**PUBLICATION OF SERVICE USER EQUALITY DATA**

**1st JANUARY 2022– 31st DECEMBER 2022**

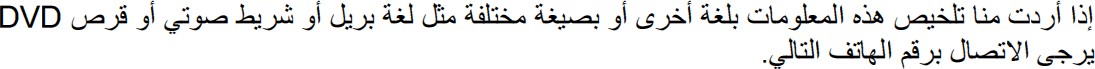
**Published 2023**

**If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below**.

Polish:

Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille’u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:



Bengali:

যদি আপদি অিয একটি ভাষায় এই তথ্যযর সংদিপ্তসার চাি অযবা ব্রেইল, কযা বলা ব্রিপ অযবা দি.দভ.দি. ফরম্যাি-এ এই তযয চাি, তাহথ্ল অিগ্রহ কথ্র দিথ্চর িম্বথ্র ব্রিদলথ্ফাি করুি।

Farsi:

در صورتی که مایلید خالصه این اطالعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره

زیر تماس بگیرید.

Hindi:

यदि आप इस सूचना का साराांश दकसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टादकां ग टेप या DVD में चाहते ह , त कृ पया नीचे दिए गए नांबर पर फ न करें ।

Kurdish (Kurmanji):

Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਕਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮ ੈੱਟ ਕਜਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਕਿਂਗ ਟੇਪ ਜਾਂ DVD ਕਵਿੱ ਚ ਚਾਹੀਦਾ ਹ ਤਾਂ ਕਕਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਕਦਿੱ ਤੇ ਨੂੰ ਬ੍ਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:

如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码

：

Urdu:

اگر آپ کو ان معلومات کے خالصہ کی کسی دیگر زبان یا شکل مثالً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو

برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

Table of Contents

[Introduction](#_bookmark0) [8](#_bookmark0)

[Access to Services](#_bookmark1) [9](#_bookmark1)

[Waiting Times](#_bookmark2) [11](#_bookmark2)

[Contact Frequency](#_bookmark3) [16](#_bookmark3)

[Interventions](#_bookmark4) [18](#_bookmark4)

[Referrals to Inpatient Services and Length of Stay](#_bookmark5) [21](#_bookmark5)

[Disengagement Rates (Did Not Attend (DNA))](#_bookmark6) [26](#_bookmark6)

[Clinical Outcomes](#_bookmark7) [28](#_bookmark7)

[Patient Experience](#_bookmark8) [35](#_bookmark8)

Publication of Service User Equality Data

Introduction

The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to:

* Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
* Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
* Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are sex, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

An in-depth analysis of Trust data has been performed to identify any statistically significant differences within protected characteristic groups across a number of measures deemed to be important. These measures include Access to Service (including weighting by census), waiting times, contacts (frequency), Interventions, Clinical Outcomes, Disengagement (dropout rates), Inpatient Spells and Patient Experience. This report aims to track key elements of a patient journey through a protected characteristic lens.

All data was extracted from the patient record system with the exception of the patient experience measure. All analysis was conducted at a patient level using SPSS V28 and all significance testing was evaluated at a 95% confidence (0.05 alpha).

Access to Services

Data: Access to services contains all referrals into the Trust between 1st January 2022 and 31st December 2022. Patients are only counted once. Marital status, Ethnicity, Gender, Religion, Sexual orientation and age were included in the data.

Analysis: Descriptive statistics were utilised to identify the access rates across the protected groups. This data was compared to the 2021 ONS Census data, where available, in order to understand the population prevalence of the groups. Marital status was the only characteristic which had to be compared against 2011 ONS Census data as 2021 had not been released at the time or writing. Reporting is now mapped to the two care groups; North Care Group (Durham, Tees Valley and Forensics) and South Care Group (North Yorkshire and York). Forensic Services is now no longer captured separately.

Results:

Ethnicity: Access to services across ethnic groups aligns to the 2021 census data. The percentage of patients accessing services appears to be proportionate when weighted by the size of the populations we serve. Approximately 80% of patients accessing services are White-British. Last year this figure was approximately 90%.

16.29% of records have no ethnicity recorded. This is a marked increase on last which had 1.5% of records with no ethnicity recorded.

Marital Status: Approximately 8% of records have a marital status of Not Disclosed/Not Known. This has improved greatly from last year which had a figure of 20%.

TEWV have a higher proportion of referrals from patients classified as single (approximately 38%) compared to any other group. However, this was around 50% last year. The percentage of single patients is around 6% higher than the figures captured in the 2011 census data. In addition, patients classing themselves as married or with a civil partner are around 18% lower than figures captured in the 2011 census data. There were no other significant trends to note in relation to access to services between marital status groups.

Gender: Census weighting could only be applied to female and male gender classifications; however, these make up 98.5% of the data recorded.

North Yorkshire and York have a significantly higher proportion of female referrals accessing services compared to the female population served (58.58% compared to 48.54%).

No other significant differences were noted.

Religion: Approximately 47% of records have a religious status of None (30%) or Not Stated (17.5%). Furthermore, those with ‘Patient religion unknown’ amount to 20%.

The largest religious group accessing services are Christian at 26.03% (this was 34.69% last year), however this is significantly less than the Christian population served (approximately 52% in census 2021 data compared to 69% in the 2011).

