Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

REPORT

Understanding health inequalities in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust services (2023/24)

June 2024

With YOU in mind

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Glossary of terms

This section explains some of the language and ideas we talk about in this report. It might be helpful to understand what we mean when we use these terms before reading the rest of the report.

Sex

The Equality Act 2010 is a law which protects people from unfair treatment. The law says your biological sex is either male or female, and that your sex is the one which is written on your birth certificate. The biological sex recorded on your birth certificate is usually decided by looking at your genitals when you are born. This is not the only way that biological sex can be understood and other genetic characteristics like your reproductive organs, hormones and chromosomes are also important in making sense of biological sex.

Some people who are intersex or have differences of sexual development might feel excluded by the legal definition of biological sex. People in these groups might have biological characteristics associated with both male and female sexes.

Gender

Biological sex and gender identity are different things.

Gender identity is our internal feelings about being a man, woman, both or neither. Even though people might use the same word to describe their gender identity, we all have a unique experience of gender. Everyone is different and there are lots of different words to describe experiences of gender identity.

Gender identity can be fixed or it can change. You might identify with a gender different to the sex you were registered with when you were born. If you choose to, you can apply to change your legal gender.

Sexuality

Sexuality and sexual orientation refer to the experience of being attracted to another person. Some people feel attracted to others and this can be emotionally, physically or romantically. Some people don't experience these attractions.

Your sexuality is not linked to your biological sex or to your gender identity. No one can know a person's sexuality by knowing their biological sex or gender identity. Research shows that that lesbian, gay, bisexual, trans and other LGBTQ+ people experience unfair differences in health compared to heterosexual (straight) and cisgender people (whose gender identity is the same as the sex recorded on their birth certificate).

You can find out more about language used to describe sex, gender and sexuality from the charity Stonewall: List of LGBTQ+ terms (stonewall.org.uk)

Ethnicity

Ethnicity describes the population group a person belongs to or identifies with. What people consider part of their ethnic identity can be different for different people, and can include things like ancestry, culture, identity, religion, language, and physical appearance.

The Equality Act 2010 is a law which protects people from unfair treatment. The law says ethnicity includes skin colour, nationality and ethnic or national origins, and protects people from unfair treatment because of these characteristics.

Ethnicity categories

The Office for National Statistics is an organisation which produces information about the UK population and society. The Office for National Statistics uses five main ethnicity categories to produce information about people living in the UK. These categories are Asian, Black, Mixed, Other and White. We have used the same categories when talking about ethnicity in this report.

Each of these five ethnicity categories contains smaller categories which describe people's ethnicity in more detail:

- Asian – this includes Asian or Asian British, Pakistani, Indian, Bangladeshi or Other Asian background.
- Black – this includes Black or Black British, African, Caribbean, and Other Black background.
- Mixed – this includes White and Asian, White and Black African, White and Black Caribbean, and Other Mixed background.
- Other – this includes Chinese, Arab, and other ethnic groups.
- White – this includes White British, Irish, and Other White backgrounds including Gypsy and Roma.

Patient and Carer Race Equality Framework

NHS England is the organisation which runs the NHS in England. NHS England has asked all NHS services which use taxpayers' money to provide mental health support to develop a plan to stop unfair treatment of people from minority ethnic and cultural groups. NHS organisations need to work together with local communities who experience unfair treatment to develop the plan, which will be called the Patient and Carer Race Equality Framework.

You can find out more about the Patient and Carer Race Equality Framework here: NHS England » Patient and carer race equality framework

Racialised and culturally minoritised backgrounds

Some people feel like the language used in laws and government documents doesn't reflect their cultural identity and experience.

The Patient and Carer Race Equality Framework uses the term 'racialised and culturally minoritised communities' to describe people from minority ethnic and cultural backgrounds, and people who do not speak English as a first language.

We use the term racialised and culturally minoritised in this report. It refers to:

- Ethnic, racial and cultural communities who are minoritised populations in England, who have been racialised, and who experience marginalisation. When we say a community has been racialised, it means people have put members of that community into a category based on what they look like and made judgments about them which are not based on fact.
- People with different cultural or ethnic identities, which can include people who speak different languages and who have different cultural traditions and spiritual or religious beliefs.
- White minorities including Gypsy, Roma and Irish Traveller groups and Jewish people.

Index of Multiple Deprivation

In England we use a system called the Index of Multiple Deprivation to understand the level of resources and services people have available to them, and whether they live in safe and healthy environments.

This system combines information about living environments, income, employment, education, health, crime, and how difficult it is to access housing and services for every postcode area in England. Each postcode is given a score, which helps us to understand which postcode areas have the worst access to resources, services and safe and healthy environments (most deprived) and which have the best (least deprived).

The Index of Multiple Deprivation system splits all English postcode areas into five groups based on their score. Each of the five groups of postcodes represents 20% of the population in England, from the most deprived to the least deprived. The five groups of postcodes are called 'quintiles'. Knowing which of the five groups or 'quintiles' a postcode belongs to helps us to understand the access to resources, services and safe and healthy environments people living in that postcode have in comparison to people living in other areas in England.

CNTW area

In this report, when we use the term 'CNTW area', we mean the group of areas where our Trust provides services: Northumberland, Newcastle, North Tyneside, North Cumbria, Gateshead, Sunderland, and South Tyneside.

Census 2021

The Census is a national survey which is carried out by the Office for National Statistics every 10 years. The Census asks questions about the person filling out the survey, the people they live with and where they live. Information from the Census helps the government and local authorities plan and fund local services including schools and education, doctors' surgeries and roads.

The last Census was carried out in 2021. We have used information from the 2021 Census in this report.

About Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (also known as CNTW) is an organisation which is part of the NHS. We provide support to people living in North Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland.

We are a specialist mental health and learning disabilities organisation, and we provide support to people of all ages with a wide range of different needs.

We employ around 9,000 people and spend more than £500 million a year to deliver our services. We support people in their own homes, their local communities and in our hospitals.

You can find out more about CNTW on our website: www.cntw.nhs.uk/

Introduction

At Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) we want to work together with compassion and care, to keep you well over the whole of your life. One of the things we need to do as a Trust to achieve our aim is to better understand and address health inequalities.

This is the first year we have published this report. We have worked together with people who have received support from CNTW services to make sure this report is clearly written and easy to understand. We will work with our communities and people who use our services to shape the information we include in next year's report.

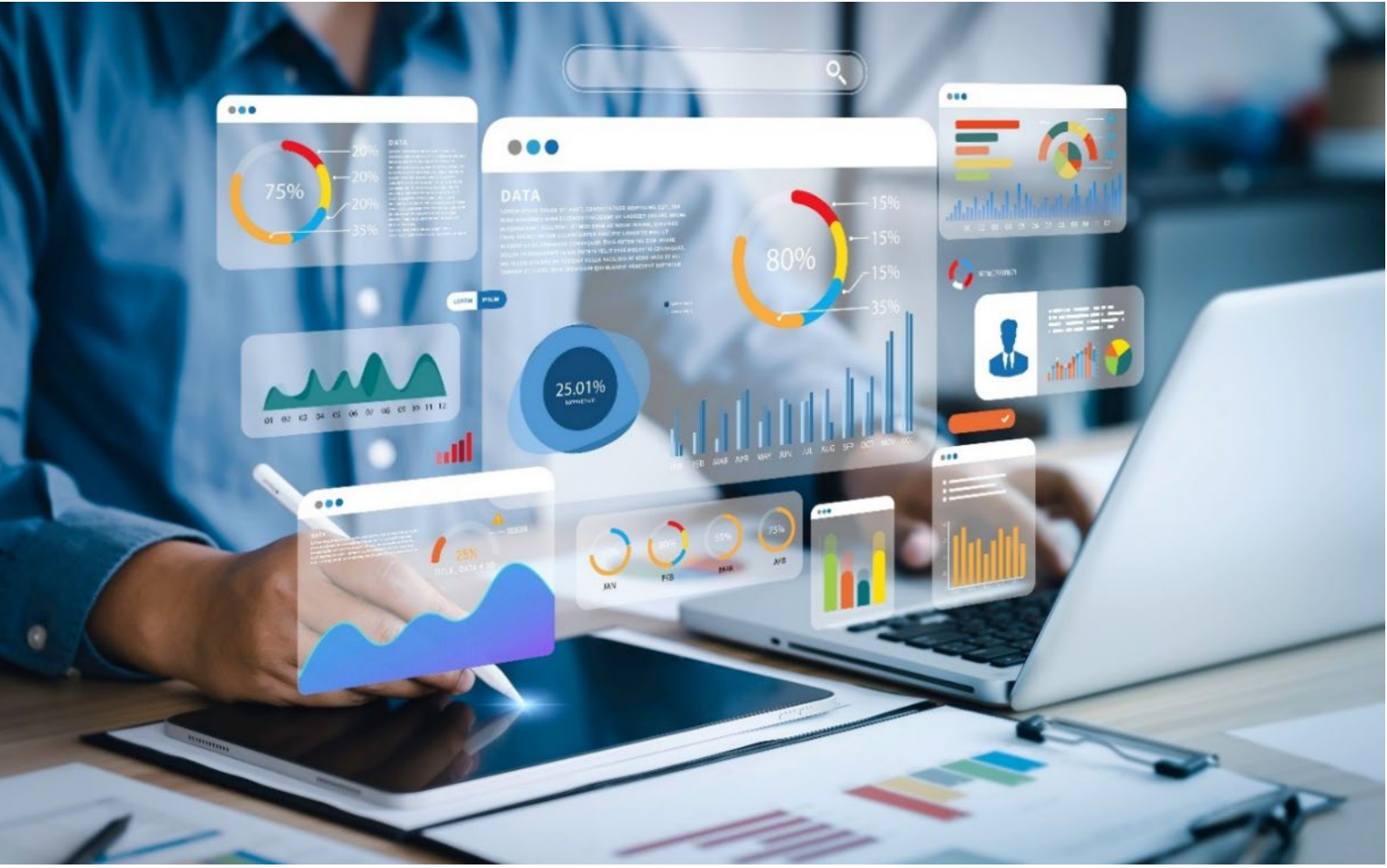
In this report we provide some suggestions about what our data is telling us about health inequalities, and what CNTW's plans are for addressing these unfair differences. At this stage in our journey, we have a lot more work to do to fully understand and tackle these inequalities. We also recognise that CNTW does not have all the answers. Over the coming months, we would like to hear directly from you about how these unfair differences affect your health and experiences of care. We will work in partnership with you, our local communities, to shape our approach to tackling inequalities together.

What are health inequalities?

Health inequalities are differences in access to health services, health outcomes and experiences of care between different groups in society. These differences are unfair and avoidable.

- People who are poorer, live in less safe and less healthy environments, and who find it difficult to use health services tend to live shorter lives. People living in the North East and North Cumbria tend to die younger than people living in some other parts of England.
- During the pandemic, people living in the UK who aren't White were more likely to die from Covid-19 than White people. People from Pakistani and Bangladeshi backgrounds had the highest chance of dying from Covid-19.

These are examples of health inequalities – unequal and unfair differences in health between different groups of people.



Using data to understand health inequalities

Understanding exactly what causes health inequalities can be difficult, as there is often more than one cause. We use the term ‘data’ to describe the information we collect about our services and the people that use them. In the NHS we collect a lot of data, and we can use this to try to understand what might be causing unfair differences in health.

