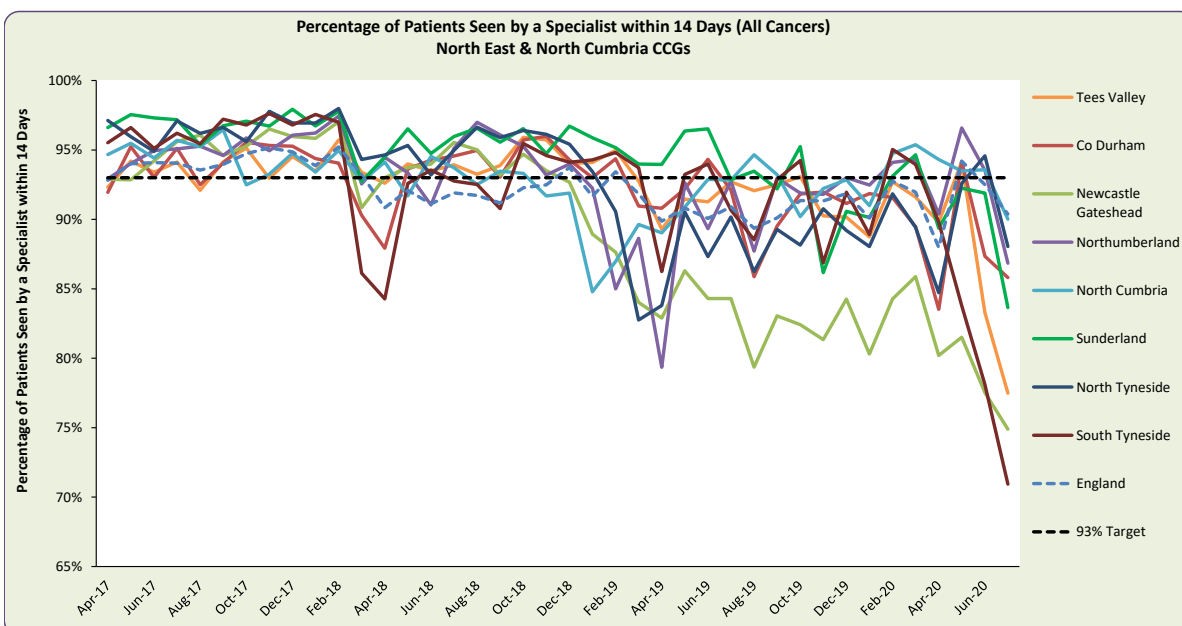
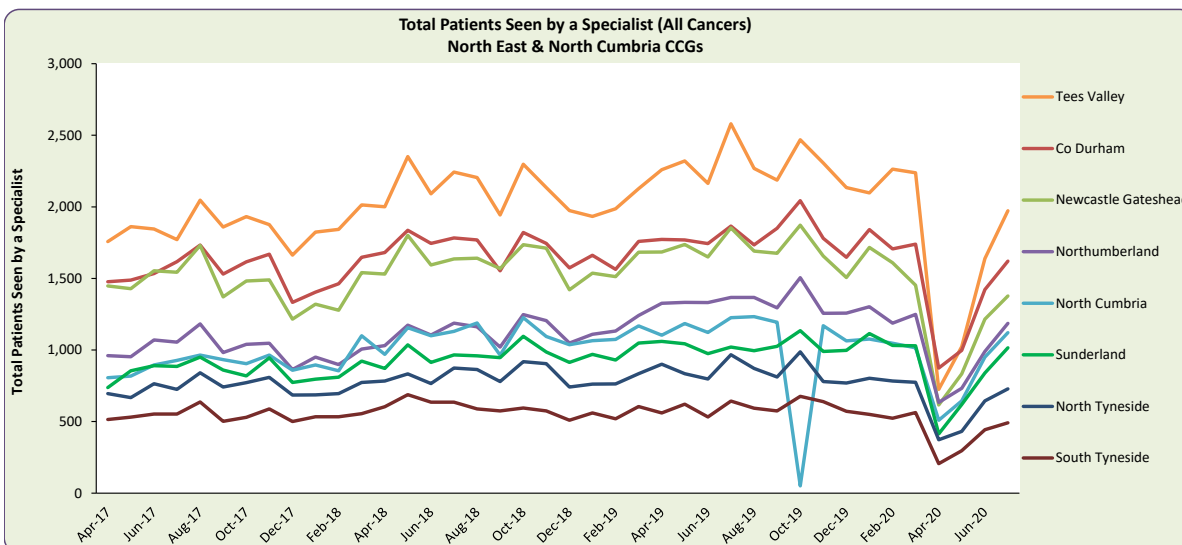
North East & North
Cumbria CCGs

England

82.3%

90.4%

Early Diagnosis



Data source(s): NHS England Commissioner-based Cancer waiting times (Provisional) Two week wait - All cancers.