The proportion of people accessing services who identify as Hindu, Buddhist, Sikh and Muslim are smaller than the population served.

Sexual Orientation: 26% of the data was not known in relation to sexual orientation, 13% was not age or developmentally appropriate, 7.5% declined to say. Of the remaining groups, 47.92% of patients accessing services identified as Heterosexual, 1.66% as gay/lesbian and 1.51% as bi-sexual. There were no significant differences between Localities or with last years data.

Age: The percentage of children and young people under 18 years accessing services is higher than the population figures across all Localities but most pronounced in Durham, Tees Valley and Forensics (26.94% of access to services in D&D relates to under 18 compared to 22.16% population rates in the locality).

However, the age groups 45-64 and 65+ appear to be underrepresented in relation to access to services compared to the population served (approximately 27% and 21% respectively in the population compared to 15.3% (for both age bands) accessing TEWV). Last year this was solely the 45-64 age group. The following table looks more closely at the age bandings and how TEWV compares to the census data. The arrow signifies if TEWV is above or below the Census population %.

*Table 1: TEWV comparison to census date, broken down by age*



Waiting Times:

Data: The data contained all patients who had their first direct contact following referral (accepted modes of face to face, telephone or video conferencing) between 1st January 2022 and 31st December 2022. For the purposes of analysis, waiting times are measured in days.

Analysis: Descriptive statistics were utilised in conjunction with analysis of variance. Analysis of variance was utilised to explore whether any significant differences exist in waiting times both between and within protected groups, accounting for differences in sample size.

Results:

Missing values for ethnicity or decline to disclose/not stated accounted for 17.20% of the data (13694 records).

At a Trust level, across all groups, the average waiting time is 24 days (95% confidence limit

23.11 to 24.01 days) with an interquartile range (IQR - middle 50%) of 24 days. However, the standard deviation is large (65 days), and some extreme values present in the data indicate a wide variation. The average waiting time is higher than last year which was 17 days.

Ethnicity:

*Modes of contact:* No Significant differences between modes of contact used were found between groups. The majority of contacts were conducted either face to face (56%) or via telephone (41%) with only 4% use of video conferencing overall. These figures are consistent with last years reported mode of contact figures.

*Waiting Times*

Significant differences at the 0.05 alpha level were found between groups in relation to waiting times. Post Hoc analysis indicated that differences were found between the following ethnic groups:

The Iranian group (N=6) though had a very small sample, had a statistically significantly shorter wait time than a number of other ethnic groups. The average wait time for Iranian was <1 day (5% trimmed mean (removal of the most extreme values) = 0.31 days), with an interquartile range (IQR) of 1 day (the middle 50% of data were all seen within 30 days). This was significantly lower than almost all other groups.

Other statistically significant differences were found between Irish Traveller waiting times and other ethnic groups. The Irish Traveller group, although represented small numbers, indicated significantly higher wait times than other ethnic groups (Mean = 30.74 days, IQR = 64 days).

No other statistically significant differences were detected.

Marital Status:

A significant number of records did not have marital status recorded (16890), this is higher than the previous year.

*Modes of Contact:*

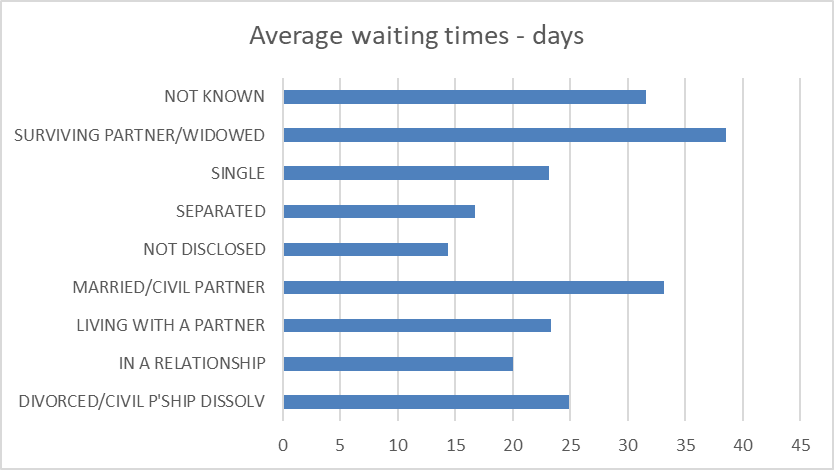
There were no significant findings in relation to modes of contact with the exception of those recorded as single. This cohort had significantly fewer face to face contacts (32% of contacts compared to a 45% average) and significantly more telephone contacts (63% compared to a 51% average).

*Waiting Times:*

Analysis of variance indicated statistically significant differences between groups in relation to waiting times to first contact.

Similarly to last year, patients with a marital status of Surviving Partner/Widowed waited a statistically significantly longer period of time than all other groups (N= 3897, mean = 38.53, IQR = 43 days). Examining the percentiles across the groups indicates that for Surviving Partner/Widowed, 95% are seen within 196 days, this is 35 days longer than the closest group (Married/Civil partner). Below is a graph which shows visually the difference in average waiting times across the different marital statuses.

