NHS
Coventry and Warwickshire

Coventry & Warwickshire ICB:

Healthcare Inequalities Legal Duties Reporting

April 2024

Contents:

Introduction

This document sets out the information required under NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006).

This details how we are performing against a set of indicators for the period 1st April 2023 to 31st March 2024 (unless otherwise stated), alongside a narrative explaining how we are working to tackle healthcare inequalities in these areas and ensure improvements against these indicators.

As set out in the ICB Annual Report, we have a system-wide approach to reducing healthcare inequalities. Underpinning all our approaches and the data in these indicators, is the need to ensure that we are collecting accurate and complete information, particularly around patient ethnicity. For this reason, improving data collection will continue to be a priority. Incomplete records, particularly with regards to ethnicity, have impacted on the quality of some of the data presented in this report.

For a more complete picture of the work we are doing as a system to tackle healthcare inequalities we would invite you to read the ICS Healthcare Inequalities Strategic Refresh 2023 and the associated Delivery Plan.

Elective Recovery

Indicators:

- Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks
- Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances
- Elective activity vs pre-pandemic levels for under 18s and over 18s

Data evidence will drive forward increasing performance in activity rates and elective/planned care activity, with minimum health inequalities requirements aligned to the legal duties; age, gender, deprivation and ethnicity, as core principles to the following planned transformational programmes of activity:

  - Analysis and utilisation of data evidence sets to drive forward transformation within priority speciality areas, using area network (AN) models and GIRFT principles (Getting it Right First Time), to improve access, experience and outcomes in services. Two ANs have commented, Urology and Cardiology, with ENT and Gynae to follow in the next 12 months. This will include analysis of referral routes across end-to-end patient pathways and condition risk factors for patient population groups.
  - Strengthening existing Trust performance reporting returns; theatre utilisation, outpatients activity (PIFU, virtual, advice and guidance), waiting lists, patient primary targeting list (PTL), to increase activity rates, identify inequalities in access to services for patient groups and determine priority areas of focus.
  - Mobilisation of a volunteer model in SWFT, similar to GEH, to support reducing DNAs, patients waiting and staying well and outpatient activity.
  - Re-instatement of Outpatient Transformation System Group, with redefined aims and objectives. This will incorporate expanding outpatients to include primary and Public Health, identifying prevention opportunities to improve population health and wellbeing.

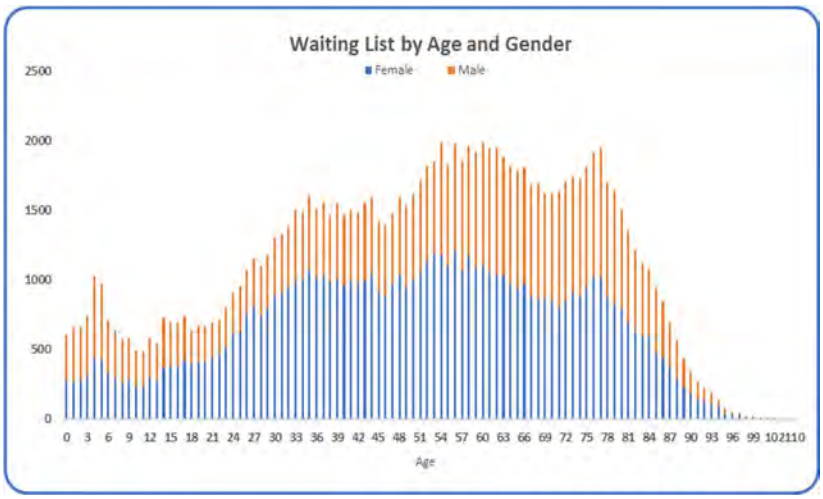
We are on track to eliminate over 65 week waits by September 2024.

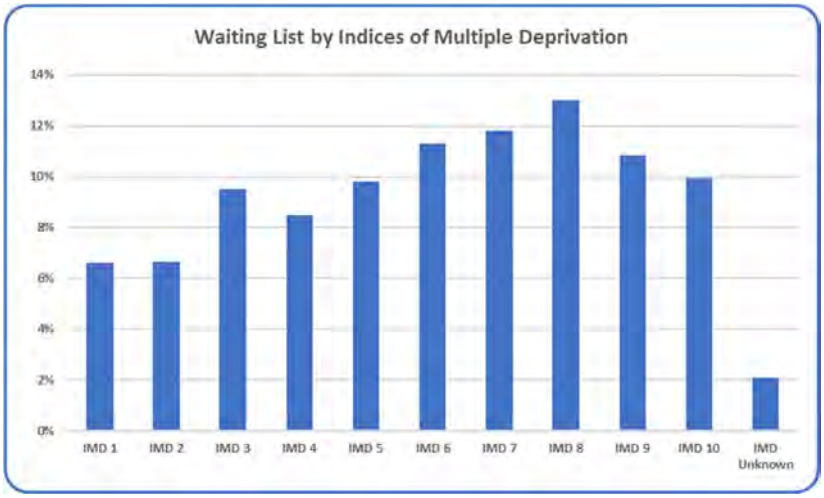
Our recent DNA (did not attend) Inequalities Briefing Pack identified a number of key findings around people not attending outpatients appointments. These included younger patients (0-19, but especially those 5-9) were the most likely of all age groups to not attend / be brought to appointments and the DNA rate was highest for male patients living in the most deprived areas.

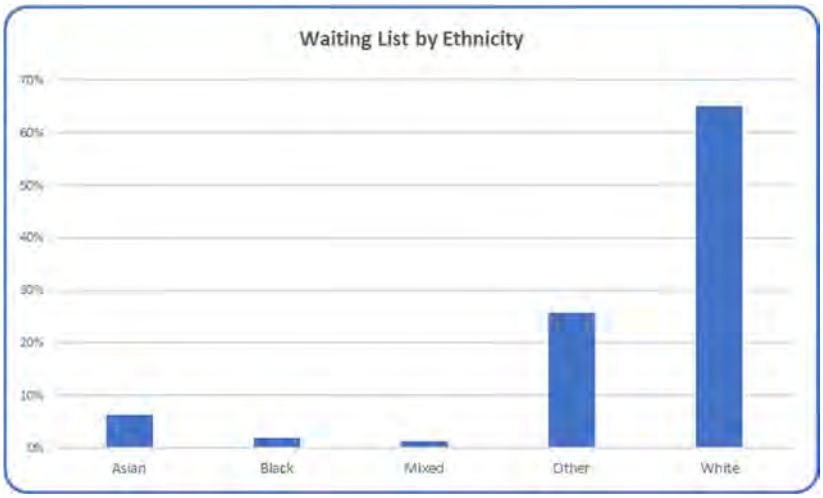
The GEH Back to Health programme is demonstrating positive impacts in supporting people experiencing healthcare inequalities. The programme uses impactful volunteering roles to support people on their journey in and out of hospital through the Waiting Well, Getting Well and Living Well elements.

UHCW have developed and implemented the Health Equity and Referral to Treatment tool because of the impact of the COVID pandemic on elective care access and increasing inequalities. The tool enables enhanced clinical prioritisation based upon outcomes, clinical status reviews to inform agile waiting and social value judgements to be applied in future to reduce inequalities further. The tool received the HSJ Award for Innovation and Improvement in Reducing Healthcare Inequalities.

- Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks







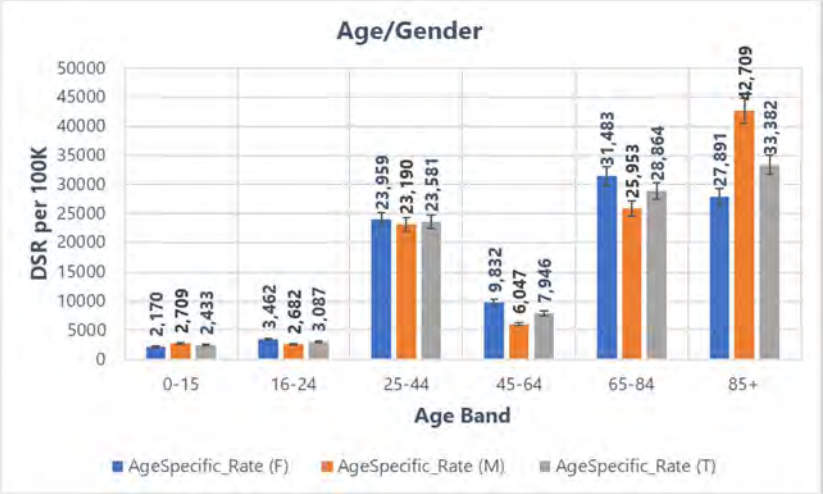
Local Data Observations

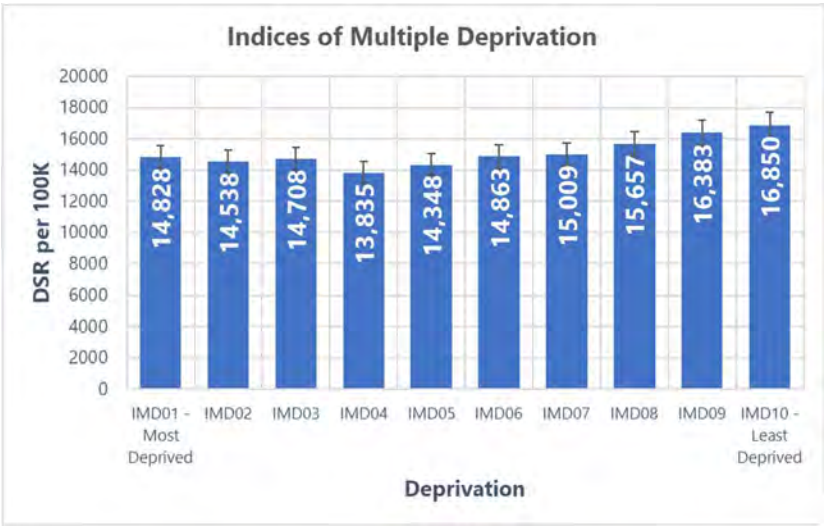
- *The waiting list consists of 10.9% Children & Young People and 89.1% Adults*
- *With a higher proportion of Females waiters (57.9%) than Males (42.1%) on the waiting list*
- *The volume of patients on the waiting list is lower in more deprived areas than the least deprived areas. A similar pattern occurs for patients waiting 18+ weeks and 52+ weeks, however, the categories start to even out for patients waiting 65+ weeks*
- *The proportion of patients on the waiting list in the White Ethnic category is considerably higher than any other Ethnic category. The Other Ethnic category accounts for the second highest proportion however this will include those patients who are reported with Unknown/Not Stated ethnicity*

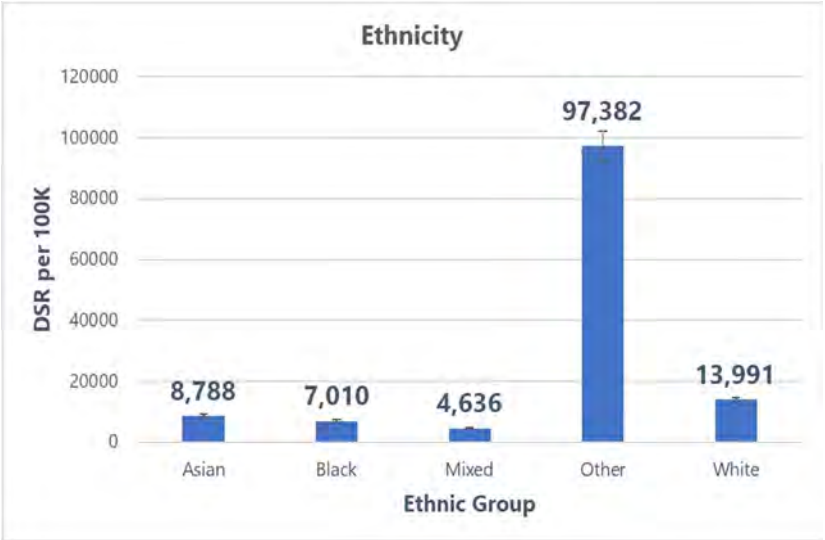
Indicator Notes

- *Data is presented at CW ICB level based on data for the ICB's three main Acute Providers*
- *Data source is Referral to Treatment Weekly Waiting List Minimum Data Set snapshot*
- *A proportion of the patients reported on the Referral to Treatment Weekly Waiting List Minimum Data Set have an Unknown/Not Stated Ethnicity or Unknown IMD.*

- Elective admissions







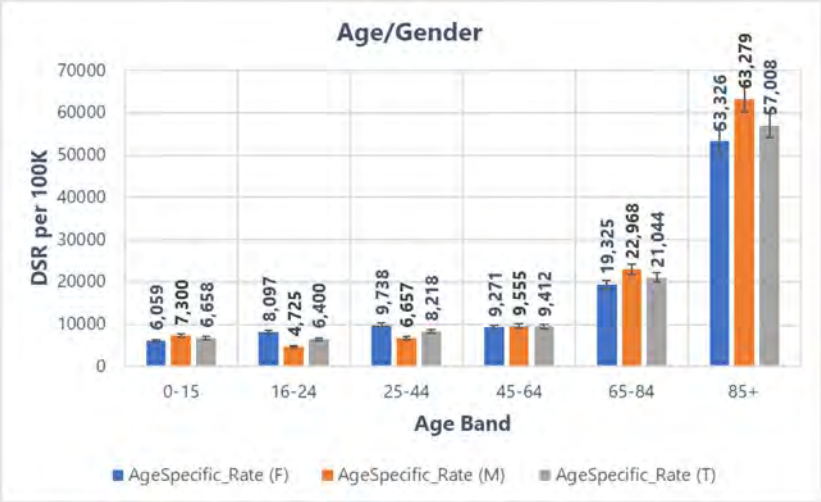
Local Data Observations

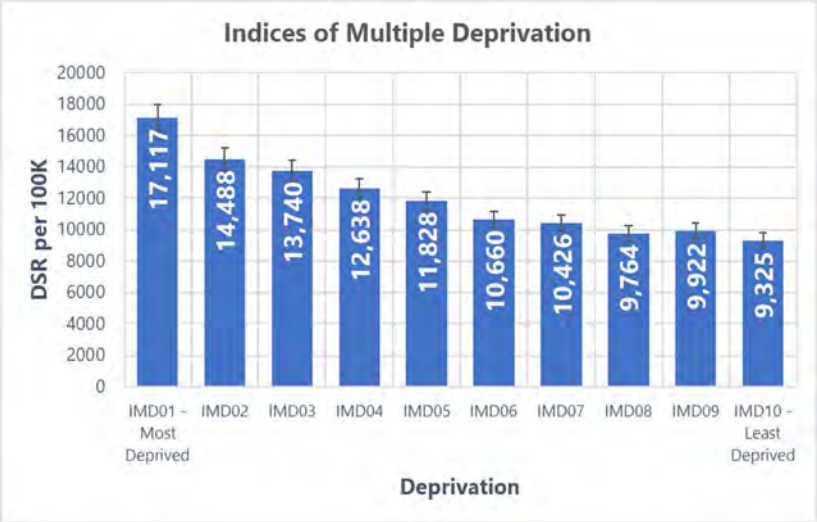
- *Elective admissions generally increase with age, particularly in the female population, with the exception of the 45-64 age group.*
- *In the 85+ population, females are twice as likely to have an elective admission than males.*
- *The less deprived have a slightly greater the rate of elective admission.*
- *White ethnic groups are more likely to have an elective admission.*
- *'Other' ethnicity group should be treated with caution due to data quality issues arising from data capture and recording practices.*

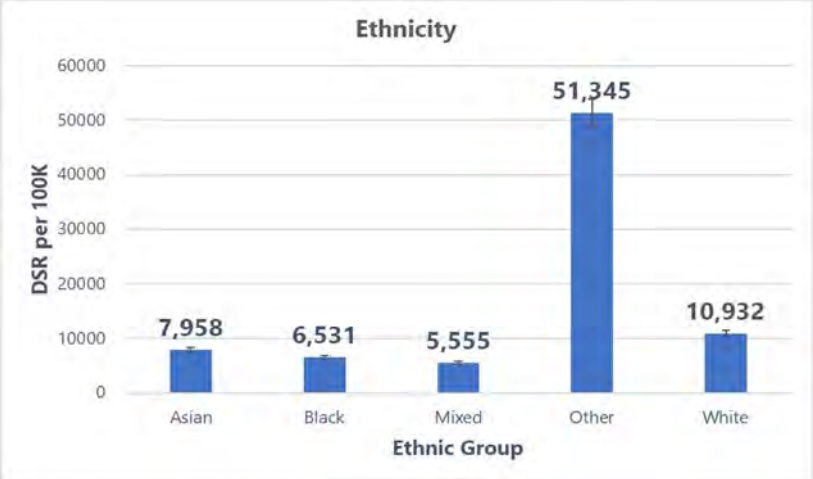
Indicator Notes:

- *Directly standardised rate against European standard population per 100,000*
- *Sourced from Admitted Patient Care CDS*
- *Elective Admissions (Admit Method Code like 1*)*
- *2023 calendar year admissions*
- *Data Presented at CWICB Level*

- Emergency admissions







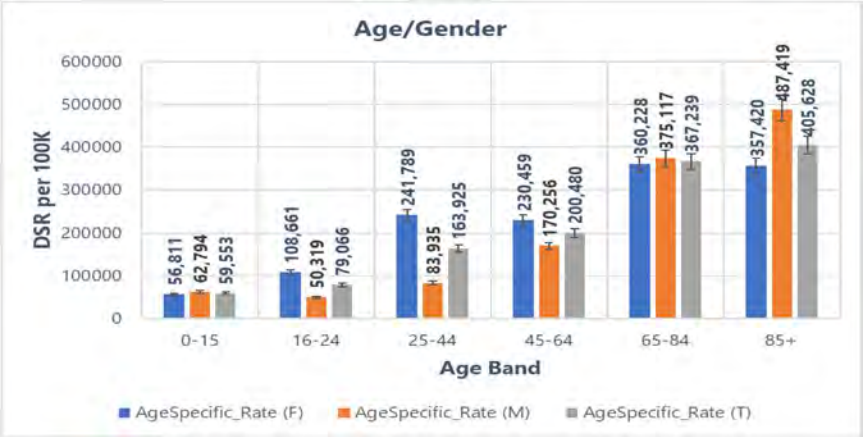
Local Data Observations

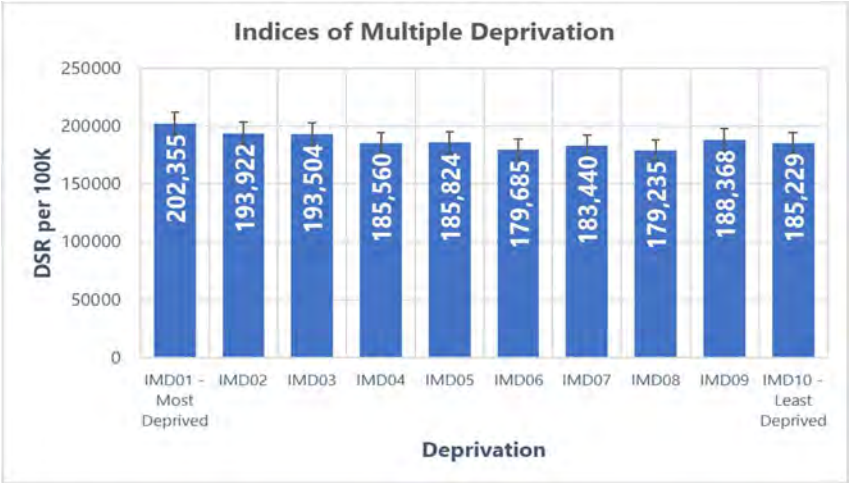
- *Emergency admissions increase with age and considerably in the 85+ age group, particularly for females.*
- *In the 85+ population, females are nearly 20% more likely to have an emergency admission than males.*
- *Although not perfectly linear, the more deprived the greater the rate. Those most deprived are 83% more likely to have an emergency admission than the least deprived.*
- *The white ethnic group is more likely to have an emergency admission.*
- *'Other' ethnicity group should be treated with caution due to data quality issues arising from data capture and recording practices.*

