South East London Integrated Care System

NHS South East London

Health Inequalities Report

Publication September 2024

We are a partnership of NHS commissioners and providers, covering the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark and the voluntary and community sector

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1. Health Inequalities

1.1. Introduction

Health inequalities are systematic, unfair and avoidable differences in health across the population and between different groups within society. They arise because of the conditions in which people are born, grow, live, work and age. Within the wider context, health inequalities are also driven by inequalities in the access people have to health services, their experience of and outcomes of healthcare.

South East London Integrated Care Board (SEL ICB) has a responsibility to address these inequalities, including working to ensure equity of access with regards healthcare access, experience and outcomes. Reducing inequalities represents a core priority for the South East London system and a golden thread that runs through our strategic and operational planning objectives and priorities, inclusive of enabling investment to support a step change in action and outcomes related to inequalities in our population.

NHS England's 2023/24 Planning Guidance details a continued drive towards narrowing health inequalities in access, experience and outcomes. In embedding measures to improve health and reduce inequalities, the guidance sets out the five priority areas for addressing health inequalities that ICBs must continue to deliver against.

This report is designed by South East London ICB to identify key metrics relating to these overall aims and should be read alongside the SEL ICB Annual Report and Annual Accounts 23/24 plus our Joint Forward Plan all of which are published on our website. Each section within this report addresses a specific health domain, looking at health inequalities by age, deprivation, ethnicity, and gender.

To further enhance our readers' understanding of health inequalities we have included an explanation of the Index of Multiple Deprivation (IMD) referred to in this report. The Index of Multiple Deprivation (IMD) is the official national measure of relative deprivation for all small areas (e.g., neighbourhoods) in England. It ranks every area in the country based on different indicators of deprivation. These indicators include levels of income, employment, education, crime and many others, which are combined to produce a deprivation score for the area. The scores for each area are then ranked from most deprived (rank 1) to least deprived. These rankings can then be divided into deciles (10 equal groups) or quintiles (5 equal groups). This then gives every area in England an Index of Multiple Deprivation.

The area a patient lives in can then be joined up on this Index of Multiple Deprivation to understand the differences between levels of deprivation. In the report, some metrics refer to deciles simply as 'D', e.g. D2 represents Decile 2. Quintiles are referred to as 'Q' e.g. Q1 represents Quintile 1, the most deprived quintile, made up of patients living

in the most deprived 20% of England. A table showing the percentage of the South East London population that reside in each decile and quintile is set out below.

Deprivation Decile	% of SEL Population	Deprivation Quintile	% of SEL Population
1	1.33%	1	18.41%
2	17.08%		
3	20.32%	2	36.16%
4	15.84%		
5	11.96%	3	21.21%
6	9.24%		
7	7.07%	4	13.39%
8	6.32%		
9	6.82%	5	10.84%
10	4.02%		

1.2 Approach in this document

In November 2023, NHS England published its first Statement on Information on Health Inequalities. The Statement is designed to help relevant NHS bodies, such as the ICB, understand their duties and powers, and how they can be exercised. The requirement is for the ICB to analyse and publish findings on specific health domains.

South East London ICB has undertaken an analysis of both national and local (internal) datasets to draw together a single assessment on health inequalities. We recognise that there are wider determinants driving inequalities in health, such as but not limited to deprivation, education, economic status, availability and quality housing, community development.

Identifying health inequalities is both complex and limited by a lack of high-quality data. Some of the inequalities highlighted in this document have already been identified with on-going partnership and improvement work in place to seek to address them. Others are lesser-known inequalities that would require further investigation with an opportunity for learning and redesigning our approach to addressing them.

Overall, this document presents a data driven opportunity for South East London ICB to review its plans to tackle inequalities, alongside on going work to further improve available data to ensuring we are fully capitalising on the information requirements as set out in the NHS England's Statement on Information on Health Inequalities.

1.3. Key findings

It has been difficult to report effectively on all measures set out in the NHS England Health Inequalities Statement, due to the following:

- the lack of standardisation and depth across externally published dashboards and local dashboards;
- the lack of availability of up-to-date information in national dashboards to understand local applicability; and
- the implementation of EPIC (the new Electronic Patient Record system) within our Integrated Care System (ICS) partner organisations Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH). EPIC launched in October 2023 with implementation continuing during 2023/24 and this has further impacted data availability for specific periods. This is a short-term issue with work to secure full data flows not EPIC in place.

Across majority of the health domains reviewed in this report, deprivation has a strong correlation with health inequalities. Of note, more than 50% percentage of South East London population live within Quintile 1 and Quintile 2 of the most deprived areas in England. It is equally important to add that while correlation can help show a relationship, in this instance between deprivation and health inequalities, correlation does not imply causation.

Two health domains suggest evidence of clear over-representation:

- Elective Recovery-a marked disproportionate disparity between male and female patients in Elective Recovery related activity rates for face to face and virtual (telephone) outpatients appointments, with women attending at a much higher rate.
- Mental Health- data shows that men have a low completion rate for Severe Mental Illness (SMI) physical health checks. Younger age group 18-34 and people from the Black ethnic group have a higher rate of Mental Health Act detentions.

The data on ethnicity continues to vary across health domains. It is important to note that occurrences of the Unknown ethnicity being comparable in size to other ethnic groups, makes it is difficult in this report to draw any definitive conclusions regarding ethnicity and its impact on health inequalities. South East London ICB continues to draw on insights gained from our communities, patients and service users. Notwithstanding this, more needs to be done in the recording of ethnicity to enable meaningful data being used to inform service provision and planning to tackle health inequalities.

1.4. Next steps

- This is South East London ICB's first health inequalities report in response to the requirements set out in the NHS England's Statement on Information on Health Inequalities. This report has been produced utilising both national and local dashboards. Over the year, we plan to progress work on validating our data sources.

- The health domains covered in this report will in some instances already have on-going partnership and improvement work in place to continue reducing health inequalities. Other health domains would have lesser-known inequalities that would require further investigation and will provide an opportunity for learning and redesigning our approach.

- We will continue to use this review to inform our planning guidance response, health inequalities plans and on-going improvement work. The data will be used to inform our strategic and operational planning including our forthcoming Joint Forward Plan refresh.

2. Elective Recovery

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

Analysis of the size and shape of the waiting list focuses on pathways waiting over 52 weeks and over 65 weeks. Analysis has not been included on pathways waiting over 18 weeks due to this element of the Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH) waiting lists not being fully validated at year end due to EPIC implementation.

Percentage of patients waiting more than 52 weeks

This metric is reporting on the percentage of patients waiting more than 52 weeks as of end March 2024.

Of the total South East London waiting list, 5.8% of patients are waiting longer than 52 weeks. Overall, there is little difference in the percentage of patients waiting longer than 52 weeks across demographic groups: age, deprivation, ethnicity and gender.

By age, the cohort with the lowest percentage of individuals on the waiting list who are waiting longer than 52 weeks is those aged 10 to 19 (4.9%). The age group with the highest percentage of patients is those aged 50 to 59 (6.5%). In relation to the overall SEL population, those below the age of 40 tend to be under-represented in the cohort waiting longer than 52 weeks. Conversely, the age groups above 50 are over-represented in this group. Those aged 40 to 49 have equal representation. This is as expected given that the older age group utilise physical health services more than the younger age group.

By deprivation, the quintile with the lowest percentage of individuals on the waiting list who are waiting longer than 52 weeks is the least deprived cohort (Quintile 5 = 5.3%) and the cohort with the highest percentage is those in the most deprived cohort (Quintile 1 = 6.3%). Those in the least deprived cohort are proportionally represented in the cohort waiting more than 52 weeks (10.8% of the registered population vs 10.7% of the patients waiting 52+ weeks). In contrast, Quintile 1 are slightly over-represented in those waiting 52+ weeks (18.2% of the registered population vs 20.5% of those waiting 52+ weeks).

By ethnicity, the group with the lowest percentage of people waiting 52+ weeks is the Asian ethnicity (5.5%) and the Other ethnicity has the highest percentage (6.1%). As the Unknown ethnicity is comparable in size to other groups within the 52+ week waiters, it is difficult to draw any definitive conclusions regarding ethnicity.

By gender, there are no notable differences between male and female long waiters, male (5.6%) and female (5.9%). Females make up 50.2% of the population registered with a GP in South East London but 58.9% of the total waiting list, which suggests women are over-represented in the total waiting list.

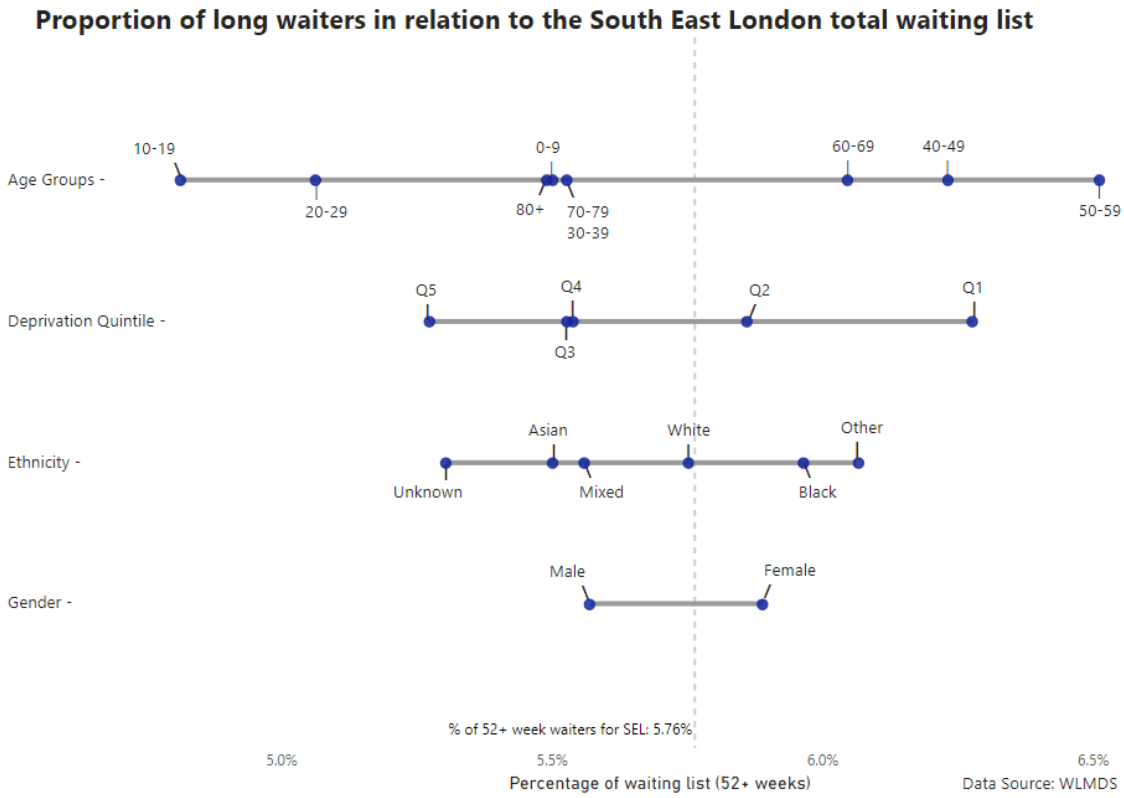

Figure 1

Percentage of patients waiting more than 65 weeks

This metric is reporting on the percentage of patients waiting more than 65 weeks as of end March 2024. The overall percentage of patients waiting 65 or more weeks for South East London was 5.8%.

By age, the group with the lowest percentage of individuals on the waiting list who are waiting 65+ weeks is those aged 20 to 29 (0.85%). The age group with the highest percentage of patients is those aged 0 to 9 (1.41%). In relation to the overall SEL population, those below the age of 40, tend to be under-represented in the cohort waiting 65+ weeks. Conversely, the age groups above 50 are over-represented in this group. Those aged 40 to 49 have equal representation. This is as expected given that the older age group utilise physical health services more than the younger age group.

By deprivation, the quintile with the lowest percentage of individuals on the waiting list who are waiting 65+ weeks is the second least deprived cohort (Quintile 4 = 0.99%) and the cohort with the highest percentage is those in the most deprived cohort (Quintile 1 = 1.31%).

By ethnicity, the group with the lowest percentage of people waiting 65+ weeks is the White ethnicity (1.11%) and the Black ethnicity has the highest percentage (1.31%). As the Unknown ethnicity is comparable in size to other groups within the 65+ week waiters, it is difficult to draw any definitive conclusions regarding ethnicity.

By gender, there are no notable differences between male and female long waiters, male (1.14%) and female (1.17%). Females make up 50.2% of the population registered to a GP in South East London but 59.6% of the 65+ week waiters, which suggests women are over-represented in this group due to their over-representation in the total waiting list.