Definitions / Notes

This data shows the levels of activity (numbers of patients) and performance for cancer waiting times, expressed by the local NHS organisation that commissions the patient care.

What is the data telling us?

The number of patients seen by a specialist (all cancers) dramatically reduced in April '20, during the peak of the pandemic, when the NHS had to make difficult decisions to delay or change appointments. Since then there is evidence that cancer services have started to recover and the number of patients seen is beginning to rise again.

The proportion of people seen within 14 days has reduced year on year since April 2017. In 2019/20 the percentage seen in 14 days was noticeably lower for Newcastle Gateshead CCG than other NENC organisations, and as expected the achievement against this standard has fallen in recent months presumably due to the backlog of patients needing to be seen.

Urgent cancer referrals, known as the two week wait, have been severely impacted. In July '20 82.3% of patients were seen within 2 weeks, which is significantly lower than the England rate of 90.4%.

In July '20, results from a survey by Cancer Research UK (May '20) found that one in three cancer patients said their treatment had been impacted by the effects of COVID-19 on the system, and 42% also said their tests, including those to find out whether their cancer had spread or returned, had been affected⁸.

8. <https://www.cancerresearchuk.org/about-us/cancer-news/news-report/2020-07-28-one-third-of-cancer-patients-say-coronavirus-has-impacted-their-treatment>

16b. Referrals to cancer 2 week wait pathway - Suspected Breast Cancer

Two week wait from GP urgent referral to first outpatient appointment for breast symptomatic referrals only

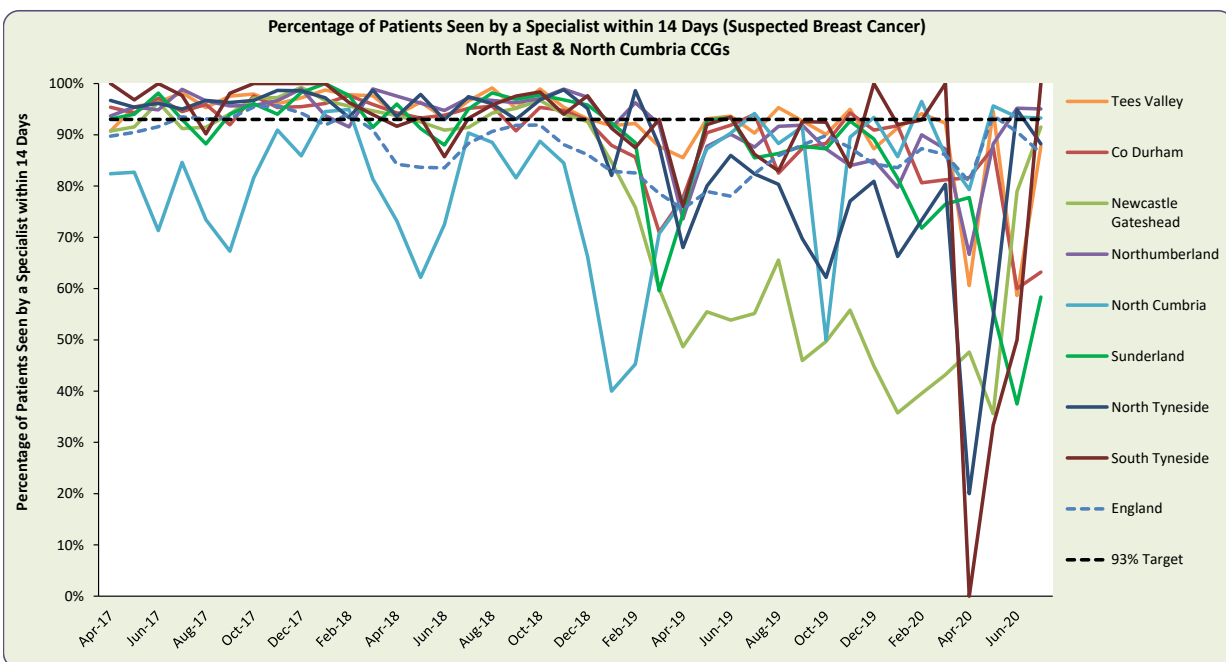
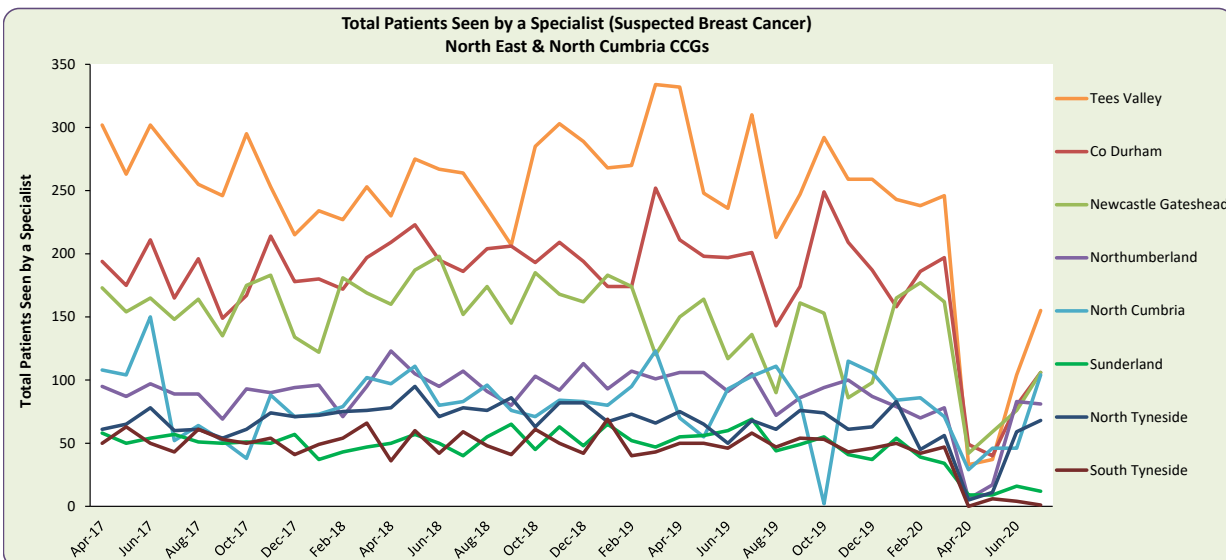
For latest month

