One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

Gloucestershire Health Inequalities Information Review

2023-24

One Gloucestershire Health Inequalities Information Review

Contents

1.0 Introduction

Health inequalities are systematic, unfair, and avoidable differences in health across the population, and between different groups within society. Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs, and as such we must have a good understanding of the population locally and identify those groups at risk of poor access, experience or outcomes and deliver targeted action to reduce these risks.

Gloucestershire is a relatively healthy and affluent county; however, some of our neighbourhoods have been among the top 10% most deprived in the county for over a decade, suggesting that there are structural long-term factors at play. The presentation of good health and wellbeing measures at county level masks underlying variations for certain areas and groups experiencing significantly worse health and wellbeing outcomes.

We are committed to tackling the persistent challenges with long-term health inequalities in our county, and the need to understand these at a system level, providing a solid foundation upon which to develop our thinking and target our efforts.

1.1 Purpose

Our ambition is to collect evidence of action and progress on reducing health inequalities across our county, ensuring that we do more for the most disadvantaged groups in our population. We are already developing dashboards to monitor variation in service uptake and report impact on health inequalities in different programme areas. We are also developing a system outcomes dashboard to identify progress on reducing inequalities in healthy life expectancy between those living in the most deprived and most affluent parts of Gloucestershire.

This is our first annual report of healthcare inequalities, enabling us to monitor progress against metrics by deprivation and ethnicity, in line with the NHS England Statement on Health Inequalities. This review of inequalities will encourage better quality data, completeness and transparency. The insights from this review will be fed into the work of our Clinical Programme Groups and other work programmes. It will be used to drive and shape improvement in the provision of good quality services and in reducing inequalities. It should be noted that the NHS England Statement does not currently include information on all priority areas for action on healthcare inequalities where there are specific limitations with available data or lack of availability of data; for example, on primary care and other key areas such as community care.

This report should be read in conjunction with our local joint strategic needs assessment (JSNA) to join the information presented here on health services with our understanding of our population and geographical distribution of our more disadvantaged groups.

2.0 Reporting by Programme Area

2.1 Elective recovery

2.1.1 –Elective waiting list – data and analysis

Following the COVID-19 pandemic, the number of people waiting for elective care in an acute hospital grew, with associated lengthening of time waited. NHS services have been focussing on reducing the overall number of people waiting for care, as well improving the waiting times for elective services as part of the elective recovery programme.

The majority of elective care in Gloucestershire is provided by a single provider trust, Gloucestershire Hospitals NHS Foundation Trust (GHFT). Analysing our waiting list will encompass all patients on any elective waiting list (including for providers out of county). Analysis of our waiting list by demographic group gives insights into where there are inequalities in experience of our elective care services, for example whether certain groups of people experience longer waits. The profile of the waiting list also helps identify groups who may be underutilising health services.

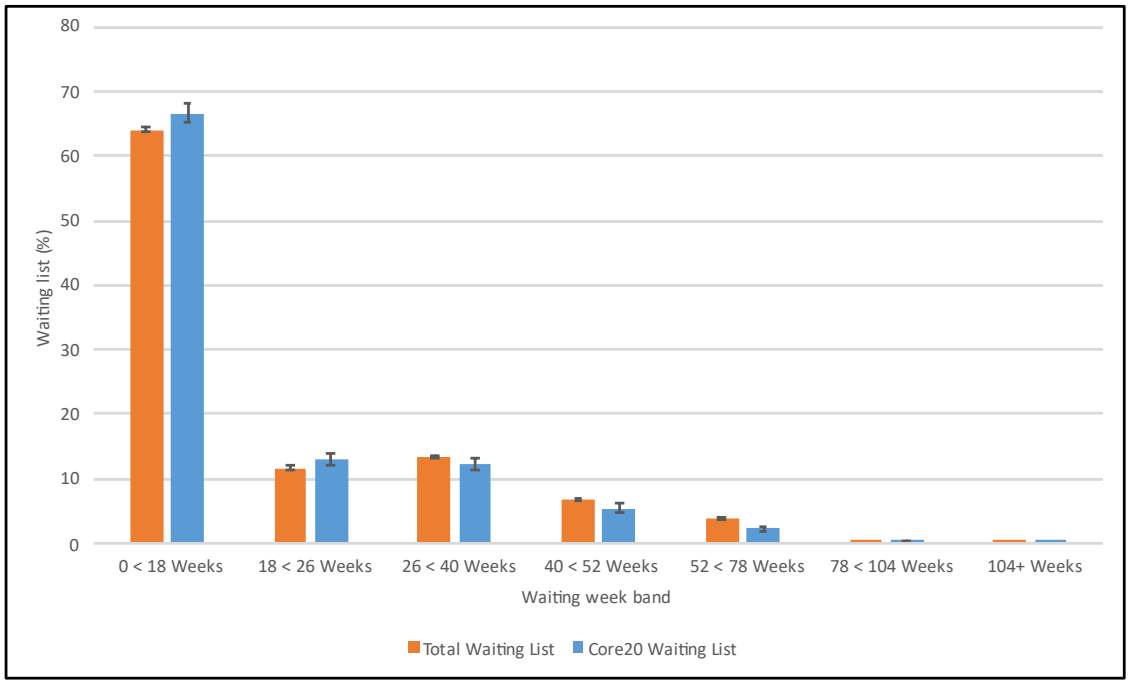


Figure 1. Elective waiting list population. Comparison of the proportion of people on the elective waiting list in Gloucestershire between the total waiting list population and the Core20 waiting list population, broken down by waiting week bands. Source: WLMDS, NHS Digital (May 2024).

Ethnic Origin	Current Waiting List			Core 20		
	Total	Crude Rate per 1000 ICB	Waiting List %	Total	Crude Rate per 1000	Waiting List %
Asian or Asian British	1513	118.06	2.02%	401	121.00	6.56%
Black or Black British	782	116.58	1.04%	248	120.04	4.06%
Mixed	930	87.05	1.24%	166	89.10	2.72%
Other Ethnic Groups	739	109.84	0.99%	177	116.45	2.90%
White	66904	133.44	89.37%	4732	143.68	77.46%
Unknown	3997	N/A	5.34%	385	N/A	6.30%
Total	**74865**	**105.10**		**6109**	**106.96**	

Table 1. Elective waiting list population. Comparison of the crude rate per 1,000 people on the elective waiting list in Gloucestershire between the total waiting list population (Gloucestershire commissioned patients and the Core20 waiting list population, broken down by ethnic group. Source: WLMDS, NHS Digital (May 2024).

Across the county, people in the Core20 population are more likely to be on an elective waiting list than the county average, with higher rates across all ethnic groups. While crude rates of people on the elective waiting list were similar across ethnic groups, Asian, Black and Mixed Ethnic groups had a higher Directly Age Standardised rate (DSR) – this was not seen in the Core20 population implying that this variation is primarily linked to deprivation.

People in the Core20 population were less likely to have long waits than the wider population with a higher proportion of the Core20 waiting list waiting under 18 weeks in particular. Further analysis is required to understand

whether this is due to this population presenting later, and therefore being seen more quickly with higher clinical priority for example.

Age Band	Total Waiting List					
	Female	Male	Female Crude Rate Per 1000	Male Crude Rate Per 1000	DSR rate per 1000 (Female)	DSR rate per 1000 (Male)
0-4	820	1149	49.69	66.35	24.84	33.18
5-9	729	1065	38.54	54.00	21.20	29.70
10-14	918	935	44.43	43.85	24.44	24.12
15-19	1146	925	58.62	46.76	32.24	25.72
20-24	1478	810	83.88	43.82	50.33	26.29
25-29	2123	1078	104.26	50.80	62.55	30.48
30-34	2669	1430	114.78	60.37	74.61	39.24
35-39	2852	1595	119.33	68.56	83.53	47.99
40-44	2955	1693	128.53	73.47	89.97	51.43
45-49	2843	1794	136.69	86.68	95.68	60.68
50-54	3581	2423	148.82	102.11	104.18	71.47
55-59	4116	3102	157.42	121.26	102.32	78.82
60-64	3982	3598	164.33	151.69	98.60	91.02
65-69	3770	3721	187.28	190.91	103.01	105.00
70-74	3873	3684	203.00	210.57	101.50	105.29
75-79	4305	3896	237.78	243.50	95.11	97.40
80-84	2764	2479	236.40	250.56	59.10	62.64
85-89	1409	1310	192.04	239.49	28.81	35.92
90+	569	407	120.04	174.30	12.00	17.43
Total	46902	37094	130.25	105.30	126.40	103.38

Table 2. Elective waiting list population. Comparison of the crude rate per 1,000 people and Directly Age Standardised (DSR) rate per 1,000 people on the elective waiting list in Gloucestershire between females and males, broken down by age band. Source: WLMDS, NHS Digital (May 2024)

Sex and age have a strong impact on the likelihood of being on an elective waiting list; as expected we see higher rates of older people being on elective lists, particularly after the age of 65. Women are more likely to be referred for elective procedures at an earlier age than men, from the age of 20-60 we see a higher DSR of women on the elective waiting list. Research evidence suggests that women exhibit greater healthcare-seeking behaviour compared to men[1], which could explain this observation; however further work is needed to confirm this.

2.1.2 Associated programmes of work

- The shape and make-up of our waiting list is reviewed at the system Planned Care Delivery Board, with findings informing the work of our referral optimisation group and associated programmes of work across the primary and secondary care interface.
- GHFT are developing a dashboard to enable clinicians to review elective waiting lists by different demographics, so that they can identify and understand any variation.

2.1.3 Further recommendations

To integrate the analysis of the waiting list fully into specific clinical and other programmes to identify specialty specific areas of focus and opportunities for reductions in variation across our population groups. Continue to expand the analysis of the waiting list, in particular to account for population structure and bringing in statistical tests to identify truly significant variation.

[1] The influence of gender and other patient characteristics on health care-seeking behaviour: a QUALICOPC study

2.1.4 Elective activity – data and analysis

There is widespread evidence that people living in more deprived areas have poorer access to planned hospital care than their more affluent counterparts[2]. Reviewing the differential use of elective and emergency health services by population group can help to see inequality in access, but also where particular groups could be experiencing different outcomes – for example a need to use more emergency healthcare as a result of poorer management of long-term conditions.

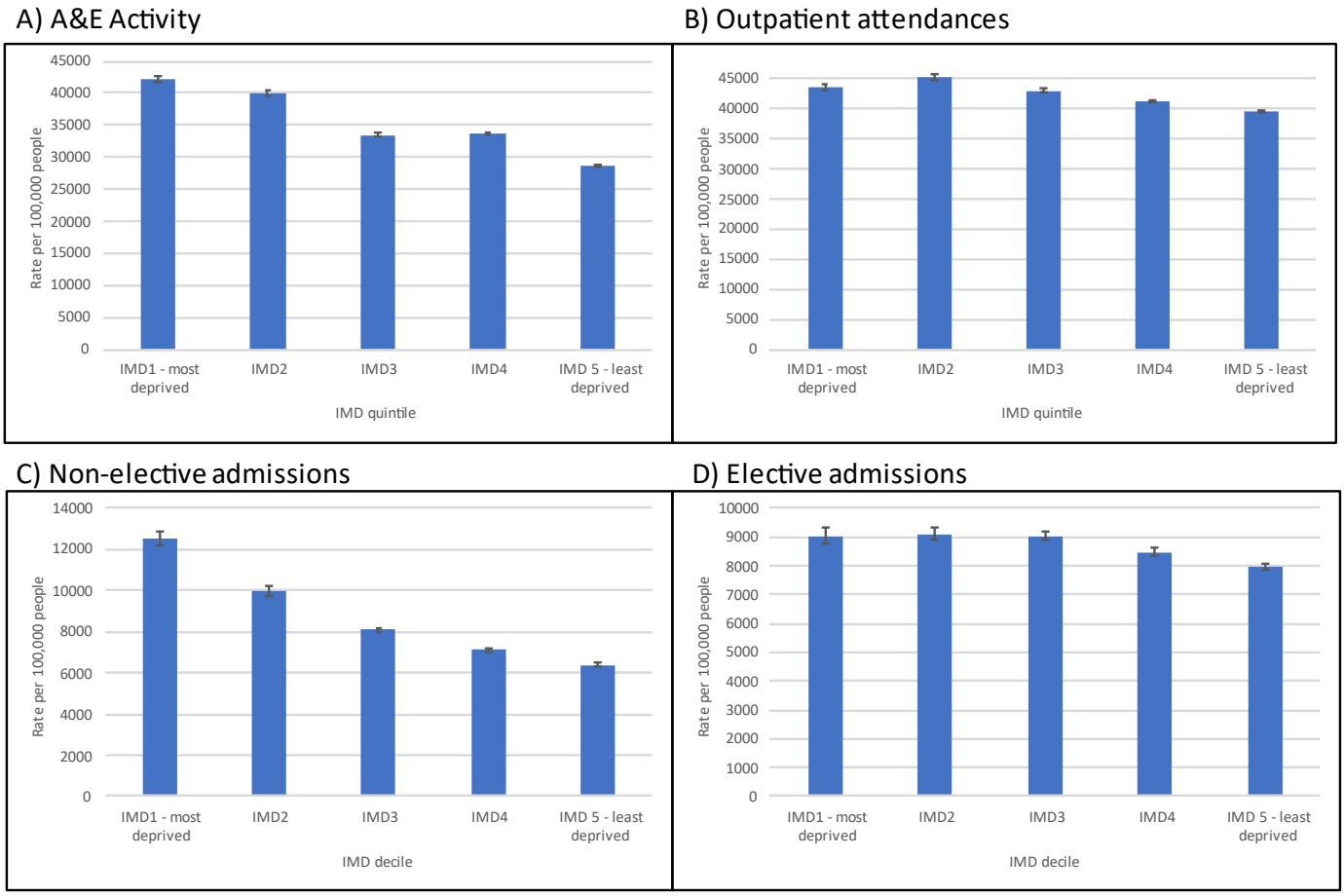


Figure 2. Elective and non-elective activity. 52-week age-standardised rate per 100,000 people who: A) had an A&E attendance; B) had an outpatient attendance; C) had a non-elective admission to hospital; D) had an elective admission to hospital, Gloucestershire. Data shown by IMD decile. Source: Health Inequalities Improvement Dashboard, NHS National Data Platform, Foundry (week ending 25th May 2024).

