North Central London
Integrated Care Board

NHS England Health Inequalities Information Duty

North Central London Health Inequalities Insights Report

2023/24

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What are health inequalities?

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people, for example differences in:

- health status, such as life expectancy
- access to care, such as availability of given services
- quality and experience of care, such as levels of patient satisfaction
- behavioural risks to health, such as smoking rates
- wider determinants of health, such as quality of housing.

People may experience different combinations of these factors.

Health inequalities are largely preventable. If we want to reduce unfair differences in health inequalities it is not enough simply to provide everyone with the same thing (equality) – we need to tailor our interventions and resources according to the needs of different population groups if we want to achieve equal outcomes (equity).

The role of North Central London Integrated Care Board (NCL ICB) in tackling health inequalities

- Integrated Care Systems (ICS) are partnerships between the organisations that meet health and care needs across an area and include NHS bodies such as Integrated Care Boards (ICBs). Driving improvements in population health and reducing health inequalities (including tackling inequalities in outcomes, experience and access to health services) is intrinsic to the purpose of an ICS.
- Tackling inequalities is at the core of NCL ICS's Population Health and Integrated Care Strategy. The Strategy sets out how our ICS will approach improving the physical and mental health of local people and reduce health inequalities. This includes a focus on our most deprived communities and a selection of other key child and adult communities who experience amongst the greatest health inequalities and poorest outcomes.
- The ICB has a legal duty to collect, analyse, publish and use information on health inequalities (Section 13SA National Health Services Act 2006).
- Good quality, robust data and analysis enables the NHS to understand more about the populations we serve. It enables NHS bodies to identify groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and deliver targeted action to reduce healthcare inequalities.

Sources: King's Fund: What are Health Inequalities? Update June 2022 https://www.kingsfund.org.uk/publications/what-are-health-inequalities

Context: Health and social inequalities in North Central London

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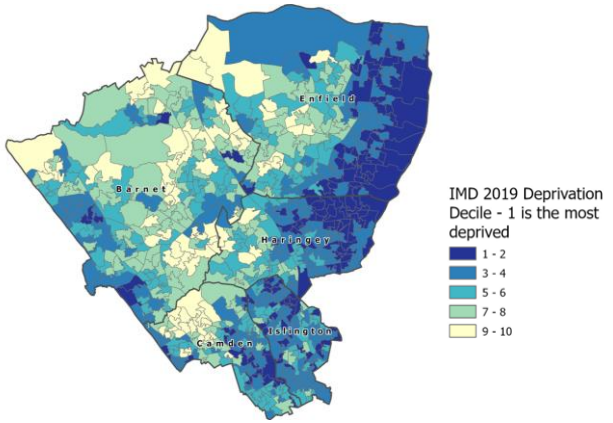
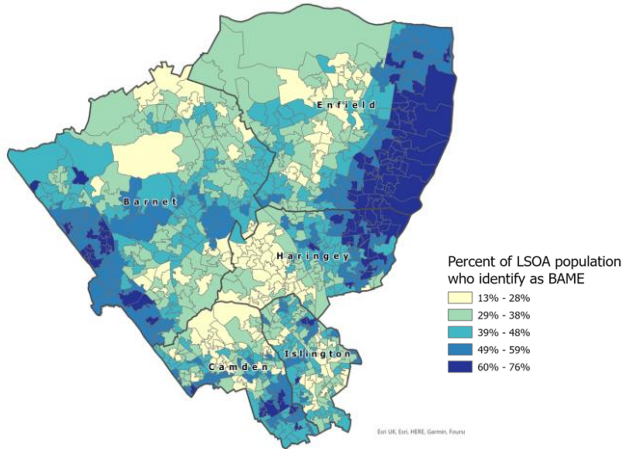
- **NCL is made up of five boroughs: Barnet, Camden, Enfield, Haringey and Islington. It is the second most deprived ICS in London and there are areas of deprivation across all five boroughs, often in close proximity to areas of affluence**. More than 1 in 5 people in NCL live in the 20% most deprived areas nationally (based on the Index of Multiple Deprivation 2019), while almost 1 in 3 live in the second most deprived 20% areas. There are distinct spatial patterns of deprivation, with particular concentrations of deprivation towards the east of NCL, with Enfield, Haringey and Islington having on average higher levels of deprivation.
- **Our population is ethnically diverse.** Although, more than half of NCL residents are White, around 20% are of an Asian and 20% of a Black ethnicity. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.
- **There is intersection between ethnicity and deprivation.** For instance, 80% of NCL's Black African, Black Caribbean, and Bangladeshi communities live in the 40% most deprived areas nationally, with 40% living in the 20% most deprived areas.
- **Across North Central London there is a high level of population health need and inequalities.** Improvements in life expectancy across NCL have stalled in recent years and life expectancy and healthy life expectancy have declined following the pandemic. **Residents in all our boroughs are living for 20 years on average in poor health.**
- **Life expectancy and healthy life expectancy varies within and across our boroughs.** Whilst residents in Barnet and Camden have higher life expectancy than the London average, Islington residents and men in Haringey have lower life expectancies. Life expectancy for men living in Upper Edmonton West in Enfield was around 15 years lower than for men and women living in Frognal and Hampstead Town (in Camden), across the five years before COVID-19. Similarly, there is nearly 20 years variation in healthy life expectancy between most and least affluent areas in NCL. For people experiencing homelessness average life expectancy is 30 years shorter than the general population, largely from preventable conditions.

Deprivation profile of NCL, by lower super output area (LSOA)



Source: Index of Multiple Deprivation (IMD 2019)

Ethnic profile of NCL, by LSOA



Source: Census 2021

Refer to Appendix for a glossary, explaining terminology around deprivation and lower super output areas, amongst other terms

Context: Overview of health inequalities data to be reported by ICBs

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- In November 2023 NHS England published their **Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)**, setting out the legal powers and responsibilities of relevant NHS bodies, including ICBs, and how they should exercise those powers for the period 2023-24 and 2024-25.
- Within the Statement, NHS England **outlined a minimum dataset** that ICBs are expected to collate, analyse and publish, within or alongside their annual reports (see below for the metrics contained within this dataset), largely based on the clinical areas within 'Core20PLUS5' (NHS England's health inequalities framework) and NHS England's 5 priority areas for addressing healthcare inequalities set out in the 2023/24 priorities and operational planning guidance, with data to be reported where possible by demographics – at a minimum deprivation and ethnicity, and where possible age and sex.