North East & North
Cumbria CCGs

85.6%

England

86.4%



Early Diagnosis

Data source(s): NHS England Commissioner-based Cancer waiting times (Provisional) Two week wait - Breast symptoms.

Definitions / Notes

This data shows the levels of activity (numbers of patients) and performance for cancer waiting times, expressed by the local NHS organisation that commissions the patient care.

What is the data telling us?

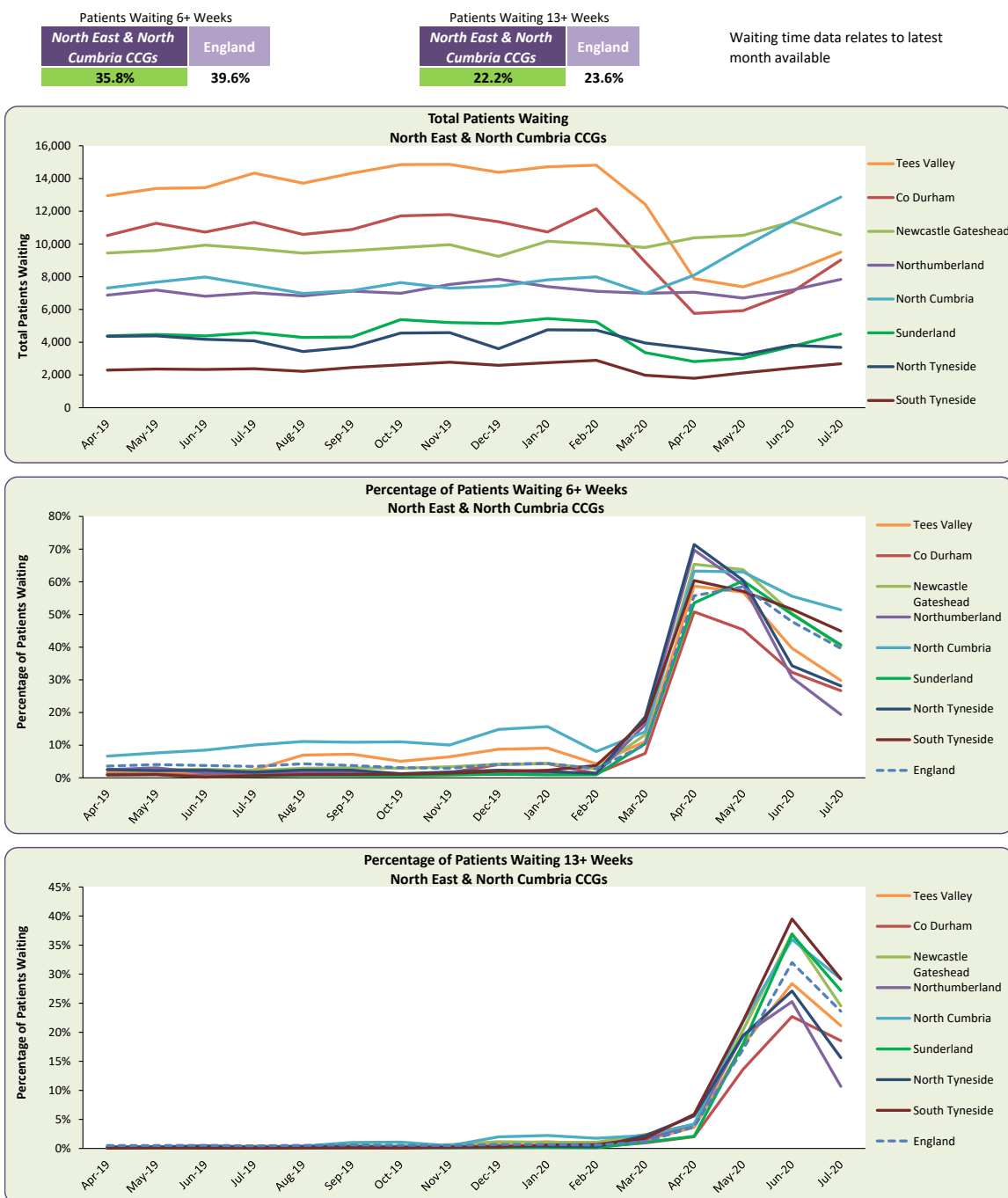
The number of patients seen by a specialist (breast symptoms) dramatically reduced in April '20, during the peak of the pandemic, however there is evidence that cancer services have started to recover and the number of patients seen is beginning to rise again.

The proportion of people seen within 14 days for suspected breast cancer has reduced since April 2019. In 2019/20 the percentage seen in 14 days was noticeably lower for Newcastle Gateshead and North Tyneside CCGs than other NENC organisations, and as expected the achievement against this standard has fallen in recent months presumably due to the backlog of patients needing to be seen. In July '20 85.6% of patients in the NENC were seen within 2 weeks compared to the England rate of 86.4%.

It is expected that the data for the next few months of 2020/21 will demonstrate an improvement in these figures. Due to the relatively small numbers here there is some variation between months.

17. Diagnostics waiting times and activity

Trends in size of waiting list over time, and those waiting 6+ and 13+ weeks to be seen for diagnostic tests and procedures



Data source(s): NHS England Monthly Diagnostics data, Commissioner-based (Provisional)

Definitions / Notes

The data presented shows the current waiting times of patients still waiting for any of 15 diagnostic tests or procedures at the end of the month. The waiting times are for those patients who have been referred for a test, but where this has not yet taken place. The data is collected from NHS providers and signed off by commissioners (CCGs).

Diagnostic waiting times are part of the NHS Constitution. A review of NHS access standards is currently being undertaken but publication of the recommendations has been delayed in light of the pandemic.

What matters now is how quickly patients are added to the waiting list (affected by access to GP services) and how quickly they are taken off it as a result of receiving the care and treatment they need.