A&E attendances and emergency admissions are generally highest in the most deprived areas of Gloucestershire and decrease as affluence increases. People living in IMD1 are significantly more likely to have an emergency attendance or admission compared to those living in all other IMD quintiles and are lowest for people living in IMD5. Proximity of an A&E to a person's home is known to impact their likelihood of attending for emergency care, and several of our most deprived areas are located nearer to acute hospital sites – however it is challenging to account for this in analysis of use of healthcare.

People living in the most affluent areas (IMD5) are significantly less likely to be an outpatient or have an elective admission compared to all other deprivation deciles.

[2] Strategies to reduce inequalities in access to planned hospital procedures

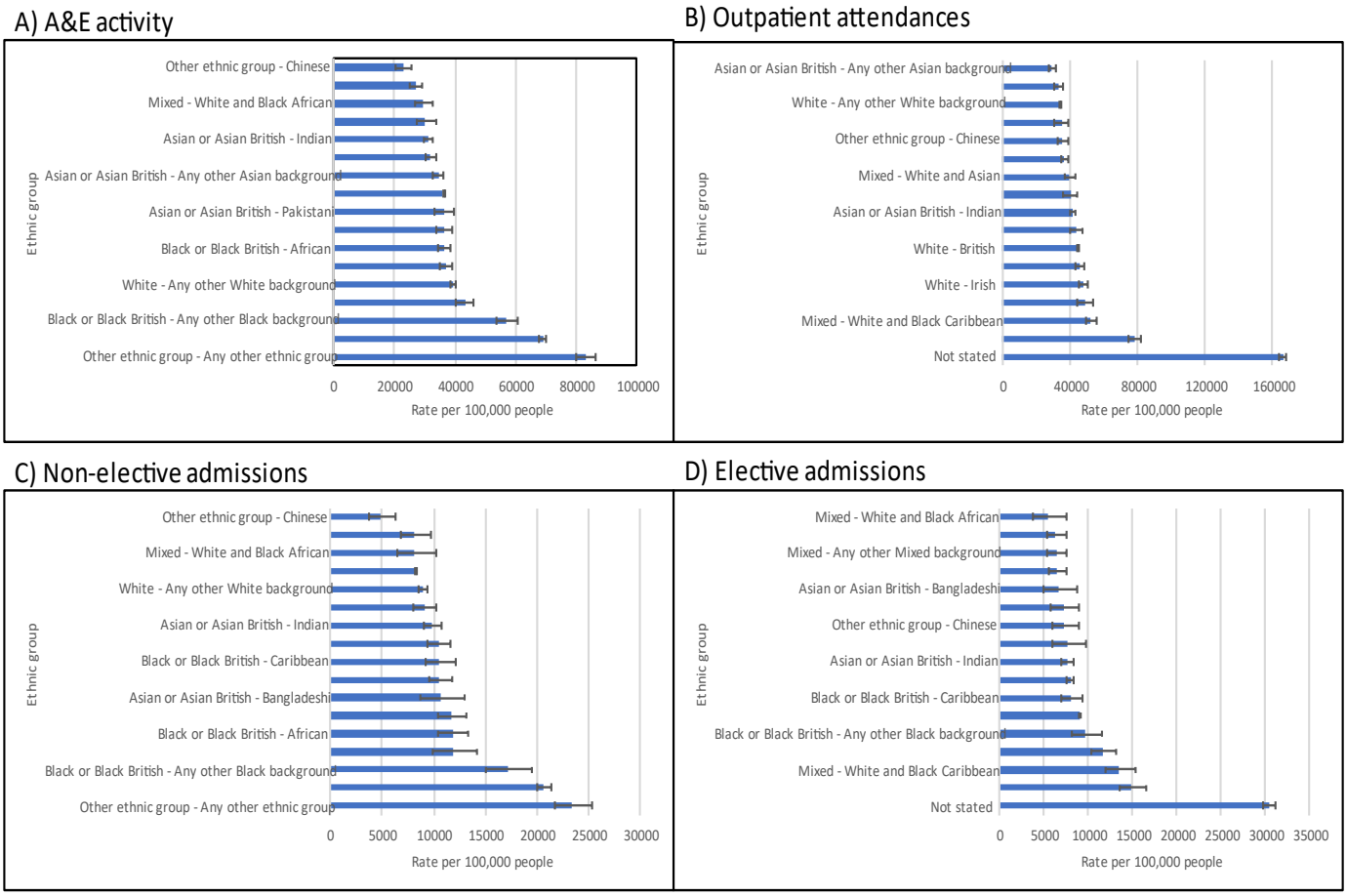
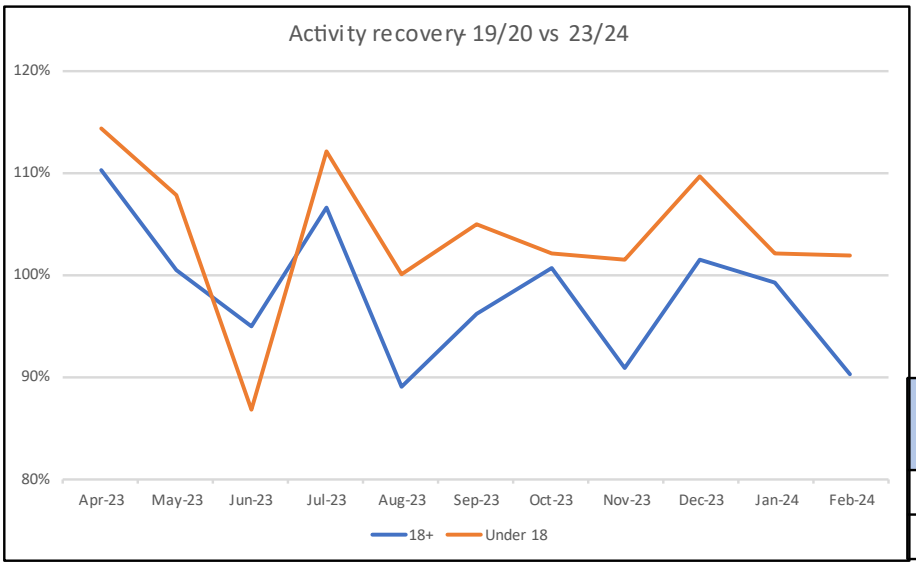


Figure 3. Elective and non-elective activity. 52-week age-standardised rate per 100,000 people who: A) had an A&E attendance; B) had an outpatient attendance; C) had a non-elective admission to hospital; D) had an elective admission to hospital, Gloucestershire. Data shown by ethnic group. Source: Health Inequalities Improvement Dashboard, NHS National Data Platform, Foundry (week ending 25th May 2024).

A&E attendances were significantly higher in people from Black or Black British – any other Black backgrounds compared to other ethnic groups. This is the same for non-elective admissions with the exception of people from the Asian or Asian British – Pakistani ethnic group.

People from Mixed – White and Black Caribbean backgrounds and were significantly more likely to be an outpatient or have an elective admission compared to people from other ethnic backgrounds.

Across all recovery activity groups, activity rates are variable, which is driven by the small numbers involved making it difficult to determine whether there is a true variation. A significant proportion of ethnicities are either not stated or within the Any Other Ethnic Group category, and these have not been included in the analysis.



Age group	Activity recovery	VWA recovery
Under 18	111%	116%
18+	105%	107%

Figure 4. Elective activity recovery. Comparison of elective activity recovery from pre-pandemic to post-pandemic levels between adults aged 18 years and over (blue line) and children and young people aged under 18 years (orange line). Source: National Commissioning Data Repository, Secondary Uses Service (SUS), NHS Digital (April 2023-February 2024).

Elective activity recovery across all points of delivery has exceeded 19/20 levels both for activity amounts and value weighted activity (VWA) on average in 2023/24. Children (under 18) show higher levels of activity recovery than adults, though this does vary month to month with June 2023 showing the lowest levels of children's elective activity.

2.1.5 Associated programmes of work

- The outpatient transformation programme has been relaunched and will support elective recovery by focusing on outpatient processes, clinic utilisation, Did Not Attend (DNA) reduction, follow-up reduction and patient portal implementation - this includes review of the variation in access, outcomes and experience that occurs across the county.
- The Elective Care Hub (ECH) offers reassurance and support to people on the elective waiting list, including referral to social prescribing. ECH staff have personal conversations with patients about their individual needs and support them to fill in the digital assessment questionnaire, facilitating access to the service.
- The wider elective recovery programme nationally is focussed on improving access to elective care, to help reduce long waits that may lead to conditions worsening.
- In line with the CYP elective recovery toolkit, the system is continuing to prioritise children' elective recovery wherever possible and will continue to monitor progress using local and national data to support identification of particular groups of children where additional resource or support is needed to facilitate recovery.
- We are committed to improving data quality and completeness in order to enable us to assess whether improvements are being made to different population groups in access, experience and outcomes.

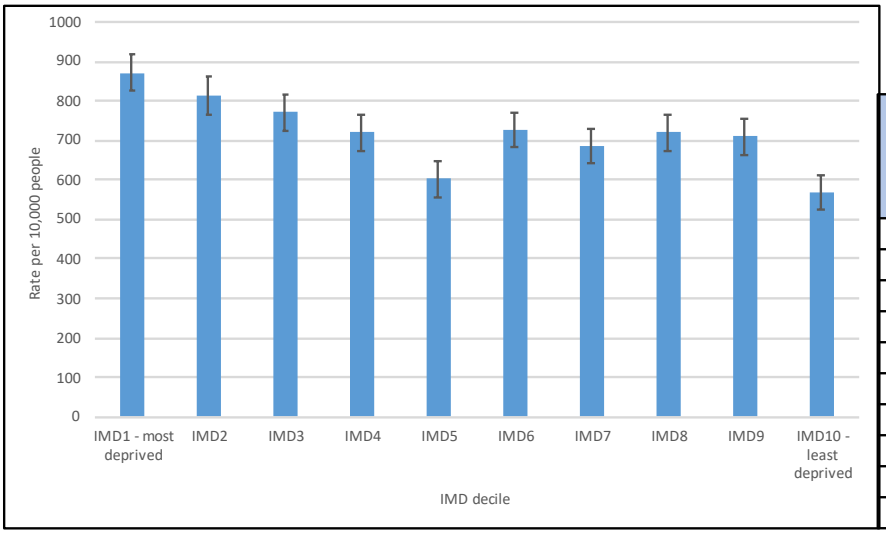
2.2 Urgent and emergency care

Use of emergency care by under 18-year-olds has been strongly linked to social inequality[3] – and nationally attendances by under 18s often include those for conditions which could be appropriately managed in primary care

[3] Admissions of inequality: emergency hospital use for children and young people

or the community (e.g. asthma, diabetes and epilepsy). The differences in rates of A&E attendance by population group may indicate an area where quality improvement work in primary care or the community could strengthen the management of these conditions.

2.2.1 Data and analysis



IMD Decile	Rate of emergency admissions for under 18 year olds per 10,000 people
IMD1 - Most deprived	1,343
IMD2	1,145
IMD3	1,184
IMD4	1,038
IMD5	717
IMD6	1,144
IMD7	891
IMD8	875
IMD9	957
IMD10 - Least deprived	647

Figure 5. Emergency admissions for under 18-year-olds. Rate per 10,000 people aged 18 years and under who experienced an emergency admission to hospital in Gloucestershire by IMD decile. Source: Children and Young People's Transformation Dashboard, NHS England (2022-23).

The rate of emergency admissions for under 18-year-olds is significantly higher in the most deprived deciles of Gloucestershire compared to the most affluent deciles, for example in IMD1 the rate of emergency admissions for under 18-year-olds was 873 per 10,000 population, compared to 568.4 per 10,000 population in IMD10.

Data on emergency admissions for under 18-year-olds is not currently available by ethnicity due to data quality concerns, however, we know that in Gloucestershire our diverse ethnic groups are more likely to live in the most deprived areas.

2.2.2 Associated programmes of work

The majority of admissions of under 18-year-olds in Gloucestershire are due to respiratory conditions, infectious diseases, or gastroenteritis.

- Acute Respiratory Infection Hubs have been established in two Primary Care Networks in our two main city areas of deprivation, Gloucester and Cheltenham.
- PCN based Respiratory Champions have been recruited in PCNs covering most of the areas of known deprivation in Gloucestershire to promote accurate and timely diagnosis.
- Asthma is included as a referral condition to have Gloucester City Homes properties assessed to ensure that children and young people do not live in conditions that might exacerbate their symptoms.
- The Respiratory Clinical Programme Group is working on the "Asthma Friendly Schools" initiative, which will encourage building and sharing of asthma plans for children between school and families to help minimise asthma exacerbation.
- Following consultation with mothers of young children to understand the barriers to getting their children vaccinated, vaccination clinics are being offered at more convenient times and in alternative settings to encourage uptake, particularly focussing on cohorts with lowest vaccine uptake.