Elective recovery

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

Urgent and emergency care

- Emergency admissions for under 18s

Respiratory

- Uptake of COVID and flu vaccines by socio-demographic group

Mental health

- Overall number of severe mental illness (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

Cardiovascular disease

- Stroke rate of non-elective 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 whom the last blood pressure reading (measured in the preceding 12 months) 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 record of CHA2DS2-VASc score of 2 or more who are currently treated with anti-coagulation drug therapy

Cancer

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

Maternity and neonatal

- Preterm births under 37 weeks

Diabetes

- Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes
- Variation of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile (National Diabetes Prevention Programme)

Smoking cessation

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

Oral health

- Tooth extractions due to decay for children admitted as inpatients to hospital (aged 10 years and under) (number of admissions not number of teeth extracted)

Learning disability and autistic people

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

Context: The new Duty in the context of NCL's work around health inequalities

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- Whilst this is an NHS England reporting requirement, we are keen to use this framework to help deliver our ambitions within our Population Health and Integrated Care Strategy to make 'population health everyone's business' and 'align resources to need'.
- As the table below demonstrates, there are strong overlaps between the clinical areas and metrics covered in NHS England's framework and:
  - Our 'Key population health risks' and 'common risk factors'
  - Our 'Key communities', which overlap with NCL's locally-defined 'PLUS' populations within 'Core20PLUS5'
  - Metrics in our NCL Outcomes Framework.
- There is also alignment with our ambitions in the strategy to embed demographics and health inequalities indicators across performance metrics and baseline our current outcomes and spend by geography and demography; as well as monitor where we are making a difference in reducing gaps in health inequalities as part of outcome monitoring.

Clinical area/ population group within the framework	NCL Population Health and Integrated Care Strategy				Core20PLUS5		NHSE's 5 priority areas for addressing healthcare inequalities (2023/24 priorities and operational planning guidance)
	(Five) Key population health risks	Common risk factors	Key communities	NCL Outcomes Framework	Adults	Children and young people	
Elective recovery							■
Urgent and emergency care							■
Respiratory	■			■	■		
Mental health	■		■	■	■	■	
Cancer	■			■	■		
Cardiovascular disease	■			■	■		
Diabetes				■			
Smoking cessation		■		■	■		■
Oral health				■		■	
Learning disability and autistic people			■		■		
Maternity and neonatal				■	■		

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Summary – Key findings from the data and next steps

Summary: Overview of approach to collating, analysing and publishing health inequalities metrics in NCL

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Overview

- Reducing health inequalities is at the core of our purpose as an ICB. Intrinsic to this is having good quality data available by demographics to be able to assess, act on and monitor how inequalities are being reduced over time, and this duty provides a helpful framework to guide us in this.
- We recognise, however, that this is the first year of this new duty and, as such, see this as the beginning of an approach that we would like to refine and build on in terms of how we detect and monitor health inequalities in NCL, and how we might report on these in future annual reports - through the exercise of reporting this data in 2023/24 there has been learning about how we might analyse and present the data in future, in addition to learning from the insights shown.
- We are publishing here a summary report, highlighting key findings from the analysis we have undertaken of each metric. Behind the summary report sits a longer, more detailed data analysis which will used internally to inform how we use this data to drive action within NCL.
- In addition to the data requested by NHSE, the ICB collect, analyse and use a range of other data to address health inequalities. This includes qualitative data from local communities, which is a vital part of understanding and addressing the needs of under-served populations. The data reported in this summary is one part of our health inequalities analysis.

Scope and data sources for this report

- In fulfilment of this duty for 2023/24 we have restricted our analysis in this report to the minimum data set suggested by NHS England (outlined on slide 6) with a small number of additions: emergency admissions for asthma for children and young people; and within the National Diabetes Prevention Programme looking at referrals by age and patients achieving first programme milestones by ethnicity.
- Where possible, we have used the nationally-available data sets and dashboards directed to us by NHS England. Where the recommended data sources were incomplete or of limited scope we have used alternative local data sources (where available).

Data quality

- We have tried to draw out in the key findings where we are aware of specific data quality issues impacting the data (such as cancer staging data), but across the board it is important to note that ethnicity recording is incomplete, which affects the certainty of conclusions that can be drawn around inequalities in ethnicity. As outlined on slide 25 this is something we are working to improve across datasets in NCL.

Informing action

- An important part of the duty on ICB's is to use the insights from the data to inform action. For some indicators this insight report represents the first time the data has been collated and analysed in this way locally and the timing of the 2023/24 report is such that it is too soon for the findings to have been used to inform action in-year, although there is a broad read across to our locally-identified population health priorities. As such, in our reporting for 2023/24, we have instead focused on broader work taken to tackle health inequalities in each clinical area/ for each population group but hope to be able to align insights more closely to specific actions in reports in future.

Key findings: Elective recovery

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Metrics examined:

- Size and shape of the waiting list – proportion of patients on referral-to-treatment (RTT) pathways waiting longer than 18 weeks; longer than 52 weeks; and longer than 65 weeks (February 2024 compared to February 2023)
- Age-standardised activity rates (with 95% confidence intervals) for elective admissions; emergency admissions; outpatient attendances (GP-referred; and non-GP referred); and emergency attendances (2022/23)
- Elective activity vs pre-pandemic levels for under 18s (2019 compared to 2023)

Key insights from data analysis:

- **Waiting lists** (unfinished inpatient and outpatient referral to treatment pathways) are growing overall at about 10% per year. However, there is little evidence that this is impacting different ethnicities and deprived communities disproportionately. Interestingly the more deprived communities have the shortest waiting time. This needs further investigation but may be due to the higher acuity of this group.
- Black and more deprived groups have significantly higher **elective and non-elective inpatient activity rates (attendances and admissions)** per head of population and the deprivation gradient is most severe for activity most closely linked to urgent care.[1]
- There is no clear pattern or differences in the **recovery of activity** discernible from the data.