While data can be a helpful starting point for understanding inequalities, it doesn’t tell us everything we need to know about what causes unfair differences in health. We need to work together with local communities to really understand how these unfair differences impact you, your health and how you experience or feel about getting support from CNTW. We also need to listen to feedback from our communities about what needs to change to make sure our services are welcoming to people from all backgrounds and able to meet their needs.

About this report

This report provides a summary of data about some of the services CNTW provides:

- Talking Therapies
- Children and young people's access to mental health services

It also includes a summary of data about what can happen to people when they need to be cared for in one of our hospitals:

- Being kept in hospital under the Mental Health Act
- Restrictive interventions

These services and types of care are explained in more detail in the different sections of this report.

In this report we talk about any unfair differences in health linked to people's age, ethnicity, biological sex and deprivation - whether people have access to safe and healthy environments and the resources and services they need to stay well. In the next section of this report, we explain what we mean when we use these terms. We have included a more detailed explanation in the Glossary section at the beginning of this report.

The data included in this report was collected between April 2023 and March 2024.

The information in this report comes from historical data stored in our electronic patient records and from official statistics and should be considered experimental. The data in this report might be different from official statistics published by NHS England or by CNTW. The data in this report might be incomplete if CNTW does not have information about a patient's sex, age, ethnicity or level of deprivation.

Key messages in this report

Health inequalities

- Health inequalities are differences in access to health services, health outcomes and experiences of care between different groups in society. These differences are unfair and avoidable.

Using data to understand health inequalities

- While data can be a helpful starting point for understanding inequalities, it doesn't tell us everything we need to know about what causes unfair differences in health. We need to listen to feedback from our communities about what needs to change to make sure our services are welcoming to people from all backgrounds and able to meet their needs.
- We don't have good data about people's sexual orientation, gender identity, religion or belief, disability, housing, or history of serving in the armed forces. Improving the data we collect is an important part of our approach to tackling inequalities.

Our communities

- The population in the area where CNTW provides services is slightly older than in other parts of the UK.
- 29% of residents in the CNTW area live in the top 20% most deprived areas in England.
- Most people living in the CNTW area (93%) identify as White.

Detentions under the Mental Health Act

- In the CNTW area, 91 people per 100,000 population were detained under the Mental Health Act between April 2023 and March 2024.
- The rate of detentions is higher among younger people (mid-20s to mid-30s), and among people aged 76 or older.
- The rate of Mental Health Act detentions is higher in more deprived areas.

Restrictive Interventions

- On average, between April 2023 and March 2024 CNTW patients experienced restrictive interventions 41 times for every 1,000 days spent in hospital.

- Rates of restrictive interventions are highest among people aged 17 and under at 337 restrictive interventions per 1,000 days spent in hospital.
- The rate of restrictive interventions is higher among younger female patients.
- There are some big differences in the rate of restrictive interventions for people from different ethnic groups.

Talking Therapies recovery

- There is a small increase in Talking Therapies recovery rates as people get older.
- Recovery rates are similar for males and females, but females are more likely to be referred to our Talking Therapies services than males.
- People from Black, Mixed, and Other ethnic groups have higher Talking Therapies recovery rates than people from a White ethnic background or an Asian background.
- People living in more deprived areas have lower Talking Therapies recovery rates. In these areas, more people are referred to Talking Therapies.

Access to Children and Young People's Services

- Most of the children and young people who received at least one contact from CNTW mental health services between April 2023 and March 2024 were White (91%).
- The rate of children and young people receiving at least one contact with CNTW mental health services is higher in more deprived areas.
- The rate of children and young people receiving at least one contact with CNTW mental health services is higher among older children, and highest among children aged 14-17.
- The rate of children and young people receiving at least one contact with CNTW mental health services is slightly higher for males than for females.

Age, sex, ethnicity and deprivation

This report highlights unfair differences in health linked to people's age, ethnicity, biological sex and deprivation - whether people have access to safe and healthy environments and the resources and services they need to stay well. This section describes the data we collect about these characteristics and experiences and some of the gaps in the data which it might be helpful to understand before reading the rest of this report.

Characteristic or experience	Data we have and don't have
Age	We collect the date of birth of all our patients, so we have accurate information about their age.
Sex	We collect data about the biological sex of our patients. At the moment, we can't record gender on our patient record system so we're not able to understand unfair differences in health due to gender among our patients. We're working to change this, and hope to report on unfair differences in health based on gender in future reports. Lots of people think that sex and gender are the same but they mean different things. Sex is biological (male or female). The biological sex recorded on your birth certificate is usually decided by looking at your genitals when you are born. This is not the only way that biological sex can be understood and other genetic characteristics like your reproductive organs, hormones and chromosomes are also important in making sense of biological sex. Gender identity is our internal feelings about being a man, woman, both or neither. Even though people might use the same word to describe their gender identity, we all have a unique experience of gender. Everyone is different and there are lots of different words to describe experiences of gender identity. Gender identity can be fixed or it can change. You might identify with a gender different to the sex you were registered with when you were born. If you choose to, you can apply to change your legal gender. We have included more information about language used to describe sex, gender and sexuality in the Glossary section at the beginning of this report.

Characteristic or experience	Data we have and don't have
Ethnicity	Ethnicity describes the population group a person belongs to or identifies with. What people consider part of their ethnic identity can be different for different people, and can include things like ancestry, culture, identity, religion, language, and physical appearance. The Equality Act 2010 is a law which protects people from unfair treatment. The law says ethnicity includes skin colour, nationality and ethnic or national origins, and protects people from unfair treatment because of these characteristics. The ethnicity data we have comes from how patients described their own ethnicity when we asked them. While we have a lot of different types of ethnicity in our patient data, in this report we have used the five main ethnicity categories used by the Office for National Statistics. These are: • Asian – this includes Asian or Asian British, Pakistani, Indian, Bangladeshi or Other Asian background. • Black – this includes Black or Black British, African, Caribbean, and Other Black background. • Mixed – this includes White and Asian, White and Black African, White and Black Caribbean, and Other Mixed background. • White – this includes White British, Irish, and Other White backgrounds including Gypsy and Roma. • Other – this includes Chinese, Arab, and other ethnic groups. We have included more information about language used to describe ethnicity, religion and nationality in our Glossary section at the start of this report.

Characteristic or experience	Data we have and don't have
Deprivation	People's health depends a lot on the resources and services they have available to them, and whether they live in safe and healthy environments. We use the term 'deprivation' to describe a lack of access to resources, services, and safe and healthy environments. We collect the postcode of all our patients, so we have accurate information about where they live. In England we use a system called the Index of Multiple Deprivation to understand the level of resources and services people have available to them, and whether they live in safe and healthy environments. This system combines information about living environments, income, employment, education, health, crime, and how difficult it is to access housing and services for every postcode area in England. Each postcode is given a score, which helps us to understand which postcode areas have the worst access to resources, services and safe and healthy environments (most deprived) and which have the best (least deprived). Because we collect the postcode of all our patients, we can use this system to understand whether our patients live in areas which have good access to resources, services, and healthy environments, and whether there are unfair differences in health linked to where patients live.

Improving the data we collect

While people can experience health inequalities because of their age, biological sex, ethnicity and whether they have access to resources and services, these are not the only characteristics and experiences which can lead to unfair differences in health.

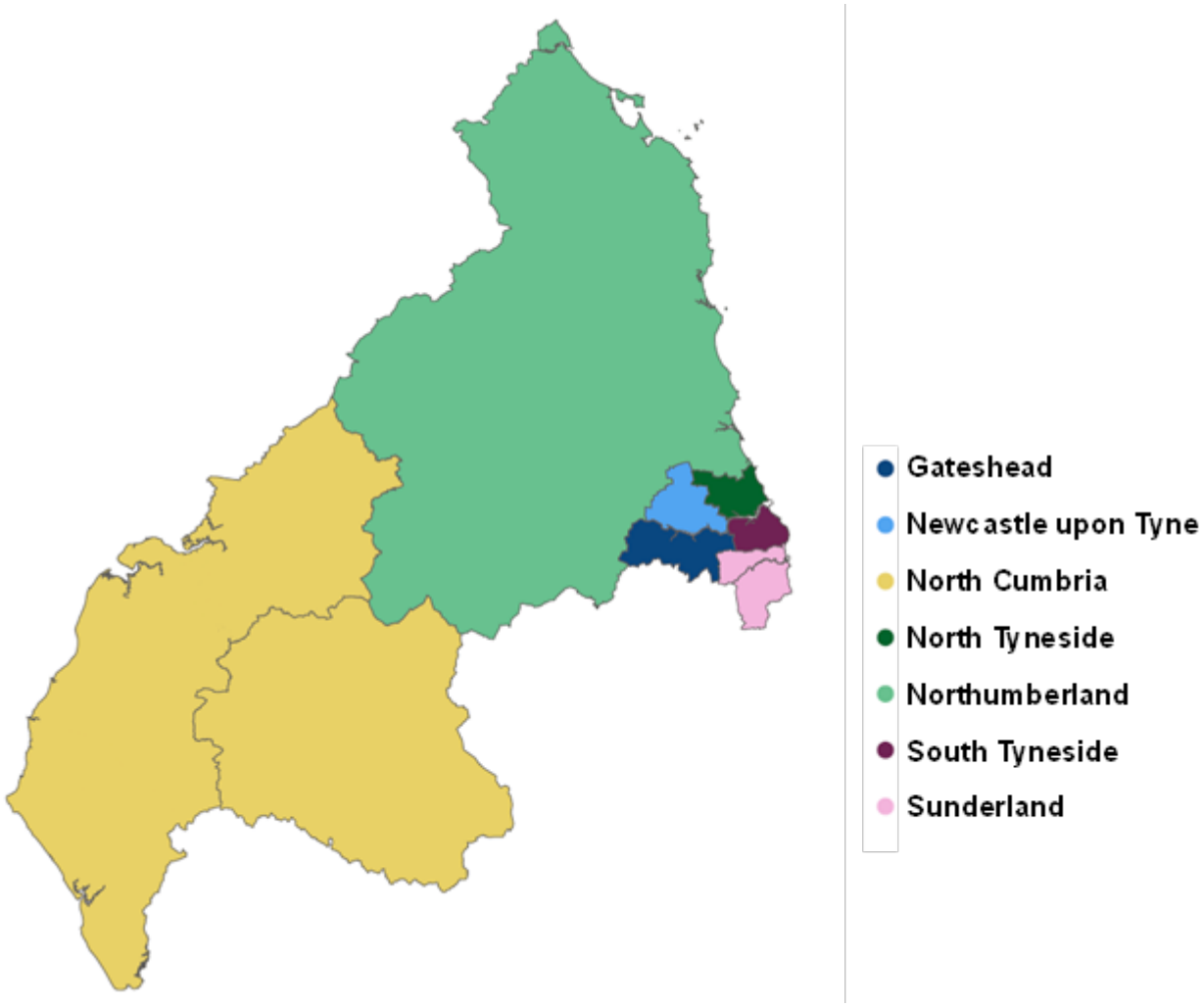
People can experience unfair differences in health because of many different characteristics and experiences including their sexual orientation, gender identity, religion or belief, because they have a disability, because they don't have a secure home, or because they have been in the armed forces. Unfortunately, we don't have as much data about these characteristics and experiences as we do about people's age, biological sex, ethnicity, and where people live. This makes it difficult to use data to understand unfair differences in health between all the different groups and communities we provide services to.

