NHS England’s Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)

27 November 2023

Integrated care boards, trusts and foundation trusts should use this statement to identify key information on health inequalities and set out how they have responded to it in annual reports.

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Contents

1. Introduction

1.1 What is this Statement on Information on Health Inequalities?

This Statement on Information on Health Inequalities (Statement) is given by NHS England further to its duty under section 13SA of the National Health Service (NHS) Act 2006 to publish a Statement setting out a description of the powers available to relevant NHS bodies to collect, analyse and publish information, and the views of NHS England about how those powers should be exercised in connection with such information.

1.2 What time period does this statement cover?

This Statement was published on ‘27 November 2023. It provides information on how powers should be exercised in connection with health inequalities information for the specific period 1 April 2023 to 31 March 2025.

This Statement will be periodically reviewed. It is envisaged that updated descriptions of how powers relating to the collection, analysis and publishing of health inequalities information should be exercised will be published initially every two years.

Any changes prior to 31 March 2025 will be clearly updated and communicated.

1.3 What are ‘relevant NHS bodies’ for the purposes of section 13SA of the NHS Act 2006 and this Statement?

For the purposes of this Statement and section 13SA of the NHS Act 2006, relevant NHS bodies are integrated care boards (ICBs), NHS trusts and NHS foundation trusts.

1.4 What is the legal status of this Statement?

This Statement is designed to help relevant NHS bodies understand their duties and powers and how they can be exercised. Relevant NHS bodies are not expressly required in the NHS Act 2006 to adhere to it. It does not create any new legal responsibilities in and of itself. However relevant NHS bodies are required, **in their annual reports, to review the extent to which the body in question has exercised its functions consistently with NHS England's views set out in this Statement**. In turn, NHS England has a statutory duty to conduct an annual assessment of ICBs including the extent to which they have fulfilled their statutory obligations regarding health inequalities. By adhering to this Statement, ICBs will strengthen their position in that annual assessment.

1.5 How will this Statement help address health inequalities?

Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can affect both our physical and mental health and wellbeing.

Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs. NHS England's Healthcare Inequalities Improvement Programme's vision is for the NHS to deliver "exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes".

Good quality, robust data enables the NHS to understand more about the populations we serve. It enables NHS bodies to identify groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and deliver targeted action to reduce healthcare inequalities.

The duty to report information on health inequalities will encourage better quality data, completeness and increased transparency. Data should be used by relevant NHS bodies to shape and monitor improvement activity to further reduce healthcare inequalities. This Statement will therefore help drive improvement in the provision of good quality services and in reducing inequalities.

1.6 What approach has been taken to developing this first statement?

While NHS England recognises the value of collecting, analysing and publishing information on health inequalities, we also recognise ICBs are still in the relatively early stages of development, since they were placed on a statutory footing in 2022. To manage the burden on systems, in relation to the Statement we are taking a proportionate and phased approach to helping organisations gather and make use of available information on health inequalities. Consequently, this first Statement focuses on a small number of data indicators that are available for interpretation, along with a limited number of expectations on how the information should be used. Of course, organisations may be gathering and using other health inequalities information as part of national monitoring or for use locally alongside this.

To determine which indicators were to be included in the Statement, NHS England considered the distribution of healthcare inequalities, including among groups that share protected characteristics as defined by the Equality Act 2010, healthcare inequalities priorities and the availability of data. Stakeholder engagement was central to this process. In developing the Statement NHS England engaged with stakeholders including:

- the National Health Inequalities Improvement Forum and Network; and the national System Transformation Delivery Partner Group
- ICBs through national and regional forums
- provider trusts through NHS Providers' networks
- the Voluntary Community and Social Enterprises (VCSE) Health and Wellbeing Alliance
- relevant government departments and arm's length bodies.

In response, the indicators selected for inclusion in this Statement:

- are aligned where possible to the five priority areas for addressing healthcare inequalities set out in the 2023/24 priorities and operational planning guidance; and the Core20PLUS5 approach for adults and children and young people
- are already available on existing dashboards (or will be within the timeframe of the Statement)
- are to be disaggregated by a limited number of variables (where available). These are age, sex, deprivation and ethnicity.