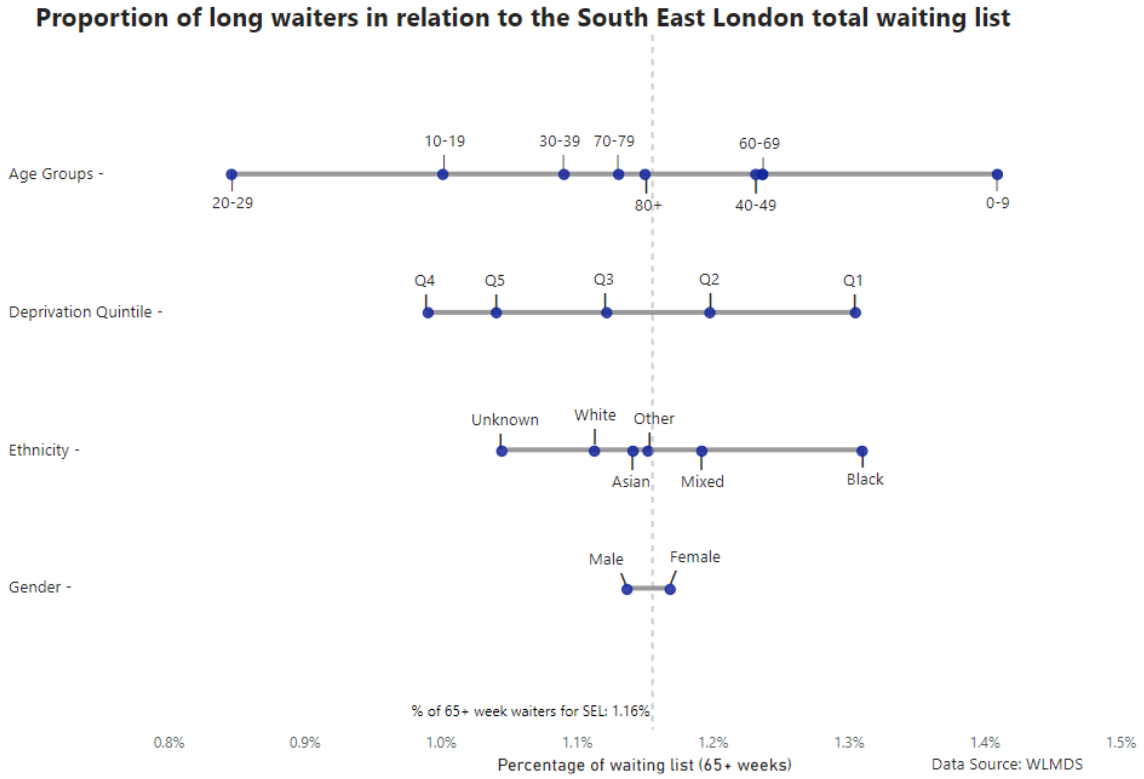

Figure 2

2.2 Age standardised activity rates for elective admissions

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

The data covers all elective admissions that occurred in South East London the for period specified above and is reported as rates per 100,000 population. The

standardised rate of elective admissions for all SEL patients was 6,545 per 100,000 population.

By deprivation, there is no clear pattern of inequality. The lowest standardised rate for elective admissions is for those in the second most deprived quintile (6,087), 7.0% below the SEL total standardised rate and the highest rate is for those in the least deprived quintile (6,956), 6.3% above the SEL total.

By ethnicity, the group with the lowest rate is those with Mixed White and Black African ethnicity (3,552), 45.7% below the SEL total standardised rate. The group with the highest rate is the White British ethnicity (7,679), 17.3% above the SEL total. The Unknown ethnicity is not large enough to have a significant impact on the ethnicity group calculations.

By gender, there is a 11.8% difference between the male (6,207) and female (6,981) cohorts.

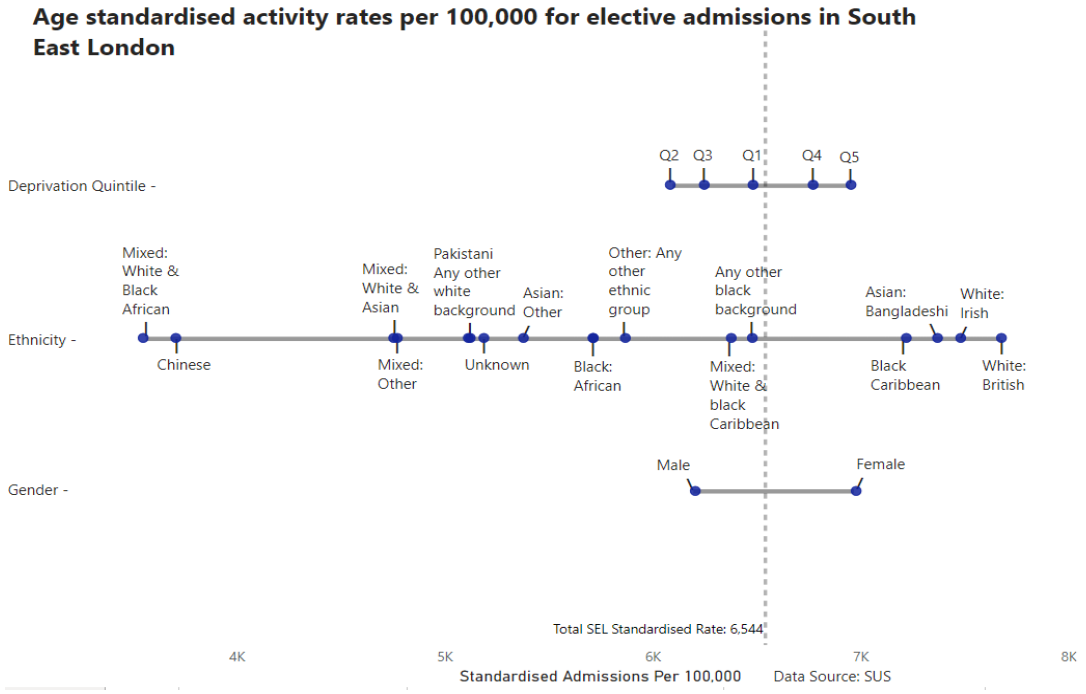

Figure 3

2.3 Age standardised activity rates for emergency admissions

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

The data covers all emergency admissions that occurred in South East London for the period specified above and is reported as rates per 100,000 population. The standardised rate of emergency admissions for all SEL patients was 6,545 per 100,000 population.

By deprivation, there is a pattern of inequality, where the more deprived the area, the higher the rate of emergency admissions. The lowest rate of emergency admissions is the least deprived quintile (Quintile 5- 3,248), 21.6% below the SEL total standardised rate and the highest rate is for those in the most deprived quintile (Quintile 1-5,088), 22.8% above the SEL total.

By ethnicity, the group with the lowest rate of emergency admission is the Chinese ethnicity (2,270), 45.2% below the SEL total standardised rate. The group with the highest rate is any other Black ethnicity (5,152), 24.4% above the SEL total. The Unknown ethnicity is not large enough to have a significant impact on the ethnicity group calculations.

By gender, there is a 5.7% difference between the female (4,055) and male (4,290) cohorts.

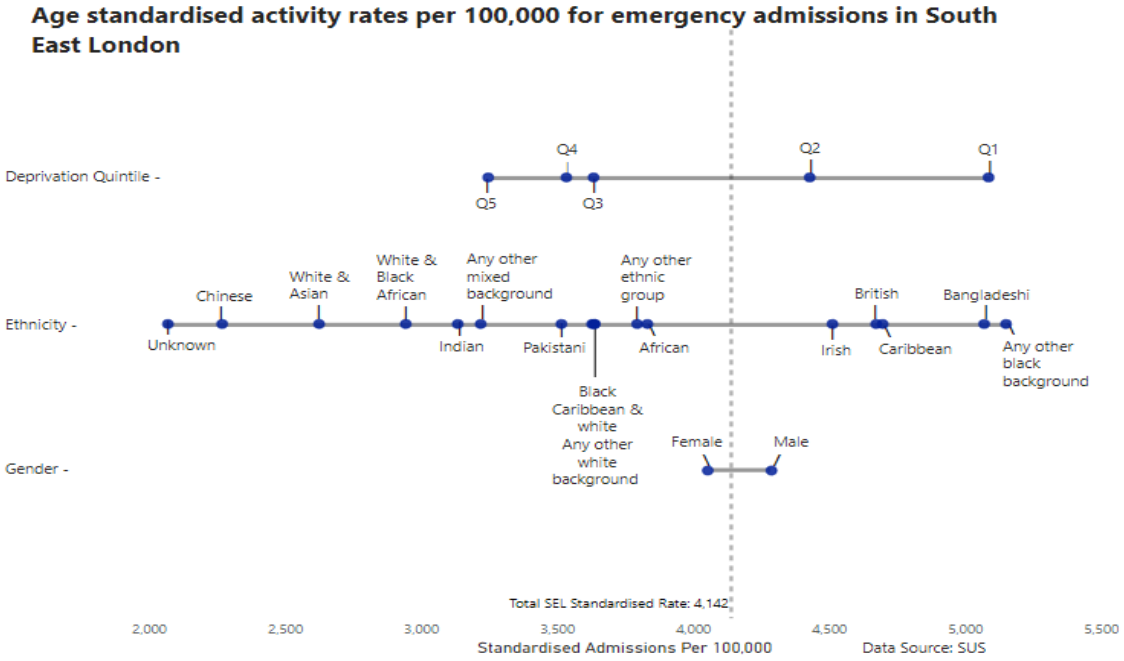

Figure 4

2.4 Age standardised activity rates for emergency attendances

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

The data covers all emergency attendances that occurred in South East London for the period specified above and is reported as rates per 100,000 people. The standardised rate of emergency attendances for all SEL patients was 23,017 per 100,000 population.

By deprivation, there is a pattern of inequality where the more deprived the cohort, the higher the rate of emergency attendances. The cohort with the lowest rate of emergency attendances is the least deprived quintile (13,666), 40.6% below the SEL total standardised rate. The cohort with the highest rate of emergency attendances is the most deprived quintile (30,735), 33.5% above the SEL total.

By ethnicity, the group with the lowest rate of is the Chinese ethnicity (9,125), 54.6% below the SEL total standardised rate. The Black Caribbean ethnicity has the highest rate (25,058), 8.9% above the SEL total. The Unknown ethnicity is not large enough to have a significant impact on the ethnicity group calculations.

By gender, there is a 2.6% difference between the male (22,544) and female (23,595) cohort.

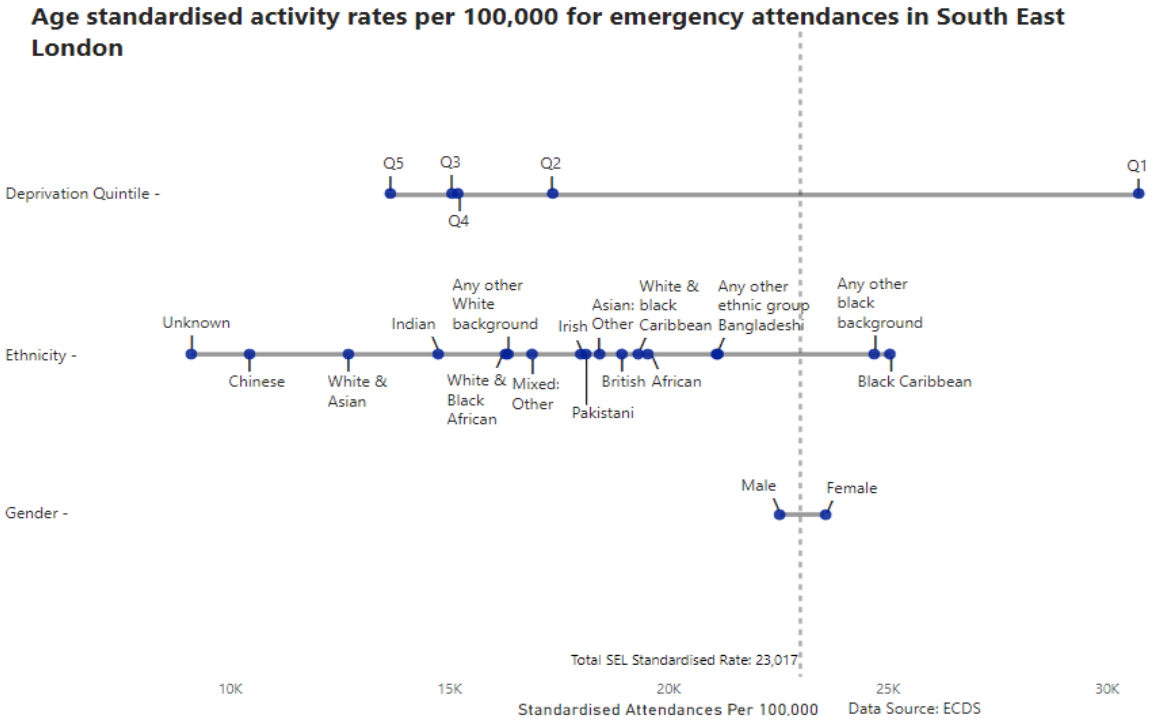

Figure 5

2.5 Age standardised activity rates for outpatient appointments

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

The data covers all outpatient appointments that occurred in South East London for the period specified above and is reported as rates per 100,000 population. The standardised rate of outpatient appointments for all SEL residents was 100,949 per 100,000 population.

By deprivation, the data indicates that the higher the deprivation the higher the rate of outpatient appointments. Residents in the most deprived areas had a higher rate of outpatient appointments than those in the least deprived areas, with the highest rate being in quintile 1, 106, 833 per 100,000 population, 5.83% above the total SEL rate. The cohort with the lowest rate was quintile 5, 95,004, 5.89% below the total SEL rate.

By ethnicity, the highest rates for outpatient appointments are seen in the Black Caribbean ethnicity (134,240 per 100,000 population), 32.98% above the total SEL rate. The lowest rate is within the Chinese ethnicity (63,976 per 100,000 population), 36.62% below the total SEL rate. Asian Bangladeshi, Other Black background, White Irish, White British, White & Black Caribbean, Asian Pakistani and Black African ethnicity all have above average rates per 100,000 population.

By gender, there is a disproportionate disparity in the rate of face-to-face outpatient appointments between men and women, with women attending at a much higher rate: 117,629 vs 85,099 per 100,000 population. The standardised rate for women is 16.52% higher than the SEL rate, whereas the rate for men is 15.70% below the SEL rate.