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- National evidence shows that surgical hubs can increase elective capacity and efficiency whilst improving clinical outcomes. Following the development of Elective Orthopaedic Centres in NCL, NCL has developed a proposal to consolidate simple cataract surgery into a specialist surgical hub at the Edgware Community Hospital. The findings from the associated health and equality impact assessment have been used to shape the proposed implementation plans, to ensure clear mitigations are in place to support groups most impacted by the changes and reduce inequalities.
- Emerging plans for elective work during 2024/25 focus on three areas: improvements in the pre-referral processes; improvements in peri-operative care to ensure patients are in the best possible state for surgery; and exploring other surgical transformation areas, including the expansion of surgical hubs to additional specialities.
- Innovation in inequality assessments, insight provision and performance improvement is a core objective of the Performance & Planning Directorate for 2024/25 and plans are in development to routinise performance reporting of inequalities to identify and reduce health disparities among different demographics, including elective recovery data sets as well as other areas of performance reporting.

[1] The ratio of values from most to least deprived for elective, non-elective and A&E are 1.7, 1.8 and 1.8 respectively i.e. even after adjusting for age and sex there is almost twice as much activity per head of population for those in the most deprived decile to the least deprived decile. The pattern with patients of a Black ethnicity is more mixed ranging from 1.6 times the average across all ethnicities (elective admissions) to 1.2 (A&E attendances and emergency admissions) and outpatients is no different to the average.

Key findings: Urgent and emergency care (children & young people)

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Metrics examined:

- Emergency admissions for under 18 year olds - overall (2022/23)
- Emergency admissions for asthma for under 18 year olds (2022/23)

Key insights from data analysis:

- This indicator focuses solely on young people. The deprivation pattern for **all emergency admissions** is a strong one but similar to the all-age admissions measure examined under elective recovery. The variations in ethnicity (demonstrating higher rates in Black, Mixed and Asian groups), although similar to adults, appear to demonstrate greater variation. [2]
- The subset of data examined for **asthma emergency admissions** must be treated with some caution due to the smaller numbers involved. However, it does show a strong ethnicity pattern with the White group 32% below the average and all non-White groups showing rates above the average, ranging from +18% (Asian), +59% (Black) and +74% (Other). The deprivation pattern is stronger overall with the most deprived group especially being an outlier – some 12 times the value for the least deprived. However, it is important to note the wide confidence intervals which mean the most deprived group is statistically significantly only slightly higher and least deprived slightly lower than the group average.

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- Implemented a paediatric hospital-at-home service at North Middlesex University Hospital NHS Trust, building on the service model at Whittington Health NHS Trust, to support patients to have a faster recovery while freeing up hospital beds for patients that need them most. Now looking to roll out these services across NCL.
- Review of the mental health crisis pathway for children and young people is expected to deliver improvements to ensure children and young people that do not require acute paediatric input are assessed and supported in a community setting or community crisis hub.
- Delivering the national bundle of care for children and young people with asthma to help improve management of childhood asthma and reduce associated admissions and developing Integrated Paediatric Services, which will draw together expertise from across the NCL system including paediatricians, specialist nurses and Local Authority services to improve care and reduce emergency presentations and admissions for children with a range of complex needs, including asthma.
- Flu vaccinations contribute to admission avoidance and we have worked to increase uptake in flu vaccinations for children and young people, including launching a GP call/re-call campaign and through engagement work with under-served communities.

[2] For children and young people's admissions overall, the mixed ethnic groups all have high rates against the average ranging from 1.4x (White and Black African) to 2x (other mixed). The "other Black" group is high (1.7) as is Black African (1.3) but the Black Caribbean group is no different to the average.

Key findings: Respiratory

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Metrics examined:

- Uptake of 1st dose and 2nd doses of COVID vaccine by socio-demographic group – from first roll out (December 2020) to February 2024
- Uptake of COVID vaccine Autumn 2023 booster by socio-demographic group (as at February 2024)
- Uptake of flu vaccine by socio-demographic group 2023/24 (as at February 2024)

Key insights from data analysis:

- **Covid and Flu vaccine uptake** shows similar patterns in terms of ethnicity and deprivation - high uptake in White and Asian ethnic groups and low update in patients of a Black ethnicity. The deprivation pattern is a pronounced one and appears even greater with the latest Covid booster which has lower uptake overall.[3]
- There are some concerns over **Flu vaccine uptake in specific cohorts** – notably those with **learning disabilities** (44%) and the **clinically at risk under 65s** (37%).

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- Conducted targeted communications work to encourage uptake of COVID and Flu vaccination (delivered in partnership with Local Authorities and Public Health teams) and improved engagement with communities through faith health partnerships across NCL, which we plan to expand next year through further engagement with voluntary sector organisations
- Provided outreach vaccination clinics in areas with low uptake and a greater concentration of fixed COVID/ Flu vaccination sites in areas of NCL with greatest need
- Worked with secondary care consultants to strengthen messages regarding the importance of seasonal vaccinations and piloted inpatient vaccination opportunities within University College London Hospitals NHS Foundation Trust and Whittington Health NHS Trust, which we are looking to expand more widely within NCL, targeting those most clinically vulnerable and likely to require secondary care intervention in the event of contracting COVID and/or Flu.

[3] All Ethnicities display decreasing levels of uptake from the first covid vaccination through to the 2023 booster but uptake in the black community fell most dramatically from 53.6% to 31.6%. The 2023/24 flu vaccine uptake in patients of a Black ethnicity was 23% lower than in patients of a White or Asian ethnicity; and there was an 23% difference in uptake between the most and least deprived quintiles.