- Smoking is one of Gloucestershire Integrated Care Partnership's unifying themes, as it is recognised as the single biggest cause of inequality in premature death rates and the leading cause of preventable disease and disability. There is specific focus on air quality with the county and district councils reconvening a forum to address this specifically with respiratory disease the primary motivation.

2.2.3 Further recommendations

Improvement of coding, in particular for emergency department and emergency admission activity to allow more complete analysis of the impact of ethnicity and other protected characteristics on the likelihood of using emergency care in the county.

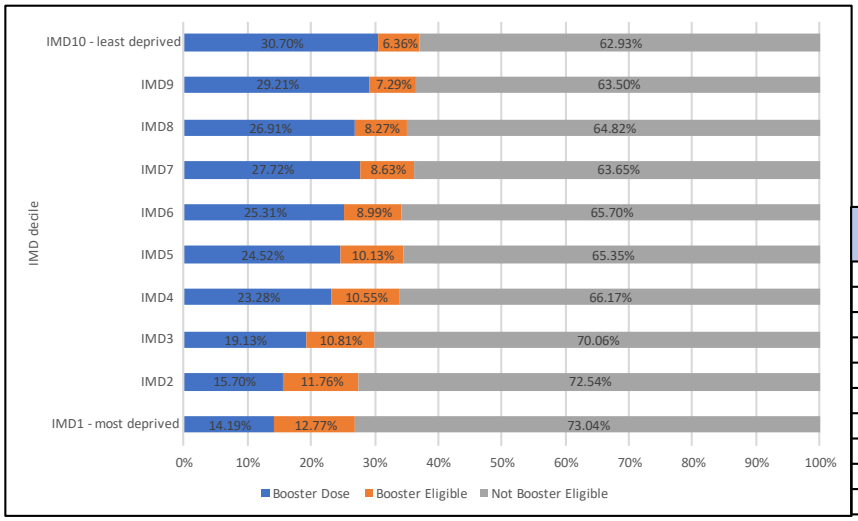
We have noted the significantly lower rate of emergency admission for IMD5 patients in our county and will interrogate this further to understand the specific driving factors.

Further work with respiratory champions to review those most likely to attend A&E could help to understand some of the drivers for use of emergency care and what can support patients in improving self-management.

2.3 Respiratory

One of the ways that the Core20+5 approach aims to address respiratory conditions is by focusing on the uptake of COVID and Influenza vaccines, as vaccine uptake has been shown to vary according to both deprivation and ethnicity[4]. Vaccination aims to reduce the spread of infection and prevent serious illness in vaccinated individuals, and so increasing uptake in all populations will improve the outcomes for the whole population. Understanding the local profile of vaccination coverage enables the targeting of interventions to specific groups to address low uptake.

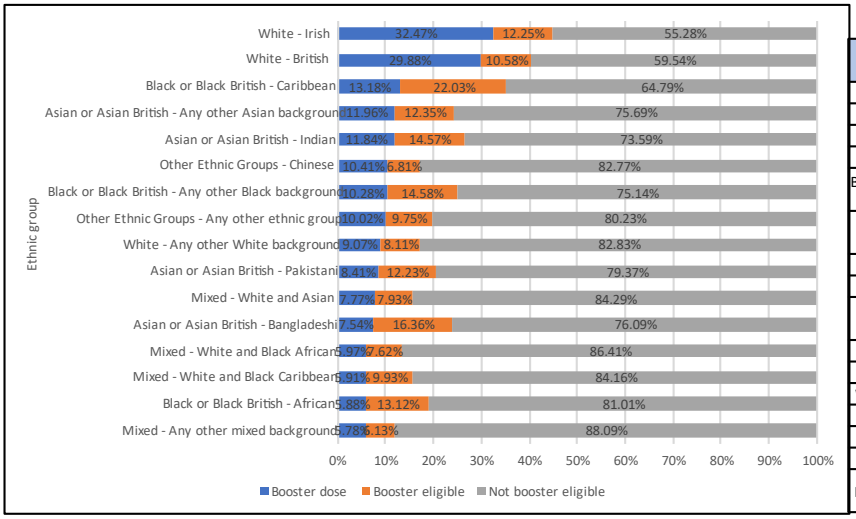
2.3.1 COVID-19 Vaccination – Data and analysis



IMD Decile	Booster eligible (%)	Eligible uptake (%)
IMD1 - Most deprived	27	52.6
IMD2	27.5	57.2
IMD3	29.9	63.9
IMD4	33.8	68.8
IMD5	34.7	70.8
IMD6	34.3	73.8
IMD7	36.4	76.3
IMD8	35.2	76.5
IMD9	36.5	80
IMD10 - least deprived	37.1	82.8

Figure 6. COVID-19 vaccination uptake. Proportion of people who were eligible for and took up the offer of the COVID-19 vaccination (blue bar); proportion of people who were eligible for the COVID-19 vaccination (orange bar); and proportion of people who were not eligible for the COVID-19 vaccination (grey bar by IMD decile. Source: COVID Local Vaccination Service Online Portal, NHS National Data Platform (Foundry) (March 2024).

[4] Coronavirus and vaccination rates in adults by socio-demographic characteristics and occupation, England: December 2020 to March 2023



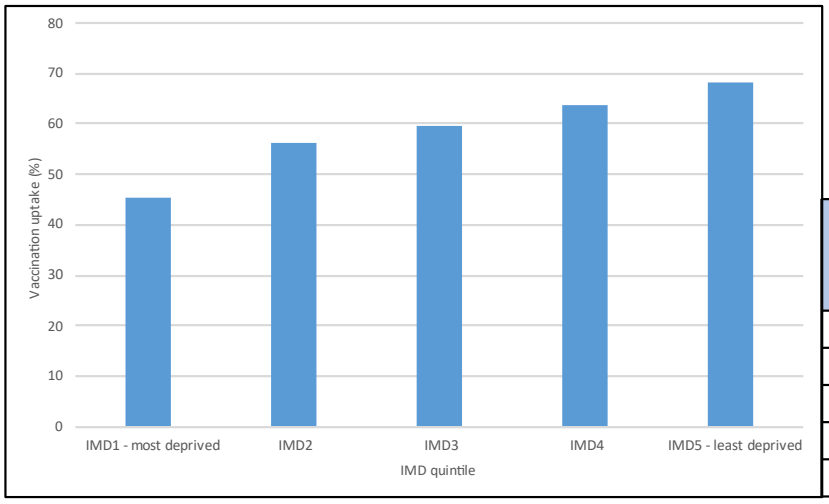
Ethnic group	Booster eligible (%)	Eligible uptake (%)
White - Irish	44.72	72.6
White - British	40.46	73.9
Black or Black British - Caribbean	35.21	37.4
Asian or Asian British - Indian	26.41	44.8
Black or Black British - Any other Black background	24.86	41.4
Asian or Asian British - Any other Asian background	24.31	49.2
Asian or Asian British - Bangladeshi	23.91	31.5
Asian or Asian British - Pakistani	20.63	40.8
Other Ethnic Groups - Any other ethnic group	19.77	50.7
Black or Black British - African	18.99	31
Other Ethnic Groups - Chinese	17.23	60.4
White - Any other White background	17.17	52.8
Mixed - White and Black Caribbean	15.84	37.3
Mixed - White and Asian	15.71	49.5
Mixed - White and Black African	13.59	43.9
Mixed - Any other mixed background	11.91	48.5

Figure 7. COVID-19 vaccination uptake. Proportion of people who were eligible for and took up the offer of the COVID-19 vaccination (blue bar); proportion of people who were eligible for the COVID-19 vaccination (orange bar); and proportion of people who were not eligible for the COVID-19 vaccination (grey bar) by ethnic group. Source: COVID Local Vaccination Service Online Portal, NHS National Data Platform, Foundry (March 2024).

People living in the most affluent areas of Gloucestershire were more likely to be eligible for and to take up the offer of a COVID-19 booster vaccination compared to those living in the least affluent areas. While the age profile of the least deprived population means that these populations are more likely to be eligible for the COVID-19 booster programme, there is clearly an impact of deprivation on the likelihood of accepting an invitation to receive a vaccination.

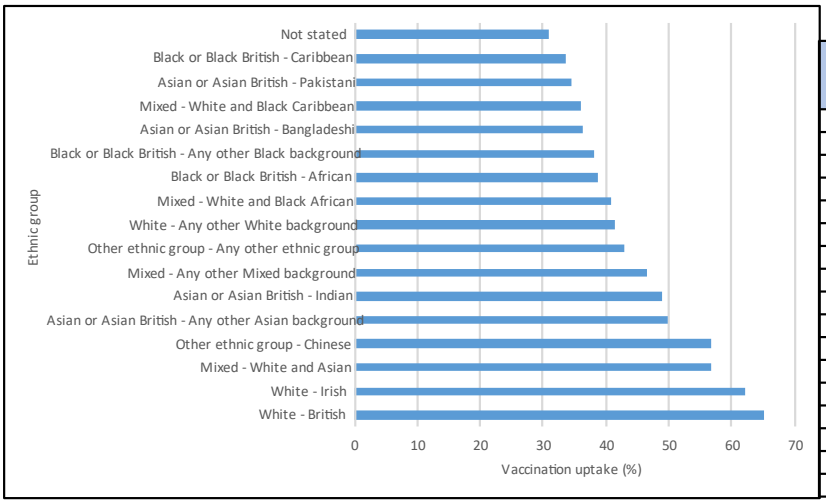
People from Black or Black British-Caribbean communities were more likely than other ethnic groups to be eligible for the COVID-19 booster vaccination but were less likely to take up the offer, followed by people from Asian or Asian British-Bangladeshi communities.

2.3.2 Influenza Vaccination – Data and analysis



IMD quintile	Overall uptake of influenza vaccination (%)
IMD1 - most deprived	45.2
IMD2	56.2
IMD3	59.6
IMD4	63.7
IMD5 - least deprived	68.3

Figure 8. Influenza vaccination uptake. Proportion of people who took up the offer of the influenza vaccination by IMD quintile. Source: Health Inequalities Improvement Dashboard, NHS National data Platform (Foundry) (2023-24).



Ethnic group	Overall uptake of influenza vaccination (%)
Not stated	30.8
Black or Black British - Caribbean	33.7
Asian or Asian British - Pakistani	34.6
Mixed - White and Black Caribbean	36.1
Asian or Asian British - Bangladeshi	36.2
Black or Black British - Any other Black background	38.2
Black or Black British - African	38.8
Mixed - White and Black African	40.9
White - Any other White background	41.4
Other ethnic group - Any other ethnic group	43
Mixed - Any other Mixed background	46.4
Asian or Asian British - Indian	48.9
Asian or Asian British - Any other Asian background	49.9
Other ethnic group - Chinese	56.7
Mixed - White and Asian	56.8
White - Irish	62
White - British	65.1

Figure 9. Influenza vaccination uptake. Proportion of people who took up the offer of the influenza vaccination by ethnic group. Source: Health Inequalities Improvement Dashboard, NHS National data Platform (Foundry) (2023-24).

Uptake of the influenza vaccination was lower in people living in the most deprived areas of Gloucestershire and increased as deprivation decreased, with 45.2% of people living in IMD1 having taken up the vaccination compared to 68.3% of people living in IMD10.

People from White - British backgrounds had the highest uptake of the influenza vaccination, followed by those from White-Irish backgrounds. The lowest uptake of the vaccination was in people from Black of Black British – Caribbean ethnic groups and Asian or Asian British – Pakistani ethnic groups.

2.3.3 Associated programmes of work

- The COVID-19 Mass Vaccination programme is targeting groups of people in Gloucestershire with poor Vaccine uptake, including people living in areas of deprivation and people from diverse ethnic communities as well as other vulnerable groups.
- Vaccination outreach teams promote and deliver vaccinations at community-based health events and in a variety of community venues including community centres, cafes, libraries, and food banks.
- Acute Respiratory Infection Hubs identify patients being treated at the Hubs who have not been vaccinated and use the opportunity to increase uptake. These are located in Gloucestershire's two main city areas of deprivation: Rosebank in Gloucester and St Pauls in Cheltenham.
- PCN based Respiratory Champions support the uptake of vaccinations for all patients diagnosed with COPD.

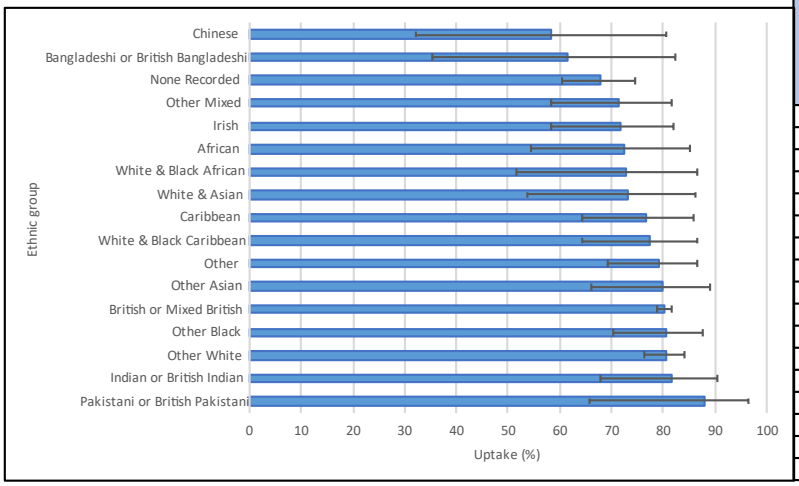
2.4 Mental health

2.4.1 Serious Mental Illness and Physical Health Checks – data and analysis

People with a Serious Mental Illness (SMI) frequently experience physical health conditions alongside their mental illness and are more likely to die prematurely than people in the general population[5]. To reduce this inequality, physical health checks for people with SMI can identify specific interventions that may improve their physical health, for example referring people to weight management programmes when a high Body Mass Index is recorded. Uptake of these health checks in the SMI population is a priority of the Core20+5 strategy[6].