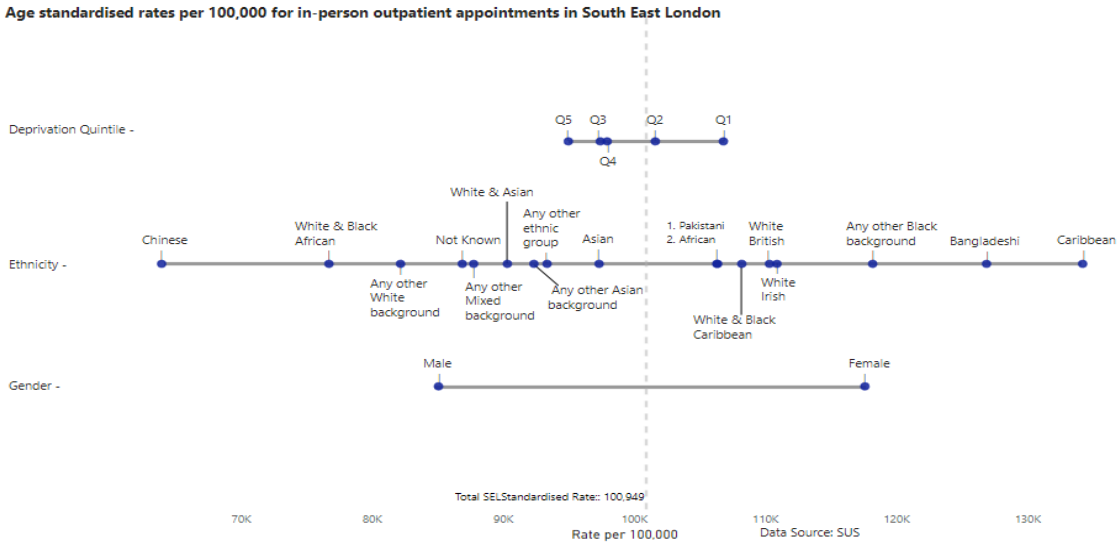

Figure 6

2.6 Age standardised activity rates for virtual outpatient appointments

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

The data covers all virtual (telephone) outpatient appointments that occurred in South East London for the period specified above and is reported as rates per 100,000 population. The standardised rate of virtual outpatient appointments for all SEL residents was 19,517 per 100,000 population.

By deprivation, there is no clear correlation between deprivation and rate of virtual outpatient appointments. Those in Quintile 1 (most deprived) have the highest rate (19,982), followed by those in Quintile 4 (19,706). The lowest rate was among those in Quintile 3 (19,151). Quintile 1 and Quintile 3, the cohorts with the highest and lowest rates respectively are both within 3% of the total SEL rate.

By ethnicity, the highest rates for virtual outpatient appointments are seen in the Black Caribbean ethnicity (24,159 per 100,000 population), 23.78% above the total SEL rate. The lowest rate is within the Chinese ethnicity (11,844 per 100,000 population), 39.32% below the SEL rate. Asian Bangladeshi, White British, White Irish, Other Black background, and White & Black Caribbean ethnicity all have above average rates.

By gender, there is a disproportionate disparity in the rate of virtual outpatient appointments between men and women, with women attending at a much higher rate: 21,562 vs 18,032 per 100,000 population. The standardised rate for women is 10.48% higher than the SEL rate, whereas the rate for men is 7.61% below the SEL rate.

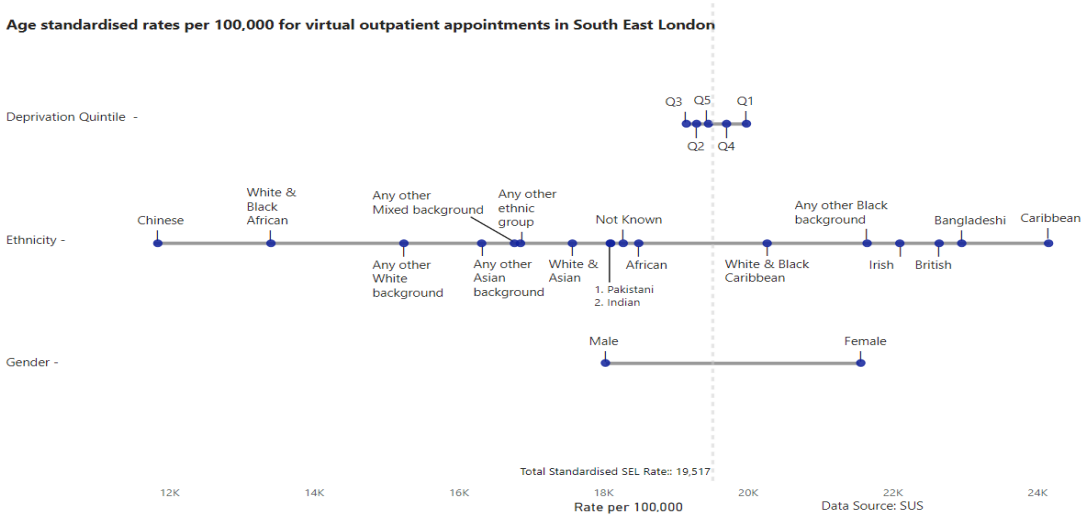

Figure 7

2.7 Elective Activity vs pre-pandemic levels for under 18s

This metric indicates the changes between the periods April 2019 to September 2019 and April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

The data covers all elective inpatient and outpatient activity that occurred for South East London patients for the period specified above. To note, any figure below 100% indicates a decrease in total activity (e.g.,95% would indicate a 5% decrease in activity from 2019/20 to 2023/24). Any figure above 100% would indicate an increase in activity (e.g., 105% indicates a 5% increase in activity).

The total change for South East London is 136.5%, a 36.5% increase in activity.
All ages have seen an increase in elective activity from 2019 to 2023, following the overall total increase between years. However, the proportional composition by age has significantly changed across age groups (0-4 = -6.2% change in total elective activity, 5-9 = -1.5%, 10-14 = 3.0%, 15-17 = 4.8%). We should note, there have also been changes in the population split (0-4 = -3.5% change in total population, 5-9 = -1.2%, 10-14 = 1.8%, 15-17 = 2.9%). The age group with the largest increase in elective activity is those aged 15 to 17 (177.5%).

By deprivation, the least deprived quintile (Quintile 5-130.8%) had the smallest increase in elective activity between 2019/20 and 2023/24. The largest increase in activity is for those in the second most deprived quintile (Quintile 2-138.2%). Across all deprivation quintiles, there is less than a 1% shift in population and activity proportions between the periods.

By ethnicity, the lowest increase in activity is those in the White ethnicity (129.7%). The largest increase in activity is for those in the Other ethnicity (156.7%). The total activity for the Unknown ethnicity is relatively small, compared to all other ethnic groups. Across all ethnic groups, there is less than a 1% shift in population and activity proportions between the periods.

By gender, the difference between female (137.1%) and male (136.0%) is approximately 1% and is relatively small. There is also less than a 1% shift in population and activity proportions between the periods.

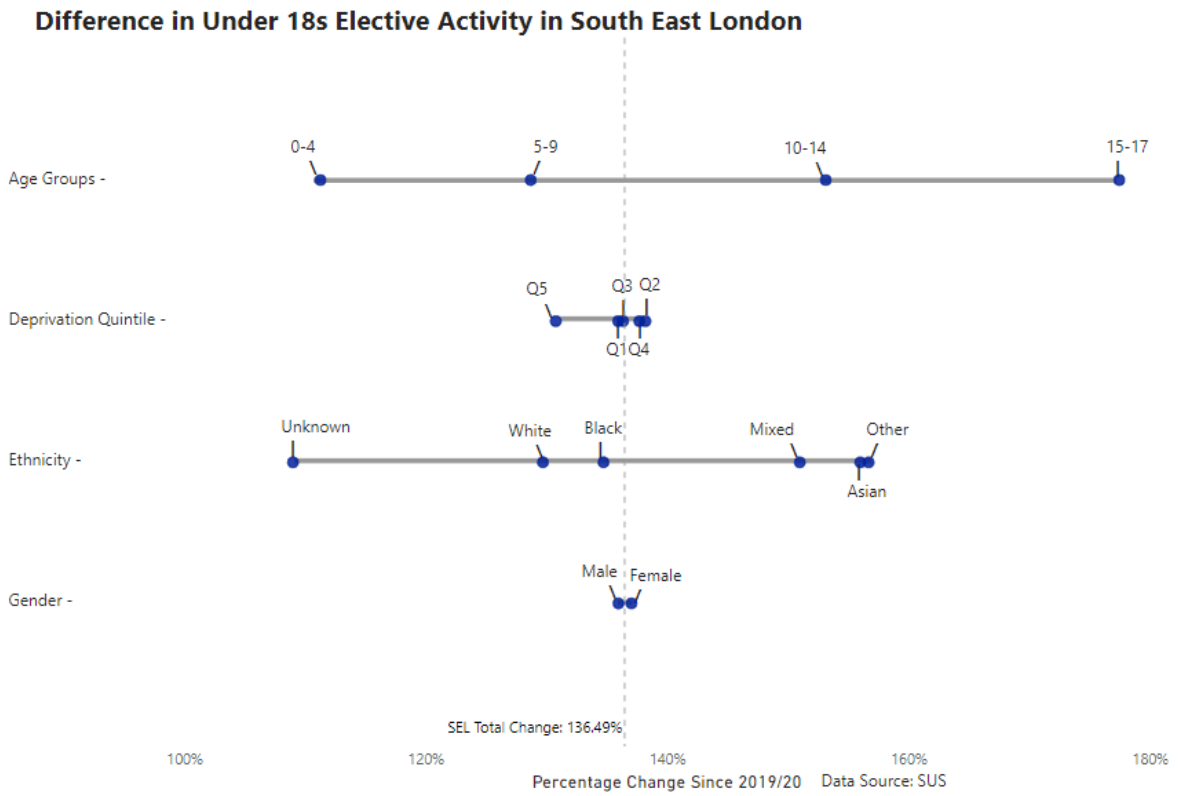

Figure 8

2.8 Elective Activity vs pre-pandemic levels for over 18s

This metric is based off the difference between April 2019 to September 2019, and April 2023 to September 2023 to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

To note, any figure below 100% indicates a decrease in total activity (e.g., 95% would indicate a 5% decrease in activity from 2019/20 to 2023/24). Any figure above 100% would indicate an increase in activity (e.g., 105% indicates a 5% increase in activity).

The total change for South East London is 123.6%, a 23.6% increase in activity.
All ages have seen an increase in elective activity from 2019 to 2023, following the overall total increase between years. Across all age groups, there is a 2% or lower shift in population and activity proportions between the periods.

By deprivation, the second most deprived quintile (Quintile 2 -122.7%) has the smallest increase in activity. The less deprived quintile (Quintile 4-125.5%) has seen the largest

increase. Across all deprivation quintiles, there is less than a 1% shift in population and activity proportions between the periods.

By ethnicity, the white ethnicity (118.1%) has the smallest increase in activity. The largest increase in activity is for those with Mixed ethnicity (146.7%). However, the proportional composition by ethnicity has significantly changed (White = -2.8% change in total elective activity, Unknown = - -0.3%, Other = 0.5%, Mixed = 3.1%, Black = 1.1%, Asian = 1.0%). It should be noted, there has also been changes in the population split (White = -4.0% change in total population Unknown = - -0.1%, Other = 1.1%, Mixed = 0.6%, Black = 1.0%, Asian = 1.4%).

By gender, the difference between male (122.5%) and female (124.3%) is approximately 2% and is relatively small. There is also less than a 1% shift in population and activity proportions between the periods.

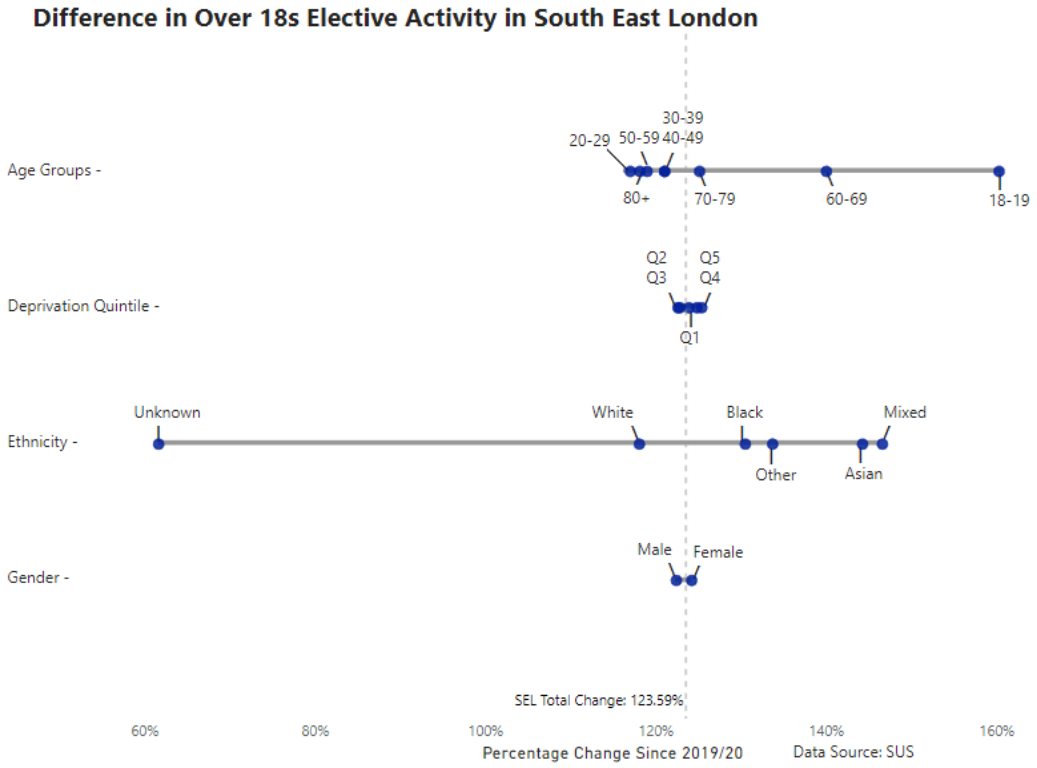

Figure 9

3. Urgent and Emergency Care

3.1 Emergency admissions for under 18s

This metric utilises data from April 2023 to September 2023 to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

By age, the three oldest cohorts are all well below the South East London total rate (21.9 per 1,000). The age group with the lowest rate of admissions being those aged 10 to 14 (11.1). The outlier for this metric is the youngest cohort, those age 4 and under (50.5), who have the largest rate of emergency admissions per 1,000 population out of any demographic group.

By deprivation, the highest rate of admissions is those in the second most deprived quintile (Quintile 2=22.9), and the lowest rate is those in the least deprived quintile (Quintile 5=17.9).