*Graph 1 : Average waiting time broken down by marital status*.



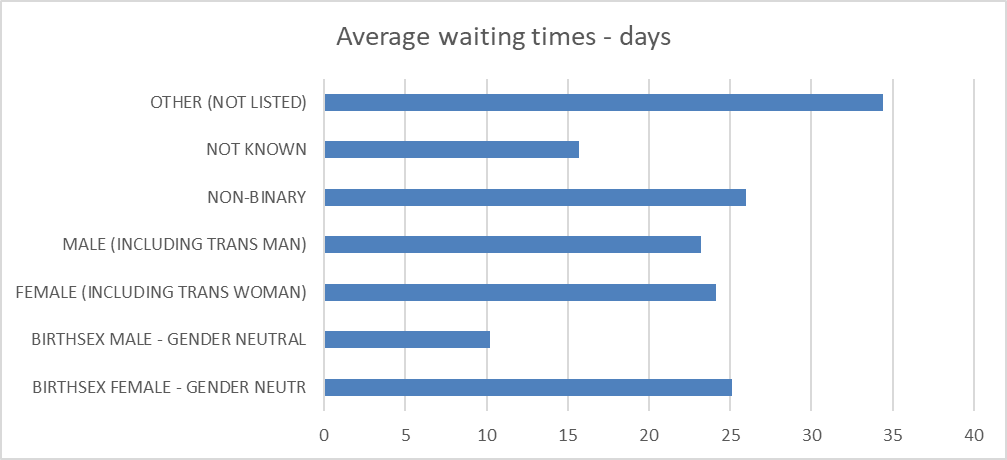
Gender:

*Modes of Contact:* There were significant differences found in relation to mode of contact. Patient’s identifying as Birthsex Female – Gender Neutral (N = 48) had lower rates of face-to-face contact compared to all other groups (31%, with 69% telephone contacts recorded). This finding is comparable to last years report, indicating that this particular cohort of patients prefer other modes of contact to face to face.

*Waiting Times:*

As in the previous report, statistically significant differences were identified in relation to the Birthsex Female – Gender Neutralgroup (N= 48, Mean = 25.13, IQR = 36 days). This gender had significantly higher waiting times than the Birth Sex Male Gender Neutral group (N= 26, mean =10.23, IQR = 15 Days). In addition, significant differences were found between the Non-Binary group and both the Birth Sex Male Gender Neutral and Male (Including Trans Man) groups. The Non-Binary group were found to have significantly higher waiting times than these two groups (N= 100, Mean = 25.99, IQR = 34 days). Shown below is a graph of the average waiting time in days broken down by Gender.

*Graph 2: Average waiting time broken down by Gender*



Religion:

*Modes of Contact:*

There were some significant differences in modes of initial contacts recorded between religious groups. Some groups had significantly higher rates of face-to-face contact, Hindu, Jewish and Sikh had 59%, 59% and 57% respectively. This is significantly higher than the 37% average. In relation to video conferencing utility, patients identifying as Pagan had significantly higher video conferencing use than any other groups (8% video contacts compared to 3% average).

Waiting Times:

No significant differences were detected between religious groups. However, large number of patients had a religion recorded as Other, Declined to Disclose, Not Stated or Patient Religion Unknown (N= 36284).

*Sexual Orientation:*

*Modes of Contact:*

Significant differences were found in relation to modes of contact used at first appointment. Similarly to last year, patients identifying with a sexual orientation of Heterosexual had a higher rate of face-to-face contacts than any other group (47%), followed closely by those who identified as being Gay/Lesbian (46%). In contrast the group of patients recorded as Not Developmentally Appropriate or Not Age Appropriate (N = 10965) had a significantly high proportion of telephone contact for initial appointment (75% for each). This may be related to process variation between Adult and Child services but was a statistically significant difference. In the table below, the difference in type of contact is shown across the different sexual orientations.

*Table 2: Type of contact broken down by Sexual Orientation*.

*Waiting Times:*

Patients identifying as Gay/Lesbian had a significantly shorter waiting time than most other groups (N=1375, Mean= 16.81, IQR=16). No other significant differences were noted.

Age:

*Modes of Contact:*

The cohort of patients classified as Under 18 (N=19429) were the only group to show a statistically significant difference in relation to modes of initial contact. This group had only 18% of initial contacts conducted Face to Face (compared to a 41% average across all patients) and an 75% telephone contact rate.

*Waiting Times:*

The same as last year, patients in the age groups 65+ (N=14864, Mean= 37.83, IQR= 42 days) and Under 18 (N=19429, Mean= 27.91, IQR=27 days) have statistically higher waiting times to initial appointment than any other group. The average days waiting has increased since the figures reported last year. Examination of the Percentiles for these groups also identifies them as outliers. The 65+ cohort have a 95th percentile of 181 days (95% of the group are seen within 181 days) and the Under 18 group have a 95th percentile of 141 days. All other age groups have 95th percentiles around the 80-90 days mark. The age group with the shortest waiting times was the 30-44 bracket (N= 15805, Mean= 15.5, IQR= 13 days).  
days).

Contact Frequency

Data: The data contained all patients discharged between 1st January 22 and 31st December 22 and tracks the number of contacts that have taken place within the patient journey. The data included all direct contact modes (face to face, direct telephone and video conferencing) and indirect contact types (Proxy).