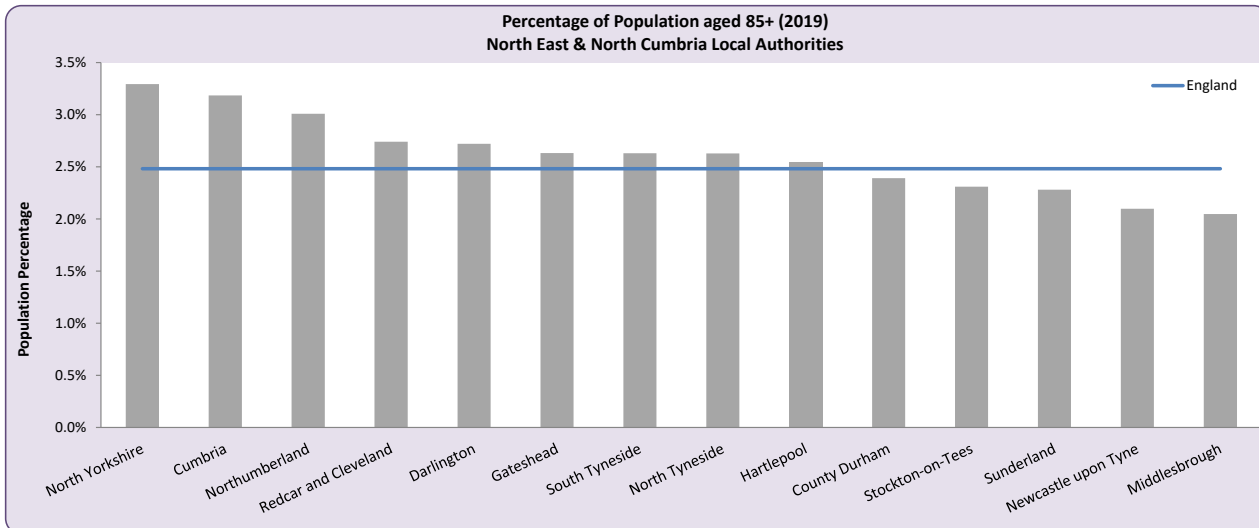
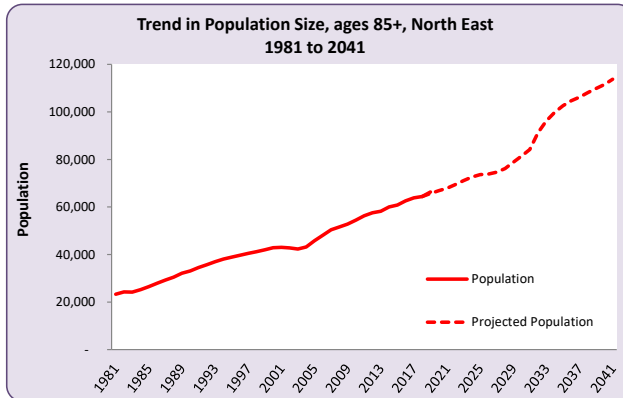
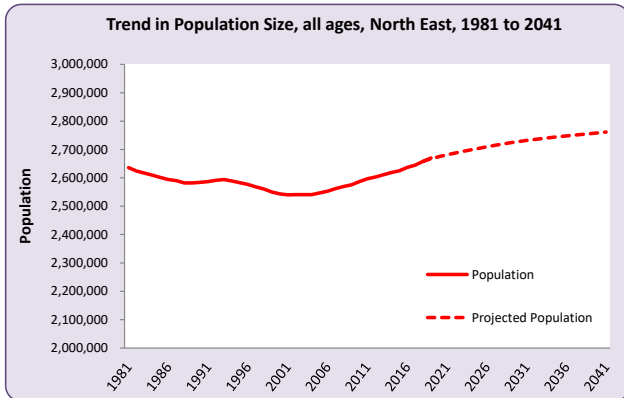
What is the data telling us?

The total number of patients waiting for a test per month remained relatively steady up to February 2020. Since then there have been substantial fluctuations in this measure, as elective care was put on hold to free up capacity for the response to COVID-19. The percentage of patients who had been waiting six weeks or more for a diagnostic test (the operational standard) increased dramatically from an average of around 3% to February 2020 to over 60% by April 2020. This percentage has reduced each month and in July 2020 the rate is now 35.8% for NENC (compared to 39.6% for England).

A similar but more delayed pattern can be seen for those waiting thirteen weeks or more, with the July rate at 22.2% of patients in NENC CCGs (compared to 23.6% for England). Further analysis of this data is possible.

18. Percentage of the population aged 85 years & over

South West	South East	East	North East	East Midlands	West Midlands	Yorkshire and The Humber	North West	London	England
3.11%	2.82%	2.79%	2.48%	2.48%	2.47%	2.40%	2.37%	1.68%	2.48%



Data source: NOMIS - ONS Crown Copyright Reserved [from Nomis, Sept 2020].

<https://www.nomisweb.co.uk/query/construct/components/date.asp?menuopt=13&subcomp=>

Definitions / Notes

One of the biggest challenges facing health and social care services is demographic change. The size of the population aged 85 years and over is an important determinant of demand for health and social care as older people have the highest usage.

Although all age groups are at risk of contracting COVID-19, older people face significant risk of developing severe illness if they contract the disease due to the physiological changes that come with ageing and potential underlying health conditions⁹.

Over 42% of COVID-19 death registrations to the end of August '20 were related to people aged 85 years and over¹⁰. This model does not yet take into account the potential impact of COVID-19 and the excess mortality rate observed in this age group.

What is the data telling us?