[5] Severe mental illness (SMI) and physical health inequalities: briefing
[6] Evidence for the five clinical priorities

Ethnicity is associated with inequality in access to care and support, such as health checks[7] and screening, therefore, SMI health check uptake has initially been reviewed by ethnicity.



Ethnic group	Patients with a current SMI diagnosis and a full Health Check in the last 12 months as of 1st May 24	Proportion of patients with a current SMI diagnosis and a full Health Check in the last 12 months as of 1st May 24 (%)
Chinese	7	58.3
Bangladeshi or British Bangladeshi	8	61.5
None Recorded	114	67.9
Other Mixed	40	71.4
Irish	38	71.7
African	21	72.4
White & Black African	16	72.7
White & Asian	19	73.1
Caribbean	43	76.8
White & Black Caribbean	41	77.4
Other	65	79.3
Other Asian	36	80
British or Mixed British	2926	80.3
Other White	326	80.5
Other Black	62	80.5
Indian or British Indian	36	81.8
Pakistani or British Pakistani	15	88.2

Figure 10. Severe mental illness (SMI) physical health checks. Proportion of people on the General Practice SMI register who received a physical health check in the 12 months to the end of the reporting period in Gloucestershire by ethnic group. Source: Adult Mental Health Dashboard, Future NHS (1st May 2024).

There is no significant difference in the proportion of patients with a current SMI diagnosis (as of March 24) who have had a Physical Health Check in the last 12 months based on their ethnic group. However, the numbers involved in this analysis are very small and a large proportion are not recorded making it difficult to draw conclusions regarding a true significant difference. Further work is planned to review SMI health check uptake by deprivation and geographical area across the county.

2.4.2 Mental Health Detention and Restrictive Interventions

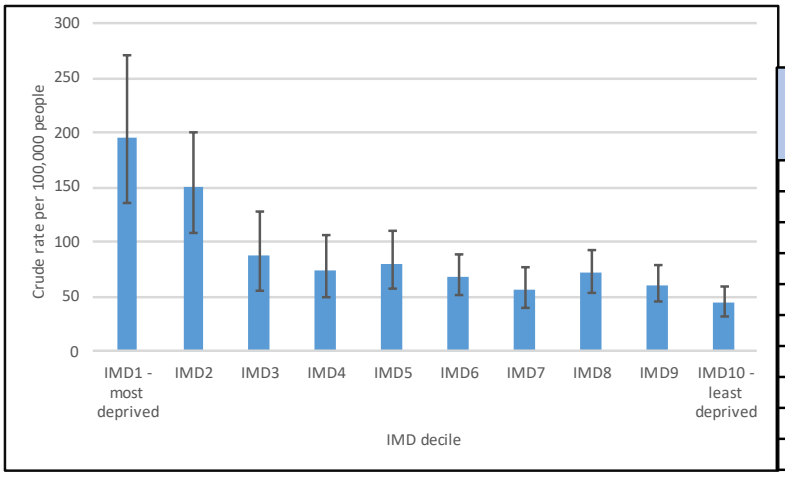
Certain groups, such as black people or people from more deprived communities have been shown to have higher rates of detention under the Mental Health Act, with little explanation as to why this may be the case. Understanding the local rate of mental health detention and variation across our population will help to identify strategies to reduce unnecessary detention in line with the national work on reforming the mental health act[8]. Restrictive interventions should likewise be used as a last resort, and there has been a long-term focus on reducing the incidence of these across care settings – monitoring the incidence of these helps measure the achievement of this strategy in our county[9].

[7] Addressing health inequalities: developing a better understanding of physical health checks for people with severe mental illness from Black African and Caribbean communities

[8] Detentions under the Mental Health Act

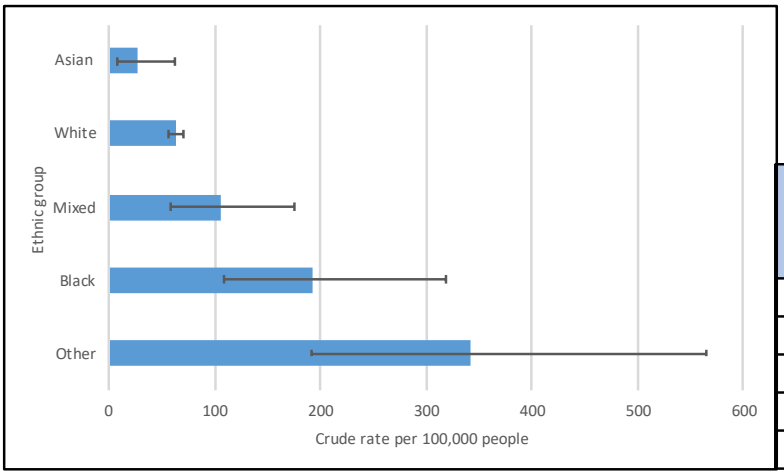
[9] Positive and proactive care: reducing the need for restrictive interventions

2.4.3 Detentions under the Mental Health Act- data and analysis



IMD Decile	Rate of detentions under the Mental Health Act 1983 per 100,000 people
IMD1 - most deprived	195
IMD2	150
IMD3	87
IMD4	75
IMD5	81
IMD6	69
IMD7	56
IMD8	72
IMD9	61
IMD10 - least deprived	44

Figure 11. Mental Health Act detentions. Crude rate per 100,000 people subject to a detention under the Mental Health Act 1983 by IMD decile. Source: Mental Health Act Statistics, Annual Figures, 2022-23, NHS Digital (2022-23).



Ethnic group	Rate of detentions under the Mental Health Act 1983 per 100,000 people
Asian	27
White	63
Mixed	106
Black	193
Other	343

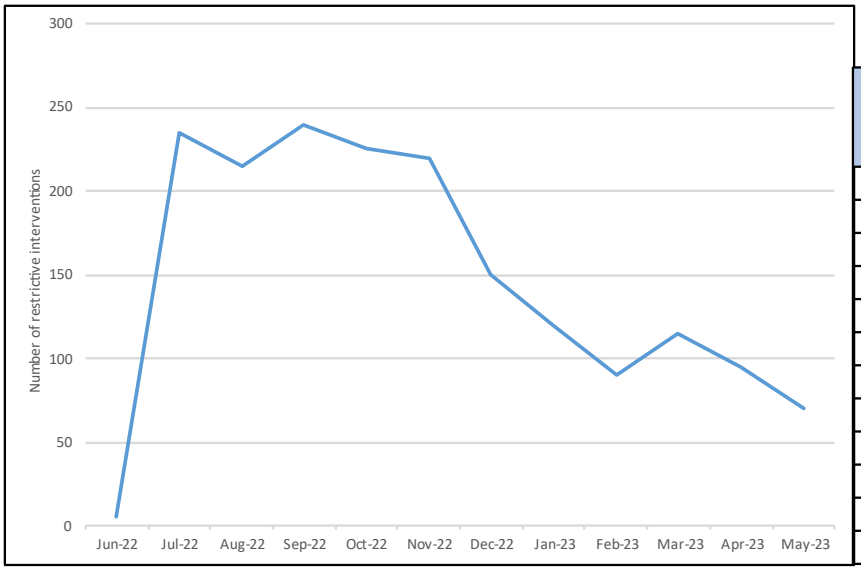
Figure 12. Mental Health Act detentions. Crude rate per 100,000 people subject to a detention under the Mental Health Act 1983 by ethnic group. Source: Mental Health Act Statistics, Annual Figures, 2022-23, NHS Digital (2022-23).

People living in the least deprived deciles (IMD1-5) were significantly less likely to experience detentions under the Mental Health Act compared to those living in the most deprived deciles (IMD9 and 10), with 44 per 100,000 population from the least deprived decile being subject to a detention compared to 195 per 100,000 population from the most deprived decile.

People from Black ethnic groups were significantly more likely to experience detentions under the Mental Health Act compared to those from White and Asian backgrounds, for example, the rate of detentions for people from Black ethnic groups was 193 per 100,000 population compared to 63 per 100,000 population for people from White backgrounds.

The numbers involved in this analysis are very small, and for ethnic group a large proportion are within the 'Other' category, making it difficult to identify a true difference between deprivation groups and ethnic groups.

2.4.4 Restrictive Intervention – Data and analysis



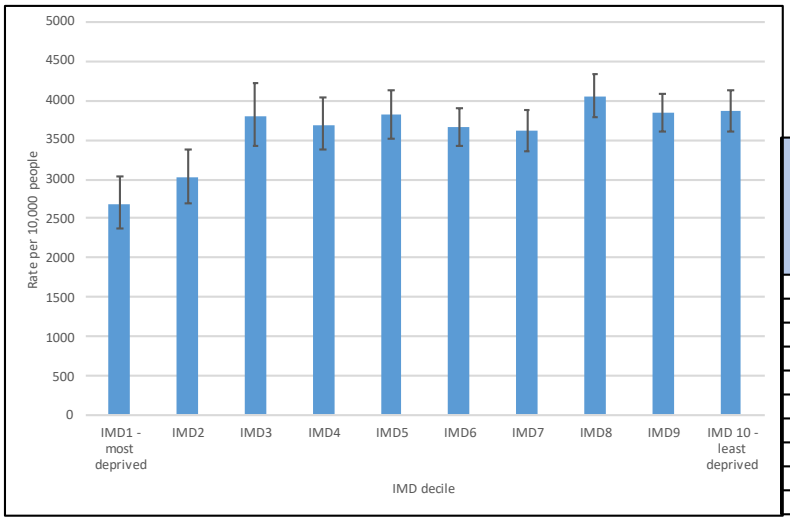
Month	Number of restrictive interventions by GHFT
Jun-22	5
Jul-22	235
Aug-22	215
Sep-22	240
Oct-22	225
Nov-22	220
Dec-22	150
Jan-23	120
Feb-23	90
Mar-23	115
Apr-23	95
May-23	70

Figure 13. Restrictive interventions. Number restrictive interventions per 1000 bed days reported by Gloucestershire Health and Care NHS Foundation Trust. Source: Restrictive interventions interactive dashboard, NHS Digital (June 2022-May 2023).

Data on restrictive interventions in Gloucestershire is not currently available by deprivation or ethnicity. In general, the number of people experiencing restrictive interventions in Gloucestershire has decreased since September 2022, when 240 people experience a restrictive intervention, compared to May 2023 when 70 people experienced a restrictive intervention, the lowest number since July 2022.

2.4.5 Talking Therapies – data and analysis

There is a strong link between deprivation and the likelihood of recovering from anxiety and depression[10]. Nationally people from more deprived areas are less likely to recover when completing a talking therapy course and are also less likely to be referred to the service. Understanding our referral profile locally will give insight into areas which may benefit from further advertising, or adaptations to the service to improve accessibility for particular groups who are less well represented.



IMD Decile	Referrals received to NHS Talking Therapies	Referrals finished treatment	Rate of referrals to NHS Talking Therapies who finished treatment per 10,000 people
IMD1 - most deprived	930	250	2688.2
IMD2	1045	315	3014.4
IMD3	960	365	3802.1
IMD4	1285	475	3696.5
IMD5	1570	600	3821.7
IMD6	2580	945	3662.8
IMD7	2075	750	3614.5
IMD8	2120	860	4056.6
IMD9	2530	970	3834
IMD10 - least deprived	2060	795	3859.2

[10] https://digital.nhs.uk/news/news-archive/2016-news-archive/mental-illness-recovery-linked-with-deprivation-report-finds

Figure 14. NHS Talking Therapies activity. Rate per 10,000 people referred to NHS Talking Therapies (formerly IAPT) who finished a course of treatment by IMD decile. Source: Psychological therapies, annual reports on the use of IAPT services, NHS Digital (2021-22).

Of those people referred to NHS Talking Therapies, people in the least deprived decile (IMD10) were significantly more likely to finish treatment compared to those in the most deprived decile (IMD1).

2.4.6 Children's Mental Health Access – data and analysis

Children living in poverty are more likely to experience mental health problems[11]. We have been increasing access to mental health services for children and increasing availability of preventative services – in particular those delivered through the voluntary and community sector (VCS).