Key findings: Mental health (1)

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Metrics examined:

- Coverage of annual physical health checks for people with Severe Mental Illness (SMI) (Quarter 4 2020/21 – Quarter 3 2023/24)
- Rates of total Mental Health Act detentions (2022/23)
- Rates of restrictive interventions – comparison of proportion of restrictive interventions and proportion of mental health inpatient bed days (April 2021 – January 2024)
- NHS Talking Therapies (formerly Improving Access to Psychological Therapies, IAPT) recovery (2021/22)
- Mental health access for children and young people – percentage of children and young people having two or more mental health contacts in the last year (2022/23)

Key insights from data analysis:

- The number of **SMI physical health checks** in NCL has tripled since January-March 2021 (3,800 to 12,200) and is now close to the 14,200 target for 2023/24. This data is currently not available by demographics but we are looking to build this into future reports.
- The crude rate of **Mental Health Act detentions** for those of Black ethnicity is over twice the NCL average. The deprivation gradient is also a steep one, with over three times the rate of detentions in the most deprived deciles compared to the two least deprived and notably low numbers in the least deprived deciles.[4]
- The use of **restrictive interventions** measure is compared against the mental health inpatient population which in itself highly skewed towards ethnic minority (especially Black) and deprived groups. There is no clear indication from the data that, once in the system, there is any higher likelihood of intervention based on your ethnicity, or deprivation status.
- There is very little variation in **talking therapy** recovery rates by ethnicity. There is, however, a deprivation slope (46% deprived v 56% least deprived) and this is pretty consistent across the deprivation deciles.
- The Black population is also over-represented in the **percentage of young people who use mental health services** (twice or more in a year), with the Asian population particularly low in comparison. Detailed ethnicity data points to high rates in those with Mixed ethnicities.[5] It is likely that as well as an indicator of greater need in some of the groups with greater access, this data potentially indicates that those with lower rates of contacts have poorer access but it not currently possible to disentangle these potential inequalities without doing more of a deep dive to understand the findings at borough and pathway level. By contrast there is no discernible deprivation gradient in this measure.

[4] The rates of Mental Health Act detentions in patients of a Black ethnicity was 273 per 100,000 compared to the NCL total of 115 per 100,000.
[5] Access rates were 33% above the average for all ethnicities in people of a Black ethnicity and 30% below for people of an Asian ethnicity.

Key findings: Mental health (2)

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Highlights from quality improvement work undertaken/planned to reduce health inequalities:

- Considerable investment in line with the NHS Long Term Plan and via the NCL ICB Mental Health Review/Core Offer since 2020/21 to transform community and crisis mental health services, tackle gaps in mental health care provision and improve outcomes, including investment in children and young people's mental health schemes.
- Continuing work to shape and develop our response in local trusts to the Patient and Carer Race Equality Framework (PCREF)
- UCL Partners were commissioned to develop an NCL *Longer Lives* delivery plan to identify ambitious but practical delivery across key clinical pathways to start shifting outcomes and reduce premature mortality for people with SMI, which we are in the process of implementing across health and care partners across NCL. To improve uptake of physical health checks for people with SMI we have shared best practice in approaches across NCL and implemented a range of approaches to community outreach and engagement
- Delivered a number of NCL Inequalities Fund programmes to support people with mental health problems, for example Tottenham Talking, a mental health Trust/VCSE initiative to increase the number of (particularly Black) patients with history of SMI and hospitalisation in more deprived neighbourhoods accessing non-statutory activities and support to help tackle their mental health issues, and we are looking at how we can sustain the schemes which have demonstrated effectiveness into the future.
- In 23/24 there has been a regional focus to address inequality of access, outcomes and experience, for children and young people including in respect to waiting times and in NCL we have planned investment into Patient Tracking Lists and analytics work to support children and young people's mental health performance.
- Planning a review of our early intervention and prevention services for adults and children to ensure consistency and a purposeful approach to tackling health inequalities in access, outcomes and model design tailored to our local populations in each borough.

Key findings: Cancer

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Metric examined:

- Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis and sex (Jan 2018 to October 2023)

Key insights from data analysis:

- **Cancer diagnosis at an early stage** (stages 1-2) has a significant deprivation gradient with a difference of 11 percentage points between the most and least deprived populations. There is little difference between ethnic categories. There is also a slight drop-off in early diagnosis with increasing age (64% for the 0-49 group compared to 51% for the 80+) and a small difference between the sexes (females 4% points higher).
- NCL has the lowest proportion of cancers which are staged (58%, against the best performer, Wessex, at 86% - based on 12 months submissions up to November 2023) and this data quality issue may be impacting on the inequalities findings.

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- Launched our NCL Cancer Prevention, Awareness and Screening Strategy (2023-28), which details priorities to improve timely presentation and participation in breast, bowel, cervical and lung screening, to enable earlier diagnosis, with a key focus on particular communities, including those from deprived areas and health inclusion groups and projects are underway to deliver the strategy's objectives.
- Developed the delivery plan for the NCL Primary Care Cancer Strategy and work will be progressed on six key areas including supporting Primary Care Networks (PCNs) to reduce variation and health inequalities.
- During 2024/25, as part of the last phase of the bowel screening age extension programme (aged 50 – 74 years) we will be working with practices in the most deprived areas that have low uptake rates, to support patients to participate. The recommendations in the *NCL Longer Lives Strategy* will also be taken forward, to identify and implement reasonable adjustments to support people with a severe mental illness to attend screening.
- Commenced work to draft a strategy that will provide a steer for the NCL cancer system on joint action that could be taken to address health inequalities. The strategy will highlight some of the known inequalities across the full cancer pathway and agree objectives on how these inequalities will be addressed.

Key findings: Cardiovascular disease (CVD) (1)

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Metrics examined:

- Stroke - rate of non-elective admissions per 100,000 population, age-sex standardised (2022/23)
- Myocardial infarction (heart attacks) - rate of non-elective admissions per 100,000 population, age-sex standardised (2022/23)
- Percentage of patients aged 18 and over, with GP recorded hypertension (high blood pressure), in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold – to September 2023
- Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more (high CVD risk) on lipid lowering therapy (referred to as cholesterol control measure below) in the last year – to September 2023
- Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more (high stroke risk) who are currently treated with anti-coagulation drug therapy last 6 months - to June 2023

Key insights from data analysis:

- The **non-elective stroke admission rate** (age-sex standardised) is significantly elevated for all Black and the Mixed White and Black Caribbean ethnic groups. The rate is also significantly above average for the two most deprived deciles with notably high rates in the most deprived decile.[6]
- The **non-elective myocardial infarction (heart attack) admission rate** (age-sex standardised) also demonstrates higher rates in the two most deprived deciles albeit to a slightly lesser extent. The ethnicity pattern shows high rates for all Asian communities (and especially Pakistani).[7]
- Control of **hypertension** and **cholesterol** have different social gradient profiles. There is little variation for hypertension but for cholesterol the more deprived communities have a higher percentage of patients on lipid control therapy. There is a steady gradient of 10% from the least to most deprived quintiles. This warrants further investigation to unpick the possible reasons and explore whether this is masking other inequalities. There is not a great difference between ethnicities in general across the two measures but there is slight concern over poor blood pressure control in those of a Black and Mixed ethnicity (62% and 63% respectively vs 67% for White). The main variations come with age - with younger age groups having lower percentages across these measures.
- For the Atrial Fibrillation metric, the data shows no outliers against the NCL mean average for both ethnicity and deprivation quintiles.