In 2019, 2.48% of the population of the North East was aged 85 years or older, the same proportion as in England as a whole. However, there is wide variation within the region with some districts having a considerably higher proportion of their residents in this age group.

Between 1981 and 2005 the total population of the North East fell by almost 3.5%, but since then it is estimated to have increased by 3.8% and in 2019 there were over 120,000 more people living in the region than in 2005.

In contrast, the population aged 85 years and older almost doubled between 1981 and 2005, from just over 23,000 to almost 46,000. Between 2005 and 2019 the numbers in this age group increased by almost 45%, and are projected to increase substantially in the future, particularly when 'baby boomers' born after World War 2 move into it. In 2019 it was estimated that there were 66,300 people in the region aged 85 or older and by 2039 it is expected that this number will be approximately 110,000.

9. www.who.int

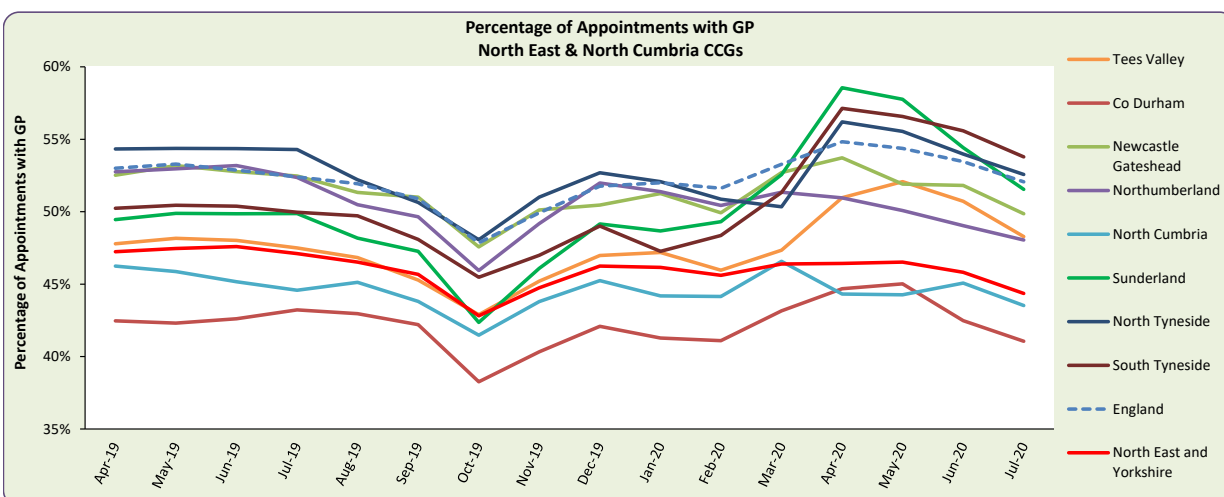
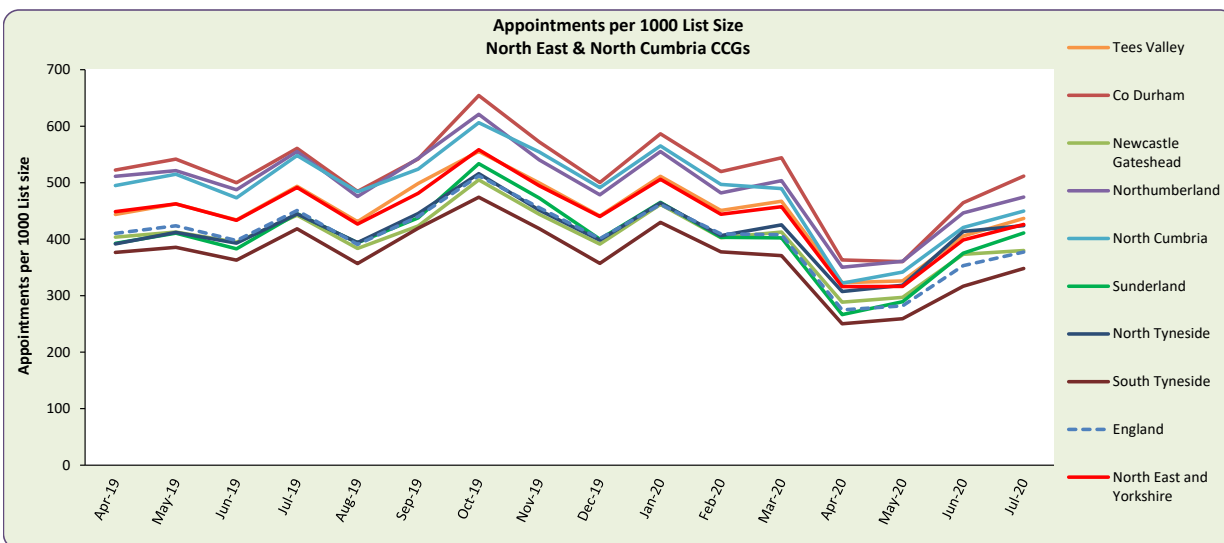
10. [ONS.gov.uk](https://www.ons.gov.uk) Deaths registered weekly in England and Wales (provisional)