Analysis: Descriptive analysis of the central tendency of data and analysis of variance were utilised to explore whether any significant differences exist in contact frequency between and within protected groups, accounting for differences in sample size.

Results:

Ethnicity:

No statistically significant differences were observed between groups in relation to the number of contacts recorded within a patient journey. The average number of contacts across all groups was 18. The ethnicity group with the highest average number of contacts is Black/Black British African (N = 10330, Mean = 92.23), followed by Eastern European (N = 580, Mean = 52.73), Asian/Asian British Indian (N = 4176, Mean = 39.03). Patients identifying themselves as White had a total of 1,339,771 contacts throughout their patient journeys (Mean = 21.04). Gypsy/Romany accounted for the smallest number of events (N = 4, Mean = 2).

Marital Status:

Statistically significant differences were detected between number of contacts and marital status. Patients with a marital status of Divorced/Civil Partnership Dissolved (N= 2063, Mean= 34.46), Single (N=816468, Mean= 20.54) or Married/Civil Partner (N = 245331, Mean= 23.30) had significantly more contacts than patients with a marital status of Living with a Partner (N = 29204, Mean = 14.30) In a Relationship (N = 30753, Mean = 12.54), and Not Known (N = 7055, Mean = 6.06).

Gender:

No statistically significant differences were identified in relation to number of contacts and Gender. However, those with the highest average number of contacts are Birthsex Male – Gender Neutral (N = 36, Mean = 27.67) and Birthsex Female – Gender Neutral (N = 66, Mean = 25.56).

Religion:

No statistically significant differences were identified in relation to number of contacts and religion. The Buddhist faith had the highest average number of contacts (N= 70, Mean= 74.24, IQR= 23) which has changed significantly from 2021 data, where it was one of the lowest within the data. However, there were large variations within the Buddhist group (standard deviation = 283 contacts), removal of the most extreme values (upper and lower 2.5%), results in a mean of 20.67 contacts. The smallest number of contacts was seen in the Zoroastrian (N=1, Mean= 1) and Jain (N = 3, Mean = 1.50).

Sexual Orientation: There were a large number of blank records where sexual orientation wasn’t recorded (17361). This group was found to have a lower average number of contacts compared to other groups (Mean = 10.17). Assessing average values, the Other (N=315) had the highest average of all groups (Mean = 41).

Age: Statistically significant differences were detected between age categories and number of contacts. The 18-29 (N = 15501, Mean = 20.52, IQR 6)) and 65+ (N = 15083, Mean = 21.64, IQR = 7) had a statistically higher number of contacts than all other groups.

Interventions:

Data: The data contained all patients discharged between 1st January 22 and 31st December 22 and tracks the number of interventions recorded within the patient journey. As a supplementary variable, duration of interventions was also recorded.

Analysis: Descriptive analysis of the central tendency of data and analysis of variance were utilised to explore whether any significant differences exist in intervention frequency between and within protected groups, accounting for differences in sample size. Interventions extracted from the system included: assessment, family/carer intervention, governed psychological therapy, lifestyle, medicine management, physical interventions, psychological well-being, role support and therapeutic interventions.

Results:

Ethnicity: No statistically significant differences were identified across Ethnic groups in relation to the average number of interventions recorded within a patient journey. There were also no significant differences identified in relation to duration. The average number of interventions across all groups (5% trimmed mean) was 5.91, with a median of 3 and an interquartile range of 8.

Marital Status: Statistical differences were identified between the groups, patients recorded as Divorced/Civil Partnership (Mean = 11.51 IQR = 11), Surviving Partner/Widowed (Mean = 11.19, IQR = 10) and Married/Civil Partnership (Mean = 10.70, IQR = 9) had a significantly higher number of interventions than all other groups. The group recorded as Not Disclosed (Mean = 5.74, IQR = 4) had the lowest number of interventions (statistically significant at the

0.05 level). An increase in data quality is required for recording of marital status in order for the data to reflect the true distribution. Below is a graph which shows the average number of interventions that have taken place broken down by Marital status.

*Graph 3: Average number of interventions broken down by marital status.*

Gender: Females (Including Trans Woman) (Mean = 9.16, IQR = 9) were found to have significantly more interventions than Males (Including Trans Man) (Mean = 8.15, IQR = 7). The difference appears only marginal on assessment of averages across the groups, but the analysis is built from a patient level and takes individual variation into consideration. No other statistically significant results were found.

Religion: No statistically significant differences were observed between religion and number/duration of interventions.

Sexual Orientation: The Not Age-Appropriate category (Mean = 6.96, IQR =8) had a significantly smaller number of interventions recorded than most other groups. No other statistical differences were identified.