Over time we will work with our staff who provide care directly to our patients to collect more data about patients' backgrounds and experiences. We will also use language which people feel accurately describes their identity and life experiences. This is an important part of tackling inequalities because it can help us understand how unfair differences in health affect different communities, and whether our work to reduce these differences is having an impact.

Our communities

This section provides some information about the places where CNTW provides services – Newcastle, Gateshead, North Cumbria, North Tyneside, Northumberland, South Tyneside, and Sunderland. In this report, we call this group of different areas the 'CNTW area'.

Map showing the 'CNTW area'



Sex

Around 1.97 million people live in the CNTW area. 51% of people are female.

Age

In the CNTW area, the population is slightly older than in other parts of the UK. There are some important differences in age between the different communities where we provide services. For example, people living in Northumberland tend to be older than people living in other parts of the CNTW area, and people living in Newcastle tend to be younger. Compared to other council areas, more of Newcastle's residents are aged between 20 and 29.

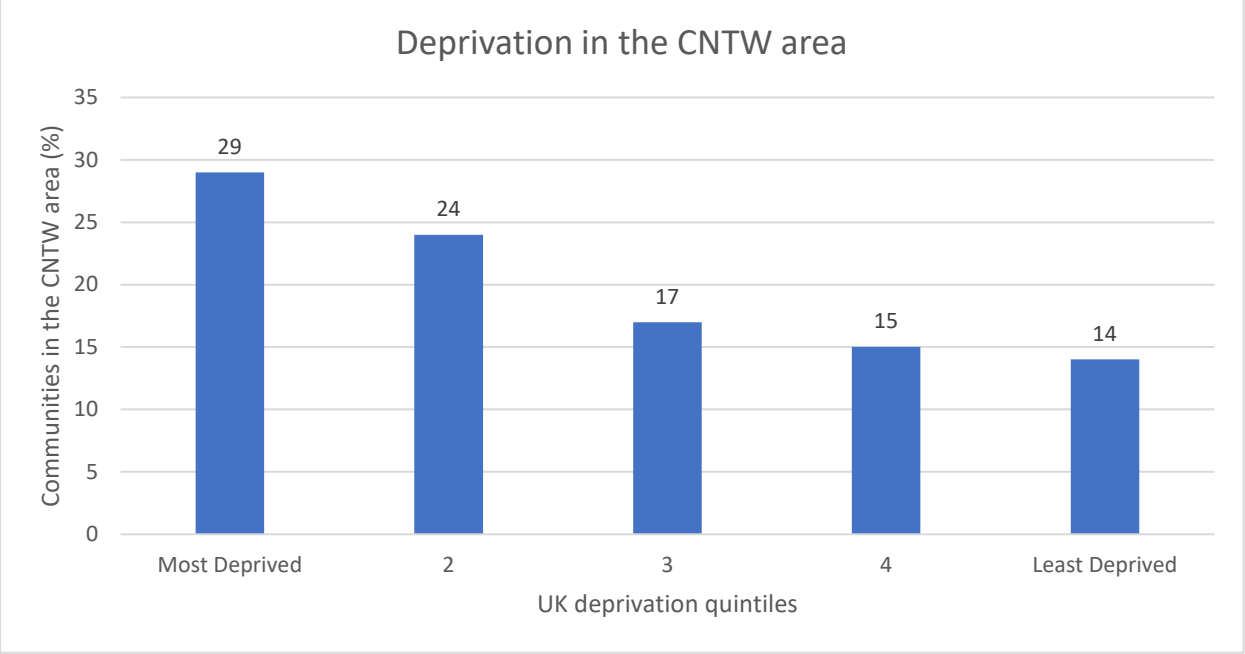
Deprivation

The Index of Multiple Deprivation system splits all English postcode areas into five groups. Each of the five groups of postcodes represents 20% of the population in England, from the most deprived to the least deprived. The five groups of postcodes are called ‘quintiles’. While an individual person might have better or worse access to resources and services than other people in their postcode area, the Index of Multiple Deprivation is a good system for understanding how deprivation causes unfair differences in health between whole communities.

There are some big differences between communities in the CNTW area in terms of access to resources, services, and healthy safe environments:

- 29% of our communities are among the most deprived areas in England.
- 14% of our communities are among the least deprived areas in England.

The chart below shows what percentage of communities in the CNTW area are among the most deprived and least deprived areas in the UK.

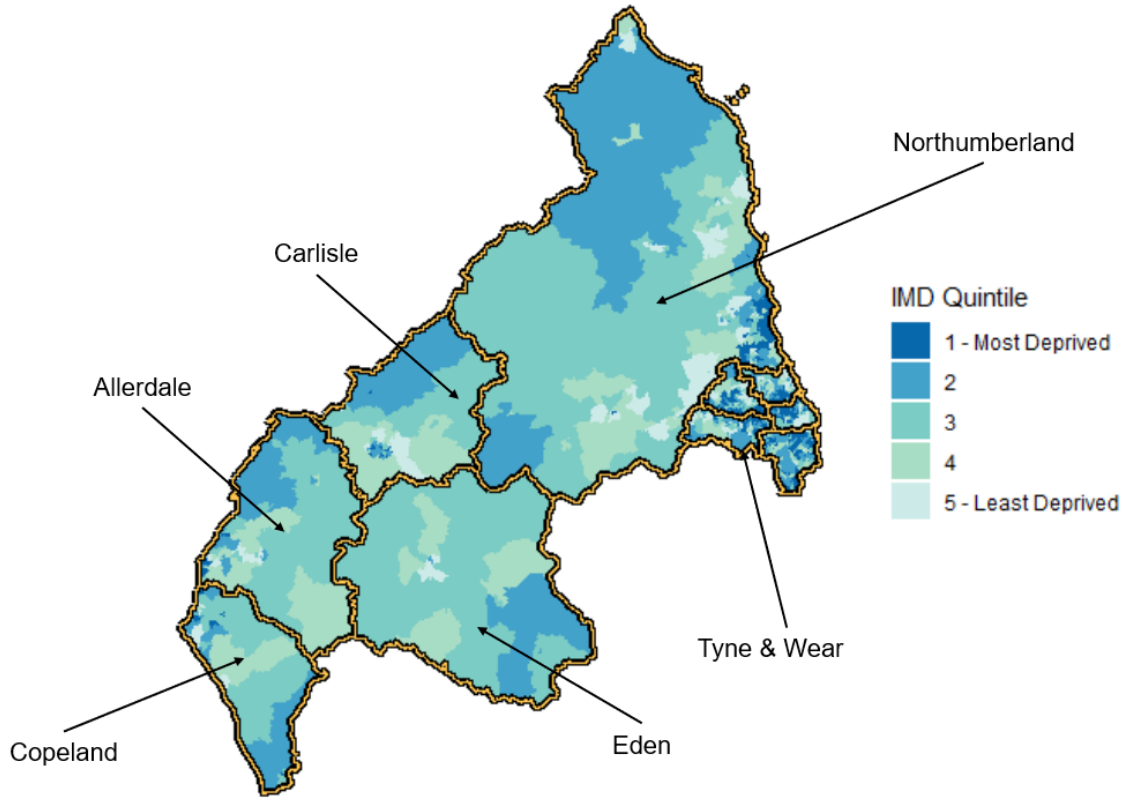


Quintile	1 (most deprived)	2	3	4	5 (least deprived)
Percentage of Population	29%	24%	17%	15%	14%

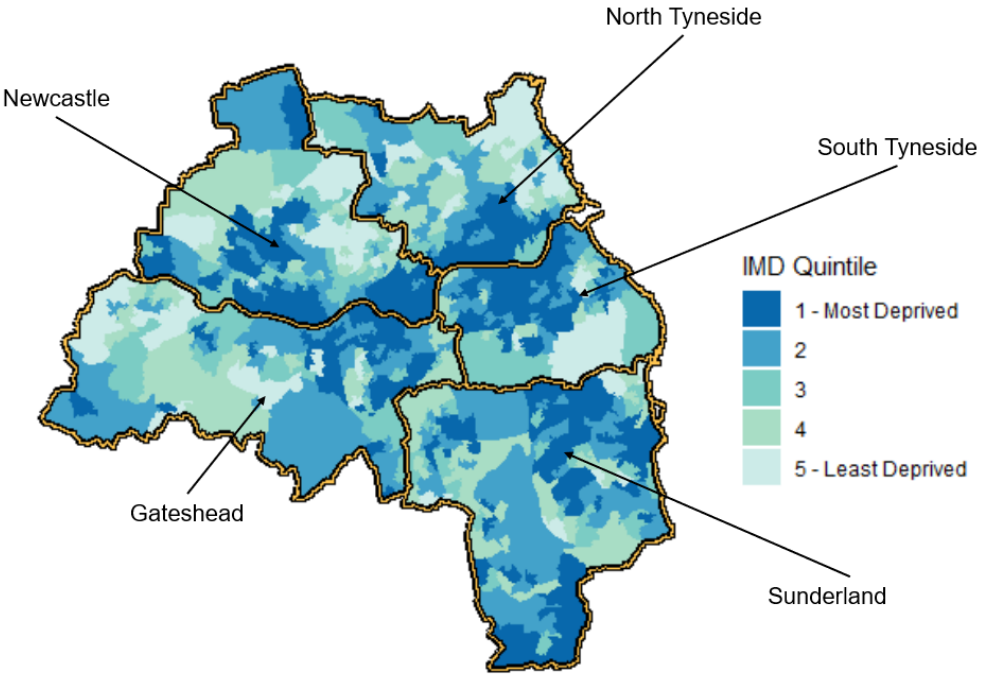
Table 1: Percentage of the CNTW population in each deprivation quintile

The maps below also show the level of deprivation in the communities where CNTW provides services. Darker colours represent areas and communities with worse access to resources, services and healthy safe environments.

Map showing deprivation in the CNTW area



Map showing deprivation in the Tyne and Wear area (Sunderland, South Tyneside, Newcastle, Gateshead, and North Tyneside)



Ethnicity

The 2021 Census asked people to describe their ethnicity. In the CNTW area, people described their ethnicity as:

- White (93%)
- Asian (4%)
- Black (1%)
- Mixed (1%)
- Other (1%)

There are big differences between rural and urban areas, with people from Asian, Black, Mixed and Other ethnicities living mainly in towns and cities.

Detentions under the Mental Health Act

The Mental Health Act is a law which says when you can be taken to hospital, kept there, and treated against your wishes. This should only happen if you are experiencing mental health issues which put you or someone else at risk and there are no other options which would keep everyone safe.

Being kept in hospital or 'detained' under the Mental Health Act is sometimes called being 'sectioned', because the law has different sections. Some sections of the Mental Health Act are used to treat people with mental illness who are in contact with the criminal justice system. For example, if you are on remand in prison and you experience serious mental illness, you can be transferred to a mental health hospital. The data presented in this report covers detentions under all sections of the Mental Health Act.