[6] Age-sex standardised non-elective stroke admission rates for the Black population are 34% above the average across all groups. The same figure for White groups is 14.8% below average . The approximated deprivation slope of age standardised admissions is higher for stroke (2.4x) than myocardial infarction (1.5x).
[7] The top five ethnic subgroups for non-elective myocardial infarction admissions are all Asian with the rate in patients of a Pakistani ethnicity 56.6% above the average of all ethnic groups.

Key findings: Cardiovascular disease (2)

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Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- Launched an NCL-wide Long Term Conditions Locally Commissioned Service (LTC LCS) - a single framework for all GP practices in NCL. Initial conditions in scope include metabolic (including cardiovascular disease) and respiratory conditions. The LTC LCS is supported by an outcomes framework, which will monitor overall population performance and inequalities to help drive improvements. It also includes a weighted payment to Primary Care Networks (PCNs) based on levels of deprivation and proportion of the population from minority ethnic groups. For 2024/25, reducing the proportion of patients with poorly controlled blood pressure is one of the NCL priority areas, whereby practices will be financially incentivised for their performance against agreed improvement goals.
- Supported delivery of a number of targeted, community-based programmes such as Barnet's Healthy Heart Peer Support Project – which aims to empower residents from South Asian, African, or Caribbean heritage to better manage their cardiovascular health, through community outreach, peer support and culturally competent resources
- Heart Health is one of our five 'Key Population Health Risks' within our NCL Population Health and Integrated Care Strategy, with the focus for this being high blood pressure – improved detection of people with undiagnosed high blood pressure and improved management; and reducing inequalities between groups. As part of this, we are planning a communications campaign and to build on existing work with our communities and underserved groups to raise awareness of importance of maintaining good blood pressure through healthy behaviours, regular blood pressure checks to know your risk, and treatment to manage diagnosed high blood pressure.
- The forthcoming launch of Hypertension and Atrial Fibrillation 'registries' in our Population Health Management system, HealtheIntent, will support clinical teams to reduce care gaps in management of these conditions/risk factors and allow targeted actions to reduce inequalities in particular groups.

Key findings: Diabetes

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Metrics examined:

- Variation between people with Type 1 Diabetes (T1D) and Type 2 Diabetes (T2D) receiving all 8 care processes (2021/22)
- National Diabetes Prevention Programme (NDPP):
  - Variation of referrals from the most deprived quintile and % of Type 2 Diabetes population from the most deprived quintile (2021/22 – Quarter 3, 2023/24)
  - Variation of referrals by sex and % of Type 2 Diabetes population for each sex (2022/23)
  - Variation of proportion of participants achieving Milestone 1 by ethnicity and % of Type 2 Diabetes population by ethnicity (2022/23)

Key insights from data analysis:

- The percentages of those with **Type 1 or Type 2 Diabetes receiving all 8 care processes** is only 32% and 44% respectively, and those with T2 diabetes have a greater coverage (by 7-20 percentage points) compared with T1 across all ethnic groups. This gap is lowest for White patients (7%) and highest for Black, Mixed and Other ethnicities (18-10%).
- The gap also varies by deprivation, peaking at 17% for the most deprived quintile against 6% in the least - accounted for by variations in T1 compliance rather than T2.
- The over-representation of **diabetes referrals from deprived communities as part of the national diabetes prevention programme (NDPP)** (against the T2 diabetes population size) is a positive sign that this resource is being targeted towards these high need groups. There are also more referrals from female patients and there is an under-representation of male patients when compared to the prevalence of T2 diabetes.
- The milestone 1 figures by ethnicity (examined here as a proxy for referrals by ethnicity) show that White and Asian groups might be under-represented compared to the size of their T2 diabetes populations.[8]

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- Diabetes is one of the conditions included within the new NCL-wide LTC LCS. For 2024/25, four NCL boroughs have chosen diabetes as one of their local focus areas to incentivise improved performance. This will improve NCL-wide performance and reduce variation across PCNs and practices, as well as help close inequalities gaps.
- Between September and November 2023 carried out an NDPP health inequalities project, the 'Centralised Referrals Project', targeting patients in the most deprived areas of NCL. Another health inequalities project is underway for 2024/25: delivery of pre-diabetes community testing events targeting communities experiencing health inequalities. Events are being planned with community partners serving Black and minority ethnic residents and in areas of high deprivation. A diabetes prevention officer will be recruited to target practices with high eligible populations and low uptake of the NDPP to increase referrals from areas experiencing inequality in access.

[8] Referrals data is not available by ethnic group. As a proxy for this and to understand any inequalities by ethnicity we have used milestone 1 (MS1 achievement). MS1 is the first milestone of the programme, representing completion of both the initial assessment and attendance at the first session. The ICB is responsible for referrals into the NDPP but providers are responsible for conversions from referral to MS1 (the first programme milestone). Although the ICB does not have control over this metric, high quality and diversity of referrals to the programme will impact on MS1 achievement.

Key findings: Smoking cessation

North Central London
Integrated Care Board

Metric examined:

- Proportion of adult acute inpatient settings and proportion of maternity inpatient settings offering smoking cessation services (as at 31 March 2024)

Key insights from data analysis:

- We have smoking cessation services in place in all of our acute inpatient and mental health settings.
- We have services in half (2/4) of our maternity services, and we anticipate that the remaining two trusts (Whittington Health NHS Trust and The Royal Free London NHS Foundation Trust) will be offering services by early May and 31 July 2024 respectively (both trusts have smoking cessation advisors appointed.)

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- Established smoke free action groups in all acute trusts and trusts are delivering the NHS Long Term Plan Ottawa model to tackle smoking as an addiction and support people to quit. We are also working to ensure all trusts have smoke free policies in place
- Developing trust electronic patient record (EPR) systems to capture data and report on activity, linked to patient demographics, to be able to understand reach, outcomes and inequalities within smoking cessation programmes
- Planning to review the equity of the smoking cessation offer across NCL by monitoring and addressing disparities in access and use of local services by different population groups and working with public health teams to explore and establish an enhanced smoking cessation pathway for people with Severe Mental Illness (SMI) and different models of care, including peer support programmes
- Ensuring tobacco dependence teams are adequately staffed to fully implement the Long Term Plan ambitions and in-house pathways are established in all maternity services in our remaining acute trusts to deliver an in-house service by March 2025. Incentive schemes to support women in pregnancy are also being explored as part of an NHS England offer.