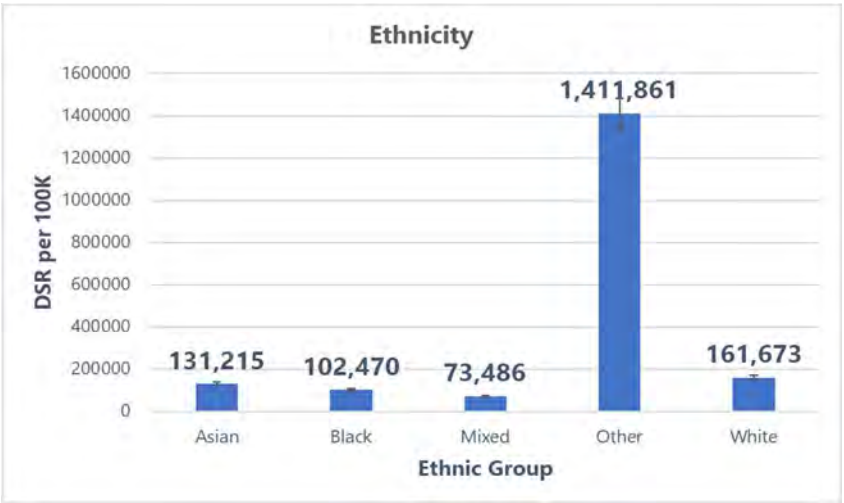
Indicator Notes:

- *Directly standardised rate against European standard population per 100,000*
- *Sourced from Admitted Patient Care CDS*
- *Emergency Admissions (Admit Method Code like 2*)*
- *2023 calendar year admissions*
- *Data Presented at CWICB Level*

- Outpatient attendances







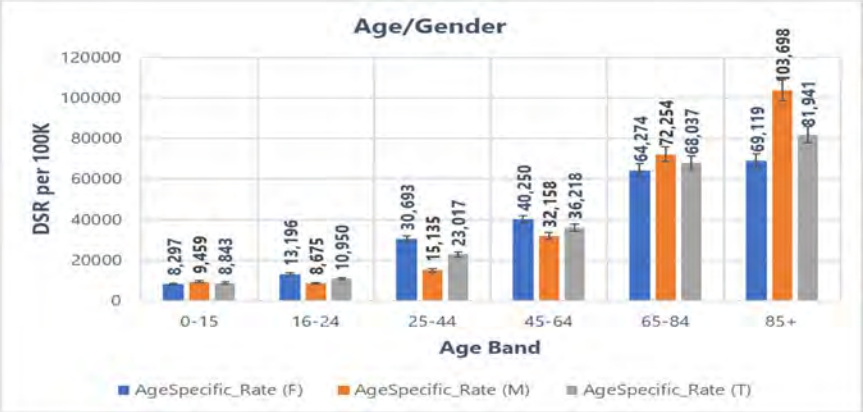
Local Data Observations

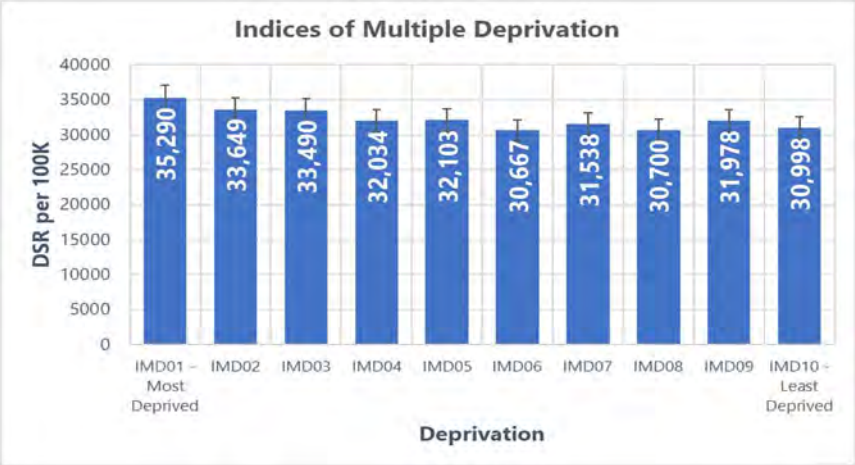
- Outpatient attendances increase with age, particularly in the 85+ population, in which females are almost a third more likely to attend an outpatient appointment than males.
- In the 25 to 44 age group, males are almost three times as likely to attend an outpatient appointment than females.
- Outpatient attendances do not vary greatly according to deprivation.
- Females are 36% more likely to attend an outpatient appointment than males.
- The white ethnic group are most likely to have an outpatient attendance.
- 'Other' ethnicity group should be treated with caution due to data quality issues arising from data capture and recording practices.

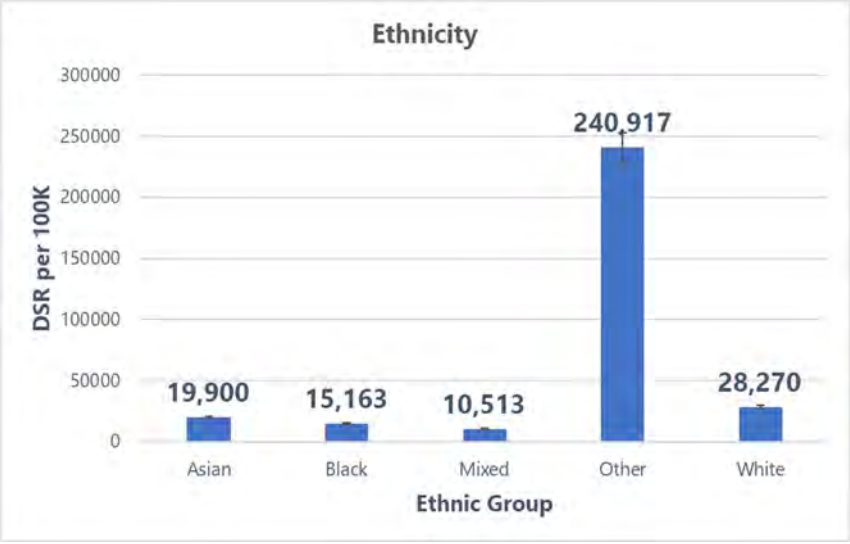
Indicator Notes:

- Directly standardised rate against European standard population per 100,000
- Sourced from Outpatient CDS
- 2023 calendar year attendances
- First and follow up attendances, including virtual attendances
- Data Presented at CWICB Level

- Virtual outpatient attendance





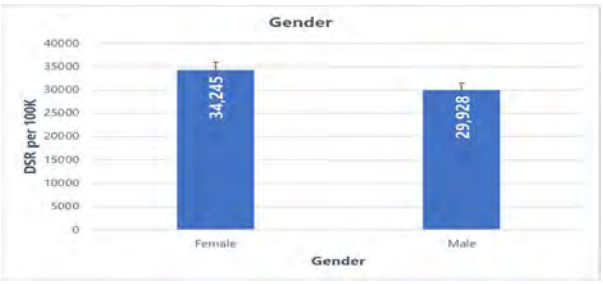


Local Data Observations

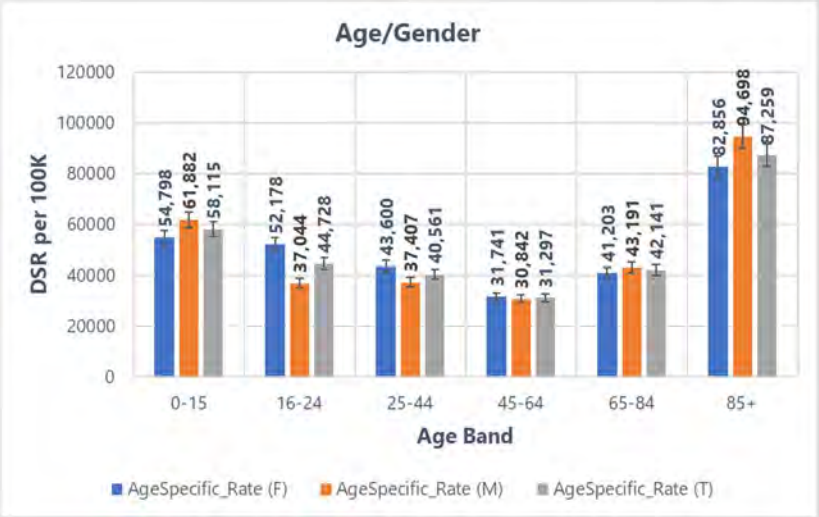
- *Virtual outpatient (OP) attendances increase with age, particularly in the 85+ population, in which females are 50% more likely to attend a virtual OP appointment than males.*
- *In the 25 to 44 age group, males are twice as likely to attend a virtual OP appointment than females.*
- *Virtual OP attendances do not vary greatly according to deprivation, however those most deprived are 14% more likely to attend a virtual OP appointment than the least deprived.*
- *Females are 14% more likely to attend an OP appointment than males.*
- *The white ethnic group are most likely to have a virtual OP attendance.*
- *'Other' ethnicity group should be treated with caution due to data quality issues arising from data capture and recording practices.*

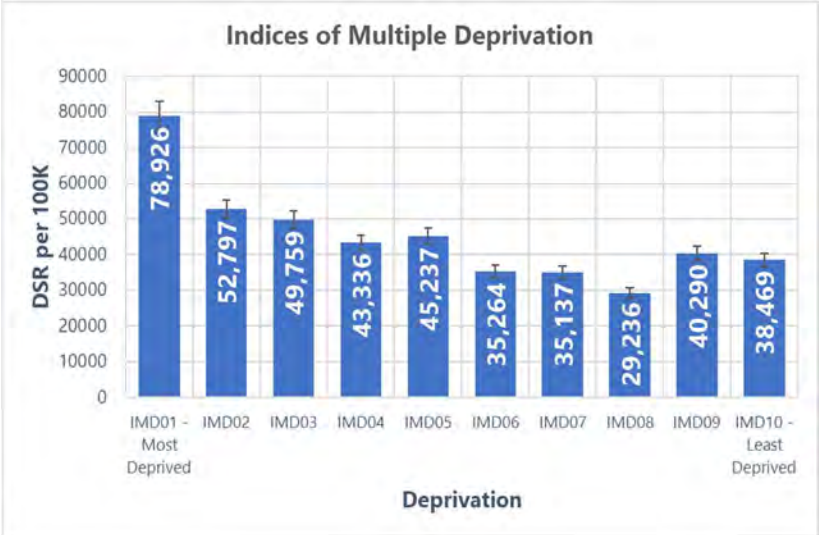
Indicator Notes:

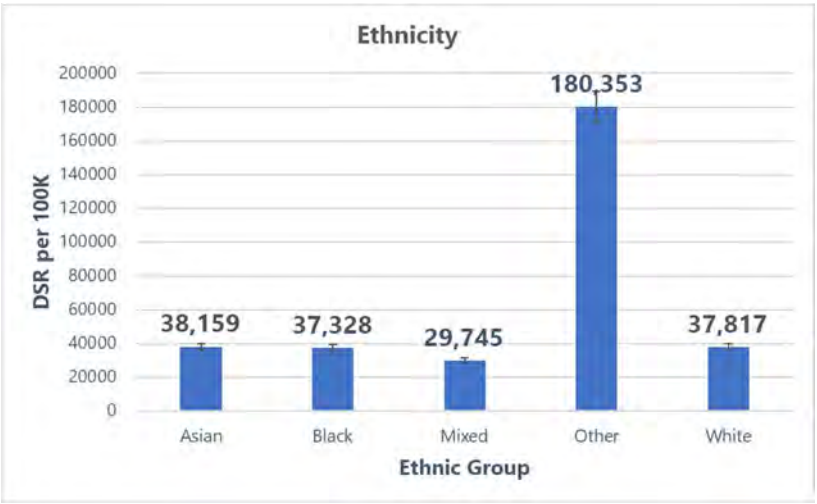
- Directly standardised rate against European standard population per 100,000
- Sourced from Outpatient CDS
- 2023 calendar year attendances
- First and follow up Virtual outpatient attendances
- Data Presented at CWICB Level



- Emergency attendances





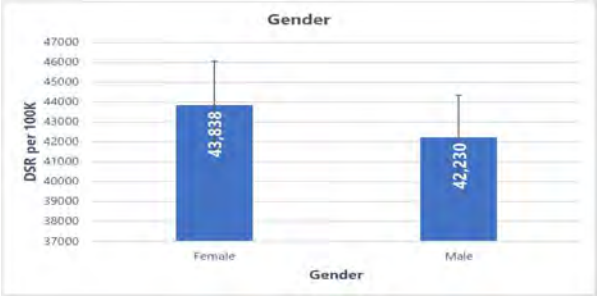


Local Data Observations

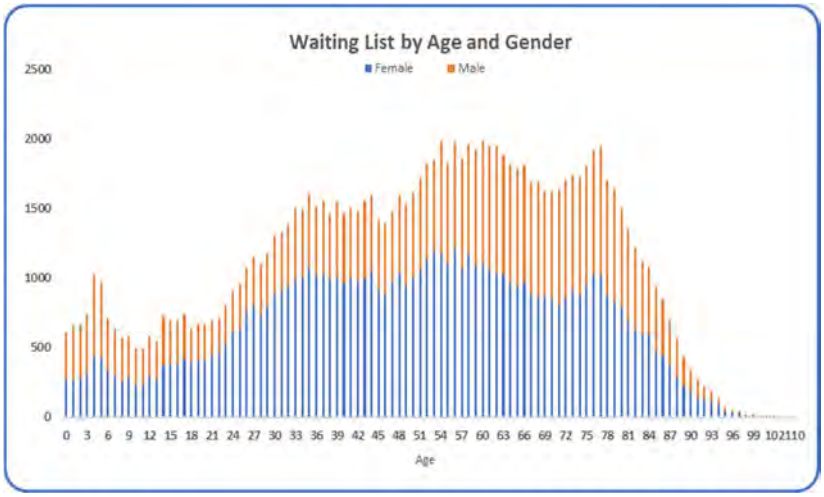
- *Emergency attendances are higher in the lower age groups (below 45), but increase considerably, more than 50%, in the 85+ age group, particularly for females.*
- *Generally, the more deprived the greater the rate. Those most deprived are over twice as likely to have an emergency attendance than the least deprived.*
- *Females are slightly more likely to have an emergency attendance than males.*
- *The mixed ethnic group are least likely to have an emergency attendance.*
- *'Other' ethnicity group should be treated with caution due to data quality issues arising from data capture and recording practices.*

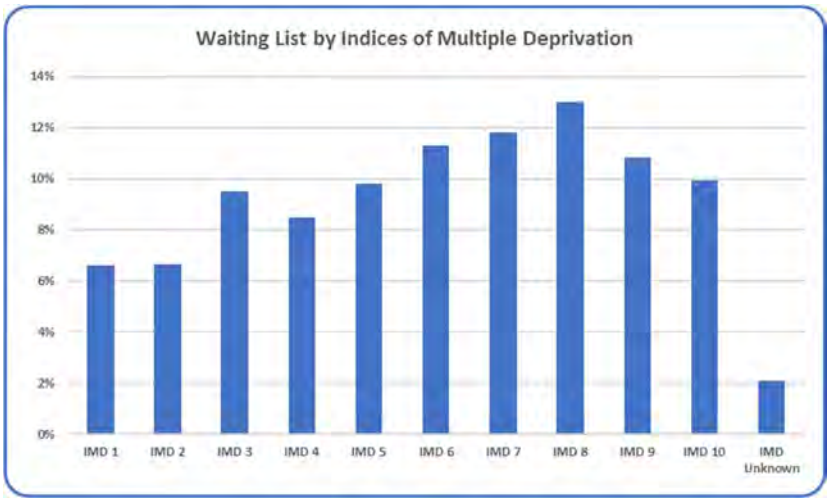
Indicator Notes:

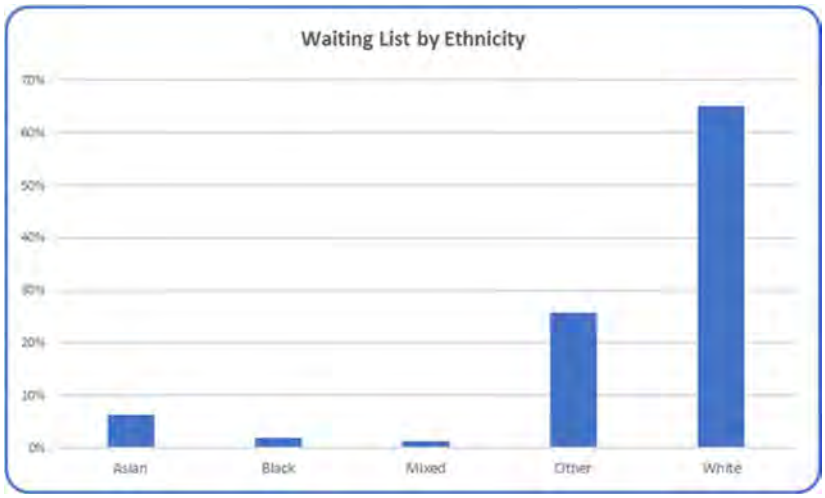
- *Directly standardised rate against European standard population per 100,000*
- *Sourced from Emergency Care CDS*
- *2023 calendar year attendances*
- *Data Presented at CWICB Level*