Number of detentions

- 1,609 people were detained under the Mental Health Act in the CNTW area between April 2023 and March 2024.
- 129 people were detained under the Mental Health Act in CNTW who are registered with a GP outside the CNTW area. This might happen because:
    - The person being detained is cared for by a CNTW service which accepts patients from the whole of the North East or the whole of England.
    - There are no mental health hospital beds available close to where a person lives, and they are brought to a CNTW hospital instead.
    - Someone is away from home or doesn't have a stable home and are in the CNTW area when they need to be detained under the Mental Health Act.

Rate of detentions per 100,000 population

We use a rate per 100,000 population to understand differences in the use of Mental Health Act detentions between different groups.

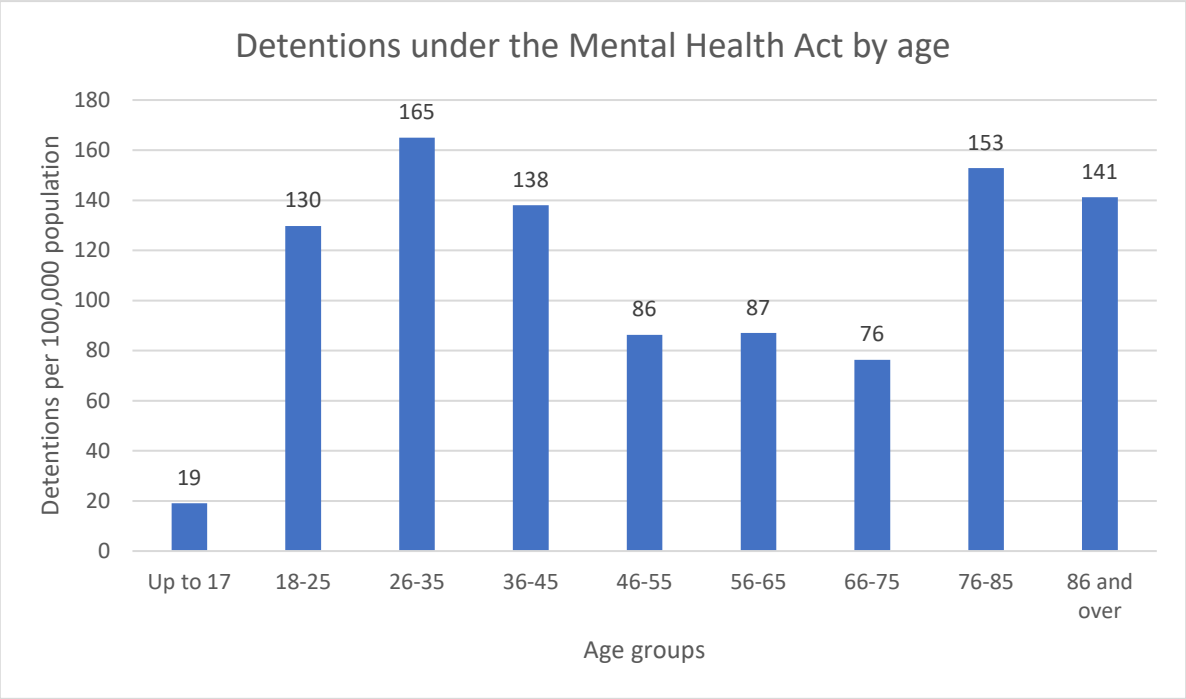
When we use 'rate of detentions per 100,000 population', we are describing how many times the Mental Health Act is used to take someone to hospital, keep them there, and treat them against their wishes for every 100,000 people.

Using a rate of detentions per 100,000 population instead of the number of detentions helps us understand whether there are unfair differences in the use of the Mental Health Act between different groups in society, even when one group might contain a lot more people than another group resulting in big differences in the actual number of detentions.

- In the CNTW area, 91 people per 100,000 population were detained under the Mental Health Act between April 2023 and March 2024.

Age

The chart below shows how the number of detentions per 100,000 population varies with age.



The rate is highest among younger people (mid-20s to mid 30s), and among people aged 76 or older.

This might be because it is common for people to first experience psychosis (seeing and hearing things other people don't) in their late teens and early 20s, and a person might need to be detained under the Mental Health Act if their symptoms of psychosis put them or someone else at risk of harm. It is also common for people to experience a second period of psychosis in later life, and our Trust also cares for a lot of patients with dementia. This could explain why we see higher rates of detention among older people.

Sex

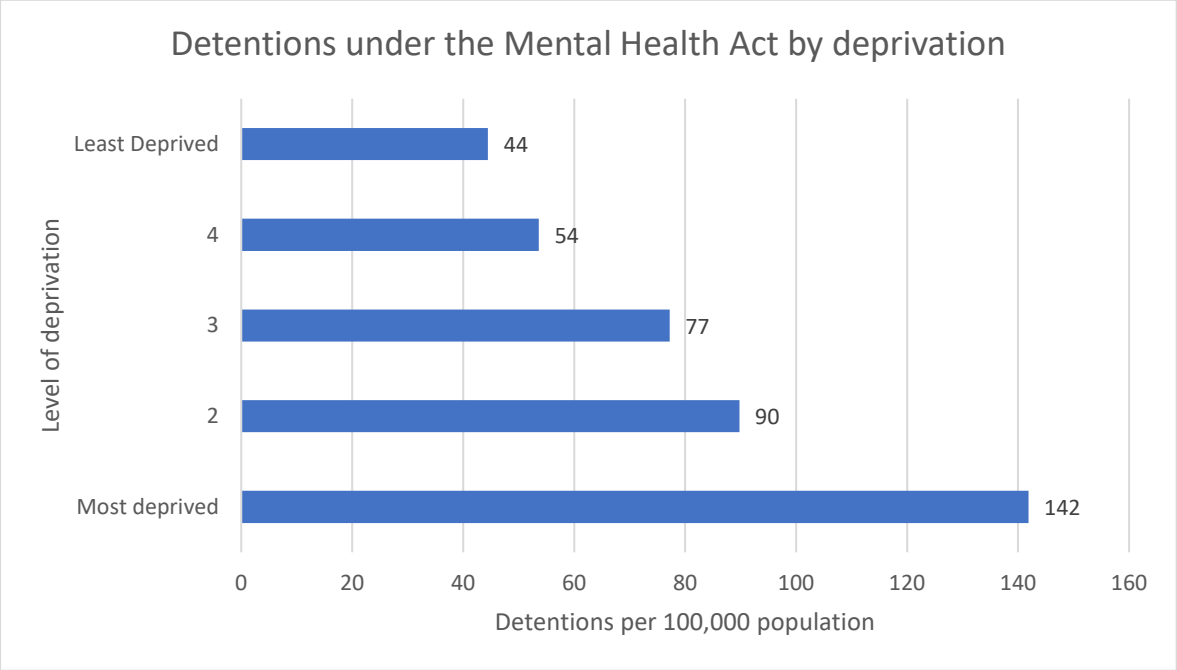
There are only small differences between the detention rates for males and females:

- 100 detentions per 100,000 males
- 95 detentions per 100,000 females

We do not think this gap on its own suggests an unfair difference in detention rates. To understand whether there are unfair differences in detention rates between males and females, we need to compare several years' data. We will do this in next year's report. As this is the first year we have produced this report, we have focused on data about detentions between April 2023 to March 2024.

Deprivation

The chart below shows the rate of Mental Health Act detentions in our communities grouped by level of deprivation. The rate of Mental Health Act detentions is highest in more deprived areas.



Quintile	1 (most deprived)	2	3	4	5 (least deprived)
Number of detentions	746	387	238	149	113
Population size	525,842	431,042	308,300	277,765	254,087
Detention rate	**142**	**90**	**77**	**54**	**44**

Table 2: Rate of detentions under the Mental Health Act per 1,000 population by deprivation (IMD quintiles)

There is strong evidence that when people don't have access to resources, services, and healthy and safe environments, their health and wellbeing can be negatively affected.

We have more work to do to fully understand unfair differences in Mental Health Act detentions linked to deprivation among CNTW patients and communities. Over the coming months we will complete a more in-depth analysis of our data on Mental Health Act detentions to better understand these unfair differences and identify the actions we could take to tackle these inequalities.

Ethnicity

We have decided not to include information about Mental Health Act detentions among people from different ethnic groups in this year's report.

This is because we are not confident we have accurate information about the size of different ethnic groups in our Trust area. To understand whether there are unfair differences in the use of the Mental Health Act between different ethnic groups, we need to calculate a detention rate for each group. We can't do this using the data we record about the number of detentions, because one ethnic group might contain a lot more people than another group resulting in big differences in the actual number of detentions. We need to know the size of each ethnic group to be able to calculate the detention rate for each group correctly, and to compare the rates for different groups to understand whether people from different ethnic groups are more likely to be detained under the Mental Health Act.

Usually, detention rates for each ethnic group are calculated using information about people's ethnicity from the 2021 Census. When we compared the 2021 Census data with other information about people's nationality and ethnicity, including the number of adults with different nationalities registering for National Insurance numbers in the CNTW area and the number of children from different ethnic backgrounds in our local schools, there were some big differences. Community leaders representing people from minoritised backgrounds in our Trust area also told us that their communities have grown a lot in the past few years. We think that detention rates calculated using information about people's ethnicity from the 2021 Census are likely to be inaccurate, which is why we have decided not to include detention rates for different ethnic groups in this report.

We plan to work with other organisations in our region and at national level to find solutions to this problem so that in future we can accurately measure any unfair differences in detention rates by ethnicity and include this information in our reports. Over the coming months CNTW will be working in partnership with racialised and culturally minoritised communities in the areas where we provide services to develop our Patient and Carer Race Equality Framework (PCREF). We will work with our local communities to develop a shared understanding of unfair differences in access, experience and outcomes in CNTW services due to ethnicity and culture, what drives and sustains these inequalities, and what actions we can take to tackle them. We know that we need to involve more people from Black, Asian, Mixed and Other ethnic backgrounds in making decisions about how long people need to be detained under the Mental Health Act, and we have already started to do this.

Use of restrictive interventions

Restrictive interventions are actions that limit someone's movement or freedom. These actions are used to reduce the risk of danger to a person or the people around them. They include:

- Seclusion – patients are kept in an area away from other patients. They are not able to leave that area, and are supervised by hospital staff.
- Long-term segregation – where patients are not allowed to mix freely with other patients on the hospital ward, and this rule is applied long-term.
- Manual restraint – physically holding a person's body to limit their movement.
- Mechanical restraint – using handcuffs or other equipment to limit someone's movement.
- Chemical restraint – using medication which is not prescribed as part of the patient's usual care. This might include rapid tranquillisation.
- Blanket restrictions – rules applied to all patients on the ward which restrict their movement or freedom, for example, searching all patients when they come back to the ward if there's evidence illegal drugs have been brought in to the unit.

Mental health hospitals provide care to people who are very unwell and who are experiencing severe symptoms which mean they can't be safely cared for in the community where they live. In hospital, situations can develop which put patients and staff at risk of harm, and hospital staff must take action to reduce the risk and keep everyone safe. Sometimes restrictive interventions are necessary to reduce the risk of harm. They should only be used when a situation can't be made safe without limiting someone's movement or freedom.