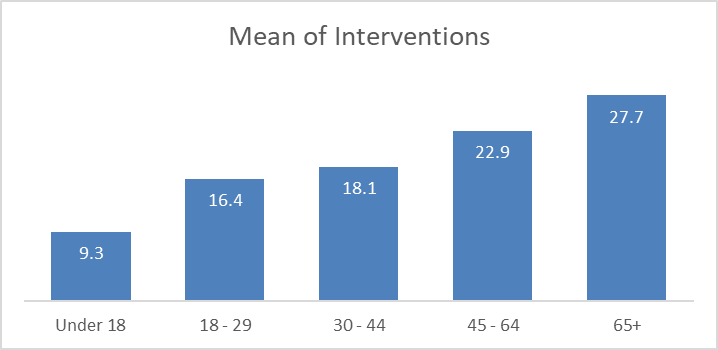
Age: The Under 18 group had significantly less interventions recorded than all other groups (Mean = 9.26, IQR =7), whilst the 65+ category had a significantly higher number of interventions recorded (Mean = 27.69, IQR = 10).

The following table and chart show in greater detail the age breakdown and the respective number of interventions and means.

*Table 3 : Interventions broken down by age grouping.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Age Band** | **Patients** | **Interventions** | **Mean** |
| Under 18 | 16716 | 154809 | 9.26 |
| 18 - 29 | 16280 | 267030 | 16.40 |
| 30 - 44 | 15852 | 286164 | 18.05 |
| 45 - 64 | 13037 | 298689 | 22.91 |
| 65+ | 15447 | 427729 | 27.69 |
| **Totals** | **77332** | **1434421** | **18.55** |

*Graph 4: Mean number of interventions broken down by age groupings.*



Referrals to Inpatient Services and Length of Stay

Data: To evaluate differences within use of inpatient services, an extract containing all referrals into inpatient wards from 1st January 2022 to 31st December 2022 was created with duplicates on patient ID removed from the dataset. Alongside this, a second extract was developed that contained all patients discharged from inpatient services between 1st Jan 21 and 31st December 21 in order to facilitate an analysis of length of stay.

Analysis: Descriptive statistics and analysis of variance were utilised to assess any differences between and within protected characteristics in relation to use of inpatient services and length of stay. All statistical significance testing was derived using a 95% confidence limit.

Results:

Ethnicity:

*Referral to Inpatient Services:*

In total, 2741 patients were referred to inpatient services within the reporting period. Of those admitted 85.4% were White – British (N=2342). 8.46% had no ethnicity recorded, 6% were made up of the following (Asian/Asian British Pakistani (0.51%), Black/Black British African (0.51%), Other ethnic group (0.47%), White – other (1.86%), Mixed – White/Black Caribbean (0.36%), White – Irish (0.29%)).

*Length of Stay:*

A statistically significant difference was detected between the White British group (N= 4300, Mean = 44, IQR = 35) and the Asian British Pakistani group (N= 63, Mean= 15). The longest average length of stay related to those who declined to disclose their ethnicity (Mean = 247), the Mixed – White/Black African (Mean = 179), Black/Black British African (Mean = 167).

Shown below is a graph which indicated the number of patients admitted broken down by Ethnicity, it also shows the length of stay.

*Graph 5: Patients admitted to an inpatient ward and their length of stay broken down by Ethnicity.*

Marital Status:

*Referral to Inpatient Services:*

The group with the highest proportion of referrals to inpatient services related to the patients identifying themselves as single (44%), followed by patients who did not disclose their marital status (20.6%). This has changed from the previous years data which found those who identified themselves as being married/civil partner following those who are single. Although those who identified themselves as being married/civil partner fell within the count of patient ID, their % make up increased by 3.06%, accounting for 18.06% of patients admitted to inpatient wards. The groups with the smallest proportion of inpatient referrals were separated (2.55%), in a relationship (2.74%), living with a partner (2.88%).

*Length of Stay:*

There are some differences which have been observed throughout the data in relation to marital status and length of stay. With those recorded as Surviving Partner/Widowed (Mean = 77, IQR= 65) this has increased since last years report however Surviving Partner/Widowed remains the marital status with the highest average length of stay, a length of stay statistically higher than other groups. They continue to have statistically higher lengths of stay compared to those In a Relationship (Mean = 21, IQR= 16), Living with a partner (Mean = 32, IQR= 35) and Single (Mean = 34, IQR- 28).

*Graph 6: Patients admitted to inpatient wards and length of stay broken down by marital status*

*Table 4: Patients admitted to inpatient wards and the average length of stay broken down by marital status.*

|  |  |  |
| --- | --- | --- |
| **Marital Status** | **Number of patients admitted to inpatient wards** | **Average of Length of stay** |
| DIVORCED/CIVIL P'SHIP DISSOLV | 142 | 61.18 |
| IN A RELATIONSHIP | 89 | 20.56 |
| LIVING WITH A PARTNER | 98 | 31.89 |
| MARRIED/CIVIL PARTNER | 572 | 66.30 |
| NOT DISCLOSED | 279 | 61.78 |
| NOT KNOWN | 1279 | 42.83 |
| SEPARATED | 82 | 47.90 |
| SINGLE | 2157 | 34.31 |
| SURVIVING PARTNER/WIDOWED | 137 | 76.64 |
| **Grand Total** | **4835** | **43.85** |

Gender:

*Referral to Inpatient Services:*

The highest proportion of referrals belonged to the group identifying as Male (including trans man) (51%) followed by Female (including trans woman) (48%).