By ethnicity, the ethnic group with the lowest rate of emergency admissions is the Back ethnic group (18.8). The highest rate for an ethnic group is those with an Unknown ethnicity (27.3). Other and Asian ethnic groups have the next highest rate of emergency admissions (26.4 and 26.3 respectively). As the Unknown ethnicity is comparable in size, it is difficult to draw any definitive conclusions regarding ethnicity

By gender, there is a slightly higher rate of admissions for males (24.0) compared to females (19.8).

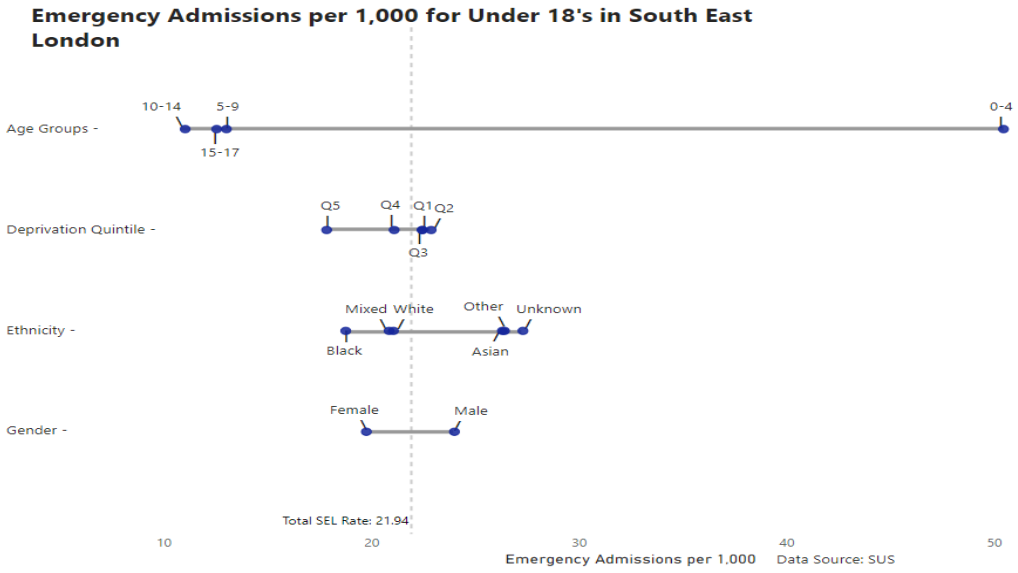

Figure 10

4. Respiratory Narrative

4.1 Uptake of COVID and flu by socio-demographic group

Uptake of COVID by socio-demographic group

The COVID vaccine data is based on the 2023/24 financial year (i.e. April 2023 to March 2024). This is also a measure of those who have had their primary COVID vaccine out of the total population.

The overall South East London percentage of COVID vaccine uptake in 2023/24 was 55.1% for the total population. Not everyone is eligible for a COVID vaccine, and this should be considered when looking at the data below.

By age, the group with the lowest COVID primary course vaccine uptake is those aged 4-11 (<0.1%), and the group with the highest uptake is those aged 80+ (89.8%). The pattern shows that the older the age group, the higher the percentage of vaccine uptake. This is to be expected given those aged 75 and over are eligible for the vaccine.

By deprivation, the group with the lowest uptake is the most deprived quintile (Quintile 1= 47.6%). The group with the highest uptake is those in the least deprived quintile (Quintile 5= 69.1%). There is a correlation between deprivation and uptake, where the less deprived the cohort, the higher the vaccine uptake.

By ethnicity, those with an Unknown ethnicity (36.8%) have the lowest percentage of COVID vaccine uptake. The Black ethnicity (39.3%) has the next lowest percentage of uptake. The only ethnicity with an above the overall average uptake (55.1%) is the White ethnicity (65.0%). As the Unknown ethnicity is comparable in size, it is difficult to draw any definitive conclusions regarding ethnicity.

By gender, there is a slightly lower uptake in the male cohort (53.2%) compared to the female cohort (57.1%).

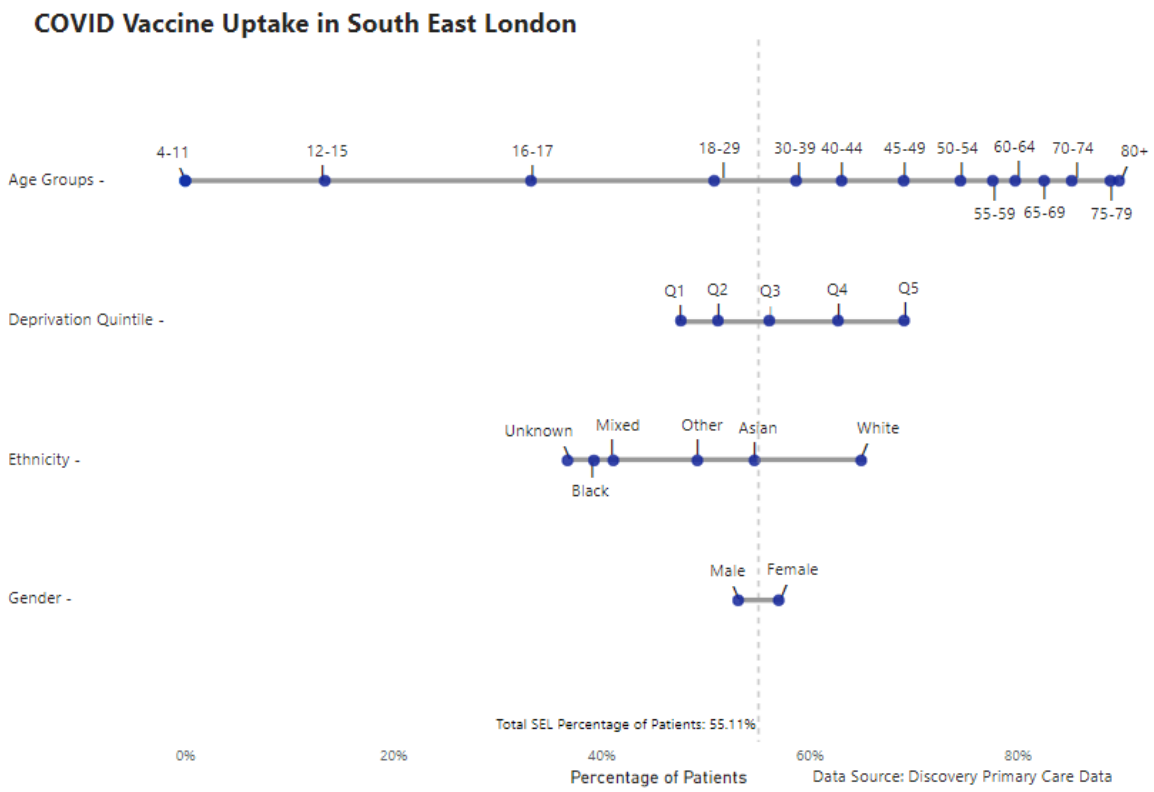

Figure 11

Uptake of flu by socio-demographic group

The flu vaccine metric is the percentage of the total population who have had a flu vaccine in the 2023/24 financial year: April 2023 to March 2024. Not everyone is eligible for a flu vaccine, and this should be considered when looking at the data below.

The overall South East London percentage of flu vaccine uptake in 2023/24 was 20.1% for the total population.

By age, the group with the lowest flu vaccine uptake is those aged 0 to 1 (0.2%), and the group with the highest uptake is those aged 80+ (74.6%). There is an approximate correlation between age and uptake, where the older the group, the higher the percentage of vaccine uptake. This is to be expected given those aged 65 and over are eligible for the vaccine.

By deprivation, the group with the lowest uptake is the most deprived quintile (Quintile 1= 15.9%). The group with the highest uptake is those in the least deprived quintile (32.1%). There is a correlation between deprivation and uptake, where the less deprived the cohort, the higher the vaccine uptake.

By ethnicity, there is a marked imbalance in flu vaccine uptake where all other ethnic groups are near or below the SEL total percentage, and the only group higher than SEL total uptake is the White ethnicity (24.2%). Those with an Unknown ethnicity (12.4%) have the lowest percentage of uptake. The Other ethnicity (14.1%) has the next lowest percentage of uptake. As the Unknown ethnicity is comparable in size, it is difficult to draw any definitive conclusions regarding ethnicity.

By gender, the male cohort (18.5%) has an uptake below the SEL total and the female cohort (21.6%) is slightly above. The difference between the male and female cohort is minimal.

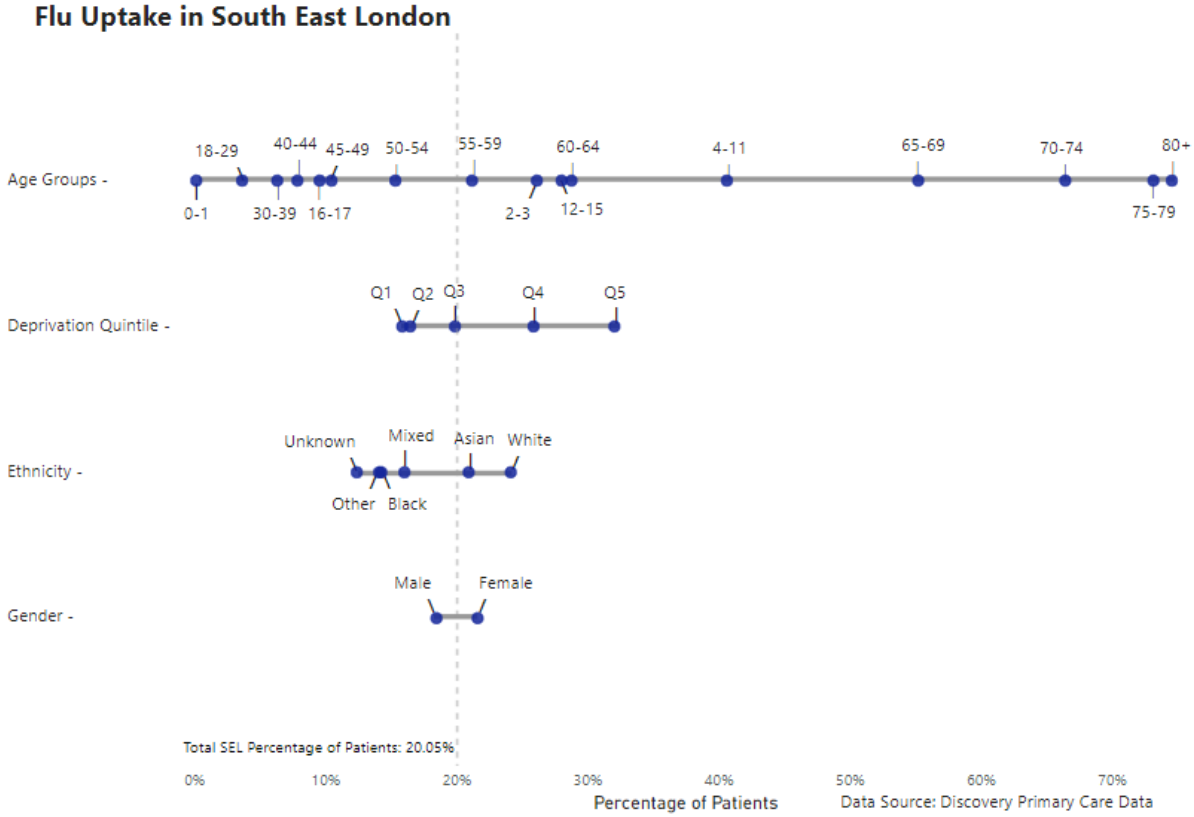

Figure 12

5. Mental Health

5.1 Overall number of Severe Mental Illness (SMI) physical health checks

This data covers the period of April 2023 to March 2024 and reports on those aged 18 and over, as physical health checks are for adults and there are very small numbers of those diagnosed with schizophrenia, bipolar affective disorder or other psychoses who are under 18, as the onset usually appears in one's late teens or early adulthood.

The number of people who received all 6 physical health checks between April 2023 and March 2024 was 12,814, in line with our trajectory for that year.

The cohort with the lowest percentage of SMI patients receiving all 6 physical health checks is those aged 18 to 25 (46.1%) and the cohort with the highest is those aged 61 to 80 (68.3%).

By deprivation, the second least deprived quintile has the lowest rates of receiving all physical health checks (Quintile 4 - 56.3%), the least deprived quintile has the highest completion rate (Quintile 5 - 60.8%).

By ethnicity, there is a low completion rate for those who have Mixed ethnicity (54.2%) and the highest completion rate is for the Asian ethnicity (64.6%).

There is a large difference in completion rate between the male (54.8%) and female (61.4%) cohorts.

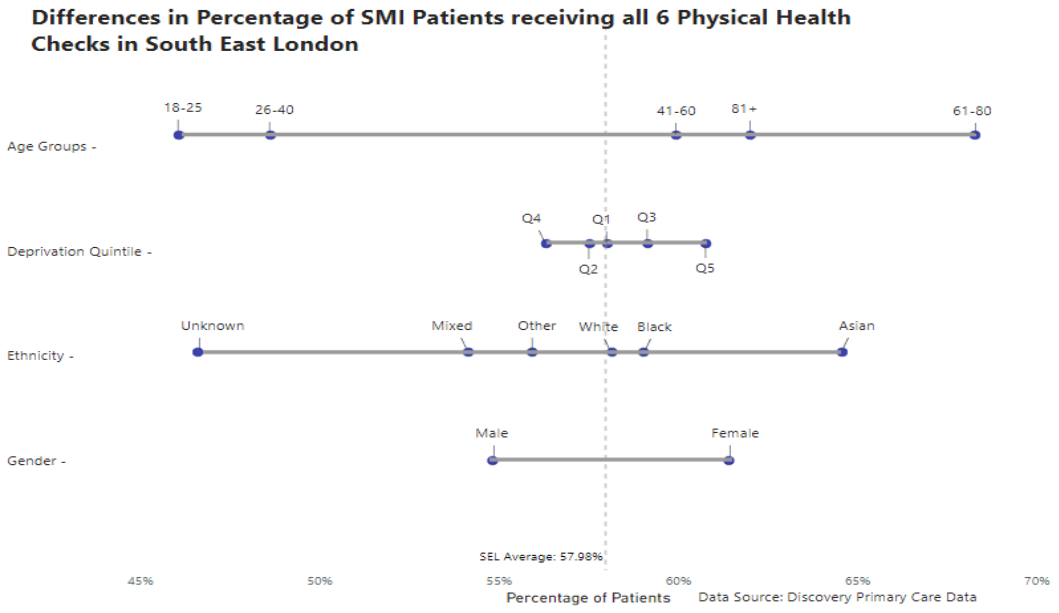

Figure 13

5.2 Rates of total Mental Health Act detentions

This data covers the period between April 2022 – March 2023. The rate of mental health act detentions in South East London was 132.30 per 100,000 population.