Rate of restrictive interventions per 1,000 days spent in hospital

We use 'rate of restrictive interventions per 1,000 days spent in hospital' to understand differences between different groups in the use of care which restricts people's movement or freedoms.

When we use 'rate of restrictive interventions per 1,000 days spent in hospital', we are describing how many times someone has their movement or freedom limited for every 1,000 days people from that group spend in hospital.

Using the rate of restrictive interventions per 1,000 days spent in hospital instead of the number of restrictive interventions helps us understand whether there are unfair differences in the use of this type of care between different groups in society.

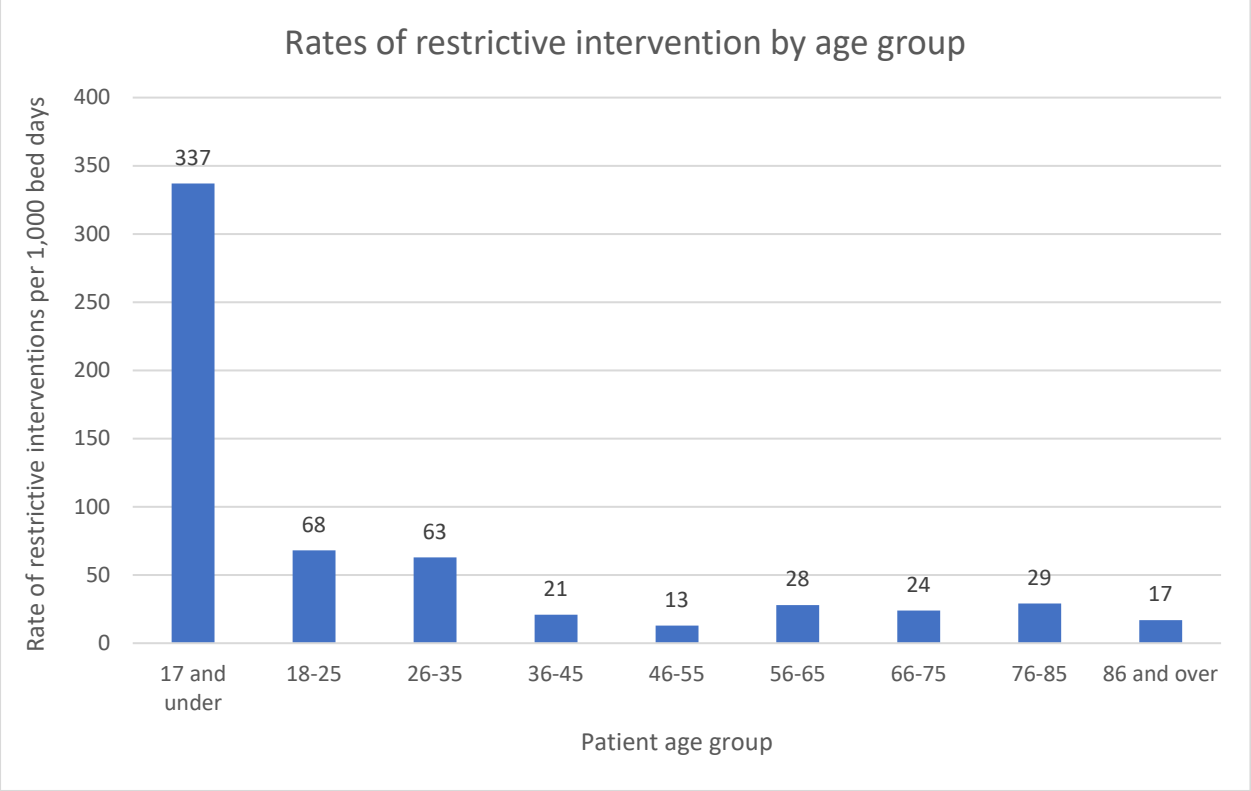
- CNTW used care which limited the movement or freedom of our patients 8,901 times between April 2023 and March 2024.
- During the same time period, our patients spent a total of 217,163 days in hospital.

- On average, CNTW patients experienced restrictive interventions 41 times for every 1,000 days spent in hospital.

This does not mean that all patients have their freedom or movement limited when they are in hospital. Depending on the situation, some individual patients might need more restrictive interventions than others to keep everyone safe. These differences in the number of restrictions between individual patients can have a big impact on the rate of interventions for particular groups of patients and CNTW patients overall.

Age

The chart below shows the rate of restrictive interventions per 1,000 days spent in hospital for people from different age groups. The rate of restrictive interventions is higher in the younger age groups. It is highest among people aged 17 and under at 337 restrictive interventions per 1,000 days spent in hospital. The average rate for all CNTW patients is much lower at 41 restrictive interventions per 1,000 days spent in hospital.



Age	17 and under	18-25	26-35	36-45	46-55	56-65	66-75	76-85	86 and over
Number of restrictive interventions	1,831	1,425	2,513	818	443	960	482	499	82
Number of occupied bed days	5,432	20,810	40,003	39,863	34,656	34,501	19,945	17,067	4,886
Rate of restrictive interventions	**337**	**68**	**63**	**21**	**13**	**28**	**24**	**29**	**17**

Table 4: Rate of restrictive interventions per 1,000 days spent in hospital for each age group

Sex

There is quite a big difference between males and females in the use of care which limits people's movements or freedom:

- 50 restrictive interventions per 1,000 days spent in hospital for females.
- 33 restrictive interventions per 1,000 days spent in hospital for males.

The rate of restrictive interventions is different for males and females of different age groups:

- Among older patients, the rate of restrictive interventions is higher for males than it is for females.
- The rate of restrictive interventions is much higher for females aged 17 and under than it is for males aged 17 and under.
- The rate of restrictive interventions is also higher for females than it is for males in the 18 – 25 and 36 – 45 age groups.

We think this could be because younger female patients are more likely to try to hurt themselves while they are in hospital. In these situations, it is very risky not to take action to keep the patient safe. Often this means staff must decide quickly to limit the patient's movement or freedom, and don't get the chance to use less restrictive approaches. Over the coming months we will work to better understand this difference, and any actions we can take to address it.

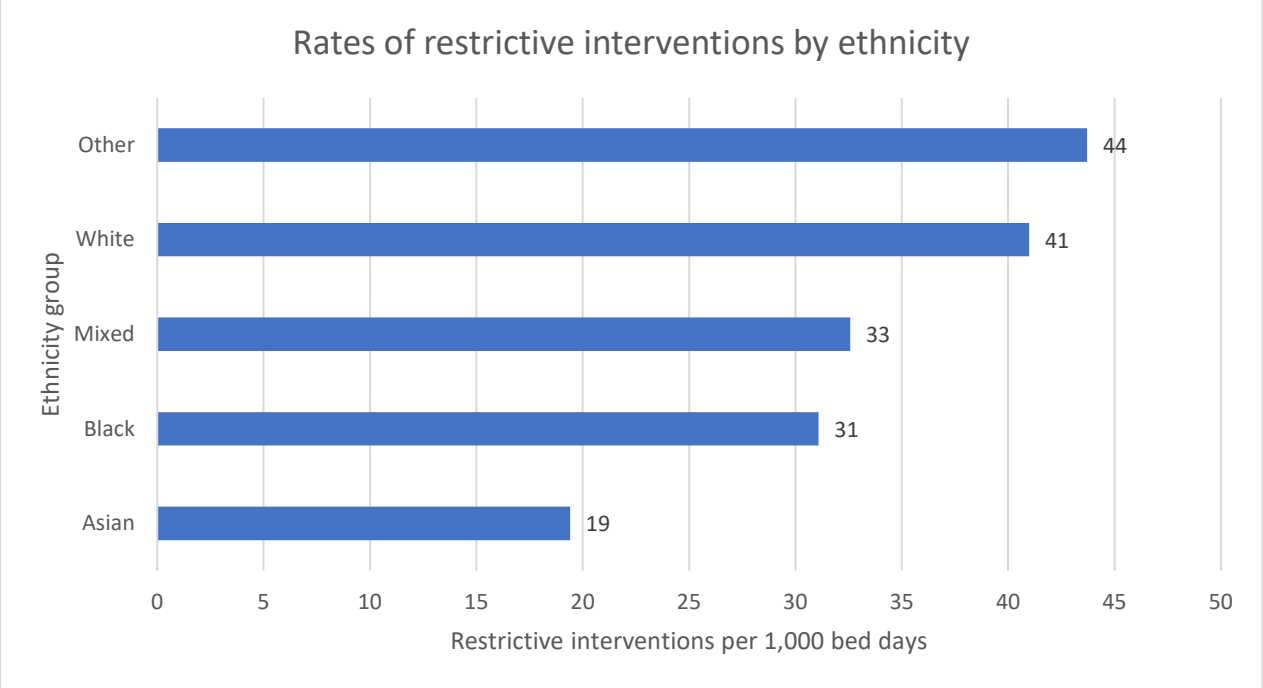
In general, many of the actions our staff take which limit the freedom or movement of our patients involve directing the behaviours and decision-making of our patients in a supportive way. Our staff also provide personal care (things like getting ready, getting washed, and going to the toilet) to patients when they need it. Because our staff are aware of the need to keep a record of care which limits a patient's freedom or movement, our data on restrictive interventions is likely to include these types of care as well as more restrictive types of care like the use of seclusion or rapid tranquillisation.

Ethnicity

There are differences between ethnic groups in the use of care which limits people's movement or freedom:

- 19 restrictive interventions per 1,000 days spent in hospital by Asian people.
- 31 restrictive interventions per 1,000 days spent in hospital by Black people.
- 33 restrictive interventions per 1,000 days spent in hospital by people with Mixed ethnicity.
- 41 restrictive interventions per 1,000 days spent in hospital by people with a White ethnicity.
- 44 restrictive interventions per 1,000 days spent in hospital by people whose ethnicity is recorded as 'Other'.

The chart below shows the rate of restrictive interventions for each of the five main ethnic groups.



Ethnicity	Asian	Black	Mixed	White	Other
Number of restrictive interventions	145	204	99	8,021	96
Number of occupied bed days	7,472	6,561	3,039	195,685	2,196
Rate of restrictive interventions	**19**	**31**	**33**	**41**	**44**

Table 5: Rate of restrictive interventions per 1,000 days spent in hospital for each ethnicity

While the differences between some of the five main ethnic groups in the use of care which limits people's movement and freedom might seem small, when we look at the use of this type of care among the more detailed ethnicity categories which make up these groups, we see bigger differences:

- 72 restrictive interventions per 1,000 days spent in hospital for people who identify as Black, Black British or Other Black background.
- 60 restrictive interventions per 1,000 days spent in hospital for people who identify as having a Mixed ethnic background. This does not include people who identify as Mixed ethnicity White and Asian, White and Black African or White and Black Caribbean.
- 73 restrictive interventions per 1,000 days spent in hospital for people who describe their ethnicity as 'Other'. This does not include people who identify as Chinese.

While the number of restrictive interventions received by individual patients can have a big impact on the rate of interventions for particular groups of patients, the rates of

restrictive interventions for these ethnic groups are much higher than the rates of restrictive interventions for people from Asian backgrounds. The rates for these groups are also higher than the rate of 41 restrictive interventions per 1,000 days spent in hospital by White people.