*Length of Stay:*

No statistical differences were found, however, the highest length of stay belonged to patients identifying as Non-Binary (Mean = 115, IQR= 317), followed by Female (including trans woman) (Mean = 49, IQR= 42), Male (including trans man) (Mean = 40, IQR= 20).

Religion:

*Referral to Inpatient Services:*

A high proportion of data was unknown for religion (27%) which matches the previous years figures. 39% of patients accessing inpatient services identified as Christian, 24% had no religion, 1% identified as Muslim and only 0.4% were made up by Buddhist, Hindu, Pagan and Sikh faiths. Compared to last years data there were no patients identifying as Jewish who were referred to inpatient services.

*Length of Stay:*

Statistical higher length of stay was found between Christian (Mean= 47, IQR=43) and both Muslim (Mean= 15 ,IQR= 4) and Sikh faiths (Mean= 26). The religion with the highest average length of stay belonged to those identifying themselves as Buddhist (Mean = 160, IQR= 229). Followed by Other (Mean = 75), Declines to Disclose (Mean = 74). With the lowest average length of stay belonging to Hindu (Mean = 32), Pagan (Mean = 30), Sikh (Mean = 26) and Muslim (Mean = 15).

Sexual Orientation:

*Referral to Inpatient Services:*

The greatest proportion of patients accessing inpatients services identified as heterosexual (67%). 29% were made up by not stated (declined), not known, not age/developmentally appropriate and person asked and does not know. 3% were represented by Gay, Lesbian and Bi-sexual.

*Length of Stay:*

No statistically significant differences were identified. The sexual orientation group with the highest average length of stay within inpatient services belonged to patients identifying themselves as Bi-sexual (Mean = 97), followed by Not stated (declined) (Mean = 63), Heterosexual (Mean = 60) and Gay/Lesbian (Mean = 52). The sexual orientation group with the lowest average length of stay is those who are not age appropriate (Mean = 5).

Age:

*Referral to Inpatient Services:*

Age split across inpatient services was reasonably even across the groups, 18-29 (21.16%), 30-44 (27.65%), 45 – 64 (26.05%), 65+ (22.65%). However, under 18s only accounted for 2.52% of referrals into inpatient wards.

*Length of Stay:*

The age category of 65+ had significantly higher lengths of stay than any other age group (Mean = 78, IQR= 74). Whilst the under 18 group has significantly lower lengths of stay than all other groups (Mean = 1, IQR= 0). Below is a graph which shows the average length of stay broken down by patient age category.

*Graph 7: Number of patients admitted to inpatient beds and the average length of stay broken down by age category.*

Disengagement Rates (Did Not Attend (DNA))

Data: For all contacts in the calendar year 2022, the attendance rate was extracted. The categories reported on include, attended, cancelled and DNA.

Analysis: Descriptive statistics were utilised to assess any differences across protected groups in relation to rates of disengagement with the Trust.

Results:

Ethnicity:

Across all groups at an aggregated level, the DNA rate for contacts was approximately 6%, cancelled appointments accounted for 2% and attended 92%, each of these figures are on improvement on last year’s figures, with the attended percentage being 83% last year.

The highest rates of disengagement were found in the mixed – White/Black Caribbean ethnicity 13% of appointments recorded as DNA. This is higher than the average rate for all groups. All other groups were comparable.

Marital Status:

DNA rates were highest in the groups categorised as In a Relationship (9%) and Living with a partner (8%). All other groups had similar figures recorded for DNA, apart from surviving partner/widowed which had significantly lower DNA rates with only 1% of appointments not attended.

Gender:

The highest rates of disengagement were recorded within the genders identifying as Birthsex Male – Gender neutral (10%) and Other (not listed) (10%). All other groups were aligned to the average.

Religion:

The greatest proportion of contacts not attended belonged to patients who are part of the BAHA’I faith (32%), followed by Sikh (14%). No other significant differences were observed.

Sexual Orientation:

Disengagement rates were highest in patients identifying as Gay/Lesbian (8%) and Bi-sexual (9%). No other DNA rates deviated from the mean. These findings echo last years findings.

Age:

Significantly low rates of disengagement were observed in the 65+ age group (only 1%) as well as cancelled appointments (1%). In contrast, patients aged 18-29 displayed DNA rates of 9%. Below is a table which shows the number and percentage of attended, cancelled and DNA, broken down by religion.

*Table 5: Attended, cancelled and DNA appointments broken down by religion.*



Clinical Outcomes

Data: For patients discharged between 1st January 22 and 31st December 21 clinical outcome measurement data was extracted. This was split at speciality level (Adult and MHSOP and Children and Young People (CYP)) due to the different measures utilised within the services. The data extracted provided information in relation to which patients had a paired measure (outcome measure repeated a minimum of twice) and for those who had a pair, the outcome achieved was measured (treatment efficacy). For Adult and MHSOP services, a model of clinical significance was used to evaluate change, for CYP, direction of change was assessed.

Analysis: Descriptive analytics were utilised to evaluate clinical outcomes and a model of clinical significance was applied, where possible, to measure treatment effect. Clinical significance is concerned with whether the change observed is a) statistically reliable and b) clinically meaningful. Both clinician and patient perspectives were considered. Groups with fewer than 5 members were removed from the analysis so as to not skew the proportions and make comparisons across groups valid.