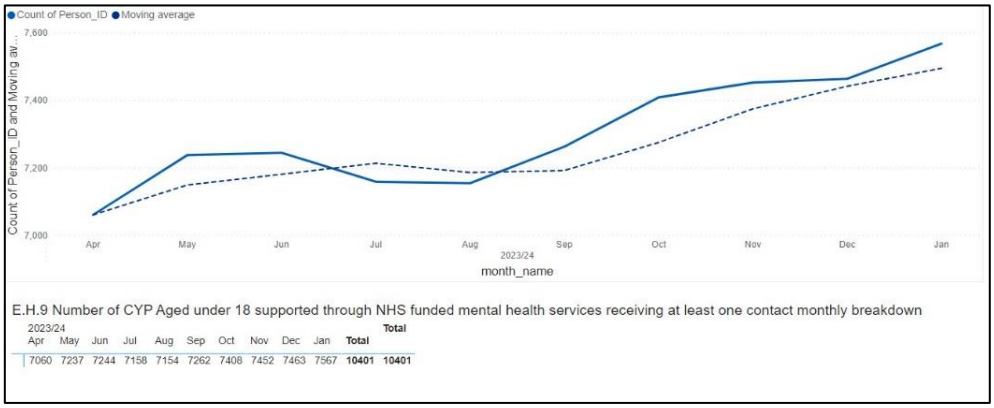


Figure 15. Children's mental health access. Number of children and young people accessing NHS funded mental health services receiving at least one contact, in Gloucestershire. Source: Mental Health Minimum Data Set, NHS Digital (April 2023 – January 2024).

Data on children and young people's access to NHS funded mental health services is not currently available by deprivation or ethnicity. The number of children and young people accessing NHS funded mental health services has increased since August 2023 from 7,154 to 7,567 in January 2024. Further work is underway to understand the breakdown of access to children's mental health services to understand the variation across our population groups.

2.4.7 Associated programmes of work across Mental Health

- The Mental Health Transformation Programme is being rolled out in our two main areas of deprivation, Gloucester and Forest of Dean. Local VCS organisations are supporting the programme, for example, Inclusion Gloucestershire is taking a health inequalities approach to the delivery of coproduction with people with lived experience.
- Key posts have been recruited across primary and secondary care to facilitate and ensure physical health checks are conducted.
- Assertive Outreach teams specifically work with adults with SMI and local VCS organisations, such as Gloucestershire Rural Community Council (GRCC) support those with SMI to attend their Annual Physical Health Checks, raise awareness and support underrepresented communities who do not actively engage with the service or Do Not Attend.

[11] Child health inequalities driven by child poverty in the UK - position statement: child health outcomes

- The Talking Therapies marketing and promotions team has been working on improving access to the service by engaging with diverse communities and raising awareness of the support available to them. This includes working with community outreach workers and attending a wide variety of community events and venues.
- Organisational adoption of frameworks such as the Patient and Carer Race Equality Framework (PCREF) and Right Care Right Person has contributed to a reduction in restrictive interventions.
- The Community Mental Health (CMH) Transformation Data and Digital Workstream has a focus on shared information governance and reporting across primary and secondary care and SMI register data sharing to ensure everyone with a SMI diagnosis receives targeted support to access their Annual Physical Health Checks.

2.5 Cancer

Cancer survival is higher for those living in the least deprived areas when compared to the most deprived areas nationally[12]. Survival from cancer is strongly associated with stage of diagnosis – there is a national target to improve early diagnosis (diagnosis at stage 1 or 2) to 75% by 2028, in addition to cancer being a key clinical priority for the Core20+5 strategy, however there is variation nationally in the proportion of cancers diagnosed currently at stage 1 or 2[13].

2.5.1 Data and analysis

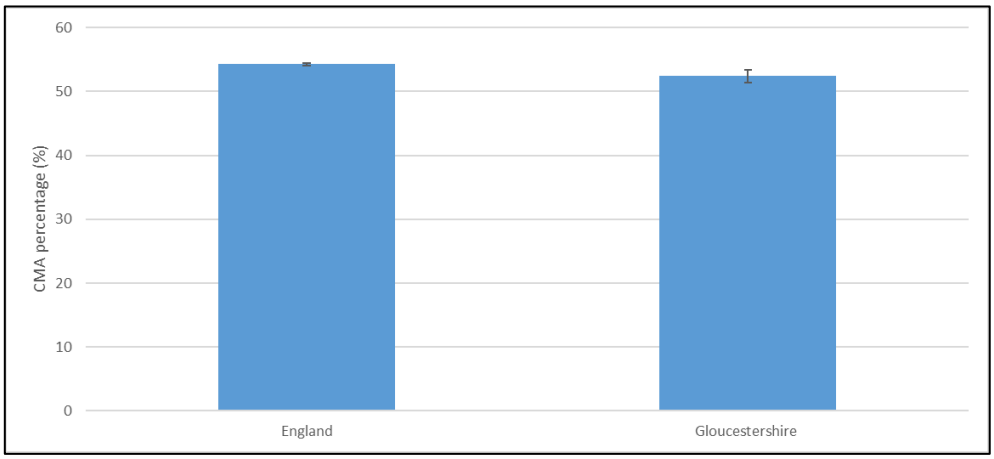


Figure 16. Early cancer diagnosis. Comparison of the percentage of 18 malignant cancers diagnosed at stage 1 and 2, case mix adjusted (CMA) for cancer site, age at diagnosis, sex, and deprivation, between England and Gloucestershire. Source: National Cancer Registration Dataset, National Disease Registration Service, NHS Digital (2019-21).

The percentage of cancers diagnosed at stage 1 and 2 is significantly lower in Gloucestershire compared to the England average. In Gloucestershire, 52.4% of cancers were diagnosed at stages 1 and 2, compared to 54.3% in England. Understanding the drivers for this variation will inform priorities in our cancer programme.

2.5.2 Associated programmes of work

We have a large programme of work to increase early-stage diagnosis of cancers in areas of deprivation and in diverse ethnic communities. This includes the following initiatives:

[12] Cancer survival in England, cancers diagnosed 2016 to 2020, followed up to 2021
[13] Core20PLUS5: Evidence for the five clinical priorities

- Development of the Cancer Health Inequalities Toolkit to look at variation across the county and by communities that experience health inequalities, which will inform a targeted approach to improving access for these communities.
- Public awareness events to help people from communities that have a lower awareness of the signs and symptoms of cancer about the importance of early detection and screening.
- The Non-Site Specific (NSS) service was launched in July 2022 in 3 PCNs in areas of high deprivation and has now been rolled out to 100% of practices covering the whole Gloucestershire population. It is a cancer exclusion service for adult patients who have symptoms that may indicate cancer but do not fit the referral criteria for a site specific urgent suspected cancer pathway.
- Targeted Lung Health Checks (TLHC) are being launched in Gloucestershire's most deprived PCN population, with roll-out being extended to other Core20 populations over the coming year.
- A collaborative approach with system partners is being taken to increasing access to screening and other cancer services for Gloucestershire's Core20 population living in Inner City Gloucester.
- Faecal Immunochemical Testing (FIT) for patients with signs and symptoms of colorectal cancer to identify those requiring a Lower GI Urgent Suspected Cancer referral and supporting PCNs to target action to address variation in completion of FIT tests in symptomatic patients by deprivation.

2.5.3 Further recommendations

Explore variation in early-stage cancer diagnosis at lower population levels and across different protected characteristic and inclusion health groups and implement appropriate interventions.

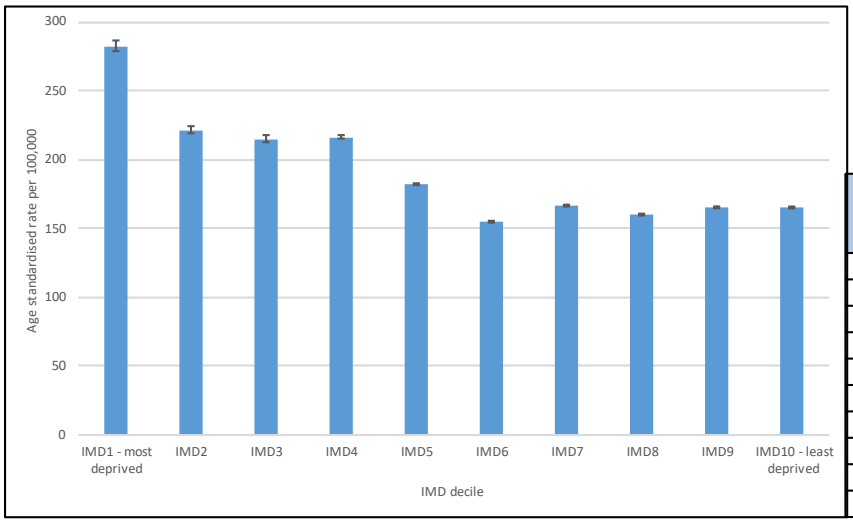
2.6 Cardiovascular disease

Cardiovascular diseases (CVD) are strongly associated with health inequalities, contributing to around one-fifth of the life expectancy gap between the most and least deprived quintiles in men and women[14]. Research suggests that the incidence of high blood pressure within the most deprived communities is roughly double that of the most affluent areas and people living in the most deprived areas are nearly twice as likely to have a stroke – which has led hypertension case finding to be one of the five clinical priorities for the Core20+5 strategy[15].

[14] How inequalities contribute to heart and circulatory diseases

[15] Core20PLUS5: Evidence for the five clinical priorities

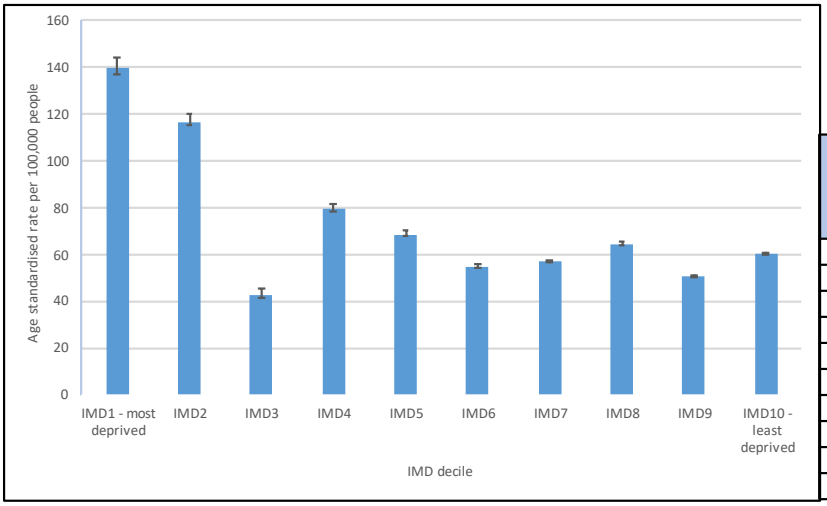
2.6.1 Stroke admissions – data and analysis



IMD Decile	Age standardised rate of non -elective admissions for stroke per 100,000 people
IMD1 - Most deprived	281.5
IMD2	221.4
IMD3	214.8
IMD4	215.9
IMD5	181.9
IMD6	154.8
IMD7	166.8
IMD8	159.5
IMD9	165.5
IMD10 - Least deprived	164.8

Figure 17. Stroke admissions. Age standardised rate per 100,000 people of admissions to hospital where stroke is the primary diagnosis, broken down by IMD decile. Source: National Commissioning Data Repository, Secondary Uses Service, NHS Digital (2023-24).

2.6.2 Myocardial Infarction admission rates



IMD Decile	Age standardised rate of non -elective admissions for myocardial infarction per 100,000 people
IMD1 - Most deprived	139.5
IMD2	116.8
IMD3	42.9
IMD4	79.5
IMD5	68.8
IMD6	55.1
IMD7	57.0
IMD8	64.5
IMD9	50.8
IMD10 - Least deprived	60.5

Figure 18. Myocardial infarction admissions. Age standardised rate per 100,000 people of admissions to hospital for acute myocardial infarction; subsequent myocardial infarction; or myocardial infarction as primary diagnosis, broken down by IMD decile. Source: National Commissioning Data Repository, Secondary Uses Service, NHS Digital (2023-24).

People living in the most deprived decile of Gloucestershire are significantly more likely to be admitted for stroke than any other decile. The rate of non-elective admissions for stroke in IMD1 was 281.5 per 100,000 population compared to 164.8 per 100,000 population for people living in IMD10.

Similarly, people living in IMD1 are significantly more likely to be admitted for myocardial infarction than those living in other deprivation deciles. The rate of non-elective admissions for myocardial infarction for people in the most deprived decile was more than double the rate of admissions for people living in the most affluent decile (139.5 admissions per 100,000 population in IMD1 compared to 60.5 per 100,000 population in IMD10).