Over the coming months CNTW will be working in partnership with racialised and culturally minoritised communities in the areas where we provide services to develop our Patient and Carer Race Equality Framework (PCREF). Understanding and addressing unfair differences linked to ethnicity in the use of care which limits people's movements and freedoms will be an important part of this work.

We have included more detailed information about ethnicity categories in the Glossary section at the start of this report.

Deprivation

There are some quite big differences in the rates of restrictive interventions per 1,000 days spent in hospital for people with different levels of access to resources, services, and safe and healthy communities. The rate of restrictive interventions per 1,000 days spent in hospital is highest for people in the third segment or 'quintile' who don't live in our most deprived or most privileged communities. The rate of restrictive interventions per 1,000 days spent in hospital is higher for people living in our most privileged communities than it is for people living in our most deprived communities. We don't think this data suggests that there are unfair differences linked to deprivation in the use of care which limits people's movement and freedoms, but we will work to better understand this data over the coming months.

Quintile	**1 (most deprived)**	**2**	**3**	**4**	**5 (least deprived)**
Number of restrictive interventions	2,837	1,507	2,699	436	424
Number of occupied bed days	83,468	47,255	37,824	18,403	10,657
Rate of restrictive interventions	**34**	**32**	**71**	**24**	**40**

Table 6: Rate of restrictive interventions per 1,000 days spent in hospital for each deprivation quintile

Talking Therapies recovery

NHS Talking Therapies is a service which provides support for people with anxiety disorders and depression. In Talking Therapies, people work with their therapist to understand their problems, overcome their challenges, and achieve their goals. As the name suggests, Talking Therapies involves talking with a therapist, as well as doing practical exercises.

CNTW provides Talking Therapies in Sunderland and North Cumbria. Talking Therapies is available across the CNTW area, but in Newcastle, Gateshead, South Tyneside, North Tyneside and Northumberland, the Talking Therapies service is not provided by CNTW.

When people are referred to Talking Therapies they are assessed to see whether their symptoms of anxiety or depression are severe enough that they could meet the criteria to be clinically diagnosed with a mental health condition. A person is considered to have recovered following their Talking Therapies treatment if they met the clinical diagnosis criteria when they were referred to the service, but their symptoms were not considered severe enough to meet the clinical diagnosis criteria at the end of their treatment.

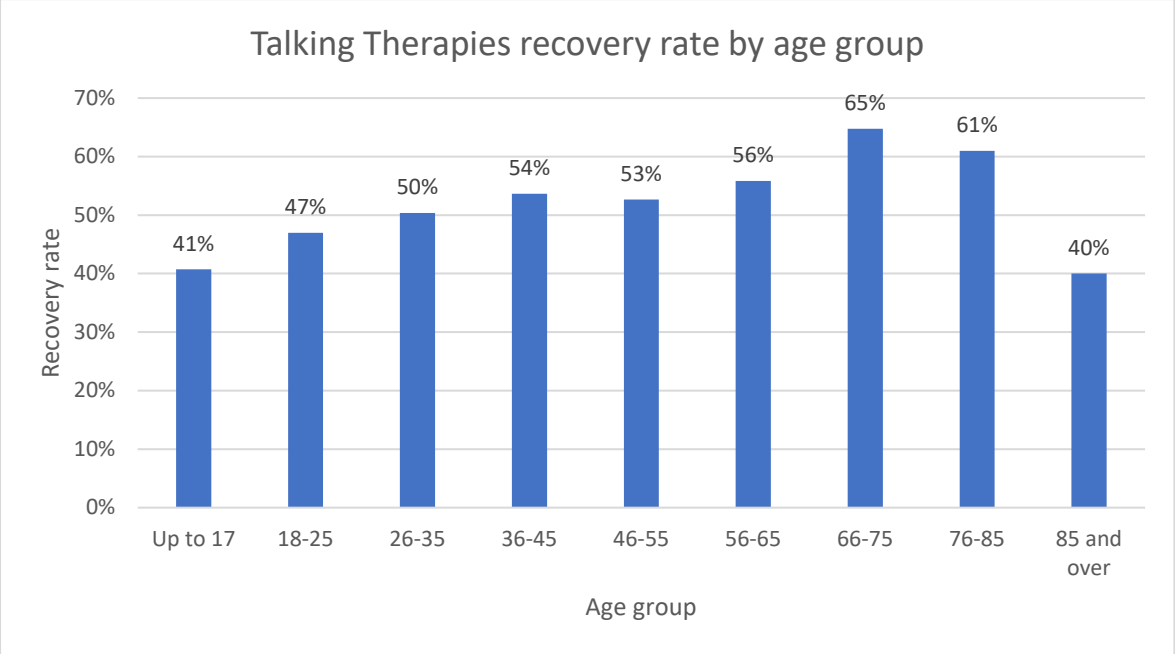
A lot of people who aren't considered 'recovered' based on this definition still feel like their mental health has improved after getting support from Talking Therapies. The term 'Talking Therapies recovery' does not mean patients no longer experience challenges with their mental health. Recovery from mental health challenges can be a long and difficult journey, and Talking Therapies can provide support to help patients manage their symptoms.

We use the term 'Talking Therapies recovery rate' to understand differences in Talking Therapies recovery between different groups. When we use 'Talking Therapies recovery rate', we mean the percentage of all the people from that group who did not have symptoms of anxiety disorder and depression severe enough to meet the criteria for a clinical diagnosis of mental illness at the time they finished receiving support from Talking Therapies.

5,410 patients in Sunderland and North Cumbria completed Talking Therapies between April 2023 and March 2024. 52% of these patients were considered to have recovered, based on the definition of Talking Therapies recovery described in the paragraph above. The information in this section of the report is about these patients.

Age

The chart below shows the Talking Therapies recovery rate for different age groups. We see a small increase in the Talking Therapies recovery rate as people get older.



Research by the Centre for Mental Health suggests that in the UK, people aged over 65 have higher than average recovery rates from Talking Therapies but are less likely to be referred to Talking Therapies in the first place[1]. The report's authors suggest that this is because of people's beliefs about later life which aren't true, like the idea that it is normal to experience mental health challenges as we get older. These beliefs and ideas stop older people from asking for help when they need it and stop people who could help from offering older people the support they need.

Our staff deliver information sessions about Talking Therapies to groups of people we know are less likely to come to us for support, including older people. We also plan to review any changes we can make to our Talking Therapies service which might help people with different needs get the support they need, for example, using different ways of communicating with people who can't see or hear very well. Over the coming months we need to continue to work with our communities and partners, including GPs and other people working in primary care, to understand whether there are any unfair differences in Talking Therapies access due to age in Sunderland and North Cumbria and what else we can do to tackle any inequalities.

[1] Centre for Mental Health, 'Mental Health in Later Life: Understanding needs, policies and services in England', March 2024. https://www.centreformentalhealth.org.uk/wp-content/uploads/2024/03/CentreforMH_MentalHealthInLaterLife-1.pdf

Sex

Talking Therapies recovery rates are very similar for male and female patients:

- 51% recovery for male patients (including trans men)
- 53% recovery for female patients (including trans women)

While this data doesn't suggest any unfair differences in Talking Therapies recovery rates between males and females, females are more likely to be referred to Talking Therapies than males. We offer information sessions about Talking Therapies to men's health groups to encourage people to get mental health support from us if they need it. Over the coming months we need to work with our communities and partners to understand whether there are any unfair differences in Talking Therapies access due to sex in Sunderland and North Cumbria and what else we can do to tackle any inequalities.

Because we use a different computer system to record information about patients who access our Talking Therapies service, we are able to collect data about Talking Therapies recovery for patients who identify as trans man, trans woman and non-binary (people who don't identify as either a man or woman). We can't publish information about very small numbers of patients because there is a risk the information could be used to identify individual people, and people's healthcare information must be kept confidential. Because of this, we haven't included the Talking Therapies recovery rate for people who identify as non-binary in this report. Some of our Talking Therapies staff have completed training on gender and trans issues and work closely with partners to make sure that the service meets the needs of people with different gender identities.

Ethnicity

The NHS Race and Health Observatory is a group of experts on unfair differences in health among people from racialised and culturally minoritised backgrounds. Research from the NHS Race and Health Observatory shows that, in general, people from Black and ethnic minority communities have worse NHS Talking Therapies recovery rates than White people[2]. They also have worse access to Talking Therapies services than White people. People from Pakistani, Bangladeshi, Other Asian, Mixed White, Black Caribbean and Other ethnic groups were found to have worse recovery rates than people from other minoritised groups.

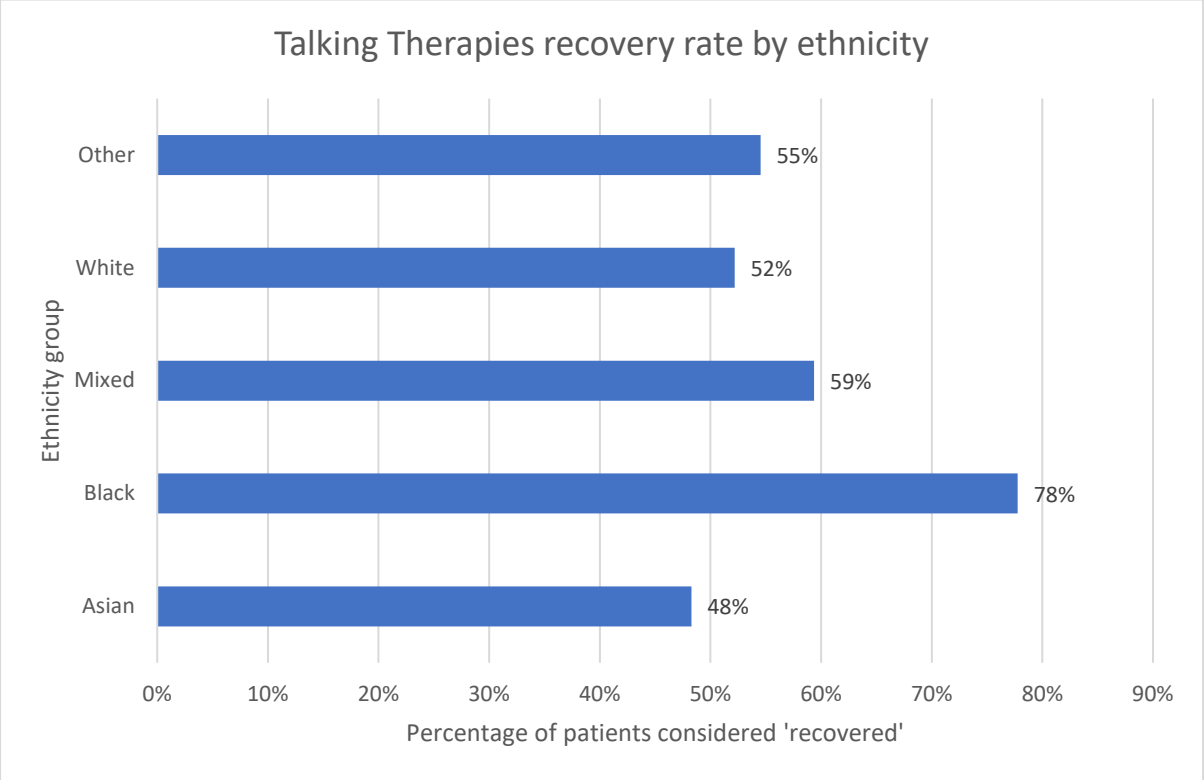
The research suggests that unfair differences in Talking Therapies recovery rates are caused by:

- People from minoritised communities being more unwell when they first go to Talking Therapies.