The Statement has also been developed to align with annual reporting processes and the NHS Standard Contract.

We recognise that the Statement only includes the requirement to collect, analyse and publish on a limited number of healthcare inequalities priorities, indicators and variables. As the Statement is periodically revised the information to be collected, analysed and published is likely to evolve over time. It is anticipated that the development of future Statements will involve further engagement including with communities. Further information can be found in the Section 5.2 on future data collection.

2. What powers are available to relevant NHS bodies?

2.1 What does section 13SA of the NHS Act 2006 say?

Section 13SA of the NHS Act 2006 sets out that NHS England is required to produce a statement setting out:

(1) (a) A description of the powers available to relevant NHS bodies to collect, analyse and publish information relating to—

(i) inequalities between persons with respect to their ability to access health services;

(ii) inequalities between persons with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 13E(3) of the NHS Act 2006- see below); and

(b) the views of NHS England about how those powers should be exercised in connection with such information.

The outcomes referenced in section 13E(3) are outcomes that show:

(a) the effectiveness of the services,

(b) the safety of the services, and

(c) the quality of the experience undergone by patients.

2.2 What powers are available to relevant NHS bodies to collect, analyse and publish information about health inequalities?

NHS England's description of the powers available to relevant NHS bodies to collect, analyse and publish information is set out below. The legal powers and responsibilities of different kinds of relevant NHS body are set out in different areas of the NHS Act 2006 and reflect the respective roles of ICBs as commissioners of healthcare services, and NHS trusts and NHS foundation trusts as providers of healthcare services.

Although many of the specific provisions described do not expressly reference the collection, analysis or publishing of information about inequalities, it is implicit that information will need to be processed to exercise the functions listed, and other general powers available to relevant NHS bodies permit information to be used to discharge their responsibilities, including around inequalities.

ICBs

ICBs have the following duties or powers that should enable and inform collection, analysis and publication of information on inequalities.

1. The core general duty to arrange healthcare services to meet reasonable requirements for the people for whom it is responsible (section 3 of the NHS Act 2006) and the associated commissioning power (section 3A of the NHS Act 2006).

It is the view of NHS England that the arrangement of healthcare services includes understanding the needs of the population that the ICB is responsible for, any barriers to access and the effectiveness of services. In commissioning services, ICBs must act consistently with the NHS Mandate (sections 3(4) and 3A(4) of the NHS Act 2006). The NHS Mandate for 2023 refers to addressing "health disparities", which are analogous to "health inequalities" referenced in the NHS Act 2006 and this Statement.

2. The power to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any of its functions (section 2 of the NHS Act 2006) – this duty, in conjunction with the core commissioning duty described above and the functions listed below, is likely to provide the key statutory foundation for processing information. This power can include collecting, analysing and publishing information insofar as it is done in compliance with other legal requirements, including the matters set out below.
3. The duty to exercise functions (among other things) efficiently and effectively (section 14Z23).
4. The duty (jointly with NHS trusts and NHS foundation trusts) to produce a forward plan annually (section 14Z52), including in particular addressing the needs of children and young people and those who are the victims of abuse. NHS England has published guidance on developing a forward plan.
5. The responsibility (jointly with upper tier local authorities) to produce joint strategic needs assessments, and health and wellbeing strategies, and to have regard to them, under section 116 and section 116A of the Local Government and Public Involvement in Health Act 2007.
6. The duty, as a member of an integrated care partnership, to produce, publish and keep under review an integrated care strategy, under section 116ZA of the Local Government and Public Involvement in Health Act 2007. The Secretary of State published statutory guidance on the creation and content of the strategy, including matters relating to health inequalities.
7. The duty of an ICB to have regard to reducing inequalities in the exercise of functions (in section 14Z35 of the NHS Act 2006), including by reference to access and outcomes.
8. Public involvement duties and promotion of patient involvement (sections 14Z36 and 14Z45 respectively). NHS England has published statutory guidance on

working in partnership with people and communities, which includes material about addressing equality and inclusion in patient and public involvement.