- Referral to treatment waiting list







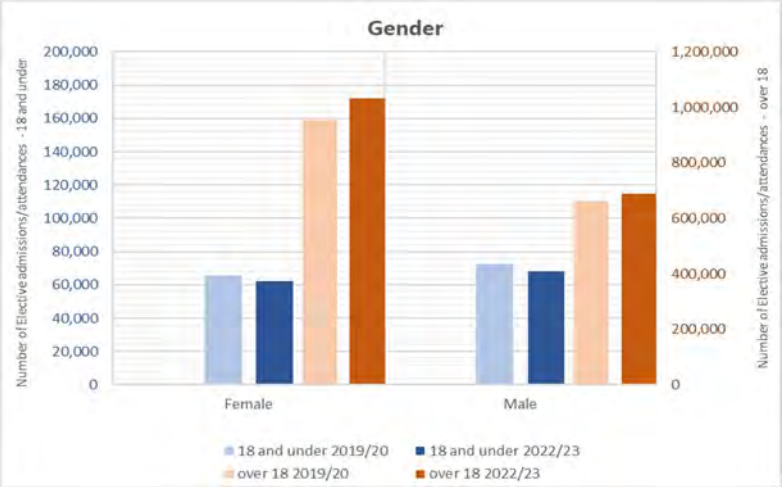
Local Data Observations

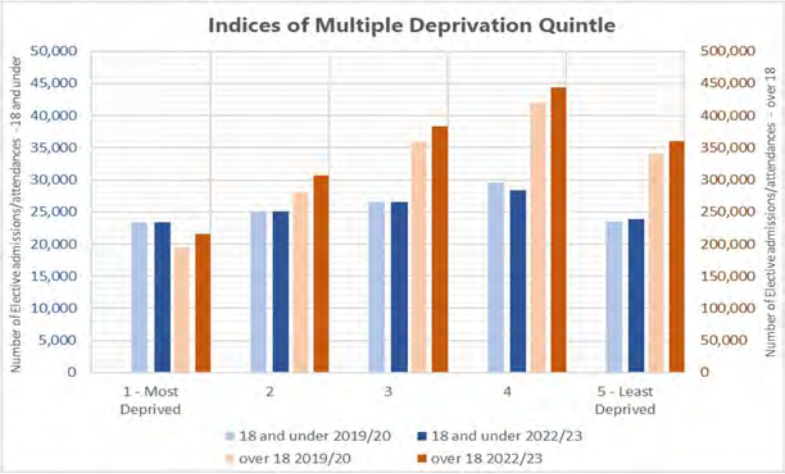
- *The waiting list consists of 10.9% Children & Young People and 89.1% Adults*
- *With a higher proportion of Females waiters (57.9%) than Males (42.1%) on the waiting list*
- *The volume of patients on the waiting list is lower in more deprived areas than the least deprived areas. A similar pattern occurs for patients waiting 18+ weeks and 52+ weeks, however, the categories start to even out for patients waiting 65+ weeks*
- *The proportion of patients on the waiting list in the White Ethnic category is considerably higher than any other Ethnic category. The Other Ethnic category accounts for the second highest proportion however this will include those patients who are reported with Unknown/Not Stated ethnicity*

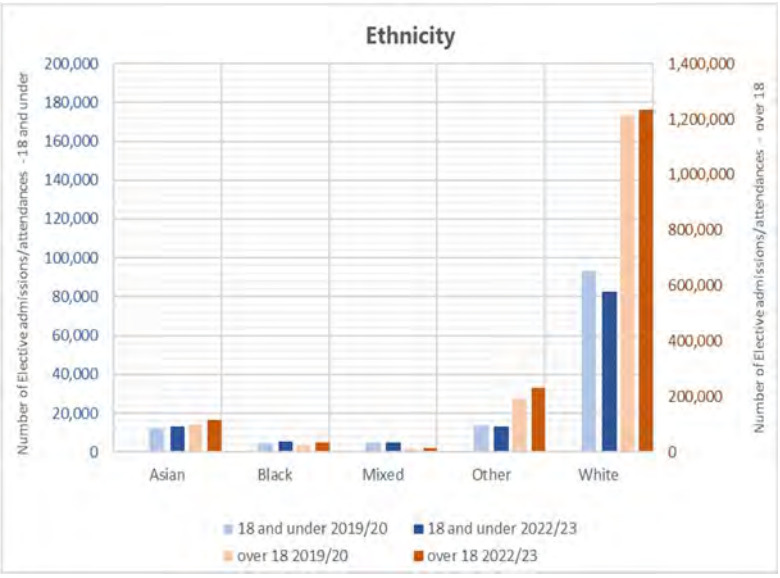
Indicator Notes

- *Data is presented at CW ICB level based on data for the ICB's three main Acute Providers*
- *Data source is Referral to Treatment Weekly Waiting List Minimum Data Set snapshot*
- *A proportion of the patients reported on the Referral to Treatment Weekly Waiting List Minimum Data Set have an Unknown/Not Stated Ethnicity or Unknown IMD.*

- Elective activity vs pre-pandemic levels for under 18s and over 18s







Local Data Observations

- *Activity levels remain broadly similar across the deprivation quintiles pre and post pandemic for the under 18s age group except in quintile 4 where activity has slightly fallen (-4.2%).*
- *In the over 18s age group, activity levels have risen across all deprivation quintiles compared to pre-pandemic levels with the highest growth in the most deprived group at 10.7%. The pattern of activity is similar in both time periods with most activity for patients in quintile 4.*
- *There are more males than females with elective activity in the under 18s age group, which is the opposite for the over 18s, where more females have elective admissions or attendances. There has been an 8% growth in female compared with 4% growth in male activity pre and post-pandemic for the over 18s age group.*
- *Activity for the under 18s white ethnic group has fallen by 11.2% compared to pre-pandemic levels but risen across the other ethnic groups, notably the black ethnic group (29.4%). For the over 18s, activity has risen across all ethnic groups compared to pre-pandemic levels, particularly in the black (32.6%) and mixed (27.9%) ethnic groups. The white ethnic group grew by just 1.7% in comparison.*
- *'Other' ethnicity group should be treated with caution due to data quality issues arising from data capture and recording practices.*

Indicator Notes:

- *Sourced from Admitted Patient Care CDS and Outpatient CDS*
- *Elective Admissions (Admit Method Code like 1*)*
- *Outpatient Attendances, new and follow up including outpatient procedures and virtual attendances*
- *2023 calendar year admissions*
- *Data Presented at CWICB Level*

Urgent & Emergency Care

Indicator:

- Emergency admissions for under 18s

A recent A&E Health Inequalities briefing pack identified that rates of children (0-19) presenting at A&E departments has increased since COVID, from 316 per 1,000 to 355.

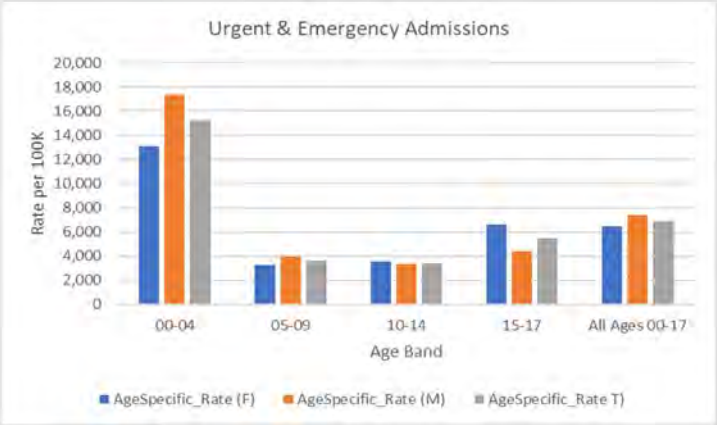
C&W Children & Young People Transformation Programme recognises that in England, children and young people make up 26% of all emergency department attendances and are the more likely age group to attend ED inappropriately, with around 30-35% of ED attendances that could be more appropriately managed in integrated care services. Children and young people urgent and emergency care is identified as one of the system priorities.

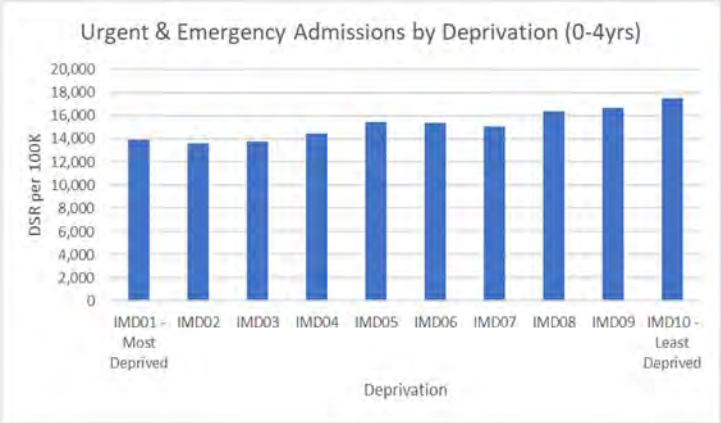
West Midlands Ambulance Service (WMAS) are working on the Improving Mental Health Ambulance Response Programme, which is an all age approach, including those under the age of 18. The key features of this programme are:

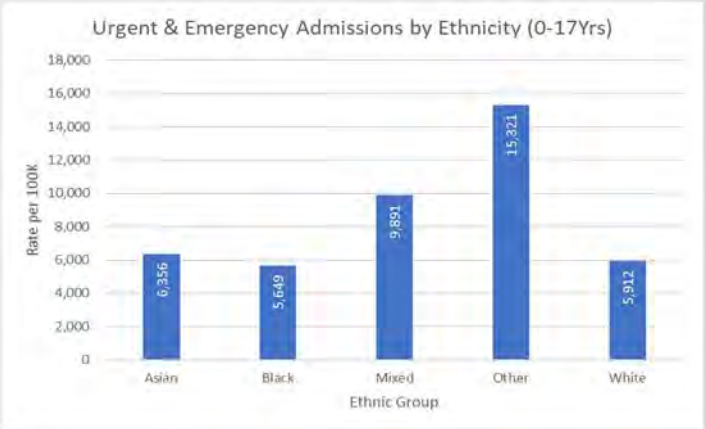
- Ongoing mobilisation and alignment of WMAS improving the ambulance response to mental health model which includes workforce training in MH, dedicated mental health response vehicles, and mental health clinicians in the EOC.
- This model has the aim to improve ambulance response to mental health emergency cases and to provide an improved patient journey for those contacting NHS 999; with mental health as a primary need.
- Triage process being managed by mental health specialist clinicians and availability of specialist mental health paramedics ensures that those in mental health crisis are provided with the right support.
- A key objective of this work is to improve utilisation of local community crisis alternative options, thereby reducing the inappropriate usage of ED.

A new project is currently being developed within the Urgent Treatment Centre at UHCW to use social prescribers to support high frequency attenders. This will include those under the age of 18 who present with non-clinical needs.
An integrated urgent care review is starting which will focus on ensuring equity of access for patients requiring urgent care. One of the consequences of this will be reducing ambulance conveyance as well as ED attendances, given that the route into urgent care services will be much more streamlined. This will be operational in 2025.

- Emergency admissions for under 18s







Local Data Observations

- *The highest rates are found in the 0-4yr age group, with rates higher in males than females. 17.3k compared to 13k per 100,000.*
- *In the 15-17yrs the rate switches between males and females and females have a higher rate of admissions than males.*
- *Across the 0-17yr age range, rates in males are slightly higher than in females.*
- *For all ages (0-17yrs) the rate of admissions remains similar across areas of most and least levels of deprivation. However, urgent & emergency admissions appear to show an increasing rate in lesser deprived areas in the 0-4 year old age group.*
- *The rate of urgent & emergency admissions is highest in the "other" and "mixed" ethnic groups, for all ages.*

Indicator Notes

Number of urgent and emergency admissions for children aged 0-17 years.
Data extracted from SUS
Data includes all urgent and emergency admissions that were discharged in 2022-23.

Data Presented at CWICB Level
Data Source : NHS Digital

Respiratory

Indicator:

- Uptake of COVID and flu vaccination by socio-economic group

It is recognised nationally that there are inequalities in vaccination uptake, with lower uptake in more deprived neighbourhoods compared to less deprived areas. Uptake is lower in some Black and minority ethnic groups than the White British population.

When looking at addressing inequalities in vaccine uptake the data and experience of the early phases of the Covid Vaccination Programme has been invaluable. The quality of data through the Foundry system was of a higher level of granularity than we have had previously and allowed us to drill down using ethnicity, socio-economic and street level address data to establish the area's / groups that require the most engagement and help dispel myths about vaccinations. For the Autumn Winter 2023 Covid phase we established 4 projects directly to do this. We engaged with the Cultural Inclusion Network to establish these links and directly commissioned community groups to work with us using the access and inequalities fund from the Covid Vaccination money.

The first was Ambacare, a community groups working primarily with South Indian communities to produce short video clips to promote the importance of vaccinations and dispel myths. These videos were used on social media (Youtube, Facebook, TikTok, Instagram and Whatsapp), screen in GP surgeries and The Gurdwara as well as being shared via email. The second part of the project included appointing a Vaccination Champion in the Gurdwara in Exhall.

The second project was with Inini, a group working directly with migrants across the system. Their project included:

- Develop informational materials and signage in multiple languages commonly spoken by migrants in our community with the help of community leaders and interpreters to bridge language gaps.
- Provide information on the legal rights and privacy protections of migrants receiving vaccinations, assuring them that their immigration status will not be impacted.
- Offer transport reimbursement (£4.50 per person) to individuals who may have difficulty accessing vaccination sites due to lack of personal transportation or public transportation access.
- Collaborate with local migrant organizations, community leaders, and faith-based groups to promote vaccination and provide trusted sources of information.
- Develop and launch culturally sensitive and community-specific educational campaigns through various media channels, including radio, social media, and community events where common vaccine misconceptions and concerns are addressed.
- Have a designated individual (support worker) offer rapid response services to address vaccine related emergencies or adverse reactions promptly for those who are too afraid to approach health services on their own. They will accompany such individuals if need be.
- Create a feedback system to gather input from migrants about their vaccination experiences, using it to improve services and outreach.
- Continuously monitor vaccination rates among migrants and adapt strategies based on real-time data.

We will collect and analyse demographic information to assess the effectiveness of outreach efforts.

The third project was with Sahil Project. Sahil Project initiated the Flu and COVID-19 Vaccine Dialogue to combat vaccine hesitancy within the South Asian community. The primary objectives were to raise awareness on flu and COVID-19 vaccinations and increase vaccine uptake among South Asian populations at higher risk. The dialogue sessions, chosen for their effectiveness, engaged participants in Coventry and Nuneaton.

Opportunistic sampling targeted Sahil Project's service users above 65 with underlying health conditions. Pre- and post-dialogue surveys measured changes in awareness and vaccine uptake. The project unfolded over two months, commencing with a pre-dialogue survey and two dialogue sessions in each location.

The final project was with CGL Homeless charity in Coventry where they ran 3 events which included a pop up vaccination offering in November. To maximise attendance we offered shopping vouchers and food to all those who came which directly resulted in 30 vaccinations being given.

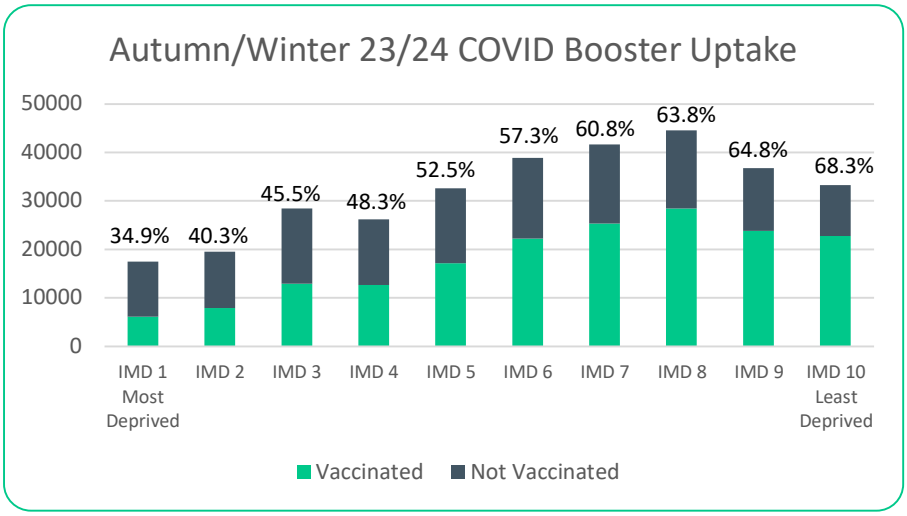
In addition to these core programmes we ran various pop up vaccination centres targeted at geographies with low uptake. One popular one was in Coventry Central Library which was run by CWPT. We have gone on to use this for MMR since as it has become established in the community.

Using the HI Innovation funding, we are developing a number of programmes which will contribute to the improvement of respiratory health. The first is in the most deprived area of South Warwickshire to take a Community Connector approach to identifying people with COPD to improve rates of vaccine uptake to reduce infective exacerbations and emergency hospital admissions. The project will also offer support around smoking cessation and greater respiratory health.

The next project is in Coventry, the Drug and Alcohol service run by CGL has received funding to develop a respiratory clinic for its clients, based on the findings that half of deaths in service were caused by respiratory issues. The service will include a focus on improving flu and covid vaccination rates for this cohort, who tend to be from the most deprived areas of the city.

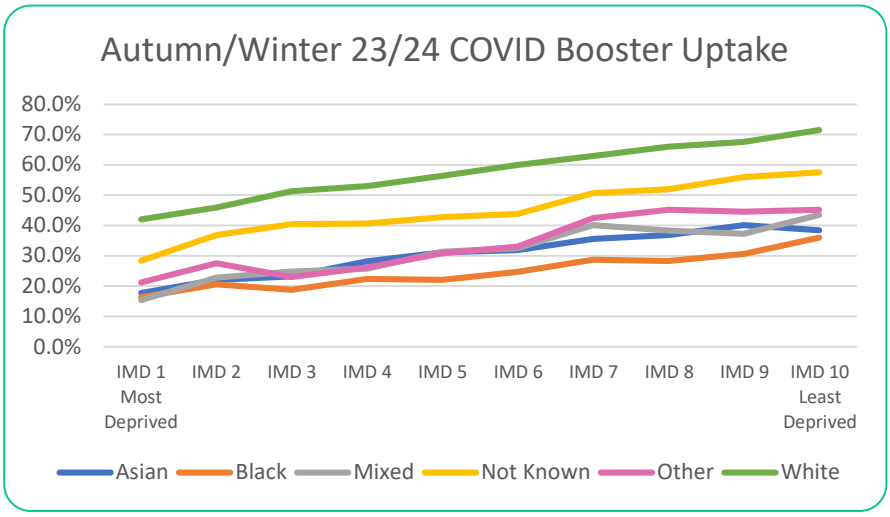
Finally, in North Warwickshire, an area with 30,000 people living in areas that fall within the 10% most deprived nationally, a project is being developed to improve the take-up of flu, pertussis (whooping cough) and covid vaccinations for pregnant women. The current uptake rate for these vaccinations for pregnant women in North Warwickshire is significantly lower than the national average. The project will by lead by a dedicated Vaccinator Midwife to provide increased access to appointments at GEH and a community-based offer. This will be coproduced with identified population groups with the lowest wake up rates.