There is a marked difference in the rate of detentions between age groups, with the highest rates seen in the 18-34 (180), 35-49 (174) and 50-64 (163) cohorts.
There is a strong correlation between deprivation and rate of detention. As deprivation increases, the rate of detention also increases. The rate of detention in decile 1, which includes the most deprived areas, is 248 per 100,000 population. This is nearly twice the SEL average and 2.7 times greater than the national average. In areas of less deprivation, decile 10, 9 and 8, the rate of detention is 39, 49 and 61 respectively.

There are also marked inequalities in the rates of detention between ethnic groups. The highest rate of 263 per 100,000 population is within the Black ethnicity, followed by 213.4 within the Other ethnicity. These rates are much higher in comparison to the Asian (70.5) and White (77) ethnicity.

Men have slightly higher rates of detention than women (137 vs 126 per 100,000 population).

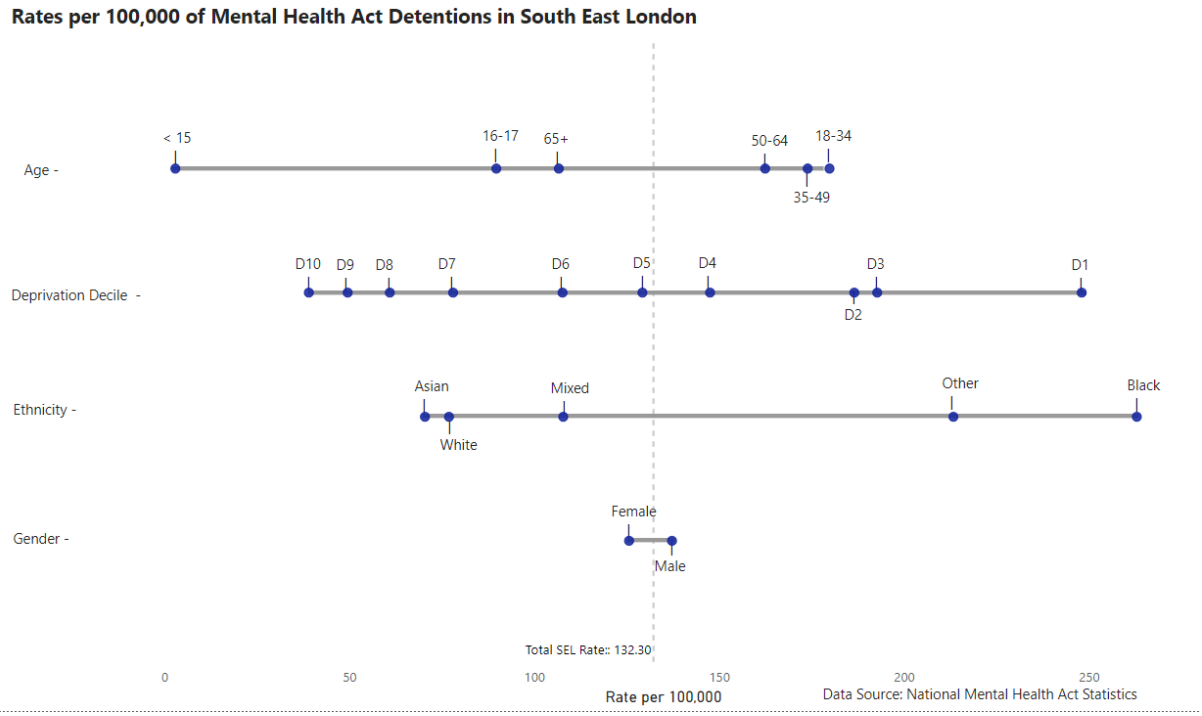

Figure 14

5.3 Rates of restrictive interventions

The most recently published data for restrictive interventions covers the period September 2020 to March 2024.

The dashboard produced by NHS Digital is heavily caveated around suppressed data, leading to most demographic groups being rounded down to 0.

As the underlying numerators and denominators are not available from the national publication, caution should be applied to decision making based on using these published rates as they are based on an overall low number of patients and are easily skewed - i.e. if restrictive interventions are administered to patients that have a very low number of bed days (e.g. if 1 patient has only 1 restrictive intervention and 1 occupied bed days (OBDs), the rate for the demographic is boosted by 3 (rounded) interventions per 1000 bed days – this rate factors up as the number of interventions or number of OBDs increases.)

Any inequality identification around restrictive interventions will require access to the underlying data to understand the experiences of different patient cohorts. As a result, we have not included a breakdown of this metric.

5.4 NHS Talking Therapies (formally IAPT) recovery

In the 2022/23 financial year, South East London received 56,285 referrals for talking therapy services (previously referred to as Improving Access to Psychological Therapies [IAPT]). Of these referrals, 41,235 (73.26%) accessed services and 24,325 (43.22%) finished a course of treatment. This is above the comparable national level figures which show that 69.70% accessed services and 38.21% finished a course of treatment.

There are two measures within the NHS Talking Therapies data:

- Talking Therapies Recovery: recovery is measured in terms of ‘caseness’, which means a patient has significant enough symptoms of anxiety or depression at the time of referral to be regarded as a clinical case of the condition. A referral is recovered if the patient was defined as a clinical case at the start of the referral and is no longer considered a clinical case at the end of their treatment. This is determined by patient questionnaires administered before and after treatment. The recovery rate is a measure of how many referrals moved to recovery. The recovery rate for SEL overall in this year was 51%, which is marginally above the national average of 49.9%.

- Reliable improvement is when a referred patient shows clinically significant improvement in their condition following a course of treatment. This is measured

by the difference in patient questionnaire scores before and after treatment. A referral has reliably recovered if it meets the criteria for both recovery and reliable improvement, i.e., a patient has moved from being a clinical case at the start of treatment to not being a clinical case at the end of treatment and there has also been a clinically significant improvement in their condition. The reliable recovery rate for SEL in this year was 47%, which is marginally above the national average of 46.8%.

By age, the general trend indicates older patients have a higher recovery rate than younger patients. The highest recovery rate is seen in the 75-89 age group (57%), which is 11.8% higher than the SEL average. The lowest recovery rate is seen in the under 18 group (32%) which is 37.3% lower than the SEL average. The same trend is identified in the reliable recovery rate It is important to note that these figures do not consider the size of each age group which might skew the results.

By gender, men have a slightly higher recovery rate than women: 53% vs 50%. The same trend is identified in the reliable recovery rate.

By ethnicity, the group with the highest recovery rate is the White ethnicity (53%), which is the only group with an above SEL average recovery rate. The lowest recovery rate is the Mixed ethnicity (44%) which is 13.7% lower than the SEL average. However, due to the small number of patients in the Mixed ethnicity this might have an impact on results.

Deprivation trends indicate that those in the least deprived areas have a higher recovery rate than those in more deprived areas. For patients living in less deprivation, there is an increased likelihood of no longer being a clinical case following a course of treatment. The recovery rate for patients in decile 9 (second least deprived group) surprisingly does not follow the general trend. These patients have a much lower recovery rate than what is expected given the general correlation between deprivation and recovery rate

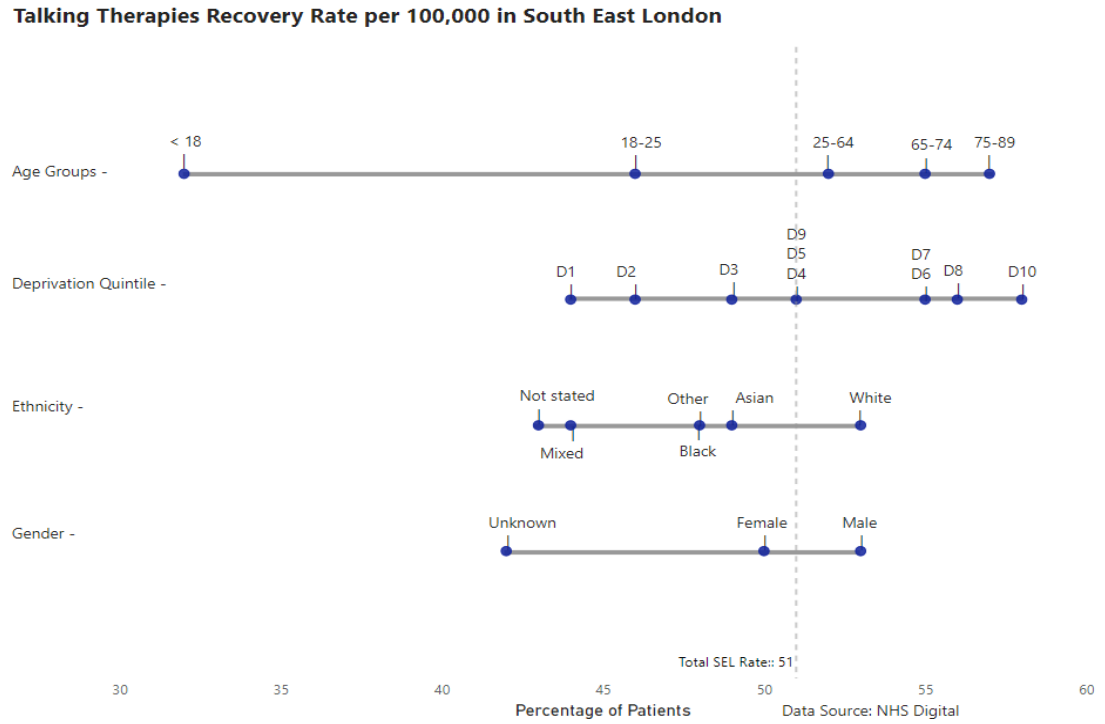

Figure 15

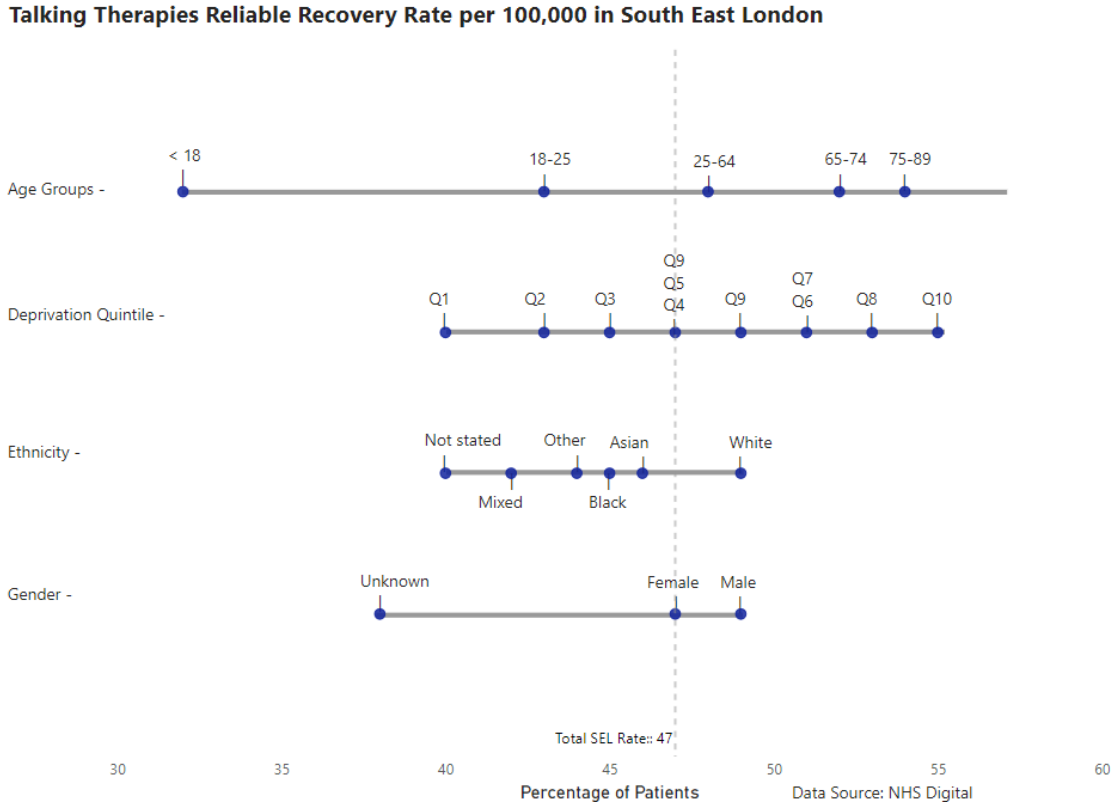

Figure 16

5.5 Children and young people's mental health access

In the 2022/23 financial year, the rate of children and young people aged under 18 that were supported through NHS funded mental health services with at least one contact was 5,271 per 100,000 population. This is below the national average of 6,026 for the same reporting period.

By age, there are large differences in the rate of mental health access for the under 18's. The lowest rate was in the 0-5 (1,381 per 100,000 population) and 6-11 (4,497 per 100,000 population) age groups and is below the national average. However, those aged 11-15, 16 and 17 had access rates above both the South East London and national averages of 8,788, 10,590 and 10,153 per 100,000 population, respectively.

By deprivation, people in the most deprived areas had lower rates of contact with NHS mental health services than those in the least deprived areas. The rates for those in the most deprived decile is 1,944, 37.96% above the SEL average. The rate for those in the least deprived decile is 7,272, 63.12% below the SEL average.

By ethnicity, the White ethnicity is the only group to access services at a rate of 1% above the SEL average (5,324). The Asian ethnicity had the lowest rates of 2,798, 46.92% below the SEL average. Followed by Black or Black British, Mixed and Other ethnicity (4050, 5053, 5188 respectively).