9. The duty, in the exercise of its functions, to facilitate or promote research into matters relevant to the health service, and the use in the health service of evidence obtained from research (section 14Z40).
10. Duties to have regard to the wider effects of decisions, including in inequalities issues (section 14Z43 of the NHS Act 2006).
11. General duties under the public sector equality duty in section 149 of the Equality Act 2010, and the specific duties to create and report equalities information further to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

NHS trusts

NHS trusts have the following duties or powers that should enable and inform the collection, analysis and publication of information on inequalities:

1. Duties to provide goods and services as part of the health service (section 25 of the NHS Act 2006).
2. Duties to exercise functions efficiently, effectively and economically (section 26 of the NHS Act 2006).
3. Duty to have regard to likely wider impacts of decisions, including on wellbeing (section 26A of the NHS Act 2006).
4. Powers to do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions (schedule 4, paragraph 14 of the NHS Act 2006).
5. Public involvement duties (section 242 NHS Act 2006).
6. Powers to undertake research (schedule 4, paragraph 16 of the NHS Act 2006).
7. General duties under the public sector equality duty in section 149 of the Equality Act 2010, and the specific duties to create and report equalities information further to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

NHS foundation trusts

NHS foundation trusts have the following duties or powers that should enable and inform the collection, analysis and publication of information on inequalities:

1. Duties to provide goods and services as part of the health service (section 43 of the NHS Act 2006).

2. Powers to do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions (section 47 of the NHS Act 2006).
3. Duty to have regard to likely wider impacts of decisions, including on wellbeing (section 63A).
4. Public involvement duties (section 242 of the NHS Act 2006).
5. General duties under the public sector equality duty in section 149 of the Equality Act 2010, and the specific duties to create and report equalities information further to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

3. What are the views of NHS England about how these powers should be exercised?

This section sets out NHS England's views about how relevant NHS bodies should exercise their powers to collect, analyse and publish information on health inequalities; and how this should be used.

As health inequalities are driven by a variety of factors, to serve communities well, relevant NHS bodies and partner organisations should work together to understand the collective health and care needs of local people and populations, as well as healthcare access, experience and outcomes.

3.1 Understanding healthcare needs

As a first step, we encourage relevant NHS bodies to build from joint strategic needs assessments (JSNAs) for local places to identify opportunities for improvement wherever possible, but over time we increasingly expect ICBs to adopt population health management approaches which use linked data to develop a deeper understanding of the extent and nature of health inequalities within their populations. As a minimum ICBs should be able to understand:

- The demographic profile of people living in the local area served, including the size and geographical distribution of more disadvantaged groups.
- The healthcare needs of the population, particularly among people living in more deprived places or who are from more disadvantaged social groups.
- Wider social, environmental and economic factors that affect health and wellbeing and underpin health inequalities, which NHS bodies should be mindful of. ICBs might be able to address these wider issues in their role shaping social and economic development.

To further inform the understanding of local populations and their needs, ongoing community engagement and co-production is recommended, and should be in line with public involvement duties. Further information can be found in NHS England's statutory guidance on working in partnership with people and communities.

ICBs will want to work with partner trusts and local authorities in making best use of local analytical capability and existing insights in line with guidance on developing ICS intelligence functions.

3.2 Understanding health access, experience and outcomes

To help understand and improve health access, experience and outcomes, NHS England's view is that relevant NHS bodies should collect, analyse and publish the information on health inequalities contained in the table in Appendix 1. This includes a range of domains, indicators and variables (where available), and the level of the system at which this data is available.

Data should include information on NHS services that relevant NHS bodies have commissioned to other providers. This may include provision by VCSE, independent or private sector organisations.

The table also notes how indicators align to the five priority areas for addressing healthcare inequalities set out in the priorities and operational planning guidance, the Core20PLUS5 approach and, in due course, NHS oversight metrics.

In addition, relevant NHS bodies should collect and analyse other information on health inequalities as required for national monitoring, or as they consider appropriate and relevant to local populations or priorities. The forthcoming Healthcare Inequalities Improvement Strategy will provide an overview of the indicators that will be used to monitor progress nationally.

3.3 Publishing information on health inequalities

Relevant NHS bodies should publish the information on the health inequalities set out in the table in Appendix 1. This could be included within or alongside the organisation's annual report as set out in Section 4 below.