2.6.3 Treatment using prescribed CVD drugs – Data and analysis

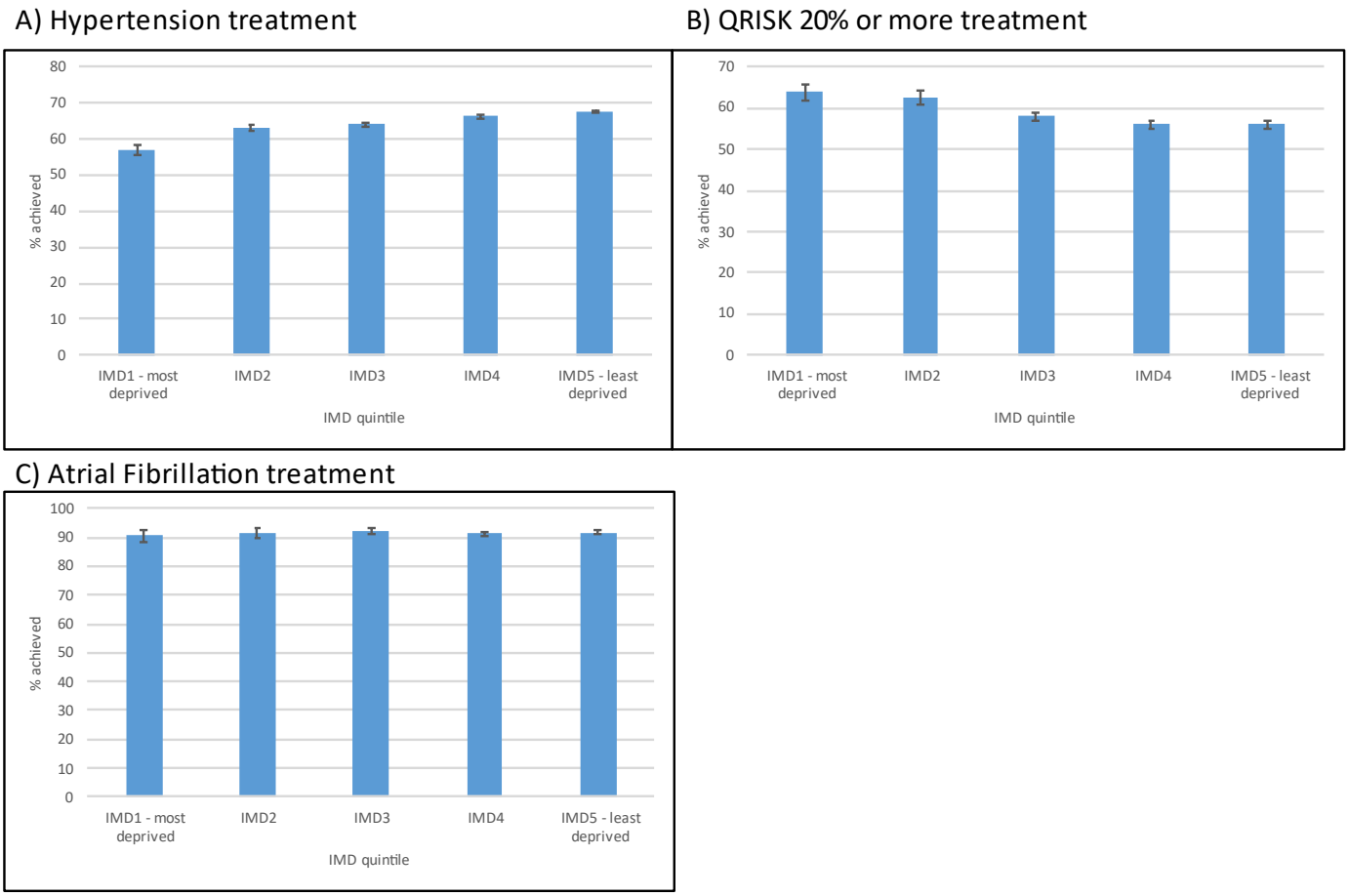


Figure 19. Treatment to target for CVD related conditions. A) Proportion of people with diagnosed hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold. B) Proportion of people with no GP recorded CVD and a QRISK score of 20% or more, on lipid lowering therapy. C) Proportion of people with diagnosed atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy. Data shown by deprivation quintile. Inclusion criteria is people aged 18 and over. Source: Cardiovascular Disease Prevention Audit (CVDPREVENT), Office for Health Improvement and Disparities and the NHS Benchmarking Network (to December 2023).

Adults with diagnosed hypertension living in the most deprived quintile of Gloucestershire are significantly less likely to be treated to target compared to those living in all other quintiles. The proportion of adults with hypertension being treated to target generally increases with affluence; for example, 57% of people living in IMD1 were treated to target for their hypertension compared to 67.6% of people living in IMD5.

Adults with a QRISK score of 20% or more living in the two least deprived quintiles of Gloucestershire are significantly less likely to have received a prescription for lipid lowering therapy than those living in the two most deprived deciles. The proportion of adults with a QRISK score of 20% or more in IMD1 on lipid lowering therapy was 63.8% compared to 56.1% of those in IMD5.

There is no significant difference between adults with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy based on deprivation decile.

In common with results seen nationally, the prevalence and access to care is not consistently split by the most and least deprived in Gloucestershire. Further work to understand and address these differences in treatment variation will feed into the work of the CVD Clinical Programme Group as outlined in the further work section.

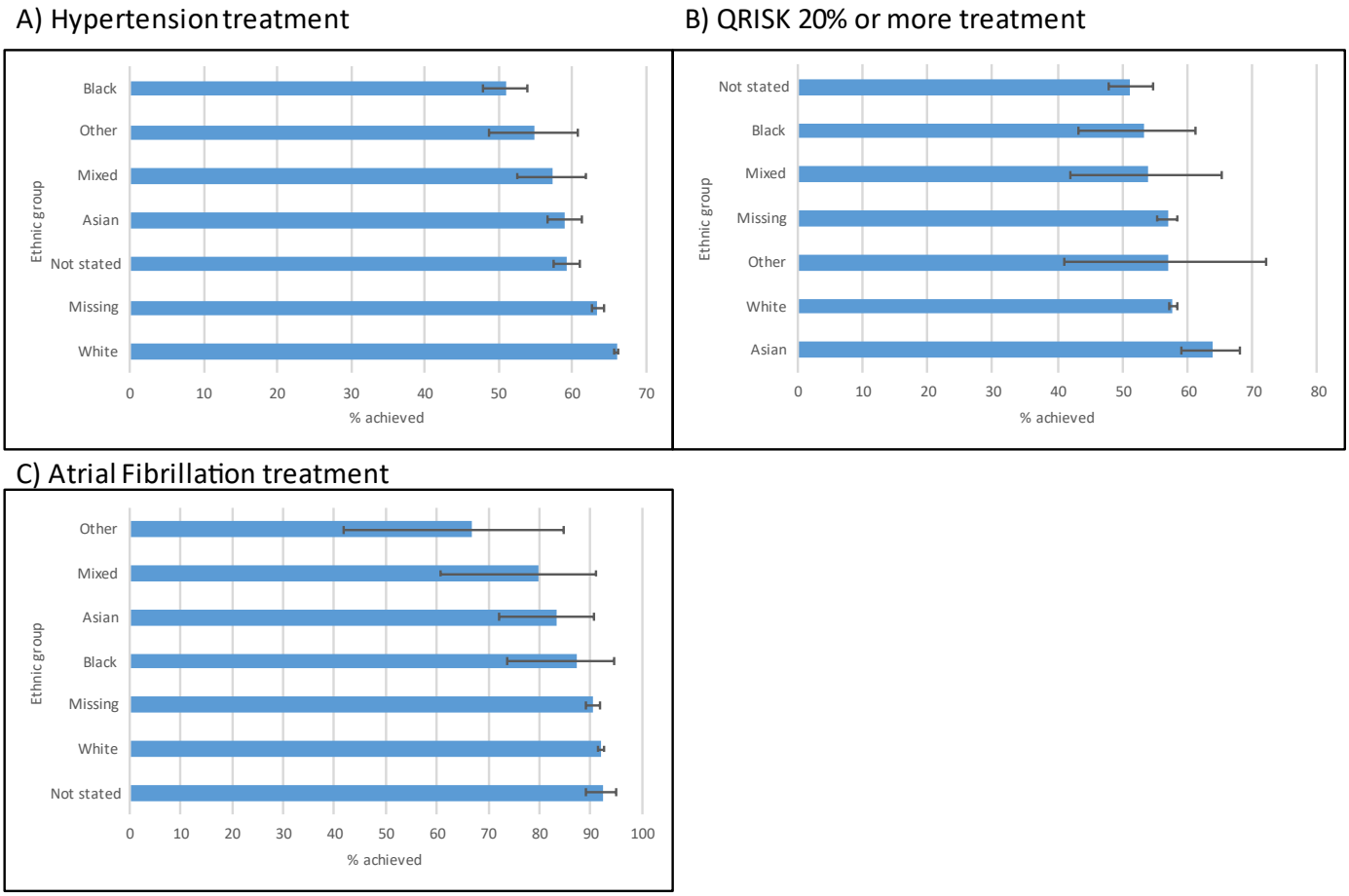


Figure 20. Treatment to target for CVD related conditions. A) Proportion of people with diagnosed hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold. B) Proportion of people with no GP recorded CVD and a QRISK score of 20% or more, on lipid lowering therapy. C) Proportion of people with diagnosed atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy. Data shown by ethnic group. Inclusion criteria is people aged 18 and over. Source: Cardiovascular Disease Prevention Audit (CVDPREVENT), Office for Health Improvement and Disparities and the NHS Benchmarking Network (to December 2023).

Adults from Black ethnic groups with diagnosed hypertension were significantly less likely to be treated to target compared to those from White and Asian backgrounds, while people from Asian and Mixed backgrounds were significantly less likely to be treated to target than people from White backgrounds.

Adults from Asian ethnic groups with a QRISK score of 20% or more were significantly more likely to be on lipid lowering therapy than adults from White backgrounds.

Adults from White backgrounds with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more were significantly more likely to be treated with anticoagulation drug therapy compared to those from Black and Mixed ethnic groups. As noted previously, in Gloucestershire our ethnic minority populations are more likely to be in our most deprived areas and therefore may be the same cohort as our Core20 population.

2.6.4 Associated programmes of work

Blood pressure has been identified as an 'Exemplar Theme' across our Integrated Care Partnership and we are working towards the national ambition of finding 80% of the expected number of people with high blood pressure and ensuring that they are treated to target by 2025. Some of the initiatives that we are delivering to achieve this include:

- Recruitment of CVD Champions at PCN level to provide additional infrastructure support for General Practices to stratify and identify patients with high blood pressure and other CVD risk factors.
- Projects with the voluntary and community sector, including GL11 Community Hub, to offer BP checks in non-health settings, and offering support for people who may be less likely to feel confident in following through with treatment and health behaviour change.
- Insights work in inner city Gloucester to understand barriers to having blood pressure and health checks- to inform other projects in the community to increase diagnosis and treatment in the most deprived communities.
- Recruitment of a CVD Specialist at county level to support training, education and sharing best practice on the use of stratification tools to identify and treat patients who are at high risk or who are not being optimally treated for hypertension.
- Promotion of blood pressure testing in the community through social marketing and behaviour change activities.
- Data analysis to identify groups at higher risk of hypertension.
- Working with General Practices and PCNs with low performance in relation to the diagnosis or treatment of hypertension to understand barriers and linking with local voluntary and community sector organisations to develop bespoke interventions to support hypertension management.
- Delivery of social marketing and behaviour change activities to raise awareness of the links between salt intake and blood pressure, and to encourage lifestyle changes in the population as part of our prevention approach to tackling high blood pressure.

2.6.5 Diabetes – Data and analysis

Diabetes incidence and treatment shows strong association with deprivation and ethnicity – particularly Type 2 diabetes, with population groups with higher incidence of Type 2 diabetes also least likely to be receiving all recommended treatments for their condition nationally[16]. As we continue to work on improving diagnosis, treatment compliance and preventative work, we should see the gap between deprivation quintiles narrow over time.

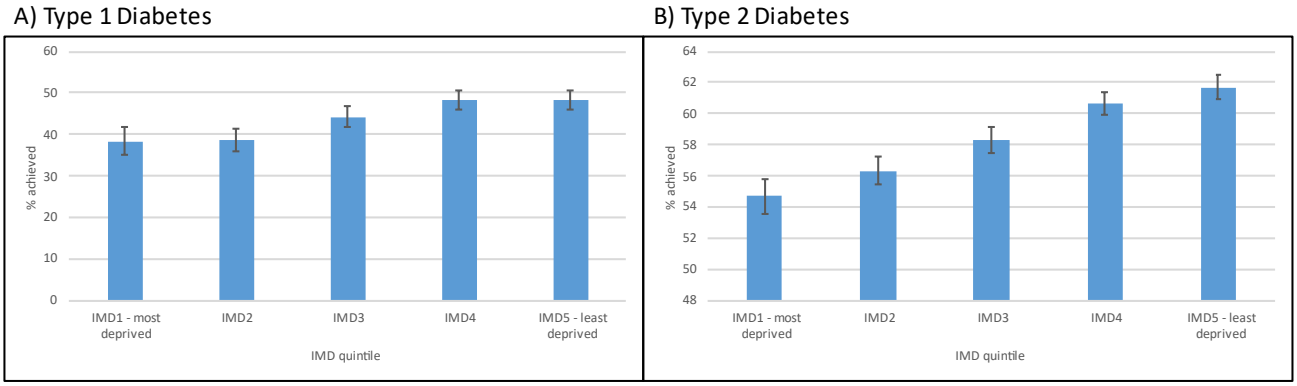


Figure 21. Proportion of people with Type 1 diabetes (A) and Type 2 diabetes (B) receiving all 8 primary care processes by deprivation quintile. Inclusion criteria is people with diabetes of all ages with a valid IMD quintile. Source: National Diabetes Audit (NDA), NHS England (January 22-March 2023).

The proportion of people with Type 1 and Type 2 diabetes receiving all 8 primary care processes in Gloucestershire increases as the level of deprivation decreases. People with Type 1 living in the most affluent quintile of Gloucestershire (IMD5) were significantly more likely to have received all 8 primary care process compared to those living in the two most deprived quintiles (IMD1 and 2). People with Type 2 diabetes living in the two most deprived

[16] National Diabetes Audit 2021-22, Report 1: Care processes and treatment targets, detailed analysis report

quintiles were significantly less likely to have received all eight care processes compared to those living in the two most affluent quintiles (IMD4 and 5).