By gender, there was little difference between male and female cohorts in rates of mental health access.

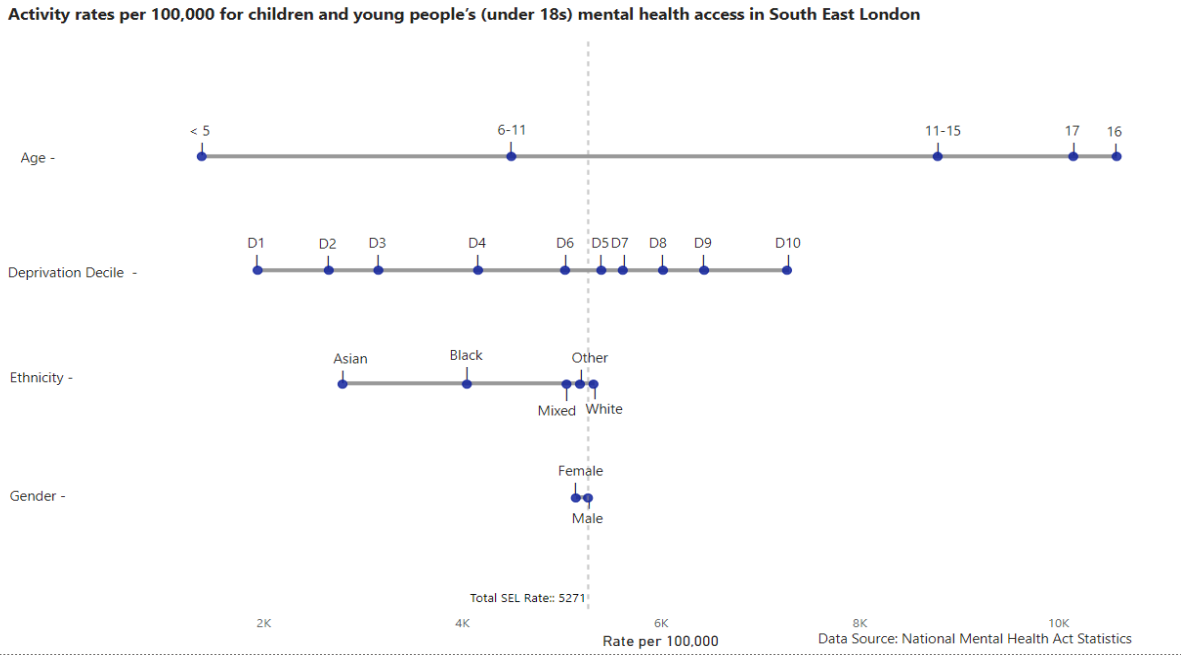

Figure 17

6. Cancer

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

The most recently published data covers the period 2013 to 2021. However, the data is only available for whole ICBs and no further demographic breakdowns on age, ethnicity, deprivation or gender are provided.

During this period, the percentage of cancers diagnosed at stage 1 and 2 in South East London ranged from 52.3% (2013) to 55% (2019). The general trend shows that the percentage of early diagnoses has reduced over these years but is close to the national average of 54%. However, this is still overt 20% below the national target of 75%. Work is being undertaken as part of the ICB's Cancer Plan to improve early diagnosis rates. Note: underlying numerators and denominators unavailable.

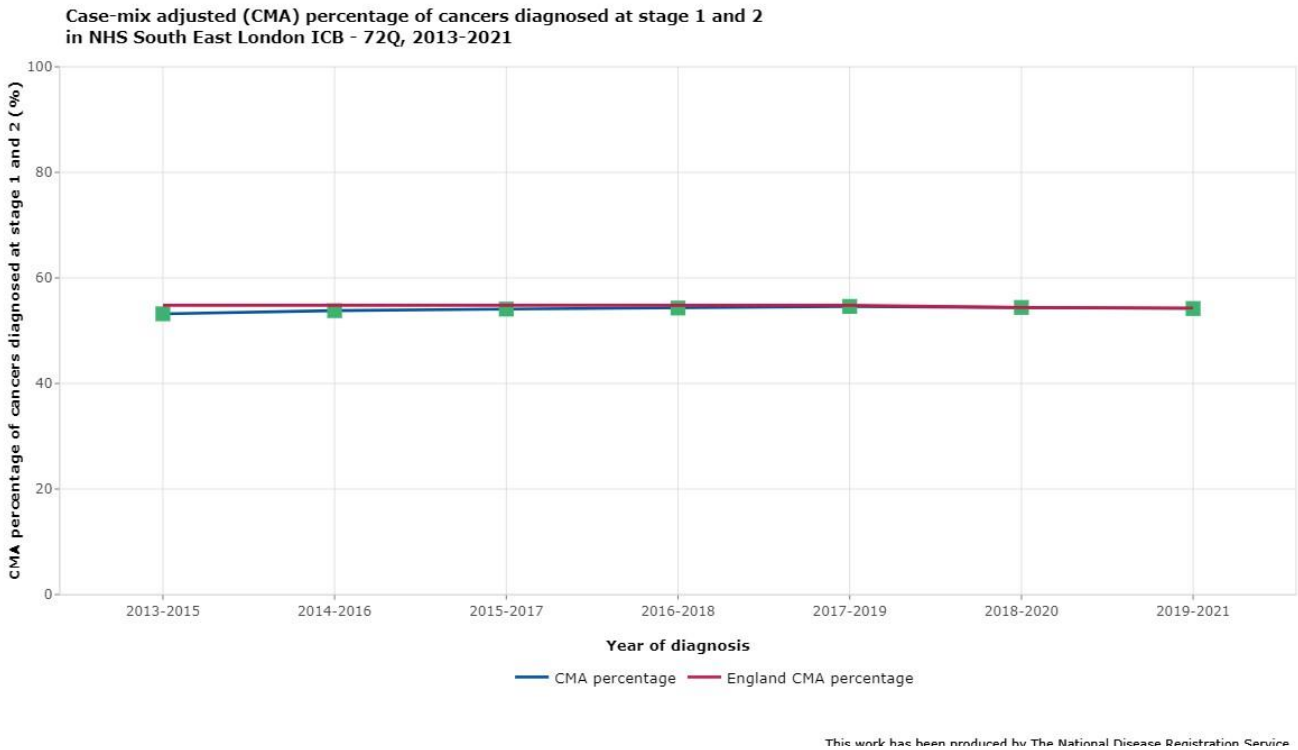

Figure 18

7. Cardiovascular Disease

7.1 Stroke rate non-elective admissions

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

For all patients registered to a South East London practice, there is an overall rate of 125.8 non-elective stroke admissions per 1,000 population.

By age, older age groups have larger rates of non-elective admissions for a primary diagnosis of stroke. The age group with the lowest rate of admissions is those between 30 and 39 (17.8 admissions per 100,000 population) and the highest rate of admissions is those over 80 (571.8).

By deprivation, the lowest rate is for those in the middle quintile (Quintile 3 =102.5) and the quintiles with the highest rate are the less deprived quintiles: 152.6 and 152 per 100,000 population in quintiles 4 and 5 respectively.

By ethnicity, the lowest rate of stroke admissions is the White ethnicity (93.9) and the highest rate is those with Unknown ethnicity (402.9). The Other ethnicity (218.2) has the next highest percentage of uptake. As the Unknown ethnicity is comparable in size, it is difficult to draw any definitive conclusions regarding ethnicity.

There is minimal difference between female (120.9) and male (130.5) cohorts.

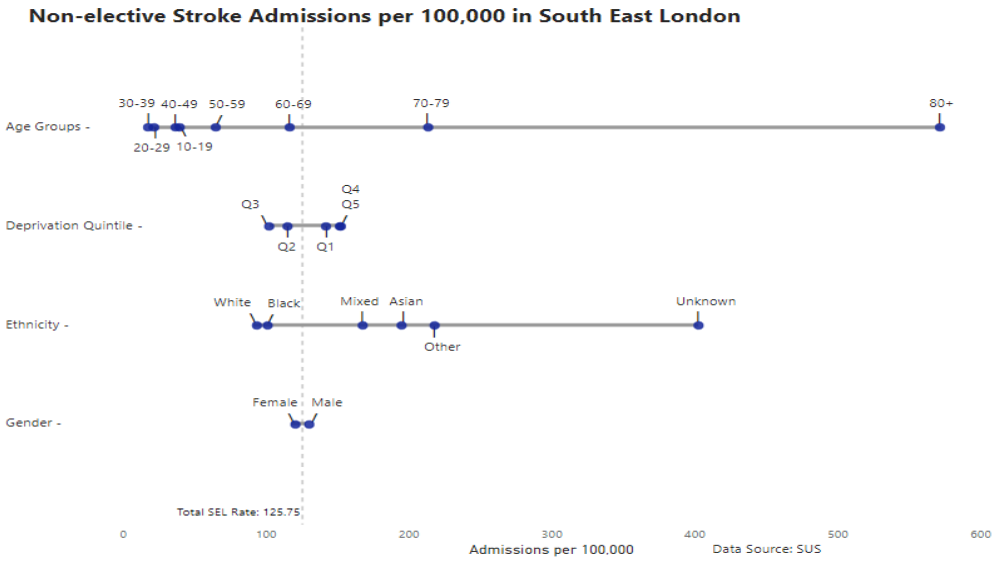

Figure 19

7.2 Myocardial infarction - rate of non-elective admissions

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

For all patients registered to a South East London practice, there is an overall rate of 60.7 non-elective myocardial infarction admissions per 100,000 population.

By age, the older the individual, the higher the rate of non-elective myocardial infarction admission. The highest rate of admission is for those aged 80+ (167.8 admissions per 100,000 population) and the lowest is for those aged 30-39 (13.0).

By deprivation, there is no clear pattern of variation, with quintile 3 having the lowest rate of admissions (Quintile 3 = 51.6), closely followed by the most deprived quintile (Quintile 1 = 52.3) and the least deprived quintile having the highest rate (Quintile 5 = 90.6).

By ethnicity, the White ethnicity (50.3) has the closest rate to the SEL total rate (60.7). The lowest rate of admissions is those in the Black ethnicity (39.8). The group with the highest rate of admissions is those in the Mixed ethnicity (1,379.3). However, the total number of patients in this group is much smaller than the others and this can have a large impact on the final calculated rate. As the Unknown ethnicity is comparable in size, it is difficult to draw any definitive conclusions regarding ethnicity.

By gender, the difference between female (59.6) and male (61.6) cohorts is negligible.

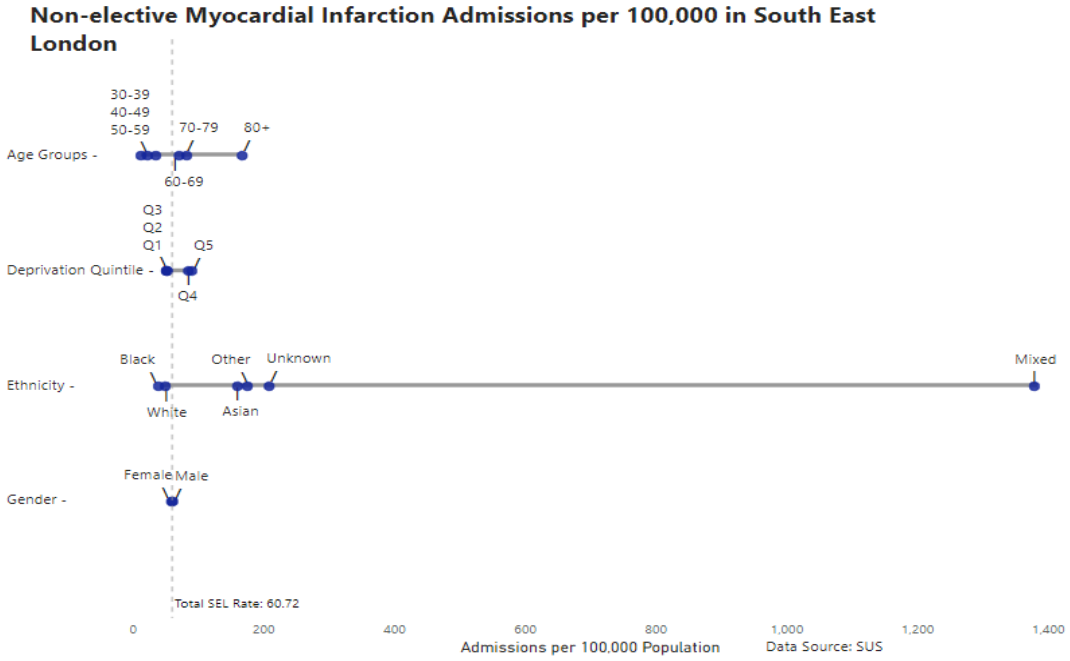

Figure 20

7.3 CVDP007HYP: 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

The most recently published Cardiovascular Disease (CVD) Prevent data for this metric is extracted up to March 2024.

In South East London, 65.40% of patients with GP recorded hypertension had a blood pressure reading below the age-appropriate treatment threshold. Within this hypertension population, there was a greater percentage of patients with lower blood pressure readings for patients with a recorded learning disability (72.06%) compared to those without (65.37%).

There is also a clear correlation between deprivation and the percentage of patients with below age-appropriate blood pressure readings. The most deprived areas had a lower percentage of patients in comparison to the least deprived areas. However, it is to be noted that the range between quintile 1 and quintile 5 is 7.06%.

By ethnicity, the Mixed (66.19%) and Black (65.78%) ethnicity had the lowest percentage of patients. Whilst the White (73.49%) and Asian (73.07%) ethnicity had the highest percentage of patients. The cohort size of each ethnic group should be taken into consideration as there are large difference between the White (130,120), Black (62,935), Asian (20,820) and Mixed (7,060) ethnicity.

By age, the general trend shows that as age increases the proportion of patients with below age-appropriate blood pressure readings also increases. The highest percentage of patients are seen in the 60-79 (73.47%) and 80+ (80.75%) cohorts. The lowest percentages are seen in the 18-39 cohort (54.82%).