- Uptake of COVID booster by socio-economic group

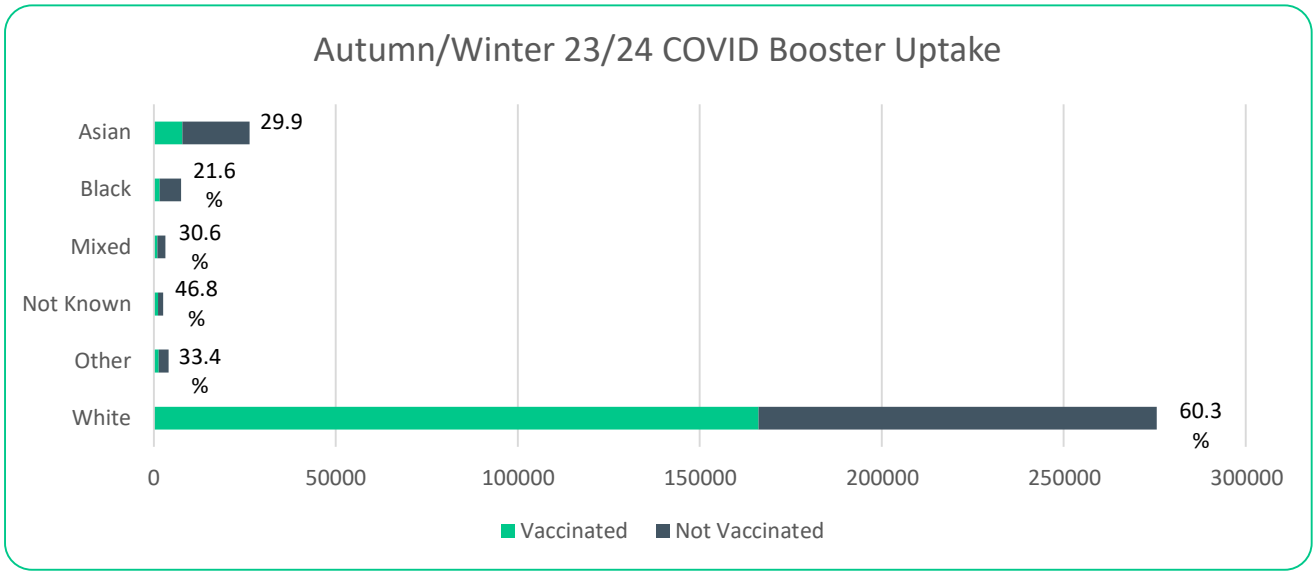


Local Data Observations

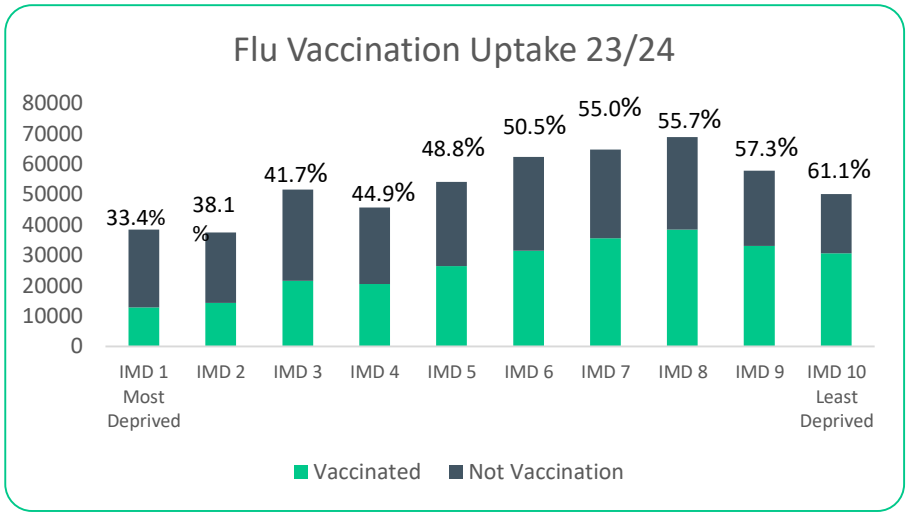
- *Vaccination uptake increases as deprivation levels decrease – trend tracks amongst all ethnicities.*
- *Uptake amongst White ethnic categories is just over 60%. All other groups are significantly lower.*



Data Presented at CWICB Level
Data Source: Foundry

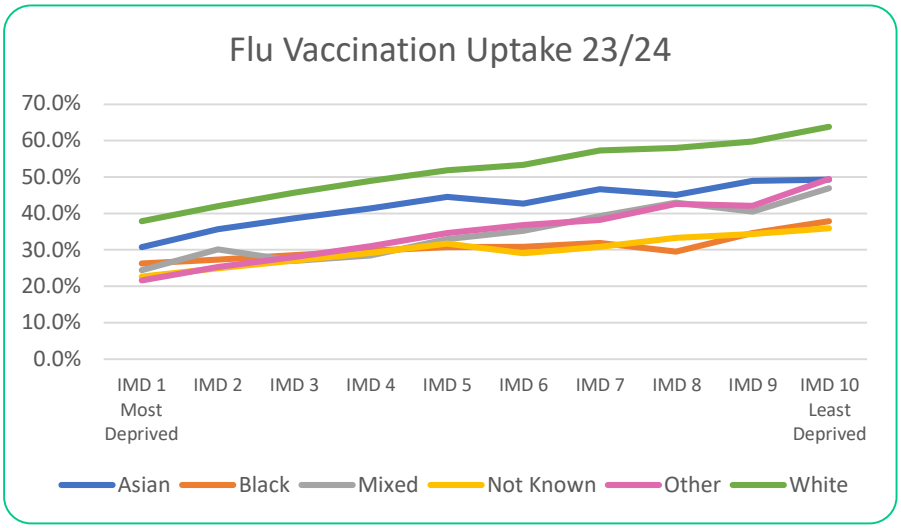


- Uptake of Flu vaccination by socio-economic group



Local Data Observations

- *Vaccination uptake increases as deprivation levels decrease – 33% for IMD 1, 61% for IMD 10.*
- *Uptake amongst White ethnic categories are over 53%. All other groups are significantly lower.*



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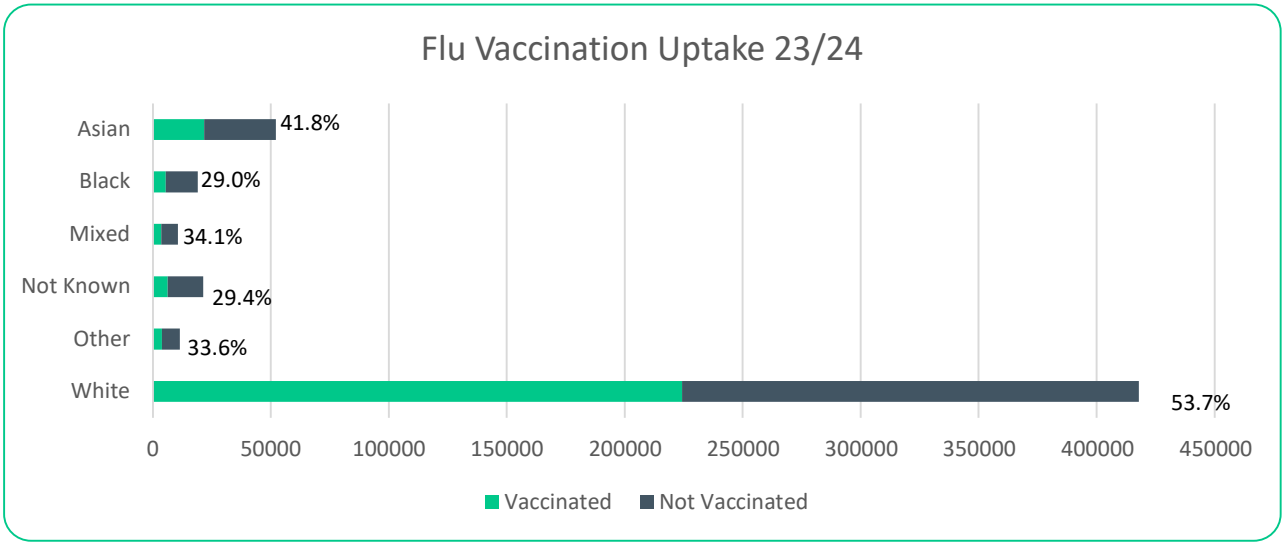


Mental Health

Indicators:

- Overall number of SMI physical health checks
- Rates of total Mental Health Act detentions
- Rates of restrictive interventions
- NHS Talking Therapies (formerly IAPT) recovery
- Children and young people's mental health access

Our recent severe mental illness (SMI) Inequalities Briefing Pack identified a number of key findings including adults with a SMI are more likely to die prematurely especially due to respiratory disease; prevalence of SMI shows over-representation of ethnic minority patients; patients from the most deprived areas are more likely to have SMI; and life expectancy for someone with SMI was 15 to 20 year lower than the general population.

National evidence tells us that people with SMI are at higher risk of poor physical health. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. As set out in the NHS Long Term Plan, by 2023/24, the NHS will ensure that at least 390,000 people living with SMI receive physical health checks each year.

A local review of health inequalities within the SMI physical health checks service has resulted in a number of recommendations which are being progressed by the SMI Steering Group and associated workstreams, including:

- Increase completion rates of physical health checks across the system in line with NHSE agreed target, with an increased priority for individuals in areas of deprivation IMD 1&2, 30-49 age range and males
- Develop pathways and onward support from referrals, for individuals identified as smokers, to reduce high rates of premature mortality due to respiratory rates, with particular focus in Coventry
- Focus on sign up rates of those GP practices within areas of IMD 1 &2 to carry out SMI physical health checks
- To review an individual's physical health check findings (where appropriate year on year), to monitor whether interventions implemented have supported overall health and wellbeing outcomes, and if an individual accessed the intervention

With regards to the rates of Mental Health Act detentions, a significant piece of work is being undertaken in the System, led by CWPT – including partners from: West Midlands Police, Warwickshire Police, Social Care and AMPHs, VCSE, Advocacy Service, and service user input (via 1:1 interviews). This work focuses on addressing the disproportionality in detentions of Black men. A number of workstreams are in progress, including (but not limited to): implementation of Advanced Choice Documents, working with Advocacy service to deliver culturally competent advocacy, review and scrutiny of current pathways.

NHS Talking Therapies (formerly IAPT) recovery: REACH (Realising Everyone's Access to Community Help) – Supporting true Coproduction.

REACH is a fully co-designed, co-delivered and co-evaluated service with Experts by Experience who used their own experiences in stepping down from Secondary Care and being on waiting lists for support but not knowing what services are available and how safe and appropriate they are. The service was co-designed with a number of staff from across CWPT and the VCSE in various operational and strategic roles. Inini, Sahil,

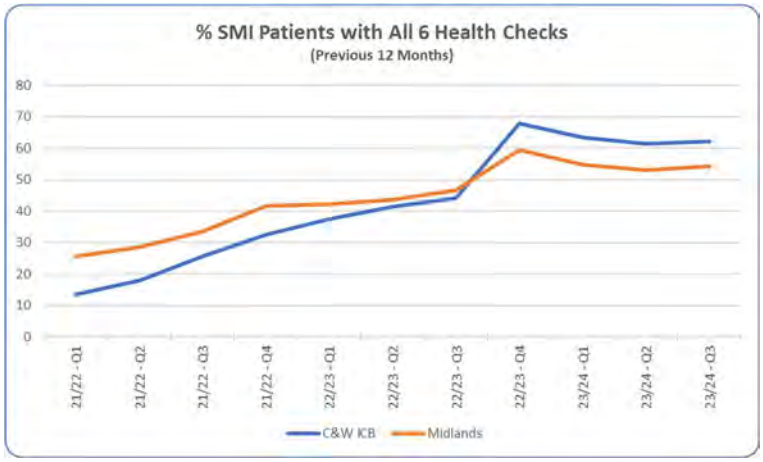
Tamarind and Ambacare are working with CWPT to develop bespoke Peer Support Training for CIN/ racialised communities.

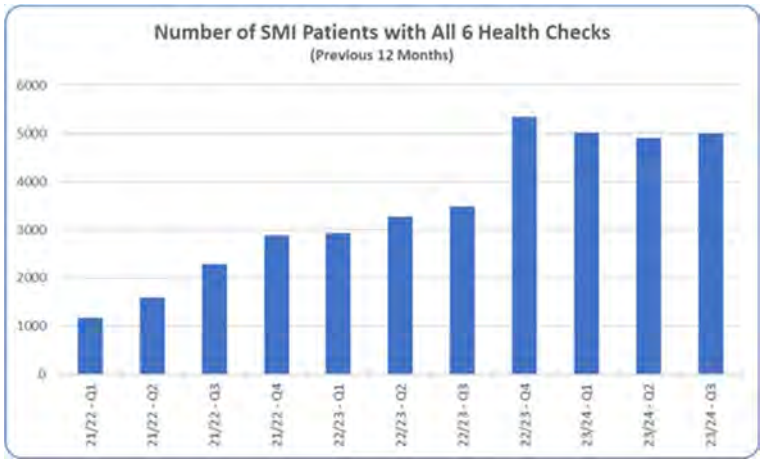
Talking Therapies Funding to increase uptake from underrepresented communities:
Grant Funding opportunity through the NHSE Talking Therapies for wider VSCE engagement. Small grants have been awarded to VCSE representing different communities (Parenting Project, Autistic Girls Network, Alzheimer's Society, Guardians Grow, Forest of Hearts, By Your Side, Wild Earth, Amythest Centre, New Start 4U) to support the increase in referrals from underrepresented communities and to capture insights form people in the communities they serve about the barriers to access and engage with Talking Therapies.

Citizens Advice Coventry, Inini, Valley House and Warwickshire Pride are currently hosting one of four VCSE Talking Therapies Leads, generating referrals and promoting the TT Service in their community and capturing insights form people in the communities they serve about the barriers to access and engage with Talking Therapies.

The main ethnicity group for access to CYPMH services is white CYP. CYPMH will be completing a focused piece of work to ensure recording of health inequality information remains up to date and will be focussing on disproportionalities in access and outcomes. A coaching and training session will also be provided to ensure accurate data recording.

- Overall number of SMI physical health checks





Local Data Observations

- ***COVENTRY & WARWICKSHIRE ICS WIN HSJ AWARD FOR APPROACH TO SUPPORTING PEOPLE WITH SEVERE MENTAL ILLNESS***
- *The work undertaken by the ICS saw an increase in the percentage of people on the SMI register receiving physical health checks increase from 10.4% in June 2021 to 67.8% in March 2023 – above the national target of 66% set out in the NHS Long-Term Plan*

FUTURE CONCERNS

- *From Q1 2024/25 SMI PHC data collection will move from SDSC to GPES, this will allow a direct feed from GP Practice systems to NHSD and will collect more granular level detail such as ethnicity, and thus enable Health Inequality analysis.*
- *Unfortunately, we are aware that there may be issues with data flows and data quality that may affect the overall numbers of SMI patients that have all 6 health checks completed. The ICB are working with NHSE/D to investigate the issues.*

Indicator Notes

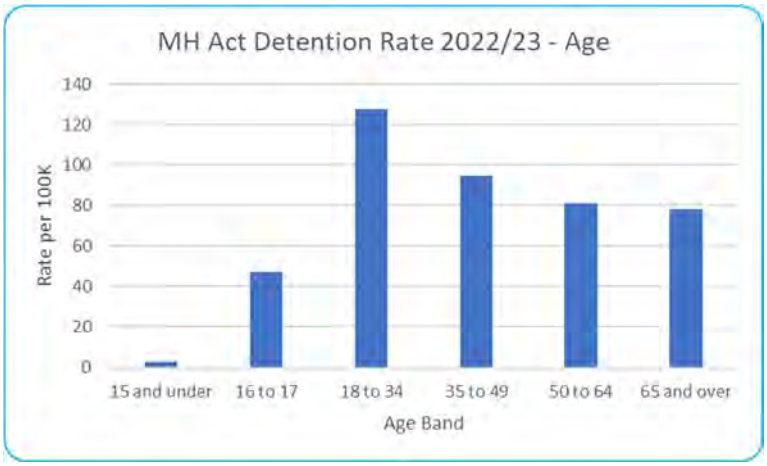
At present data is not collected at ethnicity, age, gender or deprivation levels, so inequalities cannot be analysed until Q1 2024/25 onwards.

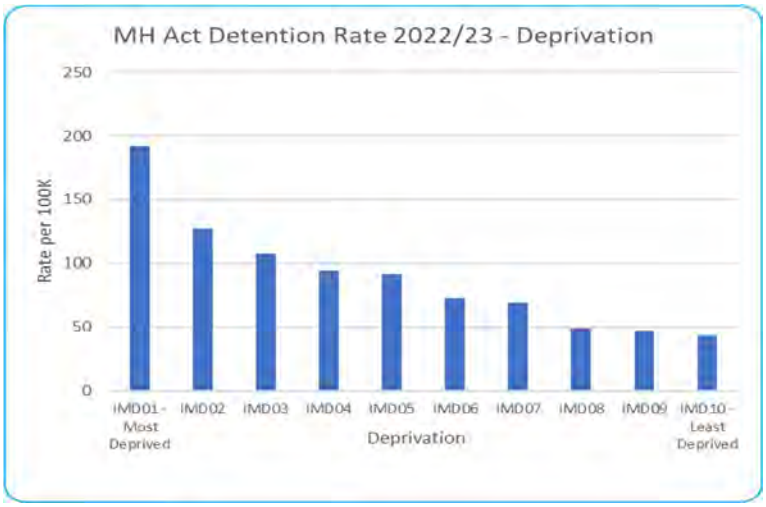
Related Measures

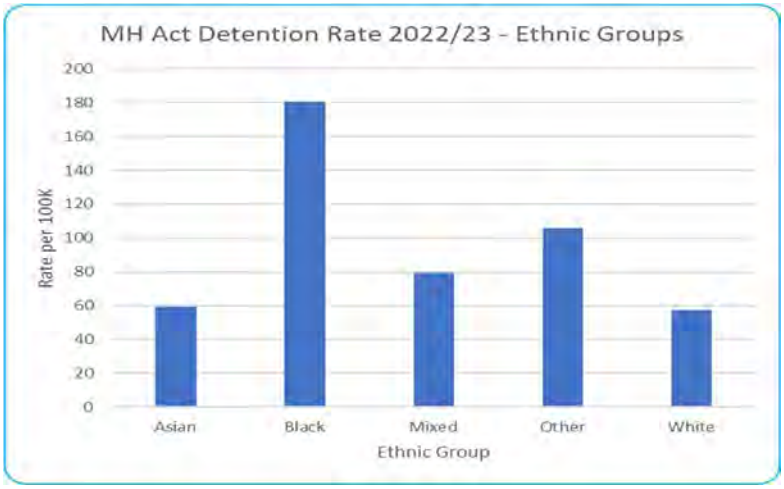
- *% of SMI Patients with all 6 Health Checks Completes*
- *Numbers & % of each individual health check (I.e. Glucose)*

Data Presented at CWICB Level
Data Source : NHS Digital

Rates of total Mental Health Act detentions:







Data Presented at CWICB Level
Data Source: NHS Digital

Local Data Observations

- *The highest rates of MH Act detentions are found in the 18 to 34 age group. Crude Rates are slightly higher in Males than Females (78.8 vs 76.2 per 100k).*
- *Rate of detention increases with Deprivation*
- *Rate of detention are found to be in the Black Ethnic group, followed by 'Other' ethnic groups.*
- *Rates locally tend to (with some differences) mirror patterns indicated in published data based on national populations. See link below.*
- Detentions: differences between groups of people - NHS England Digital

Indicator Notes

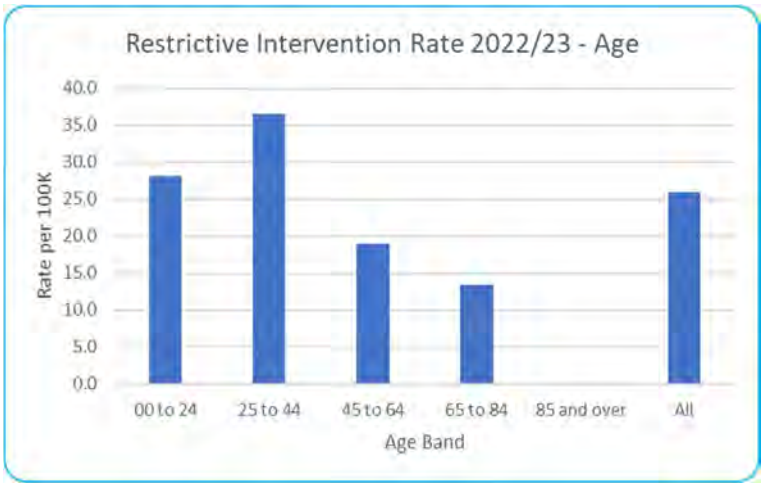
Under the Mental Health Act ('the Act') people with a mental disorder may be formally detained in hospital (or 'sectioned') in the interests of their own health or safety, or for the protection of other people. They can also be treated in the community but subject to recall to hospital for assessment and/or treatment under a Community Treatment Order (CTO).