[2] NHS Race and Health Observatory, 'Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT)', November 2023. https://www.nhsrho.org/wp-content/uploads/2023/10/Ethnic-Inequalities-in-Improving-Access-to-Psychological-Therapies-IAPT.Full-report.pdf

- People from minoritised communities living in areas with higher unemployment and worse access to resources, services, and safe and healthy environments.
- People from minoritised communities waiting longer for their first Talking Therapies appointment, and waiting longer between appointments.

The chart below shows the recovery rate for people from different ethnic groups who completed Talking Therapies treatment provided by CNTW in Sunderland and North Cumbria between April 2023 and March 2024. The data shows that in our Trust's Talking Therapies services, people from Black, Mixed, and Other ethnic groups have a higher recovery rate than people from a White ethnic background or an Asian background. 78% of people from a Black background were considered recovered following their Talking Therapies treatment, compared to 52% for people from a White background.



Ethnicity	Asian	Black	Mixed	White	Other
Number of patients recovered	28	7	19	2,747	18
Number of patients who completed Talking Therapies	58	9	32	5,262	33
Rate of recovery from Talking Therapies	**48%**	**78%**	**59%**	**52%**	**55%**

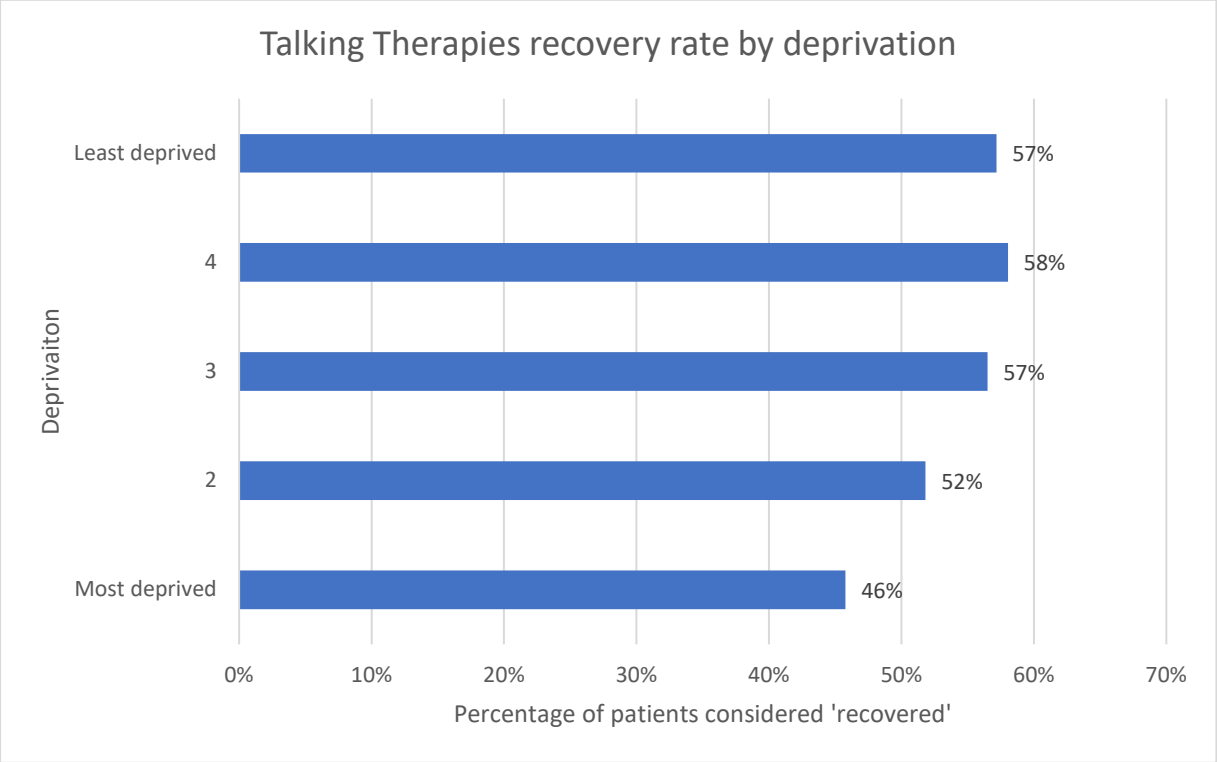
Table 7: Talking Therapies recovery rate for different ethnic groups

Because a lot less people from Black, Mixed, and Other ethnic backgrounds complete Talking Therapies than White people, we don't have enough data to understand whether people from these communities have a better experience of Talking Therapies than White people. In situations like this where we only have a small amount of data, it is possible that some of the differences in recovery rates between people from different ethnic groups could be a coincidence.

Some of our Talking Therapies teams have arranged training focused on meeting the needs of people from different cultural backgrounds for all staff who have contact with patients including administrative staff, therapists, and employment advisers. Over the coming months, we need to work to understand the reasons for the differences in recovery rates between people from different ethnic groups. We need to find out why some ethnic groups have better Talking Therapies recovery rates in our Trust even though research shows these groups usually have worse Talking Therapies recovery rates than people with a White background.

Deprivation

The chart below shows the difference in Talking Therapies recovery rates for people with different levels of access to resources, services, and safe and healthy communities.



Quintile	1 (most deprived)	2	3	4	5 (least deprived)
Number of patients recovered	602	630	478	433	233
Number of patients discharged	1,315	1,216	846	746	390
Rate of recovery from talking therapies	**46%**	**52%**	**57%**	**58%**	**57%**

Table 8: Talking Therapies recovery rate by deprivation quintile

In areas with lower levels of access to resources, services, and safe and healthy environments, more people are referred to Talking Therapies. This could be because in the CNTW area, more people live in deprived areas than in some other parts of the UK.

There is strong evidence that not having access to resources, services and safe and healthy environments negatively affects people's health. This could lead to more people needing mental health support from Talking Therapies. It could also reduce the benefit people get from therapy and make recovery more difficult - Talking Therapies can support people to manage their mental health symptoms, but it can't fix all of the issues which might cause those symptoms like money worries, job

insecurity, or poor quality housing[3]. Some of our Talking Therapies services have Employment Advisers who support people who are finding it difficult to find a job or keep their job when they come to Talking Therapies. Our Employment Advisers focus on helping people find a job or find a better job, and stay in work. This can make a big difference in terms of helping people to improve their mental health.

Unfortunately, people living in more deprived areas have lower Talking Therapies recovery rates. Over the coming months, we need to work with our patients, communities and partners to better understand what is causing this difference and the actions we can take to tackle this inequality.

[3] Nuffield Trust, NHS Talking Therapies (IAPT) programme, updated April 2024. https://www.nuffieldtrust.org.uk/resource/improving-access-to-psychological-therapies-iapt-programme

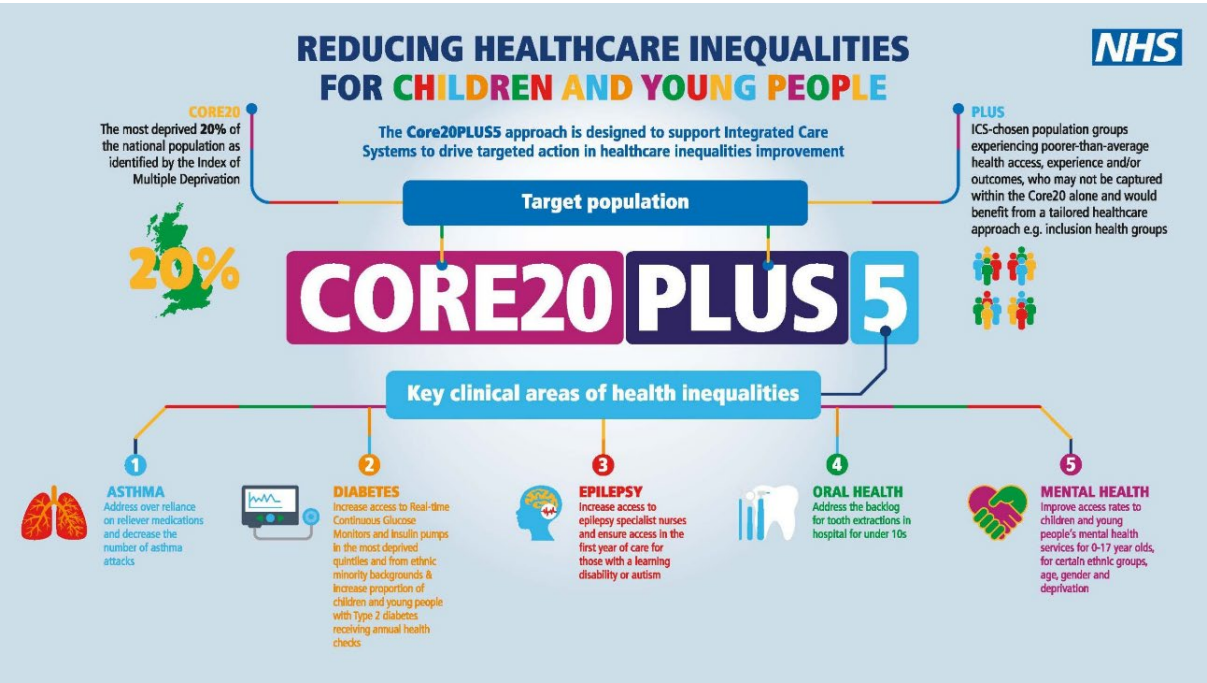
Children and young people's access to mental health services

This section of the report is about children and young people's access to mental health services. People have different ideas about what the term access means. In this report, when we use the term access, we mean a young person aged 0 – 17 (up to and including the day before their 18th birthday) has had at least one contact with CNTW mental health services. A contact can mean a face-to-face appointment, a video call or a phone call with mental health services. Contact with the parent or carer of a child or young person and conversations between staff involved in caring for a child or young person are counted as contacts. Emails and texts don't count as contacts.