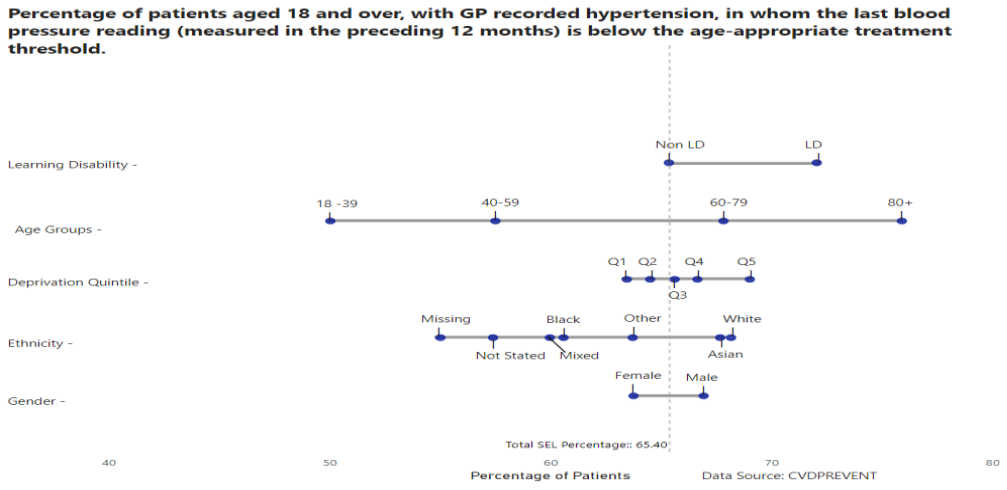

Figure 21

7.4 CVDP003CHOL: 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

The most recently published data for this metric is from September 2022 to March 2024.

In South East London, 61.09% of patients with no GP recorded CVD and a recorded QRISK score of at least 20% are receiving lipid lowering therapy.

A greater percentage of those registered with a learning disability are being treated with these drugs in comparison to those not registered with a learning disability (66.53% vs 61.07%).

By gender, the percentage of women on lipid lowering therapy is greater than the percentage of men (62.79% vs 59.91%).

By deprivation, the general trend shows that as deprivation increases the percentage of patients receiving this treatment also increases, quintile 1, the most deprived, has the highest percentage of patients (64.47%) whilst quintile 5, the least deprived, has the lowest percentage (57.01%).

By ethnicity, the Asian ethnicity has the highest percentage of patients (68.07%). Followed by the Other (65.88%) and Black (63.43%) ethnic groups which are all above the SEL total rate. The White (60.05%) and Mixed (59.58%) ethnicity are the only known groups below the SEL average.

By age, the 60-79 and 40-59 both have above average percentages of patients receiving lipid lowering therapy. The youngest age group, 18-39, has the lowest percentage of patients (46.03%).

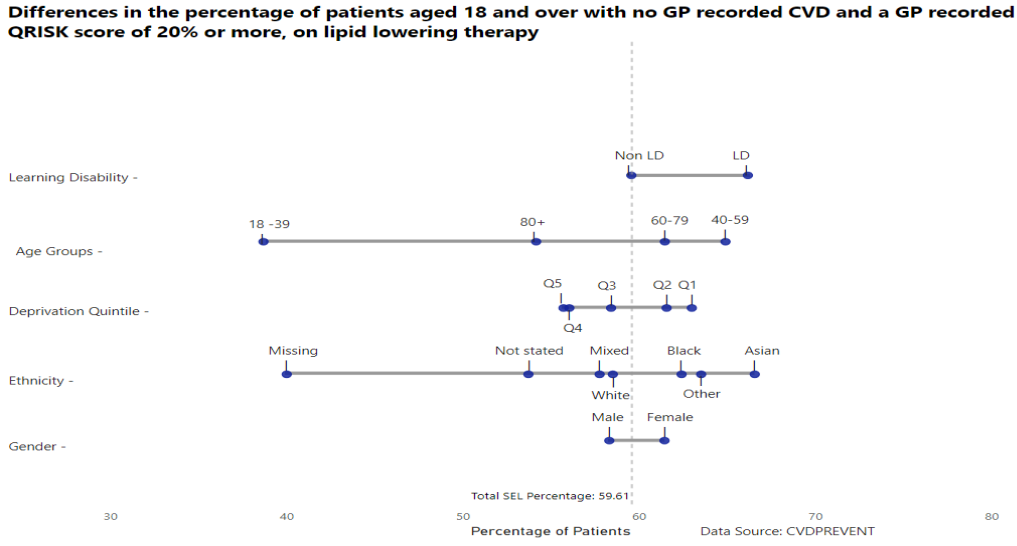

Figure 22

7.5 CVDP002AF: Percentage of patients aged 18 and over 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

The most recently published data for this metric is from September 2023 to December 2023.

In South East London, 89.17% of patients with GP recorded atrial fibrillation and a recorded CHA2DS2-VASc score of 2 or more are treated with anticoagulant drug therapy.

In terms of learning disability, there is no difference in percentage between people registered with a learning disability and people that are not. A similar picture occurs with gender - there is little difference in the percentage of men and women currently treated with anticoagulation therapy. The percentage for men (89.22%) is insignificantly higher than for women (89.12%).

The percentage of patients treated with anticoagulation drugs varies between age groups. The highest percentage of patients are seen in the 60-79 and 80+ cohorts, 89.40% and 89.46% respectively. The lowest percentages are seen in the 18-39 cohort (72.73%).

There are marginal differences between deprivation quintiles, but the overall trend suggests that as deprivation decreases, the percentage of patients receiving anticoagulation drug therapy increases. The lowest percentage being in Quintile 1 (87.40%) and the highest in Quintile 5 (90.81%).

The ethnic group with the largest percentage of patients on this treatment is the White ethnicity (89.84%). This is 3% higher than the SEL average and 3% higher than the next group which is the Asian ethnicity (87.16%).

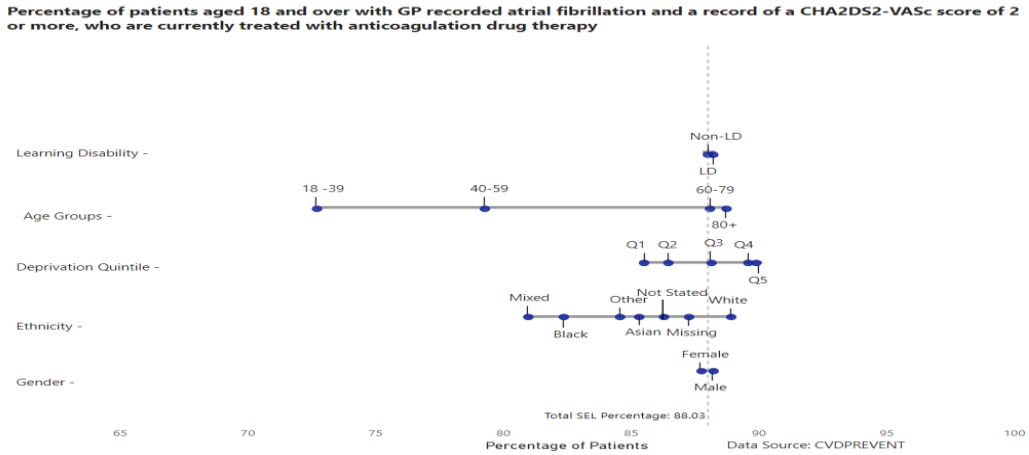

Figure 23

8. Diabetes

8.1 Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes

By age, the youngest cohort of 12-19 has much lower completion (10.4%) which may be explained by the following as advised by NHS digital *'NICE guidance changes through teens means that GPs are not incentivised to record data below age 17. Anomalies below 19 may be due to these factors'*. This age group has therefore been excluded. All older age groups are comparable. The pattern of age groups also indicates a correlation between age and receiving all 8 care processes, where the older an individual is the more likely the receipt of all care processes.

The overall South East London percentage of type 1 diabetes patients receiving all 8 care processes in 2023/24 was 39.0%. For age, the older the individual, the higher the percentage of type 1 diabetes patients receiving all 8 care processes. The highest percentage is those aged 80+ (58.8%) and the lowest those aged 19-39 (35.8%).

By deprivation, the group with the lowest percentage is the second least deprived quintile (Quintile 4 = 33.9%). The group with the highest percentage is those in the second most deprived quintile (Quintile 2 = 42.9%). For deprivation, there is no clear pattern of inequality, with the most and least deprived quintiles being within 10% of each other.

By ethnicity, Unknown ethnicity has the lowest completion rate (21.3%), with most other ethnic groups being within 10% of each other.

The male cohort (39.8%) and the female cohort (37.9%) are both similar to the overall percentage for South East London.

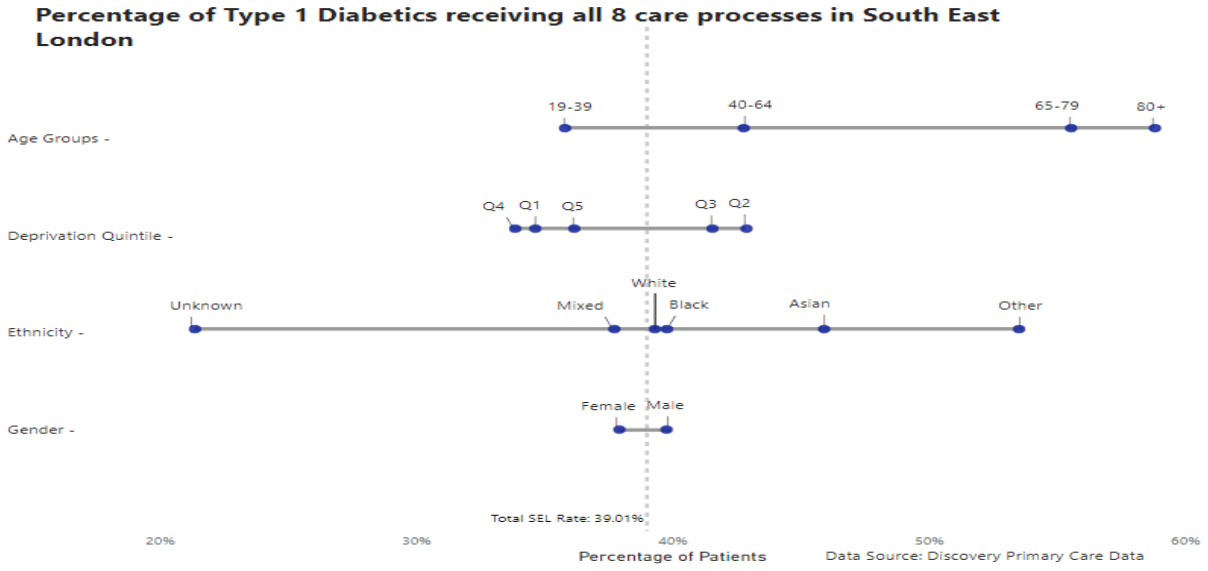

Figure 24

The overall Sout East London percentage of type 2 diabetics receiving all 8 care processes in 2023/24 was 68.5%.

By age, the highest completion rates are those age 65 to 79 (72.6%) older and younger cohorts have below average completions rates, with the lowest being 19 to 39 and younger (54.8%).

By deprivation, the group with the lowest percentage is the second least deprived quintile (Quintile 4 = 65.7%). The group with the highest percentage is those in the second most deprived quintile (Quintile 2 = 69.5%).

By ethnicity, the Black ethnicity (72.1%) has a higher completion rate than all others with most ethnic groups having near average rates of completion. Unknown ethnicity has the lowest completion rate (57.7%).

The male cohort (69.0%) and the female cohort (67.9%) are both similar to the overall percentage for South East London.

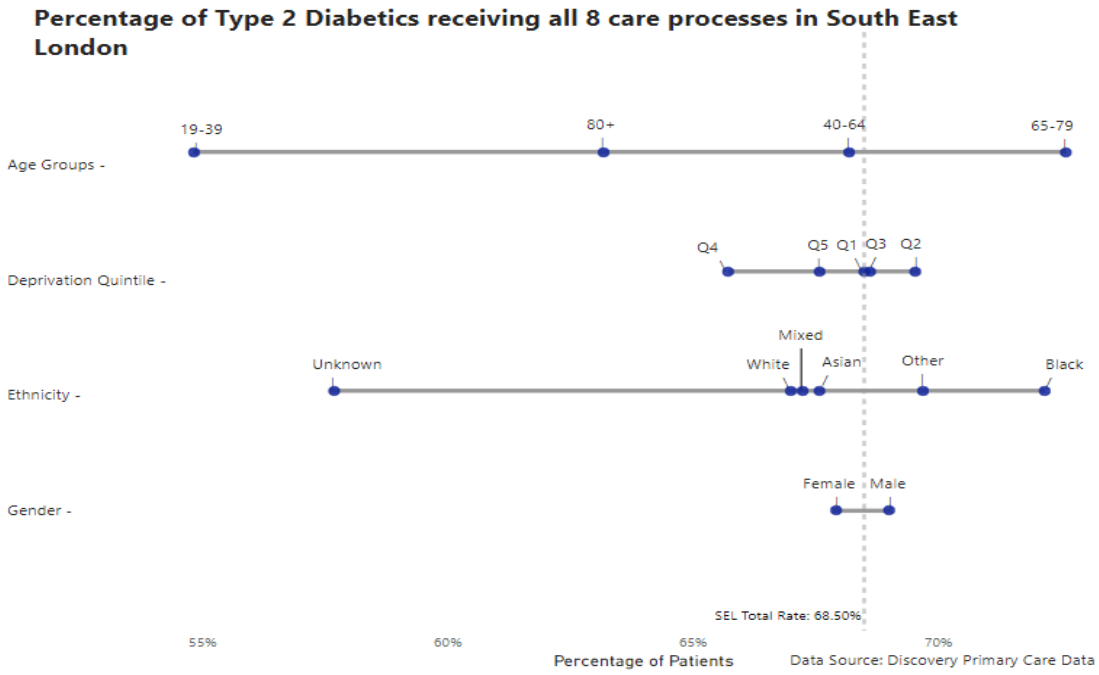

Figure 25

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

Data not available due to dashboard access.