Key findings: Oral health

North Central London
Integrated Care Board

Metric examined:

- Tooth extractions due to decay for children admitted as inpatients to hospital (aged 10 years and under) (admissions not number of teeth extracted) (2022/23)

Key insights from data analysis:

- Due to the relatively low numbers of **tooth extractions for children under 10** it is difficult to form firm conclusions from the data. However, there are clearly high rates for the most deprived communities and some evidence of high rates for some ethnicities (including Bangladeshi and some Mixed ethnic groups) and low rates for Chinese, Black Caribbean and Indian Asian groups.[9]

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- Identified funding to invest in oral health improvement activities in NCL and boost capacity within the Community Dental Service (CDS) on a recurrent basis.
- Current initiatives taking place for children and young people as part of this work include:
  - targeted work to reduce waiting times for children and young people;
  - initiatives to supplement oral health promotion work commissioned by local authorities, delivered as part of a co-designed programme of work, with the aim improving the consistency of oral health promotion support, focussed on our highest need areas, sharing best practice and working on a shared prevention agenda; and
  - a pilot programme in primary schools in two of our most deprived boroughs which combines oral health with messages around healthy diets and exercise.

[9] The 2nd and 3rd most deprived deciles (which are those with the highest variance) have rates 29.7% and 28.1% higher than the overall average.

Key findings: Learning disability and autistic people

North Central London
Integrated Care Board

Metrics examined:

- Learning Disability Annual Health Checks coverage (2022/23)
- Adult mental health inpatient rates for people with a learning disability and autistic people (August 2023 – January 2024)

Key insights from data analysis:

- The **percentage of those with a learning disability and/or autism (LDA) who have an annual health check** has improved year on year to 85% (2022/23) and is similar to other London ICBs. There is little variation between the sexes and only a slight increase with age. This data is not currently available by ethnicity and deprivation
- The number of **LDA patients admitted as an inpatient** is very low at only about 35 patients per month across the ICB (or 31 per million population). The number has come down slightly across the six months data reviewed.

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- The high proportion of respiratory-related deaths in people with learning disabilities and/or autism identified in NCL has led to the development of a respiratory pathway project to improve outcomes for these groups, through a pathway review which identifies gaps in provision; improved early intervention; training; evidence-based practice and recruitment of specialist staff.
- Strengthening our work in listening to people with learning disabilities and/or autism and their family and friends through encouraging more experts by experience attending service co-production events and sitting on learning disability and autism programme meetings
- Undertaking work to ensure all mental health inpatient facilities and provider collaboratives are fit for purpose for patients learning disabilities and/or autism, with planned developments around adjusted environmental factors e.g. quieter rooms, longer appointments, adjustable lighting, considered decor and signs.
- Set up an informal network across hospital trusts to share learning and collaborate on recommendations and quality improvements for people with learning disabilities and/or autism
- Planning to utilise electronic databases to support improvements in learning disability registers - shared records will allow all trusts to view GP records listing patients with learning disabilities/autism and ensure diagnosis coding is correct, flagging requirements for annual health checks and facilitating the monitoring of uptake.

Key findings: Maternity and neonatal

North Central London Integrated Care Board

Metric examined:

- Preterm births under 37 weeks (2022/23)

Key insights from data analysis:

- All Black ethnicities have **high percentages of babies born pre-term (<37 weeks)**, being significantly above the NCL average. By contrast, White ethnicities have a lower percentage than the NCL average. There is a slight deprivation gradient but it is not as striking as other metrics, with perhaps only the most deprived decile of particular concern.[10]

Highlights from quality improvement work undertaken/ planned to reduce health inequalities:

- A regional pre-term optimisation working group has been established across the sector to focus on reduce health inequalities and implementing focused interventions
- Worked collaboratively with UCLPartners and pan-London Local Maternity and Neonatal System (LMNS) colleagues to support the adoption and implementation of a preterm parent passport, which can support quality of care for the preterm and their parent/carers, and planning work to harmonise the preterm pathway across NCL
- An NCL LMNS In Utero Transfer (IUT) working group is in place focusing on challenges experience by trusts in achieving the right place of birth requirement; lessons learnt and shared across maternity services; supporting implementation and embedding the new national guidance
- Focus within NCL LMNS Perinatal Quality Surveillance Group meetings on neonatal agendas to share learning of local quality improvement successes, challenges faced and mutual support and quarterly Saving Babies Lives Care Bundle assurance meetings in place with NCL maternity trusts. We have embedded monthly audits on babies born below the 10th centile, with a focus on ethnicity and future aspiration to map to deciles of deprivation
- Won a successful bid for the Race Health Observatory Learning Action Network, focused on perinatal mental health, leading to shared learning and cascading of service developments
- Working to fully establish a smoking cessation wrap-around service across the maternity service in NCL.

[10] The percentage of babies born pre-term is 1.5 times higher for Black ethnic groups. The deprivation gradient from most to least deprived is 1.4 and the figures are especially high in the most deprived decile. However, note the small numbers in this group and hence wider potential variability (confidence intervals).