ICBs should at minimum publish information at an ICB level. ICBs may wish to publish information at an individual trust level, subject to discussion with the relevant trusts.

NHS trusts and NHS foundation trusts should publish information at a trust level. If a trust works with more than one ICB, they will need to discuss with each ICB if and how its data is to be included in the ICB’s publication.

It is suggested that published reports on information on health inequalities should be in an accessible format. Reports should distil the key messages and explain the data. The Good Indicators Guide provides information on how to effectively communicate what indicators are saying.

NHS bodies should describe how they intend to respond to observed inequalities and make progress, and in doing so be mindful of working with people and communities.

3.4 How does this relate to data protection?

It should be possible to report on health inequalities using existing anonymised data sources (for instance derived from Hospital Episode Statistics (HES) and Secondary Uses Service (SUS) data), without any additional processing of confidential patient information. Only aggregate data should be published.

If additional, confidential patient information is required for health inequalities analysis and reporting, then relevant NHS organisations will need to make sure that they meet the requirements of the common law duty of confidentiality and data protection law. Approval can be sought from the Secretary of State for Health and Social Care under the Health Service (Control of Patient Information) Regulations 2002. This is often known as 'section 251 support' and involves an application to the Confidentiality Advisory Group (CAG). If confidential patient information is used with section 251 support, then relevant NHS organisations will need to apply the national data opt-out.

3.5 Using information on health inequalities

The information on health inequalities set out in this Statement should be used by services and boards to inform service improvement and reductions in healthcare inequalities. This includes using the information to inform:

- strategy development
- policy options review
- resource allocation
- service design
- commissioning and delivery decisions
- service evaluations.

Specific expectations on how information should be used in relation to some of the domains are set out in Appendix 2.

Knowledge and information on health inequalities that is not included in this Statement, but is available, can and should be used by relevant NHS bodies to inform action as appropriate.

4. What should relevant NHS bodies include in and alongside their annual reports?

Relevant NHS bodies should include in their annual reports 2023/24 and 2024/25 a review of the extent to which they have exercised their functions consistently with NHS England's views set out in this Statement.

In particular, alongside their annual reports or within them, relevant NHS bodies should publish reports on the health inequalities information set out in Appendix 1; and within their annual report, explain whether the information has been published, and summarise the inequalities it reveals and how the information has been used in the relevant period to guide action.

In addition, at their discretion, relevant NHS bodies can report other information on health inequalities relevant to local populations or priorities as they consider appropriate. This could include reporting progress on inequalities identified as priorities for ICS partners in the Integrated Care Strategy or the Five Year Joint Forward Plan, or services co-commissioned by the ICB with its local authorities.

Annual reports should be in line with annual reporting guidance for ICBs and NHS trusts and NHS foundation trusts.

5. Further information

5.1 Why haven't all health inequalities priorities been included in this Statement?

Where relevant data is not yet available, or there are specific limitations with available data, it has not yet been possible to include information on all priority areas for action on healthcare inequalities in this Statement; for example, on primary care and other key areas such as community care.

While these areas are not currently included in the Statement, NHS bodies can and should still use knowledge and information available to them to inform action. Further detail is provided in Appendix 2.

In addition, as key datasets become available it is anticipated that more information on other priorities will be included in future Statements.

5.2 What data will be collected in the future?

The Statement will be periodically reviewed and the information on health inequalities that should be published by relevant NHS bodies may be revised. Future Statements may include:

- Updated or additional indicators for some or all the domains included in this Statement. This may include more indicators relating to children and young people.
- New domains, aligned to other healthcare inequalities priorities, including primary care, other routine vaccinations and screening and community care.
- The requirement to report on more variables including other protected characteristics (in addition to ethnicity, age and sex), on people with a learning disability or autistic people, inclusion health groups; or geographical communities.

5.3 Questions and feedback

It is anticipated we will produce frequently asked questions (FAQs) and further support materials in response to the needs of relevant NHS bodies.

NHS England welcomes feedback on this Statement, and account will be taken of any feedback in the development of future versions of this Statement.