9. Smoking cessation

9.1 Proportion of adult acute inpatient settings offering smoking cessation services

As of July 2024, there are five NHS Trusts in South East London with adult acute inpatient wards – Guy's and St Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, and Oxleas NHS Foundation Trust. Of these, four offer smoking cessation services in 100% of their inpatient settings and the remaining one (Oxleas) offers smoking cessation services in 90% of their inpatient settings.

9.2 Proportion of maternity inpatient settings offering smoking cessation services

As of July 2024, there are three NHS Trusts in South East London with maternity inpatient settings, two of which have maternity specific tobacco dependence treatment services offered to all women/birthing people. Guy's and St Thomas' NHS Foundation Trust offer an in-house maternity tobacco dependence treatment service which is led by specialist midwives and provided alongside midwifery care. Lewisham and Greenwich NHS Trust offer an in-reach service with collaboration between the local authority services and specialist in-house midwives. King's College Hospital NHS Foundation Trust is working towards implementation of an in-house service which will be provided by a specialist midwife, significant progress has already been made in establishing this service and the team are expecting to start seeing women/birthing people around September/October 2024.

10. Oral Health

10.1 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)

This metric utilises data from April 2023 to September 2023. This is to account for unavailable data in the latter part of 2023/24 due to EPIC implementation affecting figures being reported by Guy's and St Thomas' NHS Foundation Trust (GSTT), and King's College Hospital NHS Foundation Trust (KCH).

By deprivation, the lowest rate of tooth extractions is those in the second least deprived quintile (168.5 extraction admissions per 100,000 population). The highest rate is those in the most deprived quintile (464.3). There is an approximate correlation between deprivation and the number of tooth extraction admissions per 100,000 population.

By ethnicity, the group with the highest rate of admissions is those with an Unknown ethnicity (1,369.9). However, the total number of patients in this group is much smaller than the others which can have an impact on the final calculated rate. The Other ethnicity has the next highest rate of tooth extractions (265.2). The lowest rate is the White ethnicity (268.4). Most ethnic groups are clustered around the SEL average (303.5), with the Asian ethnicity having a higher rate of admission than the SEL rate.

By gender, both female (276.5) and male (329.0) are within the SEL average of 300 admissions per 100,000 population.

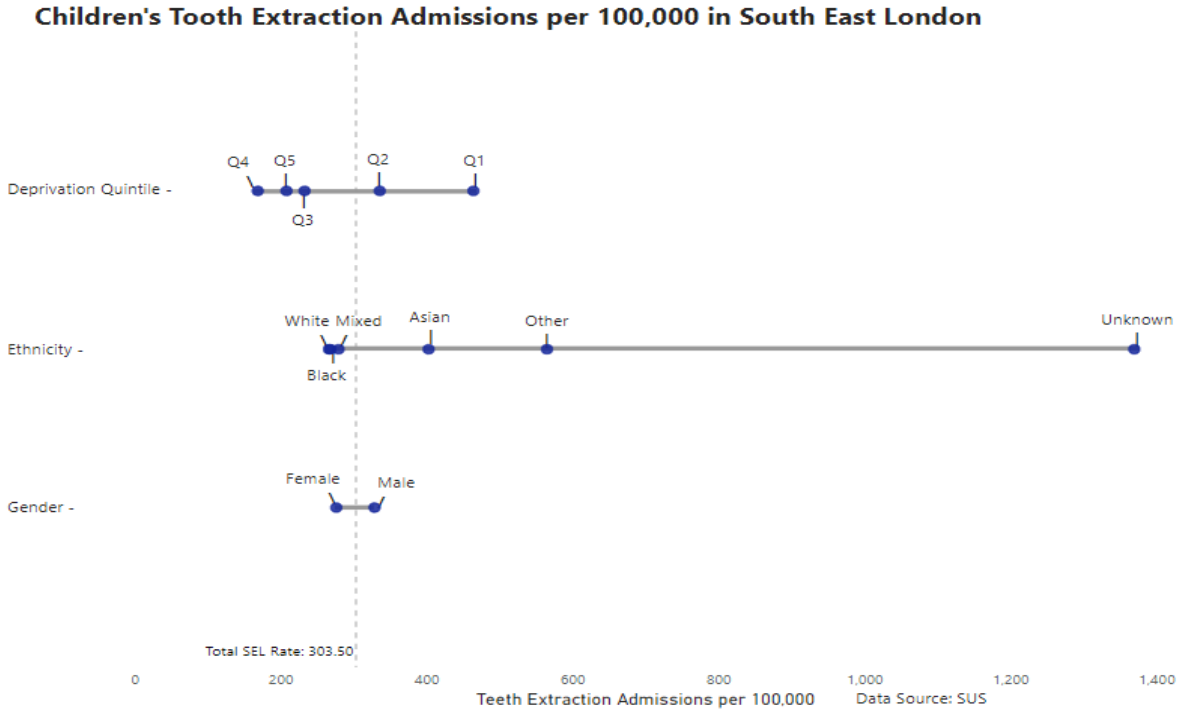

Figure 26

11. Leaning disability and autistic people

11.1 Learning disability annual health checks

The latest data for this metric covers the period from October 2023 to November 2023, with data from November 2022 provided for year-on-year comparison. Anyone on their GP's learning disability register and is aged 14 and over is eligible for an annual health check, therefore the data reported below looks at those aged 14 and over.

By November 2023, 40.1% of South East London's Learning Disability (LD) patients completed their health checks, surpassing the national average of 39.5%. For the adult LD population (aged 18+), the completion rate is 40.6%, whilst for those aged 14-17, it stands at 35.1%. Notably, the 14-17 age group constitutes only 7.7% of the total LD register.

Comparatively, by November 2022, the completion rates for health checks were 45.1% for the entire LD register, 38.1% for the 14-17 age group, and 45.7% for the 18+ population. Although the latest data shows a decline from these figures, it is an improvement over the October 2023 figures, which were 36.2%, 30.8%, and 36.6% respectively for the three groups. This indicates that while the current completion rates are lower than those of 12 months ago, they are showing a month-to-month increase in South East London.

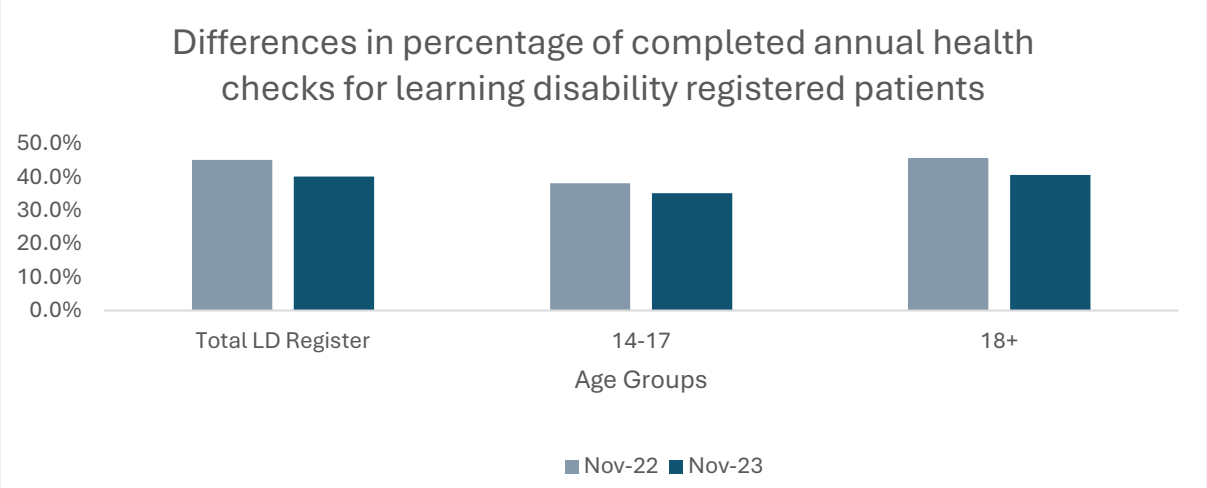

Figure 27

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

The latest data for this metric covers the period from December 2023 to May 2024. The average inpatient admission rate for adults with a learning disability and autism in South East London was 45 per million population. This is marginally above the national average of 43 per million. However, since December 2023, the rate has steadily decreased from 48 per million and demonstrates that the rate of mental health admission for this cohort in South East London is aligned with national levels.

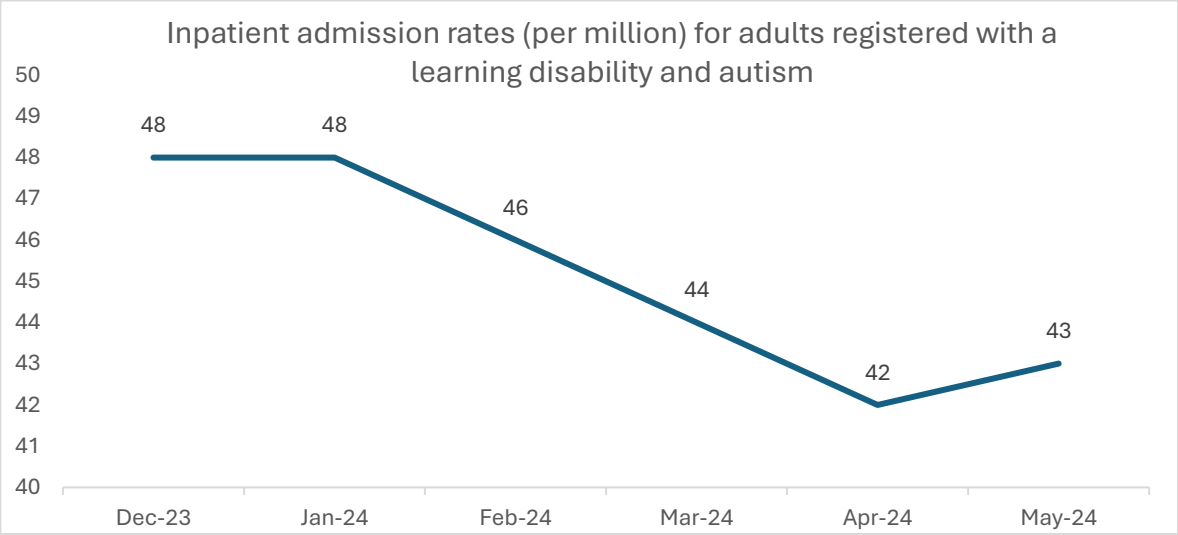

Figure 28

12. Maternity and Neonatal

12.1 Preterm births under 37 weeks

The most recent data for rates of preterm births covers the date range January 2018 to May 2024. The overall rate for April 2024 is 7.6% (data source: Maternity Services Data Set (MSDS)). However, we are unable to provide demographic breakdowns.

The dashboard produced by NHS England does not provide underlying numerators and denominators.

Any inequality identification around preterm births will require access to the underlying data to understand the experiences of different patient cohorts. South East London ICB is currently working on building a report from the MSDS that will be used going forward.

This report has been produced by South East London ICB. Should there be any questions that arise from reading this report, we ask that you direct them to the South East London contact us email address: contactus@selondonics.nhs.uk

13. Appendix 1: Data sources used in report

2. Elective Recovery		
Metric name	**National or local data**	**Data source**
2.1 Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks	Local	Waiting List Minimum Dataset (WLMDS)
2.2 Age standardised activity rates for elective admissions.	Local	Secondary Uses Service (SUS)
2.3 Age standardised activity rates for emergency admissions		
2.4 Age standardised activity rates for emergency attendances		
2.5 Age standardised activity rates for outpatient appointments		
2.6 Age standardised activity rates for virtual outpatient appointments.		
2.7 Elective activity vs pre-pandemic levels for under 18s and over 18s		
3. Urgent and Emergency Care		
Metric name	**National or local data**	**Data source**
3.1 Emergency admissions for under 18s	Local	Secondary Uses Service (SUS)
4. Respiratory		
Metric name	**National or local data**	**Data source**
4.1 Uptake of COVID and flu by socio-demographic group	Local	Local primary care data flow
5. Mental Health		
Metric name	**National or local data**	**Data source**

5.1 Overall number of severe mental illness (SMI) physical health checks	Local	Local primary care data flow
5.2 Rates of total Mental Health Act detentions	National	Mental Health Services Monthly Statistics Dashboard
5.3 Rates of restrictive interventions	National	n/a
5.4 NHS Talking Therapies (formally IAPT) recovery	National	NHS Talking Therapies for Anxiety and Depression Dashboard
5.5 Children and young people's mental health access	National	Mental Health Bulletin Dashboard
6. Cancer		
Metric name	**National or local data**	**Data source**
6.1 Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	National	Cancer Registry Staging Data
7. Cardiovascular Disease		
Metric name	**National or local data**	**Data source**
7.1 Stroke rate of non-elective admissions	Local	Secondary Uses Service (SUS)
7.2 Myocardial infarction - rate of non-elective admissions		
7.3 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.	National	CVDPREVENT
7.4 CVDP003CHOL: 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		
7.5 CVDP002AF: Percentage of patients aged 18 and over 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		
8. Diabetes		

Metric name	National or local data	Data source
8.1 Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes	Local	Local primary care data flow
8.2 Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile	n/a	n/a
9. Smoking cessation		
Metric name	**National or local data**	**Data source**
9.1 Proportion of adult acute inpatient settings offering smoking cessation services	Local	Directly from local providers
9.2 Proportion of maternity inpatient settings offering smoking cessation services	Local	Directly from local providers
10. Oral Health		
Metric name	**National or local data**	**Data source**
10.1 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)	Local	Secondary Uses Service (SUS)
11. Learning disability and autistic people		
Metric name	**National or local data**	**Data source**
11.1 Learning disability annual health checks	National	Mental Health, Learning Disability and Autism Resource Hub (FutureNHS)
11.2 Adult mental health inpatient rates for people with a learning disability and autistic people	National	Learning Disability Services Statistics
12. Maternity and neonatal		
Metric name	**National or local data**	**Data source**
12.1 Preterm births under 37 weeks	n/a	n/a