North of Tyne
Poverty Truth Commission
Call to Action

North of Tyne Poverty Truth Commission
89 Denhill Park,
Newcastle upon Tyne,
NE15 6QE

children-ne.org.uk/poverty-truth-commission

Dear [NAME],

The North of Tyne Poverty Truth Commission have spent the last two years researching the issue of health inequalities.

A Poverty Truth Commission (PTC) is a time limited process that links those who have direct experience of poverty with people who hold positions of power and influence in the local area. It puts people experiencing poverty at the heart of developing solutions.

The PTC acknowledge that there are common threads in different parts of the country that have been identified by other PTC's, but what needs to be acknowledged is the specific demographics and poverty indicators localised to our commission.

The North East has the highest rate of child poverty in the UK. It also has the highest rate of male suicide and as a female, you are 1.7 times more likely to die from a poverty related issue. The North East has the highest mortality rate for persons of all ages in England.

Culturally and Geographically we are very diverse with mining, steel and ship building, fishing and farming communities all being very different in their health care needs, lifestyle, attitudes and engagement.

Our commission has gathered detailed information and identified particular expertise and evidence of poverty and how it relates to health inequalities.

Throughout our journey, we have recognised the good work that is being done, however it is evident that there was an assumption that there was a level playing field at the beginning of previous funding allocations and this means that we have repeatedly come up against the following barriers and gaps in Health services:

- Services aren't there WHEN they're needed or are hard to access (Geography, cost)

- The complexities in navigating the system and learning how the system works alongside the HUGE barriers created by stigma

- Assumption that everyone has

    - a certain level of knowledge/ability to access a service

    - the resources to access services, including utilities, transport and the internet

    - access to and skills to use technology – digital by default is NOT the answer – it excludes people who are: Blind, Illiterate, Elderly, Neuro Divergent and people with ESOL, Disabilities

    - access to information

- Disjointed services and lack of communication within the NHS including the capacity of staff to deliver services alongside a lack of integrated services when someone is in crisis

- Lack of empowerment for individuals and value placed on engagement and involvement of users on service design and delivery

- Lack of understanding that Health is impacted throughout an individual's life by lived experiences and when living in Poverty, a person is already disadvantaged by these experiences.

- Unconscious and conscious bias

- Imminent implementation of cashless systems for car parks, the adverse links of this to stress and poor mental health

Health Inequalities for women are well documented and are system wide. Health services are designed by men for men. This includes when making decisions about funding research, choosing which medications to fund, what services to deliver and how they are delivered. Examples of this are the disparities in funding for research and product development for erectile dysfunction versus female conditions, such as the menopause. Another example is ADHD medication, where research into the hormonal effects of the normal menstrual cycle or menopause were not included in research.

Recommendations

We recognise that Poverty is a complex and multi-faceted issue, of which health inequalities is an integral part. We have considered a number of processes and solutions which underpin our recommendations:

1. **Addressing the misogyny in Health Services**

Health Inequalities for women include system wide held misogynistic attitudes and unconscious bias which result in poorer healthcare for women. The Baroness Cumberlege Report 2020 makes a somber reading of a system where women are discounted, undervalued and ignored. These can result in huge human costs such as The Sodium Valproate Scandal.

We feel this could be alleviated if there was effective and appropriate female representation at all levels, rather than 'tokenism'. We challenge you to:

- Support women already in senior positions to be empowered to challenge decisions so that women's healthcare needs are given equal consideration at every stage of research, development, funding and service delivery.

2. Addressing illness through wellness – a more positive approach

Services should consider the three levels of health promotion and disease prevention.

- Primary - measures that prevent the onset of illness or injury before the disease process begins.

- Secondary - measures that lead to early diagnosis and prompt treatment of a disease, illness or injury to prevent more severe problems developing.

- Tertiary - measures aimed at rehabilitation following significant illness.

Local health education policy relating to prevention is the key to supporting both those people who are known to be most likely to be impacted by health inequalities, as well as the wider population in general.

We challenge you to improve the education and support to EVERYONE to:

- practice some of the prevention behaviours, such as having a balanced diet so that they can protect themselves from developing diseases in the future.

- visit their local health centre when they experience symptoms of illness, such as fever, so that they can get early treatment for their health problems.

- take their medication appropriately and find ways of working towards rehabilitation for significant illness or disability.

3. Working Together with people who have lived experience

The Poverty Truth Network is a national organisation whose strapline is “Nothing about us, without us, is for us”, this identifies that lasting social change only happens when those who experience the struggle, participate in generating that change. The ideal goal would be for ALL organisations, decision makers and policy makers to work in this way.

We recognise that ‘working together’ does happen in some organisations, however this is often tokenistic. Those with lived experience are asked their views, but they are not involved in decision making or treated as equals. Our recommendation is for local organisations to think differently. Contesting the traditional processes and practices, we challenge you to:

- Work alongside people with lived experience
- Demonstrate you value their time and knowledge e.g. reward
- Don’t ‘just’ listen, but act

We are asking you to respond to our ‘Call to Action’ by sharing how you will listen to and address our recommendations.

We look forward to hearing from you and working together to tackle these health inequalities.

Yours,

Health Inequalities Working Group, North of Tyne Poverty Truth Commission:

Amy Rose, Community Commissioner

David Black, Community Commissioner

Eleanor Grice, Jobcentre Customer Service Manager at Work and Health Services Directorate

Emma Richardson, Senior Manager, Specialist Services at Northumberland County Council

Gemma Johnson, Community Commissioner

Louise Jones, Chief Executive & Founder at Support and Grow North East

Nicola Morrison, Community Commissioner