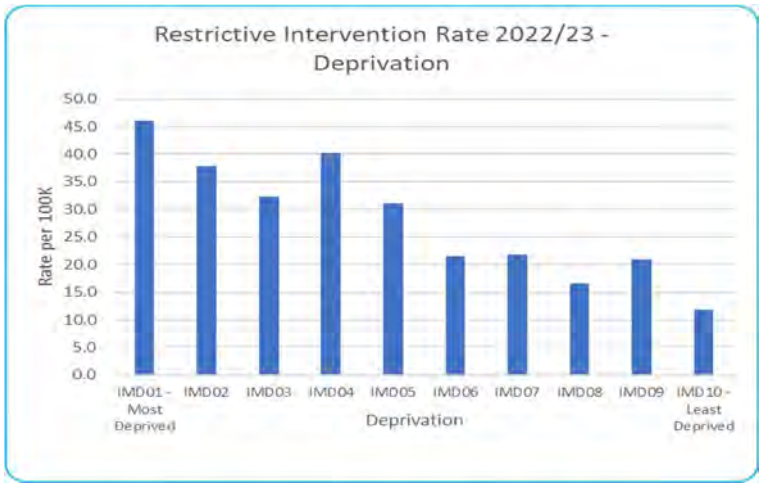
This indicator measures the number of detentions in 2022/23 per 100000 population.

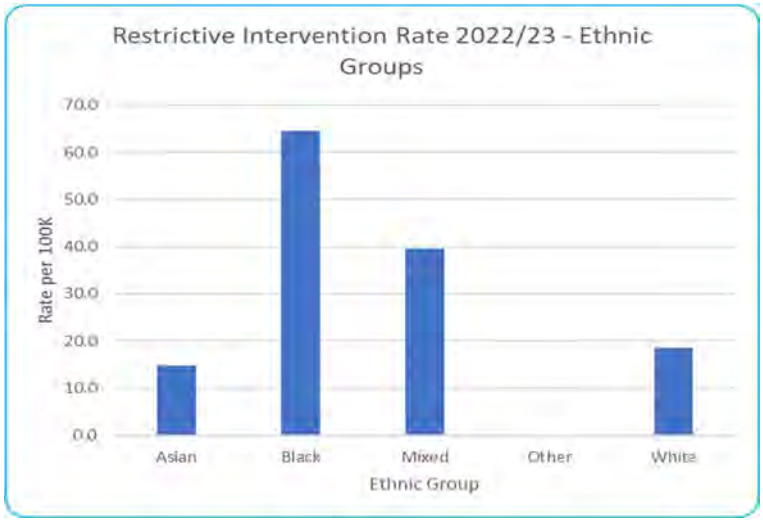
Related Measures

- *Detentions under sections 2,3, 135/136*
- *Short Term orders*
- *Detentions on/ following admission to hospital, revocation of CTO, use of place of safety.*

- Rates of restrictive interventions







Data Presented at CWICB Level
Data Source: NHS Digital

Local Data Observations

- *Highest rates of Restrictive Intervention to be found in 25 to 44 year olds, followed by under 25's. Rates in Females and Males are approximately equal (25.2 vs 25.7 per 100K).*
- *RI rates increase with deprivation.*
- *RI Rates are found to be highest in Black Ethnic Groups, followed by Mixed Ethnic Group.*
- *Crude Rates have been derived based on counts to the nearest 5 reported by NHS Digital and so may be subject to statistical uncertainty due to this and also smaller numbers reported for population subgroups.*

Indicator Notes

Restrictive interventions are defined as:

1. Planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken'; and

2. End or reduce significantly the danger to the person or others; and (3) contain or limit the person's freedom.

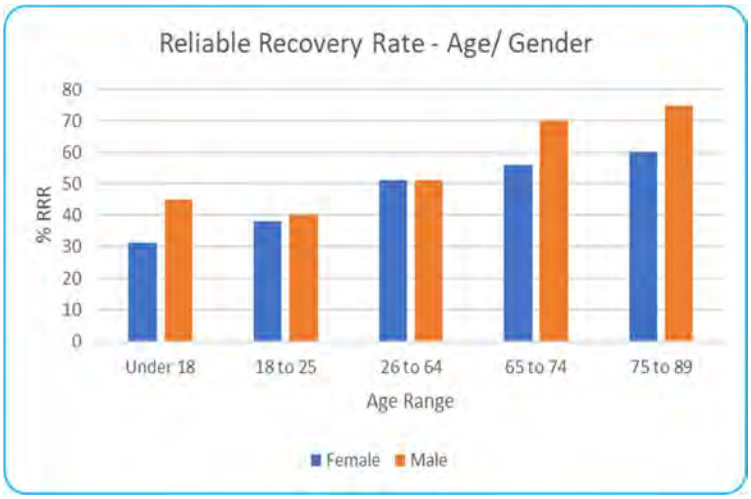
3. Contain or limit the person's freedom.

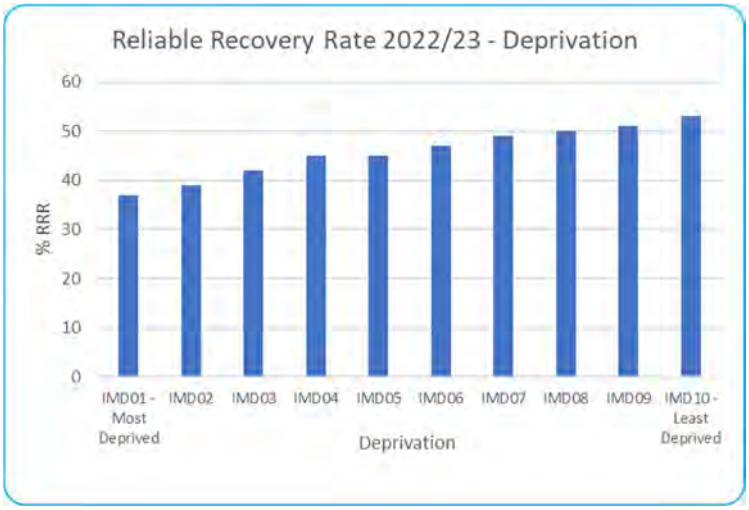
The indicator reports on numbers of restrictive interventions in 2022/23 per 100,000 population.

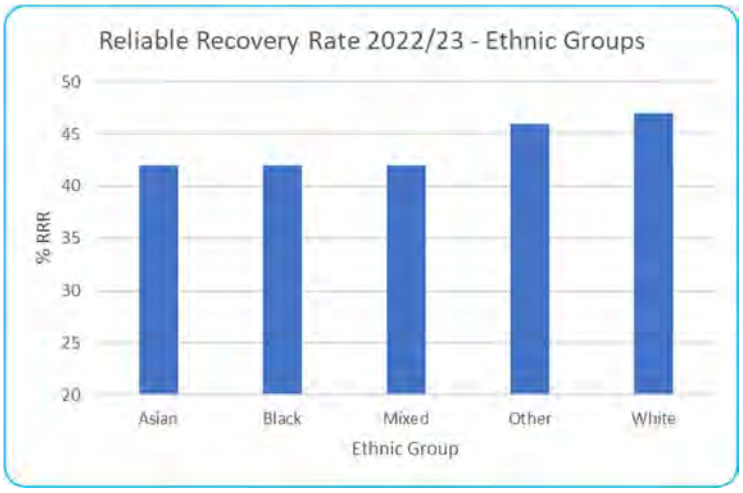
Related Measures

- *Crude Rate of Restrictive Intervention per 1000 Occupied Bed Days*

- NHS Talking Therapies (formerly IAPT) recovery







Local Data Observations

- *RRR tends to increase with age – Under 40% in Under 25's to over 60% in over 75's.*
- *Tends to be higher in Males. Males > Females.*
- *Higher rates to be found in more affluent populations, least deprived > 50%, most deprived < 40% reliable recovery*
- *Higher rates also to be found in White and Other Ethnic Groups (> 45%) than in Asian, Black and Mixed (<45%).*
- *Rates reported within deprivation levels and ethnic groups are not age standardised and would be subject to change following application of age standardisation.*

Indicator Notes

A higher reliable recovery rate indicates better treatment success

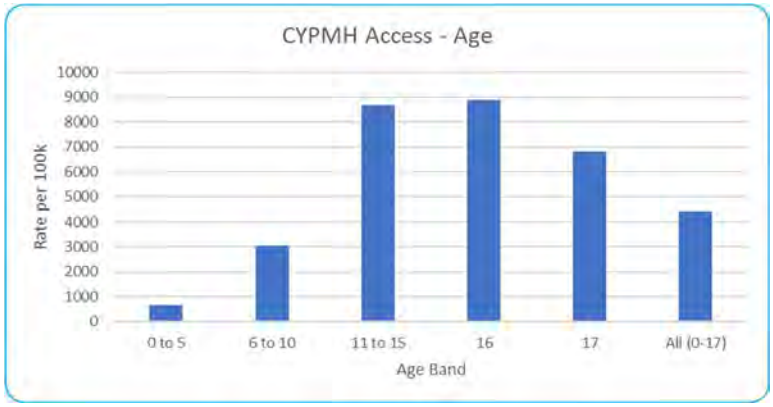
Patients are considered to be reliably recovered if they have shown both reliable improvement and have recovered as measured by their scores for Depression and/or relevant anxiety, following commencement of Talking Therapy treatment.

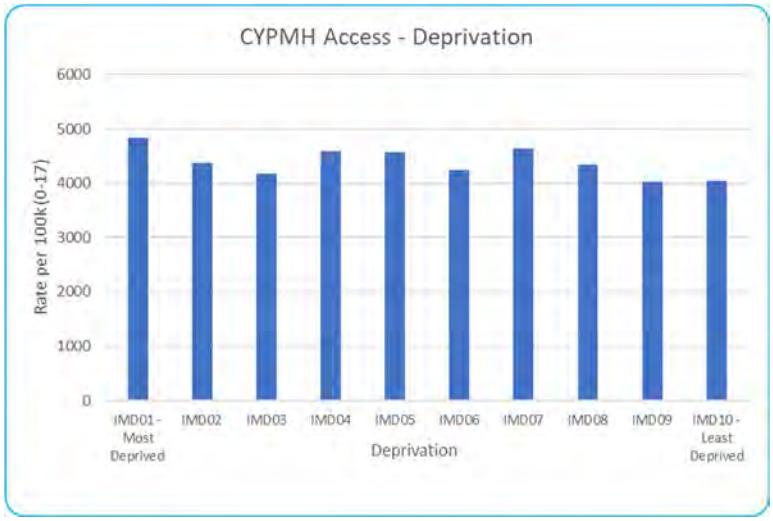
Related Measures

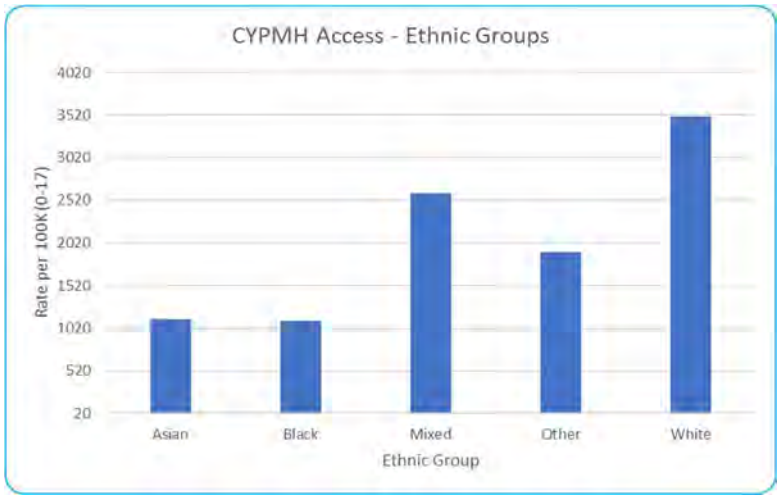
- *Reliable Improvement*
- *Reliable Recovery*

Data Presented at CWICB Level
Data Source: NHS Digital

- Children and young people's mental health access







Local Data Observations

- *Highest rates of CYP Mental Access are to be found around the ages of 11 to 16.*
- *Access 0-17 tends to be higher in females than males (4679 vs 4009 per 100K).*
- *Access tends to be slightly higher from more deprived areas. However access fluctuates across different levels of deprivation and relative levels of unmet need are not apparent from the data. presented.*
- *Access Rates in the white population are considerably higher than in other Ethnic Groups.*
- *Rate reported only reflect crude access and are not weighted towards estimated need that exists within the population and so therefore difficult to assess levels of unmet need among population groups from the data presented.*

Indicator Notes

Increasing access to Children and Young Peoples Mental Health Services is a key NHS Commitment (NHS Long Term Plan).

This indicator measures the crude rate of children and young people aged under 18 supported through NHS funded mental health with at least one contact per 100,000 population aged 0-17

Related Measures

- *CYPMH Outcomes*
- *CYPMH Access (18-24)*
- *Access to CYPMH Crisis and Eating Disorder Services*

Data Presented at CWICB Level
Data Source: NHS Digital

Cancer

Indicator:

- Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex

In 2022/23 and 2023/24 the percentage of cancers diagnosed compared to the 2019/20 position demonstrates an actual and forecast increase of 5.4% and 5.7% respectively. The ICB has set up a system to routinely monitor staging data and will set a trajectory to support delivery of the 2028 target. In 2022/23 across all tumour sites 49% of cancers were diagnosed at Stage 1 and 2 and 15% classified as unknown. Whilst high level national data is available it is recognised that further refinement is required to support and understand the wider inequalities across the ICS. A high-level system focused Inequalities report has identified variability with further plans to be developed.

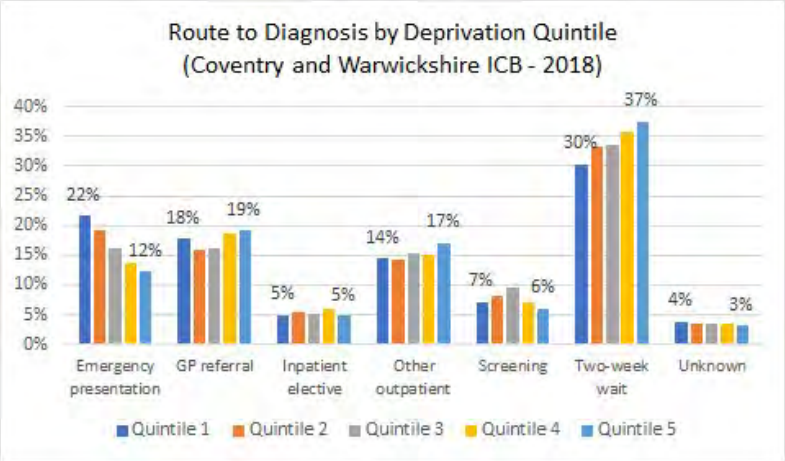
Our recent Cancer Inequalities Briefing Pack identified a number of key findings in our local cancer services, including a higher gender gap in five year survival rates after lung and colon cancer diagnoses than the national figure; patients that live in the most deprived areas are twice as likely to not attend their cancer outpatient appointment as someone from the least deprived areas; a significant difference in smoking prevalence, the leading cause of cancer, between the North and South of Warwickshire; and the local DNA ('did not attend') rate for cancer appointments varied between 3% and 15% depending on a patient's ethnicity. A Macmillan EDI Transformation lead will oversee the development of action plans to improve personalised support and access to provision for patients living with cancer. This will involve work with those communities to establish better understanding of treatment and living with and beyond cancer. It will provide a clearer understanding why certain patient groups do not present to healthcare professionals when symptoms

The ICB will continue to work closely with key stakeholders to address inequalities across the system and ensure that the bowel screening age extension roll out meets national requirements and expectations. There will be an expansion of the Targeted Lung Health Check Programme across Warwickshire. Building on the foundations and learning from the Coventry and Rugby model, this will support delivery of increased Stage 1 and 2 diagnose in areas where there are late-stage cancers identified. The programme also includes signposting to smoking cessation services.

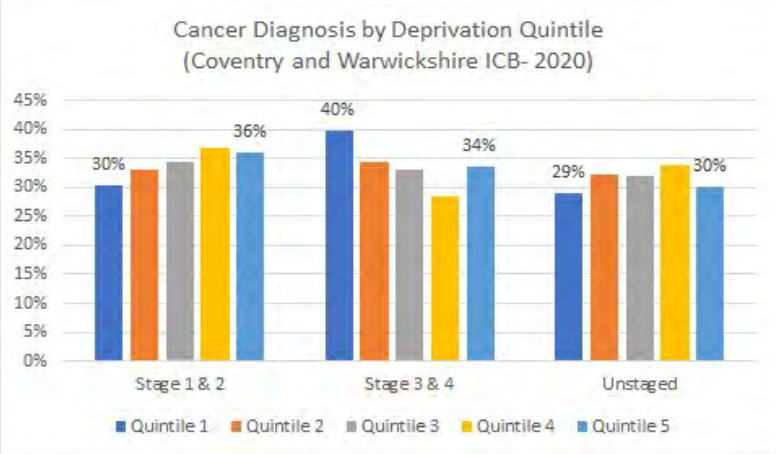
Cancer is among the top five cases of death for people with a learning disability and autistic people. People with severe mental illness (SMI) are twice as likely as those without SMI to die prematurely, with cancer being the lead cause of premature death. Because of this and data showing that we have a lower uptake in screening for these groups locally, we have recently mobilised a project which aims to increase cancer screening for people with a learning disability, people with autism and people with a severe mental illness. The project will work with Experts by Experience to coproduce effective pathways for these groups.

The ICB will continue to engage with Primary Care (including Primary Care Networks) focusing on screening and early diagnosis projects and interventions, and through the PCN DES it will be approaching PCN clinical leads to undertake tumour site specific audits on cancers identified late stage, outside of screening/2ww referral.

- Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex

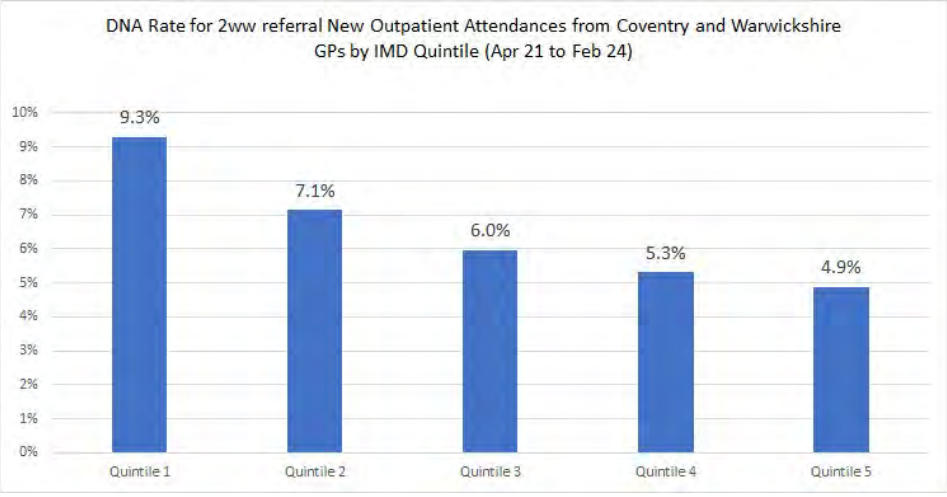


Data Presented at CWICB Level
Data Source: National Disease Registration Service
(Accessed through CancerStats)



Local Data Observations

- *The percentage of patients from CORE20 areas whose cancer was diagnosed after an emergency admission was almost twice as high as the figure for those from the least deprived quintile where a larger proportion of patients were diagnosed through the 2 week wait suspected cancer referral route.*
- *A smaller percentage of cancers were diagnosed early in CORE 20 areas than in the least deprived areas. (30% at Stage 1 or 2 vs 36%)*
- *Patients living in CORE20 areas are nearly twice as likely not to attend when referred by a GP to a consultant through a suspected cancer referral route as those in the least deprived areas*



Data Presented at CWICB Level
Data Source: SUS Data
(Accessed through ArdenGEM CSU DME)

CVD

Indicators:

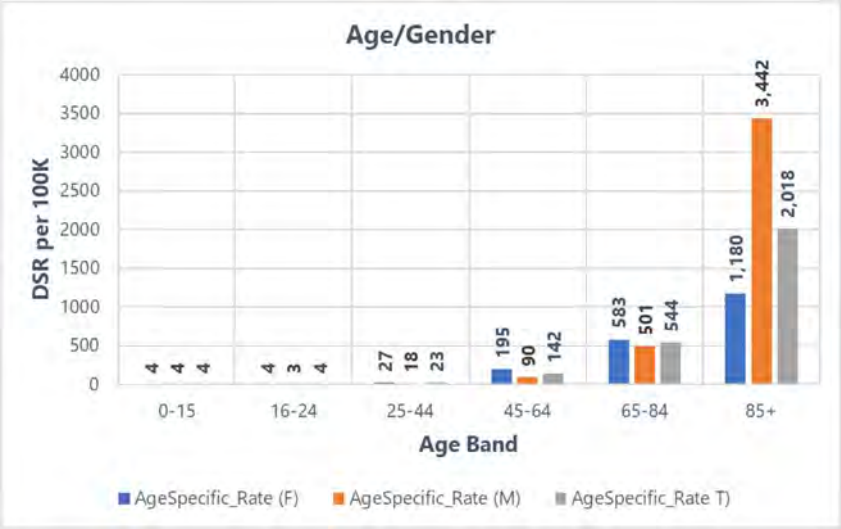
- Stroke rate of nonelective admissions (per 100,000 age sex standardised)
- Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)
- Percentage of patients aged 18 and over with GP recorded hypertension in who the last blood pressure reading is below the age-appropriate treatment threshold
- Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy
- Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a records of a CHA2DS2-VASc score of 2 or more

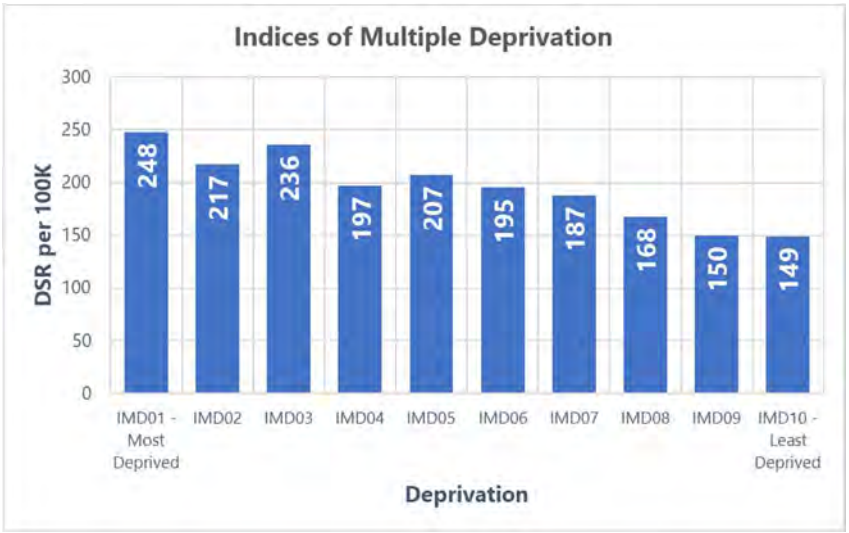
Health Inequalities Innovation funding is enabling a project in North Warwickshire to support the identification of patients at risk of hypertension using a digital Hypertension Management Platform. This programme will target communities in the Core20 areas, with an alternative approach for people unable to connect digitally. The project aims to drive improved health and equality outcomes across Warwickshire North through improved CVD case finding. This element of the hypertension management is part of the wider programme within Warwickshire North to tackle health inequalities, funded by InHiP and Going Further Faster.

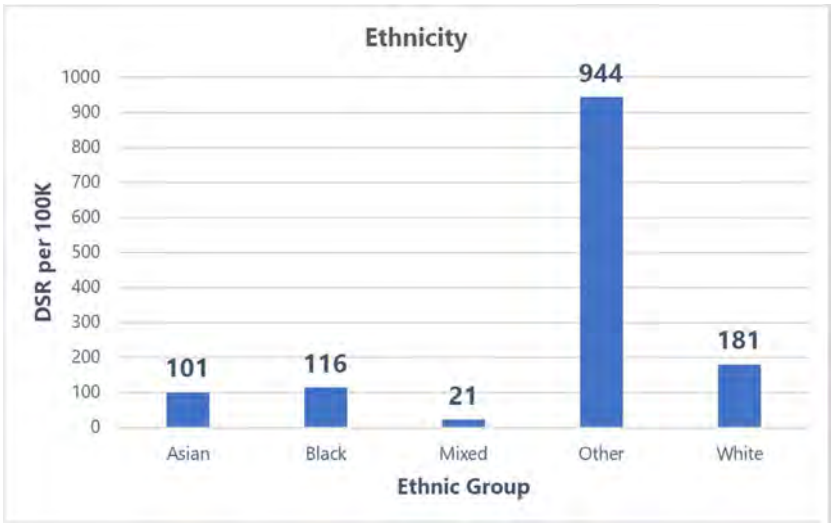
There are also a number of projects funded via the HI Innovation Fund which include a health check element. These health checks programme focus on groups known to have poorer health outcomes, such as armed forces veterans, people experiencing homelessness, migrant communities and people living in deprived communities, which should help to tackle inequalities around cardio-vascular disease identification and management.

Through use of NHSE InHIP (Innovation for Healthcare Inequalities Programme) funding, a two stage approach has been developed in North Warwickshire around the development of a hypertension, atrial fibrillation and lipid case finding and optimal management pathway. Going Further and Faster funding has been used to accelerate prevention and reduce unnecessary admissions. There is an improvement in QOF recording as an unintended benefit of the CVD prevention project in the North driving its uptake in surgeries and therefore better outcomes for our population. The programme has run a number of screening events throughout Warwickshire North, with almost half of the events taking place in Core20 areas and 35% of the checks resulting in a referral to primary care. A risk stratification audit also carried out as part of the programme has also resulted in identification of a number of new diagnoses identified within primary care .The project is still running and a report is expected at the end of Summer 2024.

- Stroke rate of non-elective admissions (per 100,000 age/sex standardised)







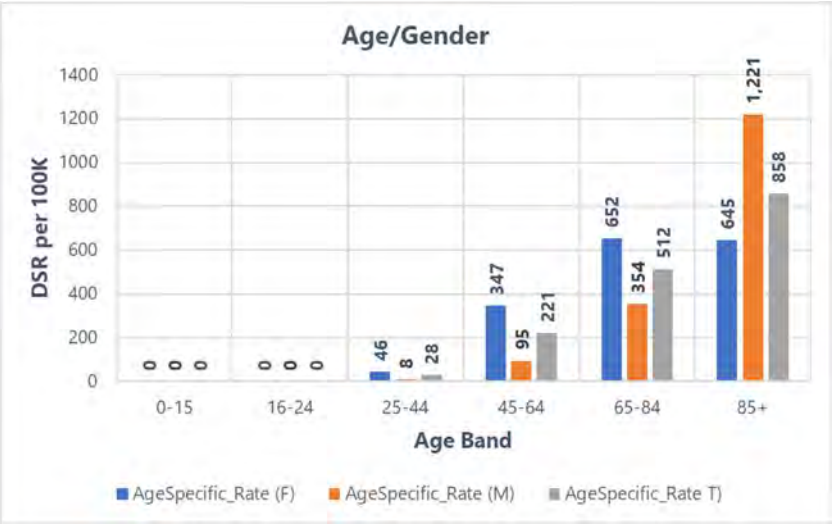
Local Data Observations

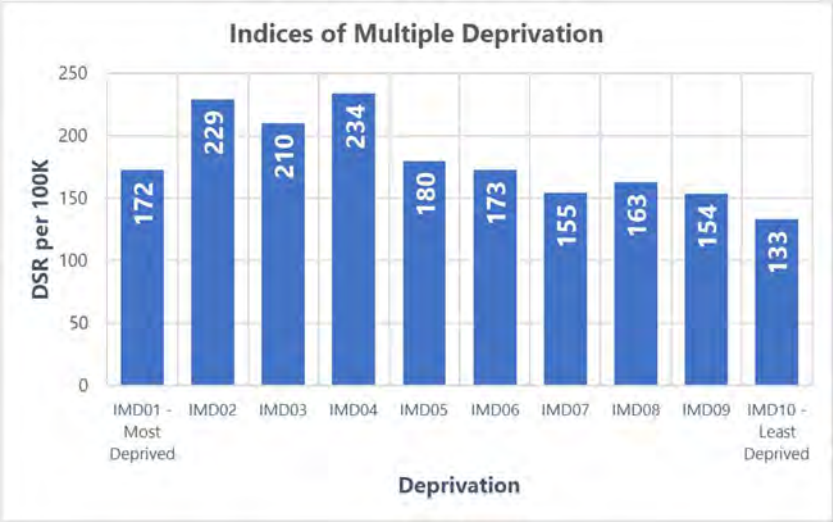
- *Prevalence increases with age, particularly in the 85 + population*
- *In the 85+ population males are almost three times as likely to be an emergency stroke admission than female*
- *Although not perfectly linear the more deprived the greater the rate. Those most deprived are 66% more likely to have a stroke admission than the least deprived.*
- *'Other' ethnicity group may be overrepresented due to relatively small population volumes and recording practices*

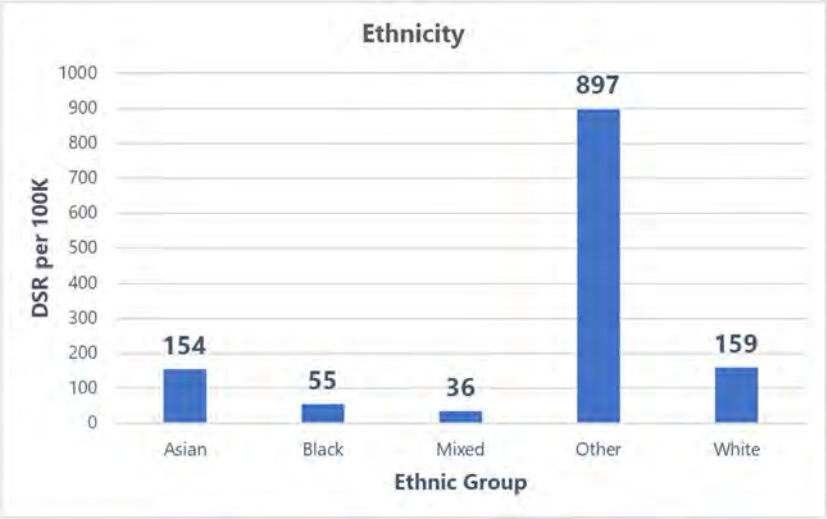
Indicator Notes:

- *Directly standardised rate against European standard population per 100,000*
- *Sourced from Admitted Patient Care CDS*
- *Emergency Admissions (Admit Method Code like 2*)*
- *2023 calendar year admissions*
- *ICD10 code of I6* in any position of admitting episode*

- Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)







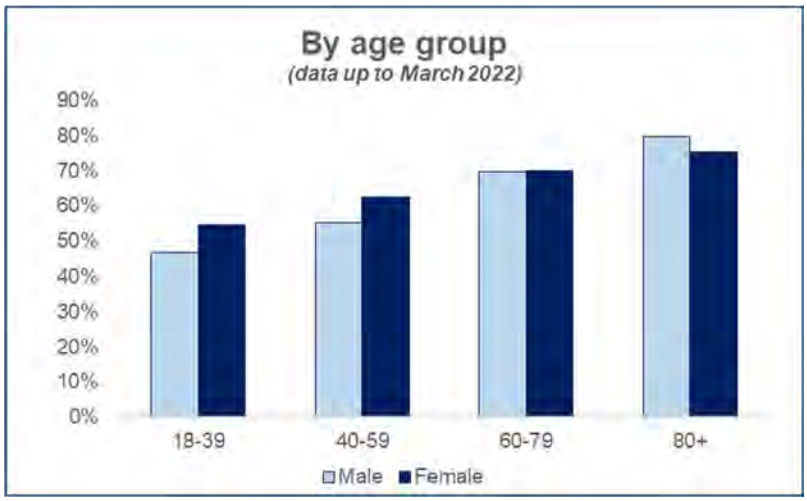
Local Data Observations

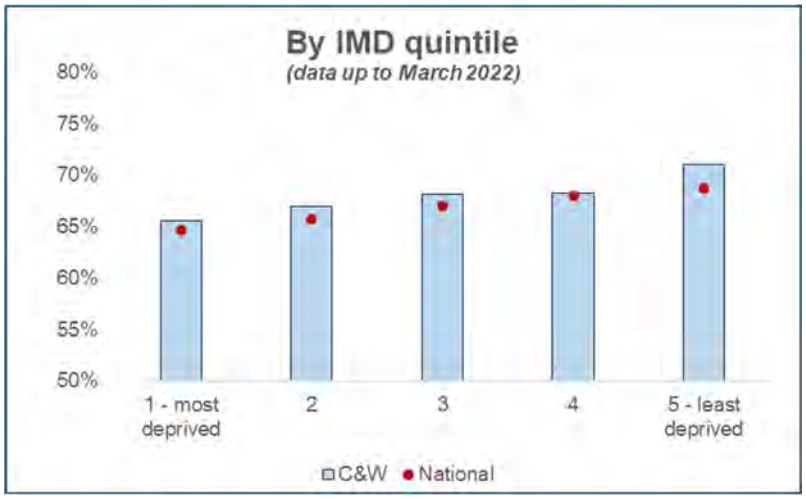
- *Prevalence increases with age. Prevalence in females increases from 45 years, males less so until 85+ years of age*
- *Overall females are 95% more prevalent to have a myocardial infarction admission*
- *There is some evidence of a relationship with deprivation but not linear. This isn't notable until the bottom four deciles*
- *'Other' ethnicity group may be overrepresented due to relatively small population volumes and recording practices*

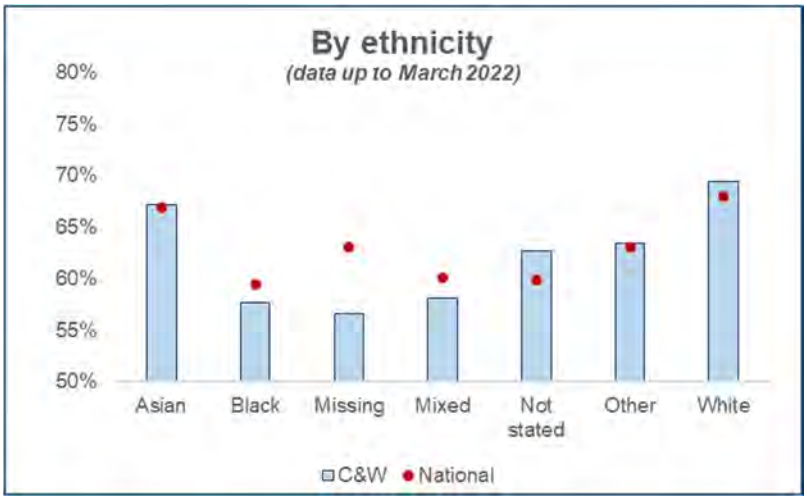
Indicator Notes:

- *Directly standardised rate against European standard population per 100,000*
- *Sourced from Admitted Patient Care CDS*
- *Emergency Admissions (Admit Method Code like 2*)*
- *2023 calendar year admissions*
- *ICD10 code of I2* in any position of admitting episode*

- Percentage of patients aged 18 and over with GP recorded hypertension in who the last blood pressure reading is below the age-appropriate treatment threshold





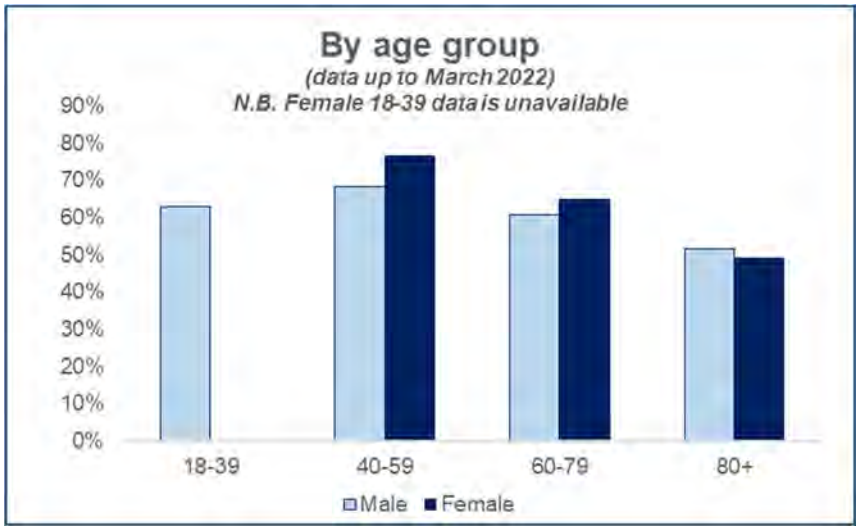


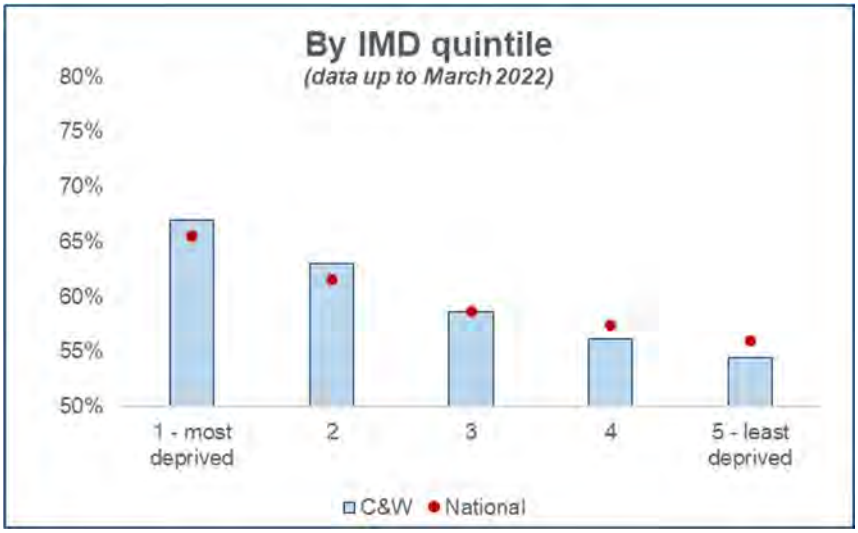
Local Data Observations

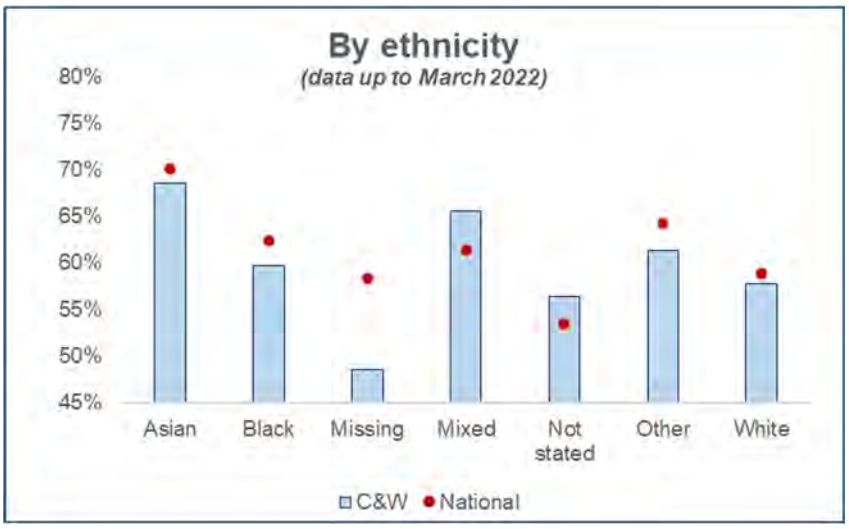
- *The percentage of patients below the age-appropriate treatment threshold is higher for the White Ethnic category, most noticeably compared to Black and Asian categories.*
- *The least deprived IMD quintile has the lowest proportion of patients above the threshold; the most deprived has the highest.*
- *Male patients under 60 are more likely to be outside the treatment threshold than female patients, although this switches for patients aged 80+*