Results

Ethnicity:

*Adult and MHSOP*

The outcome measures extracted for Adult and MHSOP services were the Health of the Nation Outcome Scales (HoNOS – Clinician perspective) and the Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS – Patient Perspective).

The compliance with paired measures being recorded varied across ethnicity. The ethnic groups with the greatest proportion without a paired HoNOS were White-Gypsy (44%) and Mixed White/black African (29%). However, numbers within these groups were relatively small, significantly impacting on the proportions. As a comparator, White British, the largest group, had 19% without a paired measure.

For the patient rated measure (SWEMWBS), the ethnicities with the greatest proportion without paired measures recorded were White Gypsy (67%), White – Irish (50%), Asian/Asian British Chinese (50%) and Asian/Asian British Pakistani (48%). Below is a table which shows the total number of patients who do not have a paired SWEMWBS or a paired HoNOS, it also shows the total that HoNOS and SWEMWBS outcome can be reported for.

*Table 6: Those that outcome can be reported for, and those discharged without a paired tool, broken down by Ethnicity.*



Of the patients who had a paired HoNOS recorded, and change could be measured, the highest category of reliable and clinically meaningful improvement was observed within the following ethnic groups: White/Black African (50%), Black/ Black British African (42%), and Mixed other (27%). The numbers within these groups are all small and have a big impact on the proportions reported. The largest group with available reportable data were White – British who achieved 15% meaningful improvement.

Significant deterioration was identified in a small number of cases: Black/ Black British other (N= 1, 14%), Mixed other (N = 1, 8%), and Other ethnic group - Arab (N = 1, 8%). It is important to note that in some instances, the paired measures are not recorded timely to the point of referral and discharge. This means that some outcomes are reflective of only a portion of the patient journey and may not capture the true change. The organisation is working hard to embed outcomes into routine practise to ensure that all patients have accurate, paired measures that are completed in a timely manner.

From a patient perspective (SWEMWBS), greater improvement was observed compared to the clinician perspective. On average, across all groups, 45% Statistically significant and clinically meaningful change was observed. However, this was most pronounced in the following groups: Black British Caribbean (N = 3, 60%), Mixed White/Black Caribbean (N = 3, 60%), Black/ Black British African (N = 9, 56%) and Asian/Asian British Pakistani (N = 10, 56%). White British (the group with the highest denominator, N = 2369) reported 40% meaningful improvement.

Some significant deterioration was observed, the greatest amount identified within White British (N = 333, 3%).

*Children and Younger People (CYP)*

The outcome measures extracted for CYP services were the Health of the Nation Outcome Scales for Children (HoNOSCA – Clinician rated measure) and a range of accepted measures capturing the child or young person perspective (CORS, ORS, EDE-Q, SCORE-15, SDQ, RCADS).

There were significant differences in relation to the number of paired HoNOSCA measures recorded, providing opportunity to evaluate effectiveness, across ethnicities. The following groups had the smallest proportions of CYP where outcome could be evaluated, Other Ethnic group – Arab (13%), Mixed White and Asian (21%), Mixed other (23%) and Asian/ Asian British Pakistani (25%).

No significant differences were observed in relation to levels of improvement across ethnicities from evaluation of the HoNOSCA.

From the patient perspective many groups had less than 20% reportable outcomes (Asian/Asian British Pakistani, White Gypsy, other ethnic group - Arab). However, the denominator for some of these groups is small.

I relation to levels of improvement across ethnic groups from the CYP perspective Black/Black British African and Black/Black British other had 100% improvement rates, however the denominator for each of these groups were 3 and 2 respectively, making them very small numbers, in comparison to white- British who had an improvement rate of 61% (N=1202).

Marital status:

*Adult and MHSOP*

No significant differences were identified in relation to patients without measures recorded for the HoNOS. In the sample, approximately 20% of patients did not have two HoNOS measures recorded. Greater variation on number recorded was identified for the patient perspective (SWEMWBS), with Surviving Partner/Widowed having 60% of patients without a repeated measure (N = 1490).

The least improvement and highest deterioration for the HoNOS was observed within the Surviving Partner/Widowed cohort (9% significant improvement and 4% significant deterioration). The best outcomes were reported for the Single or Separated patients (approximately 21% meaningful improvements).

For the SWEMWBS, the average proportion of meaningful improvement across all groups was approximately 42%. Similarly, to the clinical perspective, the group with the least amount of improvement were the Surviving Partner/Widowed group (21% improvement). The deterioration was observed within the separated group and the single group (both having 5% significant deterioration). In the two tables below, clinical significance is shown for those people who outcome could be reported for.

*Table 7: HoNOS and SWEMWBS clinical significance broken down by marital status*



Gender:

*Adult and MHSOP*

Across Genders, Females (Including Trans Woman) have the highest % without a paired HoNOS tool and without a paired SWEMWBS tool (20% and 40% respectively).

No significant differences were detected in relation to levels of improvement or deterioration on the HoNOS between groups.

From the patient perspective, the male and female (including trans man and woman) reported greater levels of meaningful improvement (40% and 40% respectively) than the other gender groups. No significant findings in relation to deterioration were observed.