Please send questions, information on the type of support you would find useful or feedback to: england.healthinequalities@nhs.net

Appendix 1: Information on health inequalities to be collected, analysed and published

The table below sets out the information on health inequalities that in NHS England's view relevant NHS bodies should collect, analyse and publish as part of addressing health inequalities. The table includes domains, indicators and variables (where data is available) and the level of the system at which this data is available. In NHS England's view:

- A report of information based on the indicators listed should itself be included in or published alongside the relevant NHS body's annual reports 2023/24 and 2024/25; and
- Within their annual report, each NHS body should explain whether the information has been published, and summarise the inequalities it reveals and how the information has been used in the relevant period to guide action.

Further information is provided in Sections 3 and 4 of the Statement.

Please note:

- ICBs should at minimum publish information at a ICB level. ICBs may wish to publish information at an individual trust level, subject to discussion with the relevant trusts.
- NHS trusts and NHS foundation trusts should publish information at a trust level. If a trust works with more than one ICB, it will need to discuss with each ICB if and how its data should be included in the ICB's publication.

Domain	**Indicator**	**Indicator source**	**Variables to be published** **NB: Sex and age should be reported where data is available**		**Level available**		**Indicator alignment**	
			Deprivation	**Ethnicity**	**ICB level**	**Trust/ FT level**	**Healthcare inequalities priority**	**Core20PLUS5 approach**
Elective recovery	Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks	WLMDS Elective Waiting List – Power BI NCDR and UDAL Elective Recovery Dashboard (palantirfoundry.co.uk) (a)	√	√	√		Priority 1 (Restore NHS services inclusively)	
	Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances	SUS data Health Inequalities Improvement Dashboard	√	√	√			

	Elective activity vs pre-pandemic levels for under 18s and over 18s	SUS data and WLMDS Elective Recovery Dashboard (palantirfoundry.co.uk) (a) Elective Waiting List – Power BI CYP Elective Recovery – Power BI (a)	√	√	√	√		
Urgent and emergency care	Emergency admissions for under 18s	SUS data CYP Transformation Dashboard (b)	√	√	√	√		
Respiratory	Uptake of COVID and flu by socio-demographic group	HIID (ICS), Actionable Insights Dashboard (PCN & MSOA) COVID Vac & Vac Equality Tool (MSOA and Vaccination Site)	√	√	√		Priority 4 (Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes)	√
Mental health	Overall number of severe mental illness (SMI) physical health checks	Adult Mental Health Dashboard		√	√		Priority 4 (Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes)	√

	Rates of total Mental Health Act detentions	Mental Health Act statistics, annual figures	√	√	√	√		
	Rates of restrictive interventions	Rates of restrictive interventions[1,2]	√	√	√	√		√
	NHS Talking Therapies (formerly IAPT) recovery	Psychological therapies, annual reports on the use of IAPT services	√		√	√	Priority 1 (Restore NHS services inclusively)	√
	Children and young people's mental health access	Mental Health Bulletin	√	√	√	√	Priority 1 (Restore NHS services inclusively)	
Cancer	Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	Cancer Registry staging data in three year cohorts	NA	NA	√			√
Cardiovascular disease	Stroke rate of non-elective admissions (per 100,000 age-sex standardised)	SUS data NCDR and UDAL	√ (d)		√(c)		Priority 4 (Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes)	√
	Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)		√ (d)		√(c)			√

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[1] Mental health services monthly statistics - Restrictive Interventions - NHS Digital – rates per 1,000 bed days (ethnicity only)

[2] Mental Health Bulletin, 2021-22 Annual report – NDRS (digital.nhs.uk) – rates per 100,000 population (ethnicity and deprivation)

	CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold, by data	NHS Benchmarking Data Explorer CVDPREVENT	√	√	√			√
	CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy		√	√	√			√
	CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with		√	√	√			√

	anticoagulation drug therapy							
Diabetes	Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes	NDA Core Quarterly Dashboard	√	√	√			√
	Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile	National DPP Dashboard	√		√		Priority 4 (Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes)	
Smoking cessation	Proportion of adult acute inpatient settings offering smoking cessation services	Tobacco Dependence Patient-Level Data Set FutureNHS Collaboration Platform: Prevention Site (a)				√	Priority 4 (Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes)	√
	Proportion of maternity inpatient settings offering smoking cessation services					√		√
Oral health	3.7.ii Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under	SUS/HES data	√	√	√	√		√