Reflections and next steps - how planning to use this report in NCL (1)

North Central London
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Reflections on the data analysis and insights

- This report has highlighted that across the majority of the metrics, performance/ outcomes are worse for more deprived communities and there is variation by ethnicity. Within this, the proportion of metrics for which patients of a Black ethnicity have poorer outcomes is striking. This reinforces the importance of looking at outcome and performance data by demographics to be able to understand and act on inequalities.
- The report also demonstrates the importance of examining inequalities through multiple outcomes/metrics related to a broad clinical area as inequalities may not be consistent at all stages of a pathway/for all risk factors. For instance, within Cardiovascular Disease, patients of a Black ethnicity had the highest rates of stroke emergency admissions but the lowest rates of admissions for heart attacks, which was highest in Asian patients.
- Although ethnicity and deprivation have been looked as separately here it is important to note that there is intersectionality between ethnicity and deprivation, and some of the patterns seen in outcomes for particular ethnic groups may be related to deprivation more than ethnicity.
- The analysis featured in this report is quite high-level – largely looking at ICB-level data, sometimes just by broad ethnic groups. As such, this should be seen as the first step in signalling where there might be variation. Further work is needed, working with service leads and service users, to understand:
    a) more specifically, in which groups, and where geographically the inequalities are;
    b) the reasons for this; and
    c) what action might be needed as a result.
- Indeed there were some metrics where, without further analysis, it was not clear in which direction the inequalities lay – for instance for children and young people's access to mental health services, is likely that ethnic groups with more contacts have higher need (perhaps indicating that more could be done to prevent the disease burden in these groups) but conversely the data for those with lower rates of contacts could mean less need or poorer access but it not currently possible to disentangle this. Similarly, there were a couple of metrics where the findings were the opposite of what might be expected - for instance there were fewer long elective waits in patients from more deprived areas and a higher percentage of patients with no GP-recorded cardiovascular disease (CVD), but high CVD risk on lipid lowering therapy, which warrant further analysis to unpick the possible reasons and explore whether this is masking other inequalities.
- Due to the combination of data sources used for the report, there was not always consistent ethnicity or deprivation groupings (e.g. deprivation decile vs quintile), and for many indicators data was only available as broad ethnic groups (the five main Census categories). Data was not always available to be analysed by ethnicity, deprivation, age and sex, and within reporting we prioritised analysis by ethnicity and deprivation. We hope to be able to look at demographics in a more consistent way in future reports (refer to Appendix for the sources of data used in the analysis for this report; and the level of demographic granularity).

Reflections and next steps - how planning to use this report in NCL (2)

North Central London
Integrated Care Board

Next steps

- This new national duty provides a helpful framework on which to consider locally how we best collate, analyse and report data on health inequalities pertinent to our population in NCL and their specific needs. It is one part of a wider system change around tackling health inequalities, the first step of which is identifying equity gaps in our population.
- Following the publication of this 2023/24 health inequalities insights report we intend to do a deeper stocktake on the findings, working with programme and system leads, to identify:
    - How we might refine what data we collate, analyse and report on health inequalities for key clinical areas and population groups on an on-going basis – including sourcing alternative data sources to enable a richer and consistent reporting of demographics and looking at data over a longer time frame; as well as conducting more granular analysis to delve deeper into different ethnic groups; geographical variation and look at patterns by age and sex where this has not been possible here, as well as for some of our 'Key communities'; and potentially expanding the list of metrics within the minimum dataset for future annual reports
    - The conclusions we can draw from reviewing a range of measures and taking into consideration the root causes that contribute to these, so we can determine the most effective stage of a pathway to place an intervention. This includes combining the measures within this report to those already collected by the ICB – e.g. from community health champions, and talking to communities about the solutions they would like to see developed
    - The relationship between this insights report and other local dashboards and intelligence, and our approach to Population Health Management and community insights in NCL. This will form a key part of implementing our Population Health Delivery Plan.
    - How we use this duty and approach to analytics to influence the reporting of demographics and inequalities as a core part of our standard performance and outcome reporting, ensuring it is embedded within existing and future dashboards
    - How we use this data to inform where we focus our efforts through service improvements and how we reduce inequalities whilst also improving overall performance within these clinical areas/ for these population groups
    - How we use this framework and insights to consider how we review different aspects of clinical pathways by inequalities and also how we look at health inequalities across the system, understanding the inter-relationship between the different metrics and clinical areas here as a starting point, but also considering missing areas such as primary and community services.
    - How we are using these insights and this approach to change the information on which we base our decisions, including those regarding resource allocation to ensure they are aligned to need.

Reflections and next steps - how planning to use this report in NCL (3)

North Central London
Integrated Care Board

Next steps (continued)

- As outlined on slide 7 there is a strong overlap between the clinical and population areas covered in this insights report and our Population Health and Integrated Care Strategy. There is also close alignment with our Delivery Plan for 2024/25 in the following areas:
    - Start Well – focus on maternity and neonates equity and equality; children and young people's mental health; family help in early years and childhood immunisations (which links to admission avoidance for children)
    - Live Well – focus on heart health (in particular high blood pressure); prevention, including smoking cessation; mental health including physical health of people with SMI; people with learning disabilities and autism; and cancer screening
    - Age Well – focus on long-term conditions (including cardiovascular disease and diabetes) and residents at risk of hospital admission
    - Whilst elective recovery, urgent and emergency care for children and young people and oral health do not feature specifically within our Delivery Plan, these are areas which, as indicated within the insights report, are areas of focus within the work of the ICB and will be impacted by programmes of work articulated within the Delivery Plan.
- The next steps will be working with relevant leads to integrated these insights and reporting into their wider work aligned to these strategy delivery areas.
- Similarly, a long-term ambition within our NCL Outcomes Framework, as a means to monitor the impact of our Strategy, has been to identify a way to do this through a health inequalities lens. There is overlap between the areas covered in our Outcomes Framework and this data set, which provides a helpful starting point to consider how we use this report and approach as part of our framework to monitor aspects of our Delivery Plan.
- This report has highlighted the importance of good quality data on which to make our decisions and we are aware that there are gaps particularly in ethnicity recording. We are working locally to improve the quality of ethnicity recording, which we hope to build on over the next year, for instance:
    - We have developed an 'Ethnicity Data Quality Dashboard' in our Population Health Management system, HealtheIntent, which combines ethnicity data from a broad range of sources within the ICS, including Primary Care, Acute, Mental Health, and Community providers. The dashboard is designed to enhance the quality and completeness of ethnicity data by identifying patients with missing or unclear records and highlighting discrepancies or incompatible records across multiple providers.
    - During 2023/24 we have had a CQUIN (Commissioning for Quality and Innovation) target for our local providers in place regarding ethnicity data collection.
    - We monitor the completeness of ethnicity and age coding within Secondary Uses Services (SUS) databases on an on-going basis.

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Appendix

Glossary and technical terminology

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- **Statistical significance** – the report refers to one data point being 'significantly' different to another. This is a reference to statistical significance. For the purpose of this report statistical significance is taken to mean that the observed difference between the data points is unlikely to be due to random chance and has a degree of certainty. This has been concluded using the confidence intervals for each value - where the confidence intervals do not overlap, the difference is said to be significantly or statistically significantly different.