*Children and Younger People*

There were no significant differences to note in relation to recording of outcome measures across genders. There were also little differences to note in relation to the change reported, with the exception of the Non-Binary group who had significantly higher self-rated deterioration (67%).

Religion:

*Adult and MHSOP*

The average meaningful improvement rate for the HoNOS was approximately 15% across all religious groups. The highest proportions of improvement were attributed to the following religions, Muslim (27%), Buddhist (22%) and Pagan (19%).

The average significant deterioration rate across all religions was 3%. However, the highest rates of deterioration were observed for Hindu (10%), Any other Religion (6%) and Christian (4%).

The average meaningful improvement rate for the SWEMWBS was approximately 42%, whilst the deterioration rate was 5%. The patient perspective of change appears to be significantly better than the clinician perspective.

The lowest rates of improvement were observed within the Christian (37%) and Any Other Religion (23%) groups and the highest achieved within the Buddhist (67%), Pagan(50%) and None (47%) groups. The highest levels of deterioration were observed within the Patient Religion Unknown (5%), Declined to Disclose (5%), other (4.5%) and Christian (4%) groups.

Sexual Orientation:

*Adult and MHSOP*

The sexual orientations with the fewest paired HoNOS measures recorded were Other (28%). This prevents assessment of treatment efficacy. The groups with the highest rates of paired measures were Heterosexual (62%), person declined (59%) and Not known (58%).

In relation to the patient perspective (SWEMWBS), Not known sexuality grouping patients had the fewest paired measures recorded (28%). For the HoNOS, despite the number of pairs being low, the Bi-sexual group achieved one of the highest rates of significant improvement (20%). The highest rates of deterioration were reported within the Heterosexual (3%), all other groups had minimal or no significant deterioration reported.

From a patient reported perspective, the proportion of significant improvement was higher for all groups compared to the clinician perspective. However, the groups reporting the highest rates of significant improvement were Other (59%), Bi-sexual (50%) and Gay/Lesbian (43%). Those groups that reported the highest levels of significant deterioration were Not Known (4.4%) and Bi-sexual (4.2%).

*Children and Younger People*

The majority of data for CYP falls within the group of not known due to the nature of the age group considered. However, some data was available for analysis for a small proportion of young people.

No significant differences were noted in relation to the number of measures recorded, from both the clinician perspective and the patient perspective. There were also no significant changes noted for the direction of change in the clinician and the patient rated outcome tools, with all groups being very similar in their output.

Age:

*Adult and MHSOP*

In relation to proportions, there were no significant differences in the number of measures collected across the age groups for the HoNOS. However, for the patient perspective (SWEMWBS), the 65+ category had significantly less measures collected (56%), this was more than double the amount of all other groups. This could be explained by the cohort of older adults with organic, degenerative conditions. The Trust is currently exploring alternative measures for organic patients that will most likely include a carer perspective.

For the HoNOS, the 65+ category had significantly less improvement than any other age categories (9%) and significantly higher rates of deterioration (4%). This could be driven by the organic cohort as discussed in the section above. For the Patient rated measure the 65+ category also had significantly less improvement than all other groups (26%), this is less than half of all other categories. No significant differences were detected for significant deterioration levels. In the two tables below, clinical significance is shown for those people who outcome could be reported for.

*Table 8: HoNOS and SWEMWBS clinical significance broken down by Age grouping.*



*Children and Younger People*

Significantly less outcomes were recorded for CYP in the age bracket 6-10 for both the clinician and patient rated measures. Only 19% had a paired HoNOSCA and 21% had a patient rated paired measure. Of those who change could be evaluated for, no significant differences in outcomes achieved were detected.

Patient Experience

Data: The data contained all patient experience measures completed between 1st Jan 2022 and 31st Dec 2022

Analysis: Descriptive statistics were utilised in order to identify any patterns of variation between and within groups in relation to patient experience. Locality level data was included in order to assess any differences across the geographical patches.

Results:

Ethnicity:

*Overall, patient experience was rated highly. In total 94% of patients across all ethnicities reported their experience as either good or very good and only 3% as poor or very poor. However, a significantly higher level of poor/very poor was observed for the group recorded as “Prefer not to say”. Of the 47 patients that identified within this group, 9% reported an experience of poor/very poor. This is significantly higher than any other group, but less than the reported figure of 16% last year. Evaluation at a locality level didn’t identify any differences that weren’t detectable at an aggregated level.*

Gender:

*Overall, the ratings match those recorded for Ethnicity. 97% of Males in NYY reported their experience as either good or very good whilst in DTV&F this was 94%. 84% of Children or young people in NYY reported their experience as either good or very good as opposed to 94% in DTV&F. Again, a significantly higher level of poor/very poor was observed for the group recorded as “Prefer not to say”. Of the 100 patients that identified within this group, only 77% reported an experience of good/very good. This is significantly lower than any other group.*

Sexual Orientation:

*No significant differences observed.*

Age:

*No significant differences in patient experience were reportable at an aggregated level across age groupings. Locality level analysis last year indicated a geographical difference in the 0-18 age group, where 14% reported poor/very poor experience within the North Yorkshire and York patch. However this year that rating had improved to only 3%*

Disability:

No significant differences were observed at any level in relation to patient experience and disability.