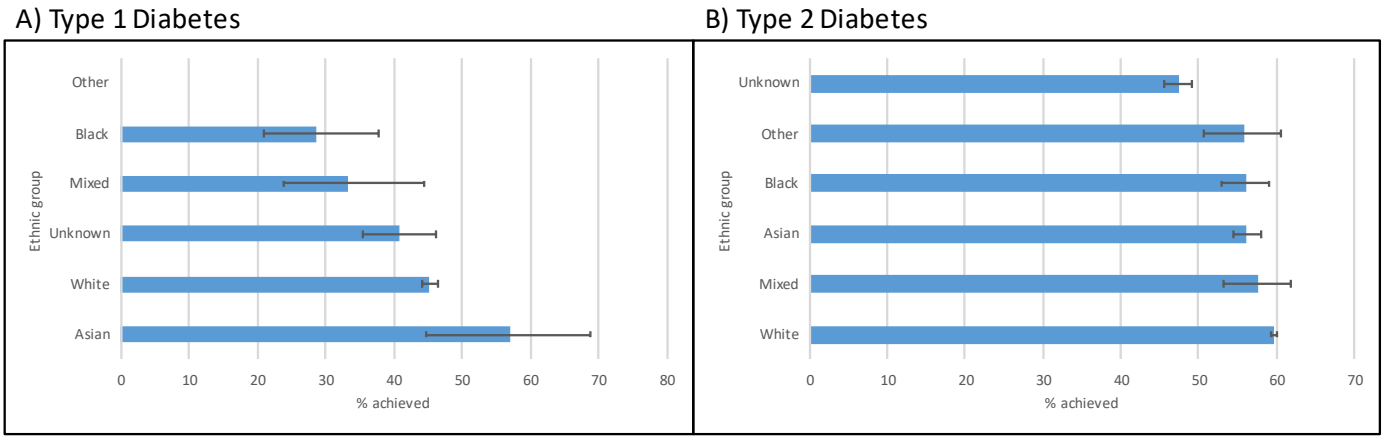


Figure 22. Proportion of people with Type 1 diabetes (A) and Type 2 diabetes (B) receiving all 8 primary care processes by ethnic group. Inclusion criteria is people of all ages with diabetes. Source: National Diabetes Audit (NDA), NHS England (January 22-March 2023).

People with Type 1 diabetes from Black and Mixed ethnic groups were significantly less likely to have received all 8 care processes compared to those from White backgrounds. People with Type 2 diabetes were significantly more likely to have received all 8 care processes if they were from White backgrounds compared to those from Asian or Black backgrounds.

2.6.6 Associated programmes of work

- Roll out of continuous glucose monitoring to those eligible within Gloucestershire.
- Implementation of hybrid closed loop technologies.
- Supporting people to access and complete the National Diabetes Prevention Programme.
- The Paediatric Team at GHFT are a pilot site for Poverty Proofing training for diabetes, which aims to educate and enable healthcare professionals to identify, acknowledge and reduce the impact poverty has on children and young people living with diabetes.
- Delivery of structured education session in Inner City Glos areas, including targeting populations where English is not their first language and offering translation services as part of the local offer. The first group will be with the Slovakian population. We saw more patients at one of these local sessions than we had seen for the whole year because of this initiative.
- Continuation of work stratifying and identifying our most at risk groups, with targeted interventions being piloted in Inner City Gloucester – if successful, this could then be applied in other areas, particularly focussed on our Core20 population.
- Targeted awareness campaigns in area of deprivation and communities less likely to use NHS services.

2.6.7 Further recommendations

We recognise that there is a health inequalities gap in relation to diabetes care and are building health inequalities into our local metrics for both continuous glucose monitoring, and hybrid closed loop technologies, allowing us to monitor variation in uptake, and informing the development of interventions that will improve access for people who

experience health inequalities. Further analysis of the incidence and how to improve the targeting of preventative programmes could also consider multi-morbidity, in line with the national Major Conditions Strategy.[17]

2.7 Smoking cessation

2.7.1 Data and analysis

Smoking is the leading cause of health inequalities and accounts for half of the difference in life expectancy between the most and least affluent communities in England[18] and for this reason has been identified as an 'Exemplar Theme' across our Integrated Care Partnership. Smoking is associated with most indicators of disadvantage and as such all acute hospital providers should ensure universal access to smoking cessation services for inpatients and maternity service users.

Adult acute inpatient settings offering smoking cessation services	Maternity inpatient settings offering smoking cessation services
Gloucestershire Hospitals NHS Foundation Trust	Gloucestershire Hospitals NHS Foundation Trust

Table 3. Adult acute inpatient settings offering smoking cessation services in Gloucestershire. Source: Gloucestershire Hospitals NHS Foundation Trust (2024).

2.7.2 Associated programmes of work

In addition to smoking cessation at the Acute, smoking cessation support is provided at all hospital settings in the county – including our mental health settings. The focus for all our smoking cessation work is to identify greater numbers of smokers and signpost to appropriate smoking cessation through an 'every contact counts' approach. As previously outlined, smoking is a priority for our system and there are a number of programmes and projects supporting our overall aim to drive down prevalence of smoking in Gloucestershire.

- The Healthy Lifestyles Service (HLS) provides support to all smokers aged 12 and over. The service is universal but more actively engages and targets those from protected characteristic and inclusion groups.
- All pregnant women are assessed for carbon monoxide at their first antenatal appointment to identify smokers and refer them to the HLS, where they are offered a full programme of support.
- The 1001 days programme is targeted at expectant women and their families to improve/maintain healthier lifestyles including smoking cessation during pregnancy and up to the child's second birthday.
- One Gloucestershire ICS is supporting the Inner-City Gloucester Primary Care Network (which has the highest smoking rates in Gloucestershire), to take a targeted and proactive approach to helping patients that are less likely to access support or have the highest clinical need, to stop smoking. This same PCN has trained a Polish speaking navigator to provide services to this group of patients- who were identified as being a significant cohort of the smoking population in this PCN.
- The Local Stop Smoking Services and Support Grant (LSSSSG) is being allocated to local authorities and aims to build capacity of local stop smoking services and support more people to quit smoking in line with the Government's plans to create a smokefree generation. Gloucestershire County Council is working to scope and design the local model for stop smoking services in Gloucestershire in collaboration with wider stakeholders.

[17] https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2

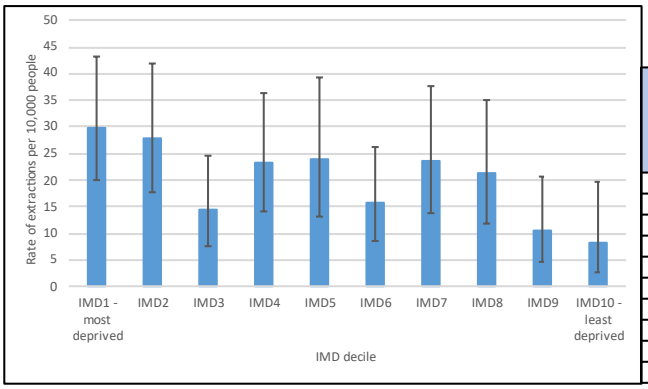
[18] https://fingertips.phe.org.uk/profile/tobacco-control/supporting-information/smokingandinequalities

- An appreciative enquiry is being undertaken in collaboration with VCSE partner organisations to understand the lived experience of smokers in Gloucestershire, many of whom are at risk of experiencing health inequalities.

2.8 Oral health

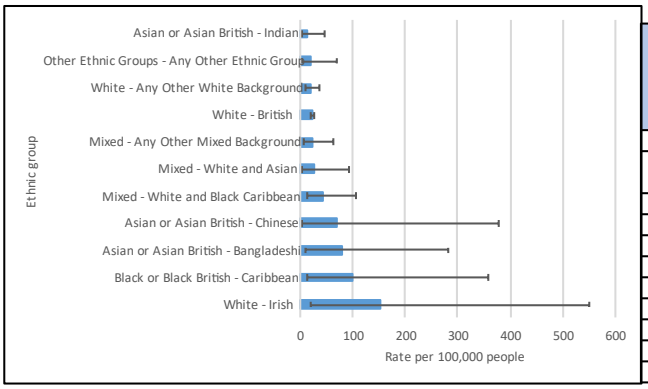
Nationally, there are disparities in access and utilisation of dental services, and there is inequality of oral health across several dental clinical indicators[19]. A key indicator of oral health in children in particular is the incidence of tooth extractions due to decay, which may indicate a lack of dental provision or incidence of poor oral health/diet.

2.8.1 Data and analysis



IMD decile	Total number of children aged 10 and under admitted to hospital as inpatients for tooth extractions due to decay	Age standardised rate per 10,000 people
IMD1 - most deprived	28	29.9
IMD2	23	28
IMD3	13	14.3
IMD4	19	23.3
IMD5	15	23.9
IMD6	14	15.7
IMD7	17	23.5
IMD8	15	21.3
IMD9	8	10.5
IMD10 - least deprived	5	8.4

Figure 23. Tooth extraction admissions due to decay. Age standardised rate per 10,000 children admitted as inpatients to hospital for: major surgical removal of a tooth, surgical removal of a tooth, extraction of multiple teeth, or minor extraction of a tooth by deprivation decile. Inclusion criteria is all children aged 10 years and under. Source: Hospital Episode Statistics, Secondary Uses Service, NHS Digital (2022-23).



Ethnic group	Total number of children aged 10 and under admitted to hospital as inpatients for tooth extractions due to decay	Age standardised rate per 10,000 people
Asian or Asian British - Indian	2	12.6
Other Ethnic Groups - Any Other Ethnic Group	2	19
White - Any Other White Background	10	20.1
White - British	128	22
Mixed - Any Other Mixed Background	4	24.2
Mixed - White and Asian	2	25.3
Mixed - White and Black Caribbean	4	41.3
Asian or Asian British - Chinese	1	67.6
Asian or Asian British - Bangladeshi	2	78.4
Black or Black British - Caribbean	2	99
White - Irish	2	152.7

Figure 24. Tooth extraction admissions due to decay. Age standardised rate per 10,000 children admitted as inpatients to hospital for: major surgical removal of a tooth, surgical removal of a tooth, extraction of multiple teeth, or minor extraction of a tooth by ethnic group. Inclusion criteria is all children aged 10 years and under Source: Hospital Episode Statistics, Secondary Uses Service, NHS Digital (2022-23).

Children aged 10 and under living in the most deprived areas of Gloucestershire were significantly more likely to be admitted as inpatients to hospital for tooth extraction than those living in the most affluent areas. 29.9 children per 10,000 population from IMD decile 1 were admitted for a tooth extraction compared to 8.4 children per 10,000 population from IMD decile 10. However, this may be driven by the small numbers in the dataset.

There was no significant difference in the rate of children aged 10 and under living in different deprivation deciles or from different ethnic groups who had been admitted as inpatients to hospital for tooth extractions due to decay. As

[19] Inequalities in oral health in England: summary

above, this may be driven by the small numbers involved. It appears that children from Asian, Black or Black British – Caribbean, and White Irish backgrounds have higher rates of admission to hospital for tooth extractions.

2.8.2 Associated programmes of work

- Schools (in IMD areas 1-6) are undertaking the supervised toothbrushing programme with At Home Dental support.
- At Home Dental are supporting oral health in schools but distributing toothbrush packs and carrying out training, along with oral health talks and question and answer sessions for parents.
- The First Dental Steps Health visitor led programme is underway with access to oral health packs; toothbrush, toothpaste and specific drinking cups that are being universally distributed at 9-12 months baby check appointments in Gloucestershire.
- Additional dental activity is being purchased from providers with capacity initially in Core20 areas with the potential that these appointments could be ringfenced to children and exempt patients.
- Health Inequalities fellowships are being offered to Dental Practices in the Core 20 areas with the aim of aiding retention and recruitment.

2.9 Learning disability and autistic people

2.9.1 Health checks – data and analysis

People with a learning disability (LD) have shorter life expectancies than the wider population, caused by a higher incidence of some physical health problems (such as diabetes and epilepsy) and a lower likelihood of receiving treatment[20]. Physical health checks help identify problems at an early stage and then can be used to proactively manage people's health. Tracking overall uptake of health checks in the county ensures that the learning disability population is appropriately being offered and completing these checks.

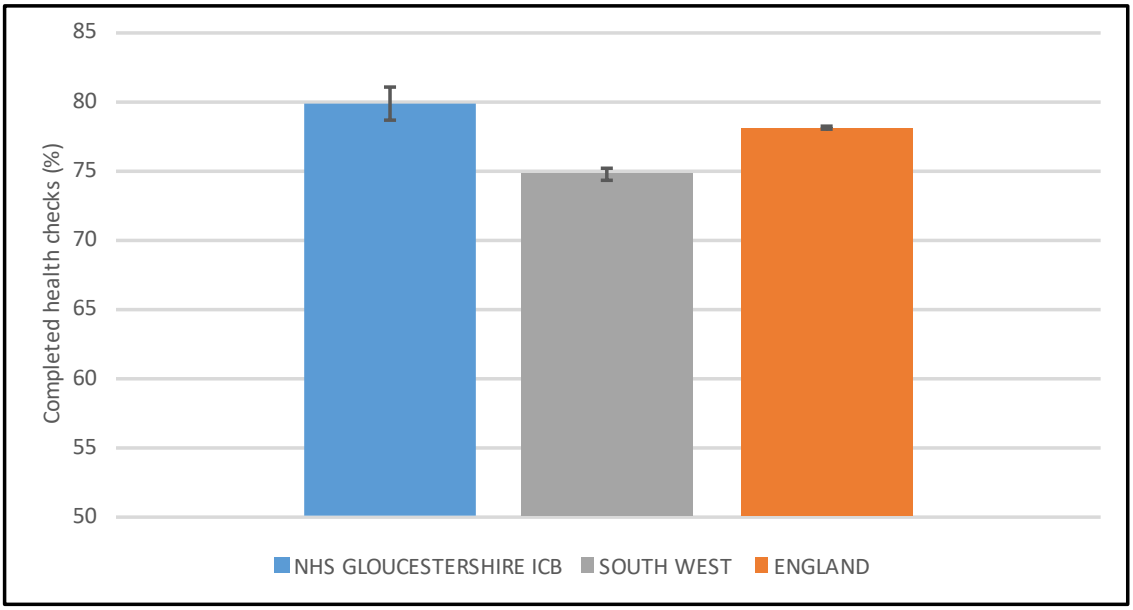


Figure 25. Learning Disability Annual Health Checks. Comparison between the proportion of eligible people with a completed Learning Disability Annual Health Check in Gloucestershire, the South West, and England. Inclusion criteria is people aged 14 years and over with a learning disability. Source: Learning Disability Health Check Scheme Statistics, NHS Digital (2022-23).