Data presented at CWICB level
Data Source: CVD Prevent

- Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy





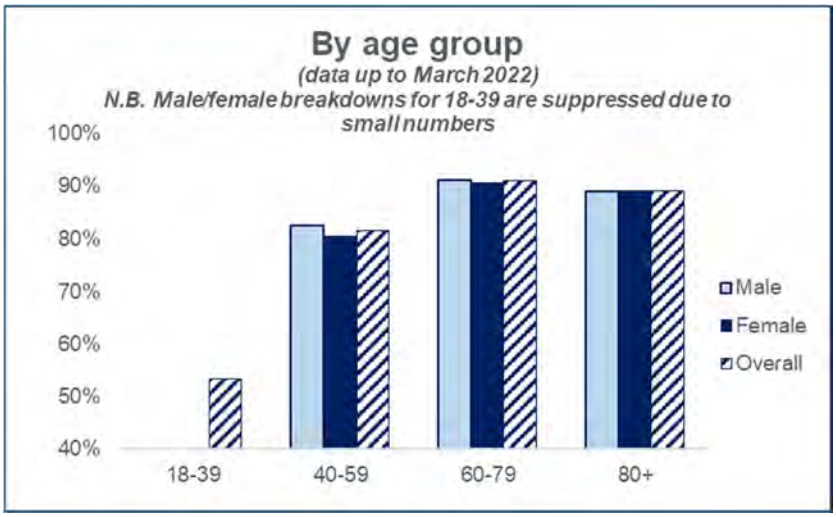


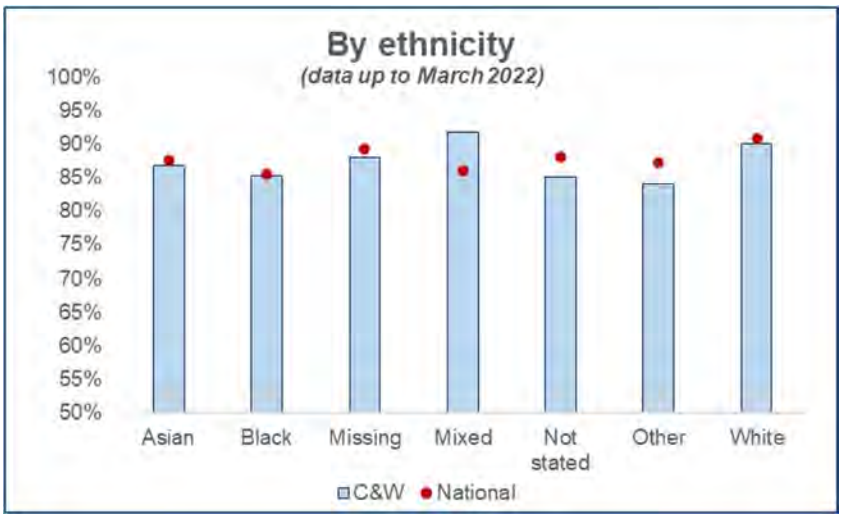
Local Data Observations

- *The White ethnic category has a lower percentage of patients with a QRISK score of >=20% but no CVD diagnosis, highlighting greater health risk amongst non-White ethnic categories.*
- *The most deprived populations in Coventry and Warwickshire have the highest percentage of patients with a high QRISK score and no CVD diagnosis. This percentage declines at each quintile point until the lowest percentage is reached with the least deprived populations.*

Data presented at CWICB level
Data Source: CVD Prevent

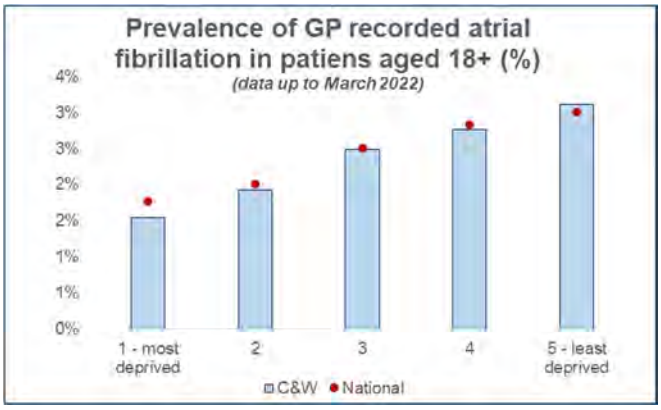
- Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a records of a CHA2DS2- VASc score of 2 or more





Local Data Observations

- *GP recorded prevalence of Atrial Fibrillation is highest in the least-deprived population. The most deprived population is the least likely to have atrial fibrillation recorded.*
- *However, when looking at treatments with a lipid lowering therapy, the percentage of patients treated is consistent across all IMD quintiles.*
- *There is also a strong level of consistency for the same treatment when looking at the patient's ethnic category.*
- *Also included is the breakdown by deprivation of prevalence of AF in patients over the age of 18*



Diabetes

Indicators:

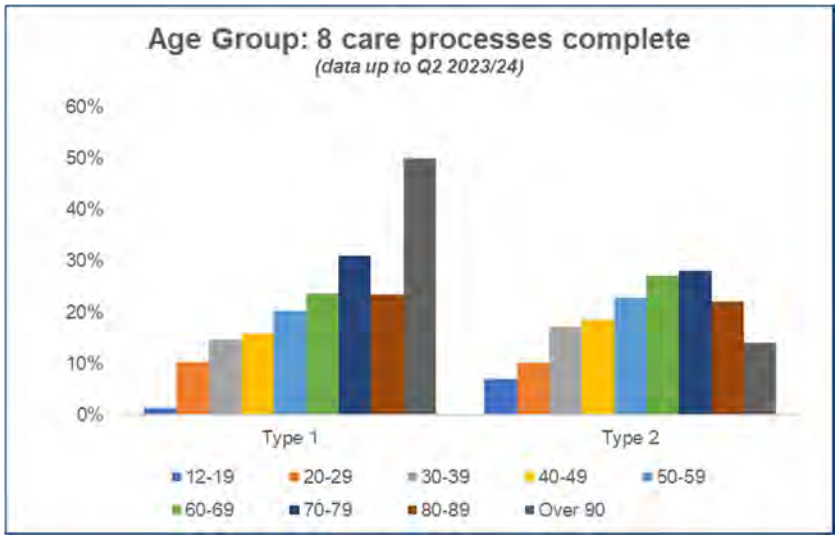
- Variation between % of people with type 1 and type 2 diabetes receiving all 8 care processes
- Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile

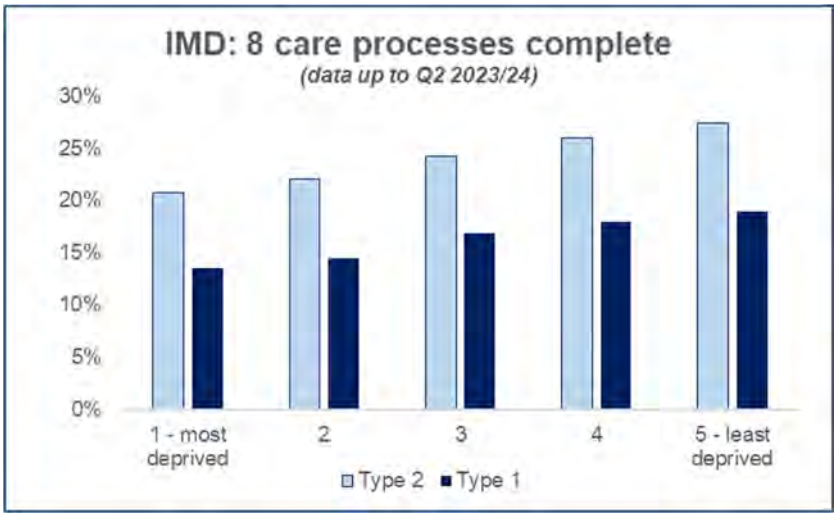
Recognition of the link between diabetes and deprivation has led to the creation of the HI funded project in Sowe Valley PCN in Coventry to take a population health management approach to managing diabetes in a more person-centred way. The project selected a cohort of 147 people who were overweight, had a diagnosis of type 2 diabetes and were between the ages of 20 and 39. Due to the location of the PCN, a high proportion of those selected were in areas of high deprivation. The patients were provided with a range of services to help them to develop the skills and knowledge to manage their diabetes, including nutrition and dietary advice, access to the Diabetic nurse, healthy lifestyles advice, pharmacy support and mental health support. The project also made use of a healthy lifestyle app, EasyChange to help engage, motivate and promote health and wellbeing for patients. The outcomes of the project are currently being evaluated and will be published on our website soon.

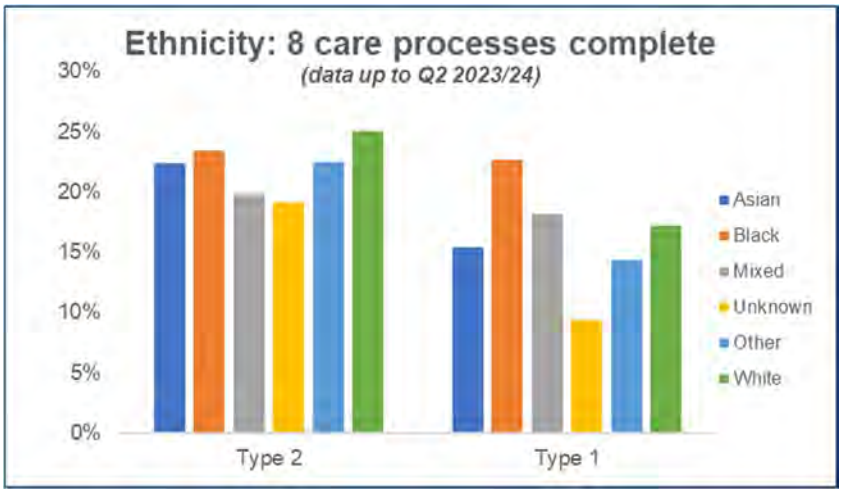
A project has recently been agreed to support children and young people with diabetes through the transition into adult services. A recent audit carried out in UHCW showed that non-attendance in diabetes clinics rises significantly from 2.8% in 15-17 year olds to 25.8% in 19-21 year olds. This pilot project, which will cover areas of Coventry and Rugby, will implement an innovation, personalised approach for these young people through the support of a Youth Worker to maintain engagement with services as they transition into adulthood.

Further information on our approach to tackle inequalities in the area of diabetes will be added when available.

- Variation between % of people with type 1 and type 2 diabetes receiving all 8 care processes





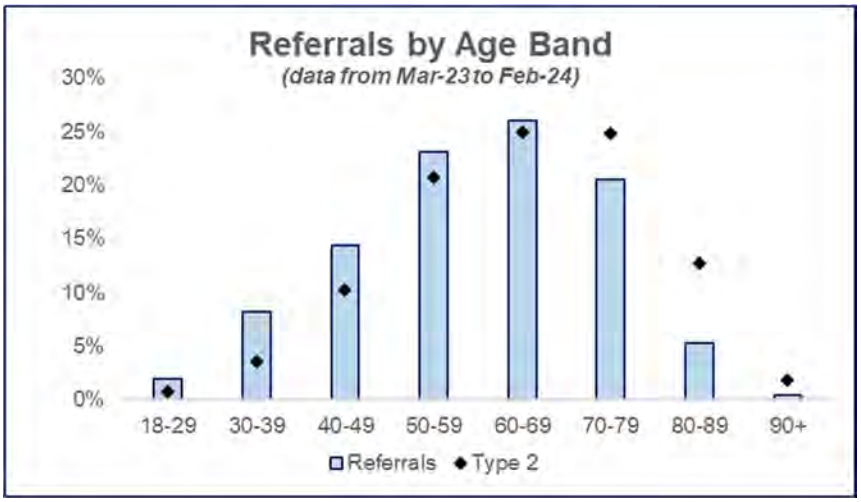


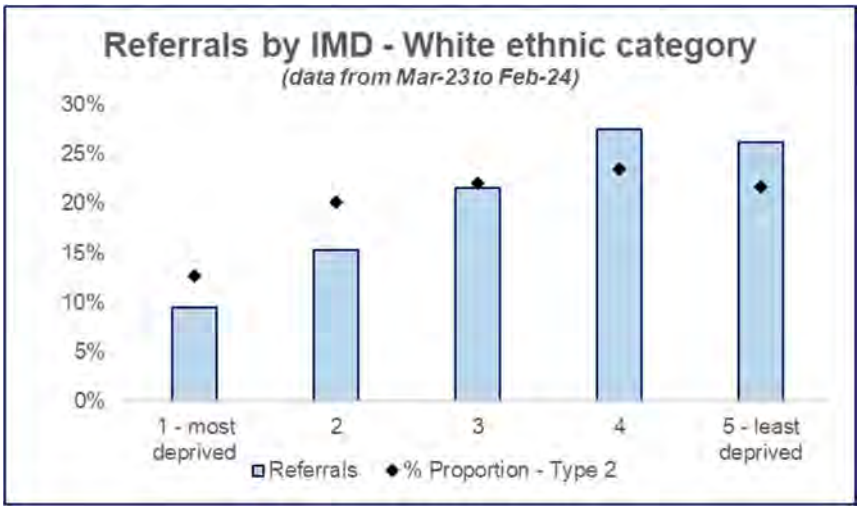
Local Data Observations

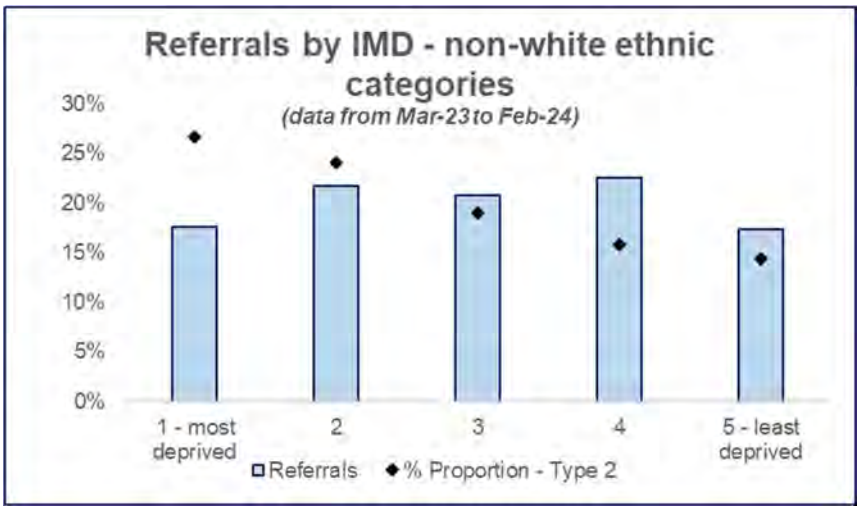
- *The percentage of patients having completed the 8 care processes for Diabetes is the highest for the least deprived patients, and lowest for the most deprived patients. This trend is consistent across both Type 1 and Type 2/Other diabetes.*
- *For Type 2 Diabetes, the White Ethnic Category is the most likely to have had 8 care processes completed. For Type 1, the highest completion percentage is for the Black ethnic category.*

Data presented at CWICB level
Data Source: NDA Core Quarterly Dashboard

- Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile







Local Data Observations

- *For the White ethnic category, the least deprived patients (IMD deciles 4-5) have the highest percentage of referrals for Type 2 diabetes. The least deprived patients also make up the highest proportions of overall referrals.*
- *The opposite trend can be observed for non-white ethnic categories. In these groups, the most deprived patients have the highest likelihood of their Diabetes referral being for Type 2 diabetes. However, amongst non-White ethnic categories, referrals are split relatively evenly across all deprivation quintiles.*

Data presented at CWICB level
Data Source: National Diabetes Prevention Programme dashboard

Smoking Cessation

Indicators:

- Proportion of adult acute inpatient settings offering smoking cessation services
- Proportion of maternity inpatient settings offering smoking cessation services

This data is required at a Trust level, rather than at ICB level, therefore, we will be providing a narrative only.

All tobacco dependency pathways (acute inpatient, maternity, and mental health) are live for all Coventry and Warwickshire Trusts, whereby patients identified as smokers are offered nicotine replacement therapy and behavioural support, alongside a transfer of care into a community service at point of discharge. Data collection on the national tobacco dependency dashboard does not reflect current position. For example, Coventry and Warwickshire Partnership Trust (CWPT) launched in January 2024, therefore a 28-day outcome would not materialise until February at the earliest, which would be submitted in April 2024. Similar situations arise with South Warwickshire Foundation Trust maternity delivery, due to the trigger activity being smoking status at time of delivery, therefore the patient data has not yet been included despite receiving support from their initial booking appointment. However, between April – February 2024, 1,802 patients across the system have been offered tobacco dependency treatment. Acute delivery accounts for 68% of the delivery, 30% maternity and 2% for mental health patients. Data quality workstreams are underway to ensure all Trusts achieve the highest quality of submissions. Furthermore, as part of future improvements a HEAT is scheduled to be completed as a system tobacco dependency pathway to assess potential healthcare inequalities.

Smoking prevalence among people with a mental health condition is substantially higher than in the general population, therefore CWPT continue to gradually rollout delivery of the tobacco dependency programme across the Trust to tackle tobacco addiction.

A system wide communication plan across all Trusts ensures staff workforce wellbeing is included as part of key national campaigns, and promote local community services and/or the national stop smoking app.