- **Confidence intervals** – this is a statistical term describing the precision of statistical estimate or value. It describes a range within which a number (like an average) lies for the whole population, based on a sample of data. By comparing the 95% confidence intervals around estimates or a target we can say whether statistically there are differences or not in the estimates we are observing.

- **Index of Multiple Deprivation** – The Indices of Deprivation are a unique measure of relative deprivation at a small local area level (Lower-layer Super Output Areas, LSOA) across England. The Indices of Deprivation 2019 is the most recent release. The Indices provide a set of relative measures of deprivation for small across England, based on seven different domains, or facets, of deprivation: income; employment; education, skills and training; health deprivation and disability; crime; barriers to housing and services; and living environment. Deprivation is measured in a broad way to encompass a wide range of aspects of an individual's living conditions. Combining information from the seven domains (with some domains having a greater weight than others) produces an overall relative measure of deprivation, the Index of Multiple Deprivation (IMD), which ranks every small area (LSOA) in England from 1 (most deprived area) to 32,844 (least deprived area).

- **Lower Super Output Area** - Lower-Layer Super Output Areas (LSOAs) are a standard statistical geography designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 LSOAs in England. They were produced by the Office for National Statistics for the reporting of small area statistics and are a standard way of evenly dividing up the country by population.

- **Deprivation deciles and quintiles** – Whilst there is no definitive cut-off above which an area is described as 'deprived' it is common to describe how relatively deprived a neighbourhood (or LSOA) is by saying whether it falls among the most deprived 10 per cent (decile) or 20 per cent (quintile) of LSOAs in England. Within the Index of Multiple Deprivation every LSOA in England is ranked in order of their deprivation score, and then these are grouped into ten equal sized pools of LSOAs, each representing 10% (a decile) of the total list of LSOAs. For a given borough, we know what proportion of our LSOAs are ranked within each deprivation decile, and what proportion of our population live within those deciles. When an outcome is described as being better or worse in one decile or quintile compared to another it means that the populations living within LSOAs in our area which are ranked within the most deprived 10% or 20% of LSOAs nationally have better or worse outcomes than a different decile or quintile.

Granularity of data reviewed for 2023/24 report and data sources

NHS
North Central London
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NHS England's minimum data set requirement			Data reviewed for this metric	Geographic level reviewed	Type of demographic data reviewed				Data source used
Domain	Id.	Metric description			Ethnicity	Deprivation	Age	Sex	
Elective recovery	1	Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks	■	ICB	■	■			Waiting List Minimum Data Set (WLMDS)
	2	Age-standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient and emergency attendances	■	ICB	■	■			Secondary Uses Services (SUS)
	3	Elective activity vs pre-pandemic levels for under 18s and over 18s	■	ICB	■	■	■		SUS
Urgent and emergency care	4a	Emergency admissions for under 18s (all)	■	ICB	■	■			SUS
	4b	Emergency admissions for under 18s for asthma	■	ICB	■	■			SUS
Respiratory	5a	Uptake of COVID vaccine by socio-demographic group	■	ICB	■	■			HealtheIntent COVID & Flu dashboard
	5b	Uptake of flu vaccine by socio-demographic group	■	ICB	■	■	■		HealtheIntent COVID & Flu dashboard
Mental health	6	Overall number of severe mental illness (SMI) physical health checks*	■	ICB					Internal NCL ICB performance data
	7	Rates of total Mental Health Act detentions	■	ICB	■	■	■	■	Mental Health Act Statistics Annual Figures
	8	Rates of restrictive interventions	■	ICB	■	■			Mental Health Services Data Set (MHSDS)
	9	NHS Talking Therapies (formerly IAPT) recovery	■	ICB	■	■			Psychological therapies, annual reports on the use of IAPT services
	10	Children and young people's mental health access	■	ICB	■	■			MHSDS
Cancer	11	Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	■	ICB	■	■	■	■	Rapid Cancer Registration Dataset (RCRD)
Cardiovascular disease	12	Stroke rate of non-elective admissions (per 100,000 age-sex standardised)	■	ICB	■	■			SUS
	13	Myocardial infarction - rate of non-elective admissions (per 100,000 age-sex standardised)	■	ICB	■	■			SUS
	14	Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold	■	ICB	■	■	■	■	CVD Prevent - indicator CVDP007HYP
	15	Percentage of patients aged 18 and over with no GP recorded DVD and a GP recorded QRISK score of 20% or more on lipid lowering therapy	■	ICB	■	■	■	■	CVD Prevent - indicator CVDP003CHOL
	16	Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more who are currently treated with anti-coagulation drug therapy	■	ICB	■	■	■	■	CVD Prevent - indicator CVDP002AF
Diabetes	17	Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes	■	ICB	■	■	■		National Diabetes Audit dashboards - NHS Digital
	18	Variation of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile (National Diabetes Prevention Programme)	■	ICB	n/a	■	n/a	■	National NDPP dashboard and internal NCL ICB performance data
Smoking cessation	19	Proportion of adult acute inpatient settings and proportion of maternity inpatient settings offering smoking cessation services	■	Trust	n/a	n/a	n/a	n/a	Information provided via Trusts and ICB long term plan tobacco lead
Oral health	20	Tooth extractions due to decay for children admitted as inpatients to hospital (aged 10 years and under) (admissions not number of teeth extracted)	■	ICB	■	■			SUS
Learning disability and autistic people	21	Learning Disability Annual Health Checks	■	ICB			■	■	NHS England Health and Care of People with Learning Disabilities dashboard
	22	Adult mental health inpatient rates for people with a learning disability and autistic people*	■	ICB					NHS England Learning Disability monthly statistics from Assuring transformation dataset
Maternity and neonatal	23	Preterm births under 37 weeks	■	ICB	■	■			Maternity Services Data Set (MSDS)

*Note: these two indicators are not currently available with demographic breakdowns. We hope to have demographic data for SMI healthchecks in time for 2024/25 reporting. The numbers of adult inpatients with a learning disability and/or autism is so small (currently 35 per month) that breaking down by demographics would not be appropriate. In both instances, however, the indicators also represent an inequality in their own right irrespective of demographic breakdown so are important to include.