[20] The learning disability health check programme

The proportion of eligible patients with a completed Learning Disability Annual Health Check was significantly higher in Gloucestershire compared to the South West and England averages. In Gloucestershire, 79.9% of eligible patients had a completed Learning Disability Annual Health Check compared to 74.9% of eligible patients in the South West and 78.1% of eligible patients in England.

2.9.2 Inpatient Care – data and analysis

People with a learning disability are disproportionately likely to have a long length of stay in inpatient care – with over half of LD patients in an inpatient setting having a total stay of more than 2 years nationally[21]. Reduction in the use of inpatient care should be seen over time evidencing a lessening reliance on this care setting and ensuring people have access to appropriate services at the right time and in the right setting.

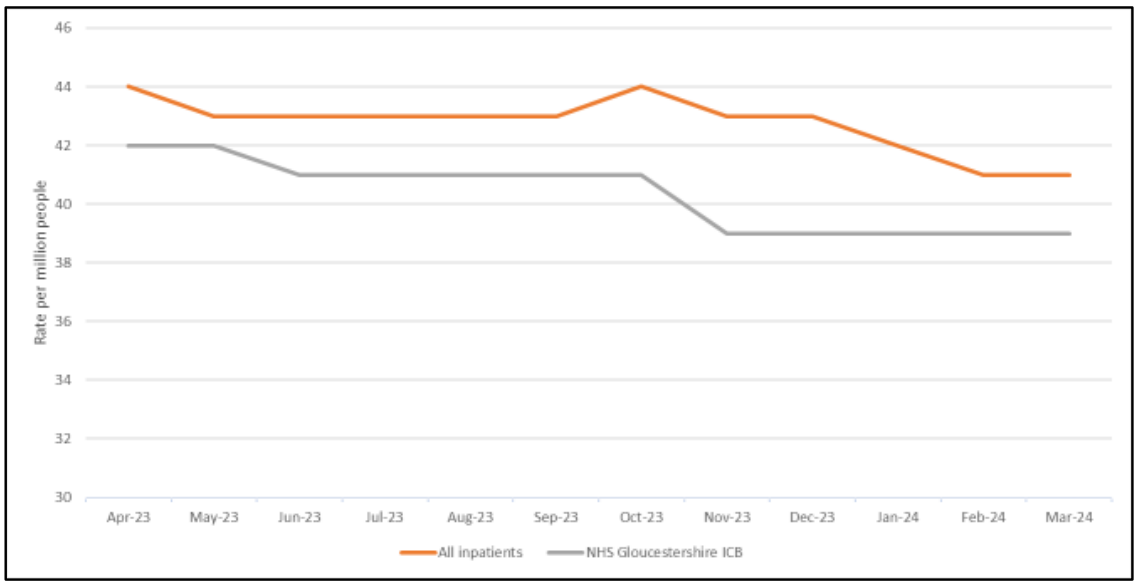


Figure 26. Adult Mental Health inpatient rates. Comparison between the rate per million people admitted to hospital for Adult Mental Health services with a learning disability or autism in Gloucestershire (NHS Gloucestershire ICB) and England (All inpatients). Inclusion criteria is adults aged with a learning disability or autism. Source: Learning Disability Service Statistics, NHS Digital (April 2023 – April 2024).

Adult Mental Health inpatient rates for people with a learning disability and autistic people in Gloucestershire decreased gradually between April 2023 and March 2024, from 42 per million population to 39 per million population. This was lower than the rate for England ("all inpatients") – however the numbers are extremely small and direct comparison is challenging.

2.9.3 Associated programmes of work

- Identification of people with a learning disability to ensure the primary care registers are complete and support to primary care to maintain uptake of health checks.
- Targeted support for children and young people, including bespoke support for autistic children and young people.

[21] Learning disabilities: policies to reduce inpatient care

- Investment in an Adult Autism Acute Liaison Nurse in the local hospital trust to improve the support available to autistic people admitted to hospital.

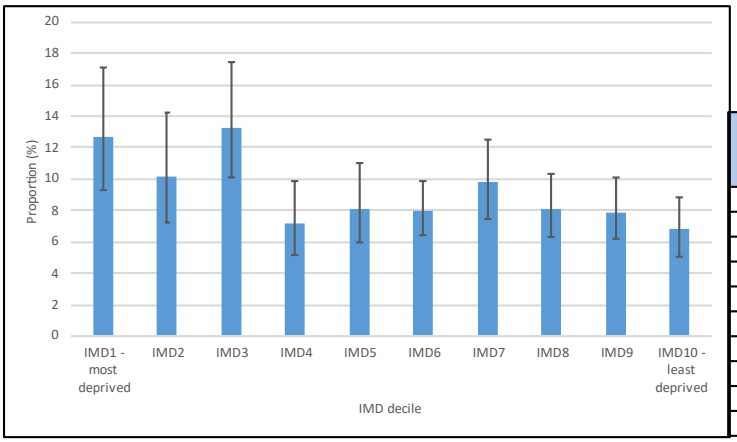
2.9.4 Further recommendations

Further work in understanding the breakdown of health check uptake by different groups within the LD population would be helpful in directing future strategies to increase uptake.

2.10 Maternity and neonatal

Preterm birth incidence is between 7-8% nationally and has been shown to have a strong association with deprivation nationally[22], with smoking in pregnancy a key associated factor. Understanding the incidence of preterm births across our county helps to direct resources such as our continuity of care pathway and smoking cessation services, and tracking the incidence of preterm birth over time will indicate success of these programmes (where reductions are seen).

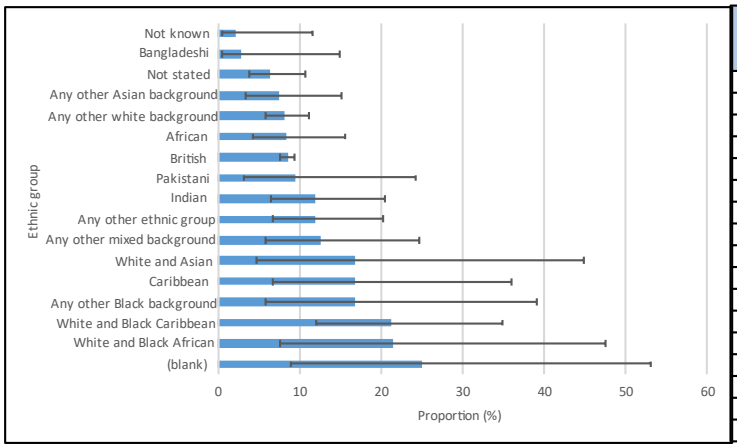
2.10.1 Data and analysis



IMD Decile	Total births	Preterm births (<37 weeks)	Proportion of preterm births (<37 weeks) (%)
IMD1 - Most deprived	283	36	12.7
IMD2	286	29	10.1
IMD3	330	44	13.3
IMD4	486	35	7.2
IMD5	454	37	8.1
IMD6	938	75	8
IMD7	543	53	9.8
IMD8	716	58	8.1
IMD9	745	59	7.9
IMD10 - Least deprived	710	48	6.8

Figure 27. Preterm births under 37 weeks. Proportion of babies who were born preterm (<37 weeks) recorded by Gloucestershire Hospitals NHS Foundation Trust Maternity Services, by deprivation decile. Source: Maternity Services Data Set, NHS Digital (2022-23).

[22] How are socioeconomic inequalities in preterm birth explained by maternal smoking and maternal body mass index: A mediation analysis



Ethnic Group of mother	Total number of births	Preterm births (<37 weeks)	Proportion of preterm births against total births by ethnicity (%)
Not known	45	1	2.2
Bangladeshi	34	1	2.9
Not stated	202	13	6.4
Any other Asian background	81	6	7.4
Any other white background	418	34	8.1
African	96	8	8.3
British	4197	356	8.5
Pakistani	32	3	9.4
Indian	84	10	11.9
Any other ethnic group	92	11	12
Any other mixed background	48	6	12.5
Any other Black background	18	3	16.7
Caribbean	24	4	16.7
White and Asian	12	2	16.7
White and Black Caribbean	47	10	21.3
White and Black African	14	3	21.4
(blank)	12	3	25

Figure 28. Preterm births under 37 weeks. Proportion of babies who were born preterm (<37 weeks) recorded by Gloucestershire Hospitals NHS Foundation Trust Maternity Services, by ethnic group. Source: Maternity Services Data Set, NHS Digital (2022-23).

People living in the most deprived areas of Gloucestershire were significantly more likely to have a preterm birth compared to those in the most affluent areas. For example, 12.7% of births by people living in the most deprived decile (IMD1) were preterm births, compared to 6.5% of births by people living in the least deprived decile (IMD10).

There was no significant difference in the proportion of preterm births by ethnic group. It is likely that this is driven by poor data quality and low numbers.

2.10.2 Associated programmes of work

- Two Maternity Continuity of Carer teams have been established in areas of high deprivation and diverse ethnic communities to reduce maternal health inequalities.
- Maternity Support Workers (MSWs) support the Continuity of Carer teams to provide additional safeguarding support, increased antenatal education, and ensure access to interpreters and translated resources.
- The Perinatal Emotional Health and Wellbeing Service (PEHWS) supports women with low/moderate perinatal mental health needs, focussing on those from the most deprived areas of the county, diverse ethnic communities, and inclusion health groups.
- Forest Voluntary Action Forum (FVAF) offers a Young Mums support group, providing support and guidance to mothers under 20 years old.
- The Perinatal Pelvic Health Service provides information and support for women in pregnancy and postnatally and includes free physio groups in areas of high deprivation or where there are large numbers of women from diverse ethnic groups.
- GHFT are distributing lanyards with a visible quick guide to booking an interpreter to midwives, to increase awareness and uptake of the Interpreting and Translating service.
- Work to identify and support smokers to quit, including those accessing maternity services is detailed in the Smoking Cessation section above.

2.10.3 Further recommendations

There is an increased focus on maternity services nationally due to challenges, including lack of staffing.

Although incidents of maternal mortality and morbidity are small in number, we know that there are disparities in maternal outcomes for women from diverse ethnic groups and those living in deprived areas, and in Gloucestershire our diverse ethnic populations are more likely to be living in our most deprived deciles. The Local Maternity and

Neonatal System is currently developing more detailed reporting to allow specific areas of variation between our population and inclusion groups to be fully identified and actioned.

It is important that we keep our maternity services under review and continue to learn and make improvements across the maternity pathway so that we can close the inequality gap in maternal outcomes.

3.0 Conclusion

It is a priority of the One Gloucestershire Integrated Care System that every service across our system understands the health inequalities that exist in our population; the data presented here describes and highlights the inequalities that exist in our area. Despite having good outcomes overall, this report shows our health inequalities gap, with people living in the most deprived communities and those from diverse ethnic backgrounds experiencing poorer access, experience, and outcomes with respect to our healthcare services. This is despite at least a decade of effort to address such issues.

We recognise that there is an urgent need for effective approaches to prevention across our system alongside strategies that combat inequalities within our healthcare services, particularly 'upstream' interventions which impact on the wider determinants of health and wellbeing and address the biggest risk factors causing premature death or disease, including smoking, poor diet, high blood pressure, obesity, and alcohol and drug use. We are committed to embedding prevention, early intervention and tackling health inequalities across all our work and in our health, care and wellbeing policies and programmes, for example, Gloucestershire's Joint Health and Wellbeing Strategy sets out 7 priorities for joint focus and action, which include increasing physical activity and promoting healthy lifestyles, with a focus on reducing the gap in childhood obesity rates between the most and least deprived parts of the county.

We have developed a framework that sets out our approach to addressing health inequalities, which focuses on contributory activity, targeted interventions to improve health and remove barriers, and improving the equity of mainstream service delivery. The adoption of this framework by the One Gloucestershire Integrated Care System will enable our commitment to tackling health inequalities to be visible throughout all of our work.

This review showed that in some of our datasets, a significant amount of demographic data is not stated, unknown or missing. Our long-term ambition is to improve our data quality and completeness, and routinely present analysis by ethnicity and deprivation, as well as aim to be able to consider wider characteristics and vulnerable groups with more confidence in our recording systems.

Data from this report will be fed into our programme areas to continue to inform action to achieve health equity. The data will be subject to an annual review, and we expect to see improvements year-on-year to narrow the health inequalities gap in Gloucestershire.