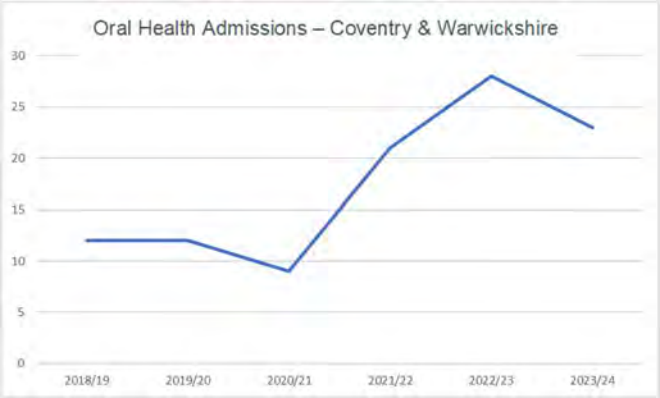
On going systematic development through specific LTP pathway workshops with a focus on reflecting on the last 12 months of delivery, deep dives into disengagement rates, and facilitation of partner wide discussions on next steps for service improvement.

Oral Health

Indicator:

- CYP Tooth extractions due to decay for children admitted as inpatients to hospital aged 10 and under

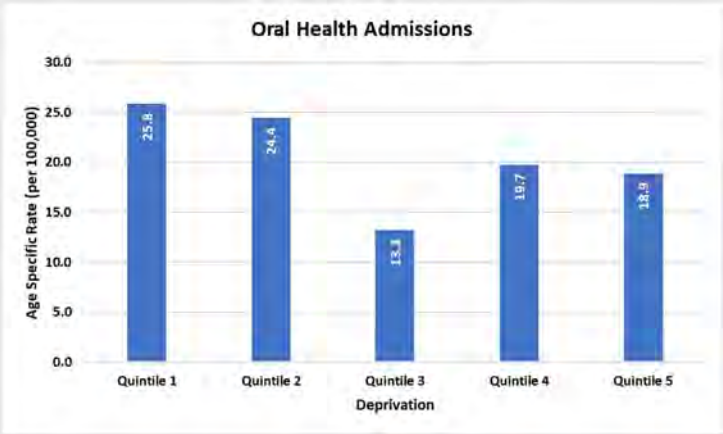
The number of tooth extractions for children aged 10 and under admitted as inpatients in Coventry & Warwickshire is very low, as show in the chart below. This means that it is challenging to break the data down further in a meaningful way, although the local data does indicate a higher prevalence in more deprived groups.

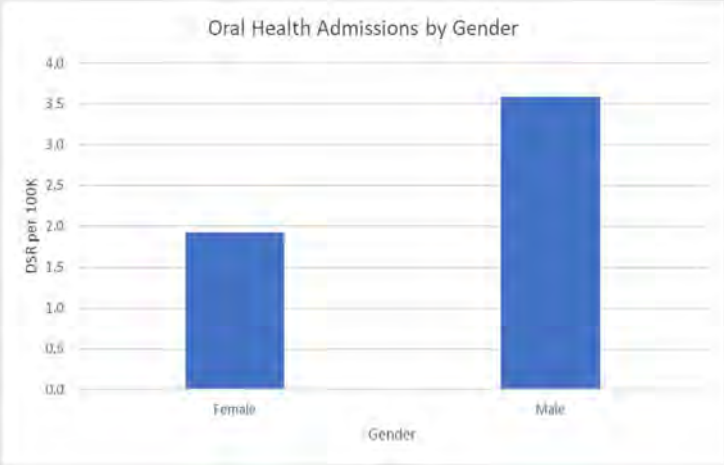


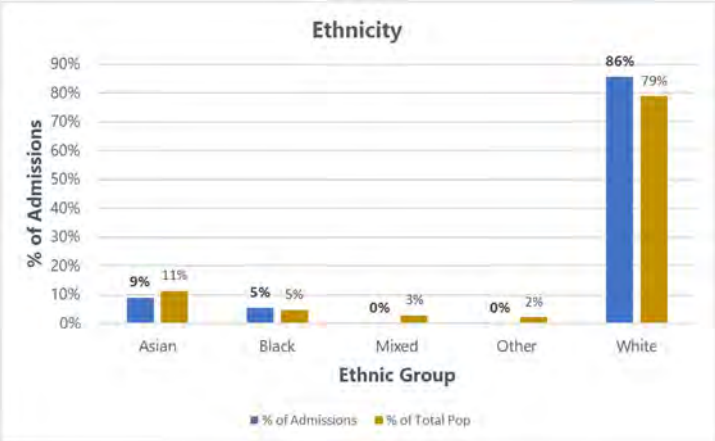
National data supports this trend, with children living in the most deprived communities 3.5 times more likely to have tooth extractions that those living in the most affluent. Research published in the British Dental Journal concluded that there were ethnic inequalities in child toothbrushing and dental visiting, with children of Asian ethnicity being most affected.

Further information on our approach to tackle inequalities in the area of oral health for children and young people will be added when available.

- CYP Tooth extractions due to decay for children admitted as inpatients to hospital aged 10 and under







Local Data Observations

- *The number of admissions for tooth extractions increased in 2021/22, and further increased the year after. Peaking at 28 admissions in 2022/23. This has reduced by 5 in 2023/24*
- *Of the 28 admissions in 2022/23, 64% of them were males and 36% females. Analysing activity over time shows that there are a higher proportion of males being admitted for tooth extractions than females. Supported by the DSR per 100,000 by gender chart.*
- *The % of admissions where the ethnicity is White is higher than the proportion of the ICBs White population. 6 of the 28 admissions did not have an ethnicity stated.*
- *DSR of admissions show that there is a higher rate of admissions in more deprived areas of C&W, but the number of admissions are relatively small, giving rise to greater uncertainty in the rates.*

Indicator Notes

Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years or under (number of admissions not number of teeth extracted).
Admission extracted from Admitted Patient Care CDS.
Admissions analysed by HI are for fiscal year 2022/23.
ICD10 diagnosis used: K021 (Caries of dentine), K025 (Caries with pulp exposure), K028 (Other dental caries), K029 (Dental caries, unspecified), K040 (Pulpitis), K045 (Chronic apical periodontitis), K046 (Periapical abscess with sinus) and K047 (Periapical abscess without sinus)

Learning disability and autism

Indicators:

- Learning Disability Annual Health Checks
- Adult mental health inpatient rates for people with a learning disability and autistic people

In the past year a project has been carried out that explored the quality of Learning Disability Annual Health Checks (AHCs) being delivered in Coventry and Warwickshire, as well as the barriers being faced in being able to access AHCs. The project has seen eight practices receive a service evaluation carried out by our commissioned LD Nurses, which in total looked at 32 AHCs carried out. We have also collated the feedback received from 20 people/their carers from the under-served population work we have done, and we are looking at any patterns and barriers mentioned in the feedback, that have prevented them from attending an AHC ever or in the last few years. We are in the process of writing a report to summarise the findings, which will be available for April 2024 and will inform service planning and delivery. The aim of this work is to improve uptake and quality of Annual Health Checks for people with a learning disability, and particularly for people who also have an intersectionality.

Currently we do not have the in-depth data available that would allow us to track and explore inequalities within Learning Disability AHCs. In the absence of this, we aim to utilise the HEAT tool against AHCs, to highlight the data gaps, and to explore inequalities relating to those who haven't attended their AHCs.

Our LDA Health Inequalities Steering Group has been looking at intersectionality relating to health and healthcare inequalities for autistic people and people who have a learning disability. One area of focus that has been agreed in the local system for 24/25 is 'Healthcare outcomes for people who are autistic or who have a learning disability, who have a mental health diagnosis, or who access mental health services.'
As part of this we are analysing Assuring Transformation data for Coventry and Warwickshire inpatients through the lens of IMD and ethnicity. We are developing a digital dynamic support register which will include information on ethnicity and place. The combination of these datasets will help us understand the different health and healthcare outcomes for autistic people and people with a learning disability who are at risk of admission to hospital, or who are admitted to an inpatient setting, through the lens of their ethnicity, age, deprivation, sex and other intersectionality, which will help us to inform service planning and delivery.

The ICB has recently launched a Learning Disabilities Friendly Badge for GP surgeries, to acknowledge good practice taking place in primary care to make practices a welcoming place for people with a learning disability and to those providing the best personalised care. As a system, we have also signed up to the Mencap 'Treat me Well' campaign to transform the way people with a learning disability are treated in hospital.

- Learning Disability Annual Health Checks

Learning Disability Annual Health Checks and Health Action Plans - November 2023

Source: Learning Disability Health Check Scheme (https://digital.nhs.uk/data-and-information/publications/statistical/learning-disabilities-health-check-scheme)

ICB Age 14+

			Latest Month November 2023							Previous Year Comparison November 2022			
ICB or TCP Code	ICB or TCP Name	Region	Total LD Register (age 14 to 17)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks	Completed Health Action Plans	% Completed Health Action Plans	Total LD Register (age 14 to 17)	Completed health checks (age 14 to 17)	Health Checks Declined	% Completed health checks
ENGLAND			347,263	137,149	3,202	206,912	39.5%	124,949	36.0%	310,199	131,301	3,178	42.3%
QWU	NHS COVENTRY AND WARWICKSHIRE ICB	MIDLANDS	5,037	1,753	50	3,234	34.8%	1,583	31.4%	4,428	1,869	54	42.2%
MIDLAND	MIDLANDS	MIDLANDS	67,837	26,829	560	40,448	39.5%	24,692	36.4%	60,851	25,645	543	42.1%

ICB Age 14-17

			Latest Month November 2023							Previous Year Comparison November 2022			
ICB or TCP Code	ICB or TCP Name	Region	Total LD Register (age 14 to 17)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks	Completed Health Action Plans	% Completed Health Action Plans	Total LD Register (age 14 to 17)	Completed health checks (age 14 to 17)	Health Checks Declined	% Completed health checks
ENGLAND			26,201	7,782	233	18,186	29.7%	7,059	26.9%	23,085	7,416	217	32.1%
QWU	NHS COVENTRY AND WARWICKSHIRE ICB	MIDLANDS	342	91	1	250	26.6%	86	25.1%	314	111	8	35.4%
MIDLAND	MIDLANDS	MIDLANDS	5,108	1,551	37	3,520	30.4%	1,417	27.7%	4,651	1,472	36	31.6%

ICB Age 18+

			Latest Month November 2023							Previous Year Comparison November 2022			
ICB or TCP Code	ICB or TCP Name	Region	Total LD Register (age 14 to 17)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks	Completed Health Action Plans	% Completed Health Action Plans	Total LD Register (age 14 to 17)	Completed health checks (age 14 to 17)	Health Checks Declined	% Completed health checks
ENGLAND			321,062	129,367	2,969	188,726	40.3%	117,890	36.7%	287,114	123,885	2,961	43.1%
QWU	NHS COVENTRY AND WARWICKSHIRE ICB	MIDLANDS	4,695	1,662	49	2,984	35.4%	1,497	31.9%	4,114	1,758	46	42.7%
MIDLAND	MIDLANDS	MIDLANDS	62,729	25,278	523	36,928	40.3%	23,275	37.1%	56,200	24,173	507	43.0%

Local Data Observations

- *Data is not available at gender, ethnicity or levels of deprivation to be able to undertake health inequalities analysis.*

Indicator Notes

Data is only available at an ICB level.

Latest reporting months performance compared to same time last year.

Compared to regional

- Adult mental health inpatient rates for people with a learning disability and autistic people

Local Data Observations

- *At December 2023 Coventry and Warwickshire ICB had 40 Adult Mental Health inpatients with Learning Disability and Autism. This represents 51 per million population, compared to a national average of 41 per million.*

Indicator Notes

The indicator reports on Adult mental health inpatient rates for people with a learning disability and autistic people per million as at Dec 2023 and compares Coventry and Warwickshire to England.

Maternity

Indicator:

- Preterm births under 37 weeks

In 2021 the LMNS developed their Equity and Equality Strategy which highlight higher rates of smoking in pregnancy particularly in North Warwickshire with 15% of women smoking at booking and 12% smoking at the time of delivery. The analysis also revealed that women of mixed race were particularly at risk of poorer outcomes in a number of areas. Within this group, women more likely to have a teenage pregnancy, deliver under 37wks, low birth weight of baby, induced, increased likelihood of caesarean section and an instrumental delivery. Women in the most deprived areas were less likely to access maternity services early. Preterm births under 32 weeks gestation accounted for 2% of all total births in 2021. However, data demonstrated that women from Black, Asian, and Mixed ethnic groups were disproportionately more likely to deliver prematurely. The increase in obesity, complexities of pregnancy such as gestational diabetes, and the impact of wider determinants of health were all evident within the strategy.

The Equity and Equality plan along with national reports and plans including Ockenden, East Kent, Saving Lives Care Bundle v 2 &3 and the Three-Year Maternity and Neonatal Delivery Plan are all drivers to support change and improve quality and safety of maternity care. In order to deliver on these, it was vital as a LMNS, that there was greater collaboration and involvement with the neonatal teams and who are now an integral part of the LMNS Board and workstreams. As a result, the LMNS has seen an increase in clinical and maternity engagement as well as engagement from voluntary sector and local authorities, developing bespoke pilots to support our communities.

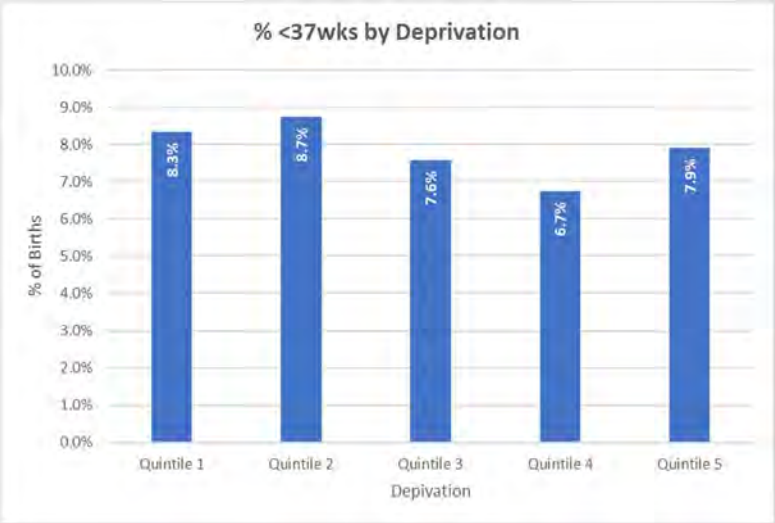
It has also enabled several pieces of work including the development of a system wide perinatal optimisation pathway has been developed and aims to improve preterm outcomes. This tool was adapted from the national British Association of Perinatal Medicine (BAPM) tool with the LMNS working collaboratively to collate data; the tool will provide essential information for parents and families around continuity of care especially when care is transferred across the different sites. All three units are now delivering evidence-based interventions in the antenatal, intrapartum, and neonatal period to improve preterm outcomes including the administration of magnesium sulphate, utilising optimal cord clamping and antenatal steroids. Data is now being collated on a monthly basis to form a new dashboard.

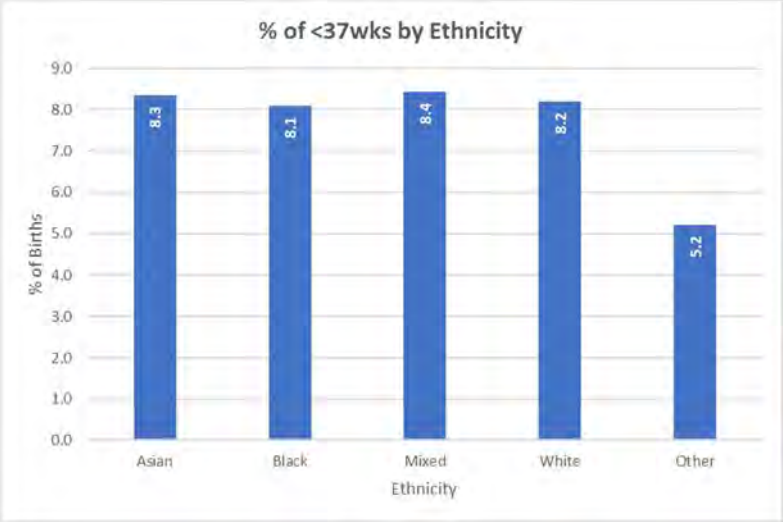
The providers have also implemented a ‘midday huddle’ which brings together the providers on a daily basis to discuss acuity, complexities, and escalations. It enables teams to support patient flow and support through patient transfers. The system has seen an increase in the number of babies under 32 weeks gestation being born in the right place with 79% of babies (2022) under 32 weeks being delivered in our Level 3 unit, UHCW. This is compared to 93% (2023) of babies in the last 12 months, which is a significant improvement to ensuring the right care is given at the right time.

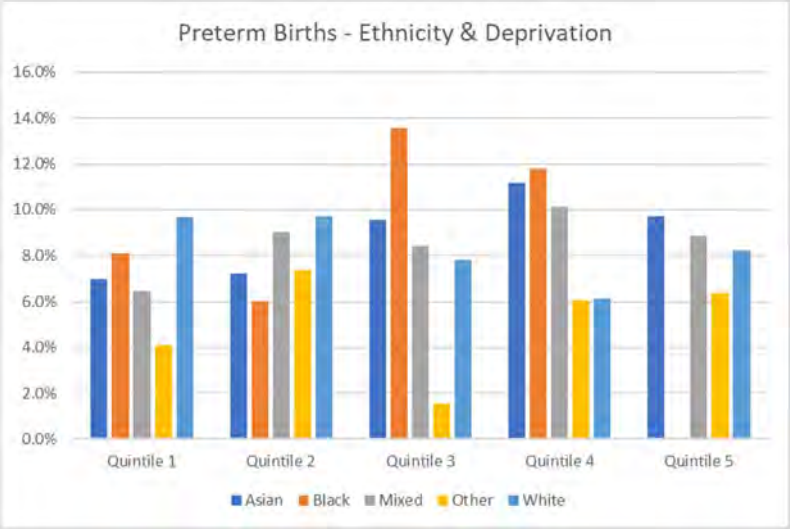
Another significant progress has been in the development system roles, these are roles hosted by one of the provider organisations but work across the other sites. As a LMNS there are currently four system roles/teams with one in development. The roles have focused primarily on neonates with a counsellor to support families and staff and a neonatal community outreach team which supports care in the community and enable earlier discharge. There is a neonatal allied health professional team, hosted by CWPT, with dietetic, occupational therapy, physiotherapy and speech and language professionals supporting families, neonates and staff on the neonatal units and there is also a pre-term birth team ensuring continuity of care, skills are developed within each of the providers and sustainability of a service.

Through the Health Inequalities Innovation Funding a pilot programme is underway for continuity of care and early access for women from Black, Asian and ethnic minority communities, transient communities and areas of deprivation, including a transport pilot to support with travel costs for women in areas of the greatest deprivation in Warwickshire North. This area has also received funding to develop an enhanced service model to increase vaccination rates for pregnant women.

- Preterm births under 37 weeks







Local Data Observations

- Analysis of preterm births by ethnicity, as a percentage of total births, shows very little difference between Asian, Black, Mixed and White populations. However there seems to be lower numbers of preterm births in the "Other" ethnic group.
- *Preterm births as a % of total births seem to decrease with lesser levels of deprivation.*
- *Combining deprivation and ethnicity shows that for the Asian group, women have a greater proportion of preterm babies as the level of derivation lessens.*

Indicator Notes

People from Black and Asian backgrounds and those living in the most deprived areas of the UK are more likely to experience premature birth than those from White backgrounds and those living in the least deprived areas.[1]
Data extracted from the MSDS for financial year 2022/23.
Unable to report by age as the dataset does not contain Mothers age due to it being PID.
1 - New research drive to tackle UK's premature birth rate | Imperial News | Imperial College London

Data Presented at CWICB
Data Source: NHS Digital - MSDS