19a. Appointments in general practice - appointments available and those with a GP

Activity and usage of GP appointments and how this has been impacted by the COVID pandemic

Percentage of appointments with GP

North East & North Cumbria CCGs	England
47.3%	52.1%



Data source(s): NHS Digital: Appointments in General Practice - experimental statistics (<https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice>) Copyright © 2020 Health and Social Care Information Centre.

Definitions / Notes

General practice is currently under unprecedented pressure for contact and support for patients. This data has been collated from the appointment systems held in General Practice and therefore limits the activity reported on and does not represent all work happening within a primary care setting or assess the complexity of activity. The data quality of this information may result in limitations in what can be inferred. There are plans from NHSE/I to improve the quality of general practice appointment data, including the use of an agreed definition of an appointment.

The aim of this data is to inform users about activity and usage of GP appointments historically.

What is the data telling us?

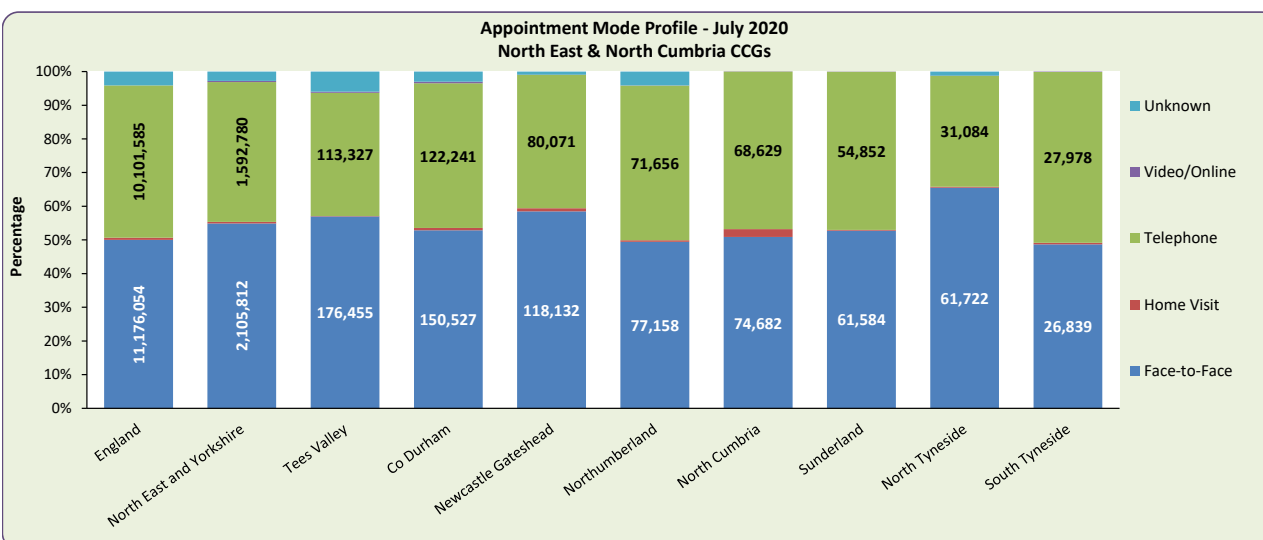
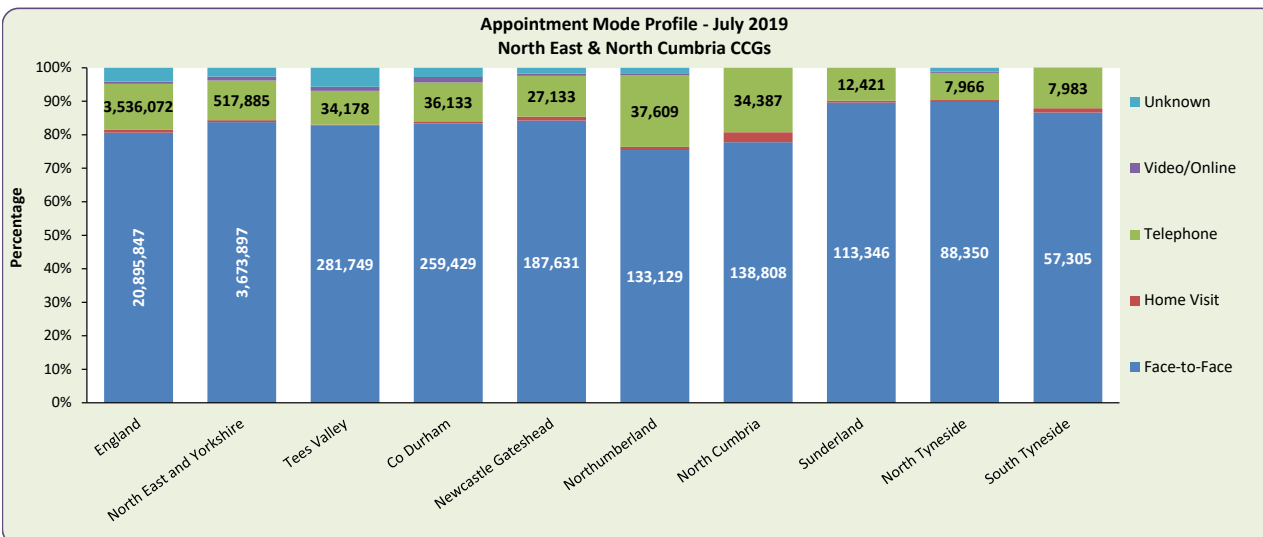
The number of appointments per 1000 registered patients varies by CCG and over time. There was a substantial drop in the appointment rate in April 2020 however this is steadily increasing again, with all CCGs except South Tyneside having an appointment rate which is higher than the England rate in July 2020.