NHS England is the organisation which runs the NHS in England. NHS England has created a system called Core20Plus5 to help NHS organisations tackle unfair differences in health among children and young people. The Core20Plus5 system focuses on three things:

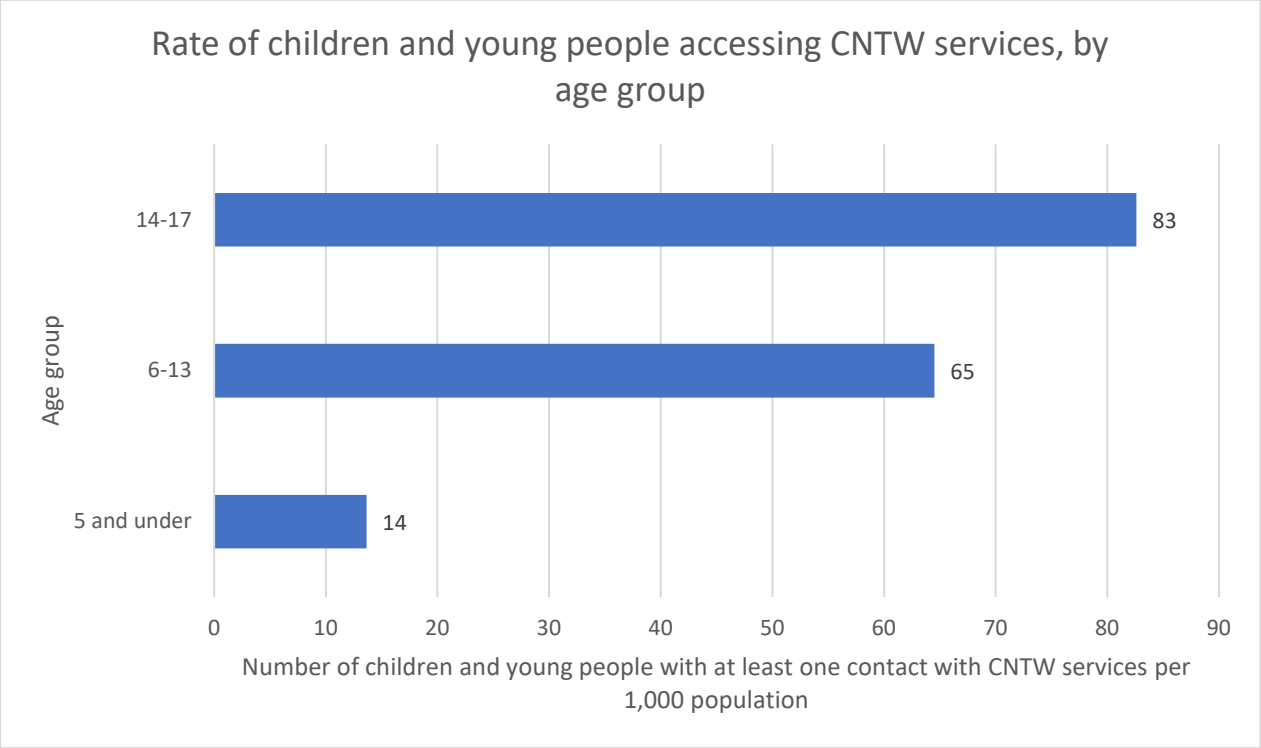
- Unfair differences among children and young people who live in the 20% of postcodes with the worst access to resources, services, and safe and healthy environments.
- Unfair differences among children and young people from racialised and culturally minoritised communities, and any unfair differences because of age or gender among children of all ethnicities and cultures.
- Five different areas of healthcare, including access to children and young people's mental health services.

Over the coming year we will use the Core20Plus5 system to tackle unfair differences in access to CNTW mental health services for children and young people.



Age

The chart below shows how many children and young people in every 1,000 had at least one contact with CNTW services between April 2023 and March 2024, broken down by age group.



Age group	5 years of age and under	6-13 years of age	14-17 years of age
Number of children and young people receiving at least one contact with CNTW	1,457	10,229	6,214
Number of children and young people living in the CNTW area	106,811	158,553	75,220
Rate per 1,000 population	**14**	**65**	**83**

Table 9: Children and young people receiving at least one contact with CNTW services, by age group

Older children and young people are more likely to receive at least one contact with CNTW services:

- 83 in every 1,000 children and young people aged between 14 and 17 had at least one contact with CNTW services between April 2023 and March 2024.
- 14 in every 1,000 children aged 5 and under had at least one contact with CNTW services.

Half of all mental health issues begin by the age of 14, and three quarters of mental health problems begin by the age of 24[4]. While this might explain why we see a higher rate of contact with CNTW services among older children and young people, we need to work with our patients, communities and partners to better understand these differences and the actions we need to take to tackle any inequalities as part of our work to deliver the Core20Plus5 approach.

Sex

There is a small difference between males and females in the rate of children and young people accessing our services:

- 49 in every 1,000 female children and young people in our area had at least one contact with CNTW services between April 2023 and March 2024.
- 56 in every 1,000 male children and young people in our area had at least one contact with CNTW services.

In England as a whole, similar numbers of males and females aged 8 to 16 experience mental health problems[5]. While the small difference between males and females in rates of access to CNTW services might not suggest any unfair differences, we will explore this further over the coming year as part of our work to deliver the Core20Plus5 approach.

[4] NHS England, NHS Long Term Plan, 2019. https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/children-and-young-peoples-mental-health-services/#:~:text=Mental%20health%20problems%20often%20develop,years%20of%20age%20%5B91%5D.

[5] NHS England, Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey, November 2023. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up

Ethnicity

The table below shows how many children and young people receiving at least one contact from CNTW mental health services come from different ethnic backgrounds:

- 91% are White
- 5% are Mixed ethnicity
- 1% are Asian
- 1% are Black
- 1% have their ethnicity recorded as 'Other'.

Ethnicity	Asian	Black	Mixed	White	Other
Number of children and young people receiving at least one contact with CNTW services	251	114	830	15,263	133
% of patients	**1%**	**1%**	**5%**	**91%**	**1%**

Table 10: Children and young people's contacts with mental health services by ethnicity

Unfortunately, this data on its own doesn't tell us everything we need to know to understand whether there are any unfair differences in children and young people's access to mental health services because of ethnicity.

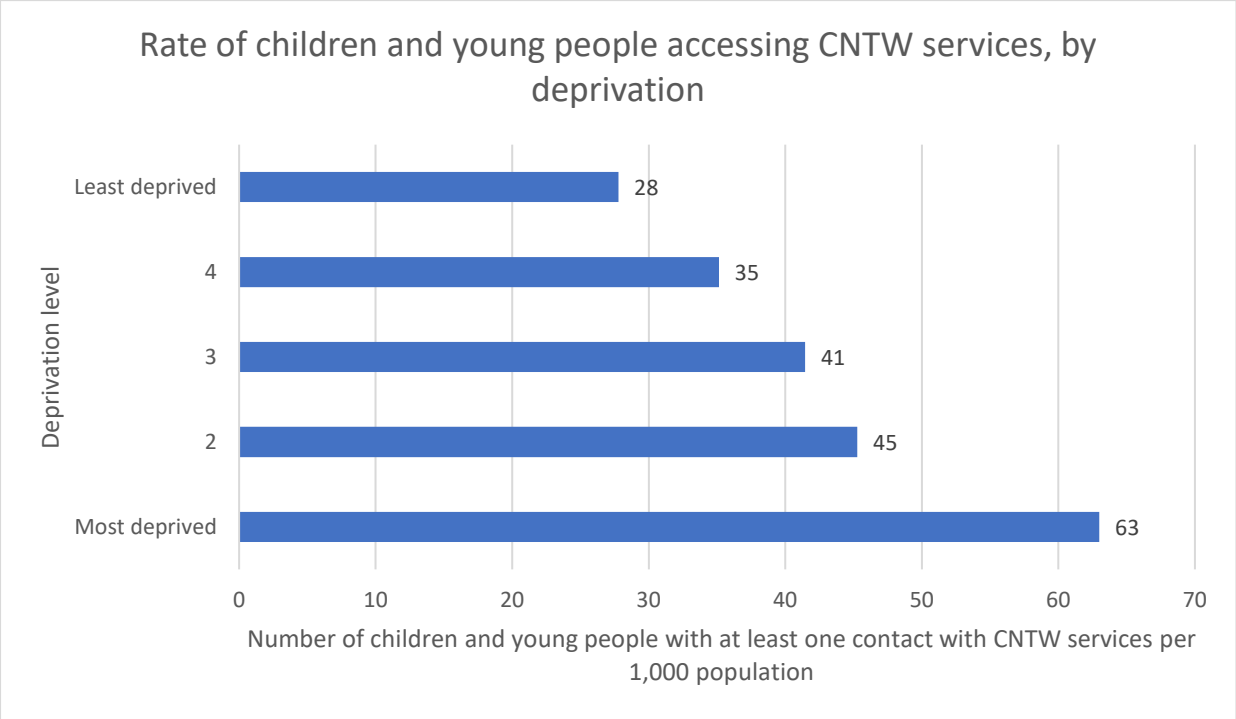
Data from the 2021 Census shows that in England and Wales, there are some big age differences between ethnic groups. For example, the Census showed that while 18.5% of all the people living in England and Wales were aged 0 – 15, nearly half (48.6%) of all the people in England and Wales who identified as White and Black African were aged 0 – 15[6].

To understand whether there are unfair differences in children and young people's access to mental health services because of ethnicity, we need to know how many children and young people aged under 18 from each ethnic group live in the CNTW area. This data would allow us to understand whether differences in the number of children and young people from each ethnic group who had at least one contact with CNTW mental health services are caused by differences in the size of each ethnic group, or are unfair and caused by inequalities which we can take action to tackle. If there are differences caused by inequalities, the data would also allow us to understand whether the actions we take to make access fairer are having an impact. Because of rules which stop data about small numbers of people being made public, there are some gaps in the data we have access to about the number of children and young people from each ethnic group who live in the CNTW area. We will continue to explore the data over the coming months as part of our work to deliver the Core20Plus5 approach.

[6] Office for National Statistics 'Ethnic group by age and sex, England and Wales: Census 2021', January 2023. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicgroupbyageandsexenglandandwales/census2021#ethnic-group-by-age

Deprivation

The chart below shows how many children and young people in every 1,000 received at least one contact from CNTW mental health services between April 2023 and March 2024 in areas with different levels of access to resources, services, and safe and healthy environments. Using a rate per 1,000 population allows us to understand whether there are unfair differences in children and young people's access to mental health services between areas, even when one area might contain a lot more people than another resulting in big differences in the actual number of children and young people accessing CNTW services.



Quintile	1 (most deprived)	2	3	4	5 (least deprived)
Number of children and young people receiving at least one contact with CNTW	7,581	3,660	2,175	1,618	1,252
Number of children and young people living in the CNTW area	120,331	80,834	52,474	46,037	45,080
Rate per 1,000 population	**63**	**45**	**41**	**35**	**28**

Table 11: Children and young people receiving at least one contact with CNTW services, by deprivation

The rate of children and young people receiving at least one contact with CNTW services is highest in the areas with the worst access to services, resources and safe and healthy environments (most deprived):

- In the areas with the worst access to services, resources and safe and healthy environments (most deprived), 63 in every 1,000 children accessed CNTW services between April 2023 and March 2024.
- In the areas with the best access to services, resources and safe and healthy environments (least deprived), 28 in every 1,000 children accessed CNTW services.

There is strong evidence that not having access to resources, services and safe and healthy environments negatively affects people's health. Over the coming months, we need to work with our patients, communities and partners to better understand this difference and the actions we can take to tackle this inequality as part of our work to deliver the Core20Plus5 approach.

Interested in getting involved?

If you would like to get involved in making sure our services are welcoming to people from all backgrounds and able to meet their needs, we want to hear from you!

Please take 5 minutes to answer a few questions about yourself and we will be in touch about opportunities to get involved in our work to tackle health inequalities:

Join the CNTW Health Equity Network

You don't need to have received support from CNTW before, and you don't need to know anything about mental health, learning disabilities or the services we provide.

This report is available on request in other formats; we will do our best to provide a version of this report in a format that meets your needs.

For other versions telephone 0191 246 6877
or email us at communications@cntw.nhs.uk