This data reports the number of appointments available per 1000 list size and by CCG and in the NENC area approximate 91% of these were attended in July 2020.

Information relating to appointments by healthcare professional type is also available and shows that on average around 49% of appointments were with a GP between April '19 and March '20 (the slight dip in Oct '19 was due to a higher number of appointments with 'other practice staff' which would include nurses, and possibly links to flu vaccinations) but since April '20 there has been an increase in the variation across NENC CCGs in terms of the percentage of appointments that were with a GP (during which time the actual number of appointments was also reduced). All NENC CCGs except for South Tyneside and North Tyneside have a lower percentage of appointments with a GP (47.3% for NENC) than the England rate (52.1%).

19b. Appointments in general practice - appointment mode

Activity and usage of GP appointments and how this has been impacted by the COVID pandemic



Data source(s): NHS Digital: Appointments in General Practice - experimental statistics (<https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice>) Copyright © 2020 Health and Social Care Information Centre.

Definitions / Notes

Care provision in GP practices has dramatically changed due to COVID-19, and remote consultation has been rapidly introduced to protect patients and staff from the risks of infection. Remote consultations can provide both benefits and challenges for patients and GPs. Post-pandemic it is vital that patients are able to access GP services in ways that meet their needs and preferences.

A letter was sent from NHSE to GPs and commissioner colleagues on 9th July as part of the second phase of the General Practice response to COVID-19. Practices were advised in this letter that they must now also deliver face to face care, where clinically appropriate, and it must be made clear to patients that all practice premises are open to provide care, with adjustments made to the mode of delivery¹¹.

What is the data telling us?

In July 2019 there were just over 80% of appointments that were seen face to face in England, and for the NENC CCGs, this ranged from 75% to almost 90% of appointments. The majority of the remainder of appointments were via telephone (which varied across the NENC CCGs from 8% to 21% of appointments). Only 0.8% of consultations were held by video/online, and the majority of these related to practices in the County Durham and Tees Valley areas.

For the same month in 2020 (second chart) there were around 13% fewer appointments available in total.

For England overall there were just under 50% of appointments seen face to face, and this ranged from 48% to 66% in the NENC CCGs. There has been a significant rise in telephone appointments to meet patient demand, and a very small proportion of appointments (0.21% in the NENC) were held via video or online.

It must be noted that some appointments had an 'unknown' mode reported (which was 2.4% of appointments in July 2019 and 2.7% in July 2020).

11. <https://www.england.nhs.uk/coronavirus/primary-care/>

DOCUMENT GOVERNANCE	
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Version	1
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Approved by Project Director	
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Website of originating organisation	<p>www.neqos.nhs.uk -</p> <p>Please contact the NEQOS advisory service through this web link for further information or to enquire about NEQOS undertaking similar work.</p>
Contact email address	neqos@cntw.nhs.uk
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