	(number of admissions not number of teeth extracted)							
Learning disability and autistic people	Learning Disability Annual Health Checks	FutureNHS Collaboration Platform: Annual Health Check Data - Mental Health, Learning Disability and Autism Resource Hub			√			Aligned (no indicator)
	Adult mental health inpatient rates for people with a learning disability and autistic people	Learning Disability Services Statistics - LDA Monthly Statistics from AT Data Tables (Table 5.2)	NA	NA	√			
Maternity and neonatal	Preterm births under 37 weeks	Maternity Services Data Set (MSDS)	√	√	√			√

Notes:

(a) It is anticipated that this data will be available during the timeframe of the Statement.

(b) Email england.cyptransformation@nhs.net for access.

(c) Where statistical power allows.

(d) It may be necessary to compare the most deprived and least deprived halves.

Abbreviations

CYP – children and young people

DPP – Diabetes Prevention Programme

FT – foundation trust

MSOA – middle layer super output areas

NCDR – National Commissioning Data Repository

NA – currently not available

NDA – National Diabetes Audit

PCN – primary care network

SUS – Secondary Uses Service

UDAL – unified data access layer

WLMDS – Waiting List Minimum Data Set

Appendix 2: How inequalities information should be used

As set out in Section 3.3, information on health inequalities should be used by the boards and services of relevant NHS bodies to inform service improvement and actions to reduce healthcare inequalities. Relevant NHS bodies should include information in their annual reports on how this information has been used in the relevant period to guide action as set out in Section 4.

A2.1 Specific expectations for using data included in the Statement

For some of the domains included in Appendix 1, specific expectations on how information should be used is set out below.

Elective recovery

Relevant NHS bodies are expected to:

- Examine both the current profile of people on waiting lists and how this is changing over time, and actively using data to empower improvement in the delivery of services.
- Use national guidance and definitions to calculate indicators to be consistent with the national view and take action to improve the accuracy and completeness of patient demographics recorded in core elective datasets, particularly Secondary Uses Service (SUS) and Waiting List Minimum Data Set (WLMDS).

Mental health

With the introduction of the Advancing mental health equalities strategy, health organisations should take concrete steps to fight stigma and inequalities, with the Patient and carers race equalities framework (PCREF) being a core part of delivering the strategy by NHS mental health trusts and mental health service providers. Using the indicators in Appendix 1 to identify progress, organisations should demonstrate how they have embedded the principles of the PCREF in the actions taken, in particular co-production and governance with local communities. To find out more about the PCREF, go to the FutureNHS Collaboration platform.

The indicators cover a range of mental health service pathways and align with those prioritised in the PCREF. They should be used to examine how and where NHS Trusts and Foundation Trusts, mental health service providers and ICBs can improve the experiences of mental health care for those from ethnic minority communities, and other vulnerable groups such as people with a learning disability and autistic people. Further contextual information for each of the indicators is noted below.

Trusts and mental health service providers are to provide a narrative explanation of data trends and over time should be able to demonstrate reduced inequalities. To support Trusts and mental health service providers, national mental health statistical data are published on the Mental Health Services Data Set (MHSDS) and NHS England has developed a mental health data quality dashboard on protected characteristics.

Further contextual information on the indicators

The table in Appendix 1 notes which indicators need to be reported by ICBs, Trusts and Foundation Trusts.

- **Overall number of severe mental illness (SMI) physical health checks** – There are significant inequalities in life expectancy for mental health patients, with people in contact with mental health services nearly five times more likely to die prematurely than those not in contact with mental health services. The metric on delivery of health checks reflects a key intervention the NHS can provide to identify where support for a patient's physical health needs is required, and should be used alongside local demographic data to assess need for targeted outreach to support people to access the health checks and follow-up interventions.
- **Rates of total Mental Health Act detentions** and **rates of restrictive interventions** – More deprived patients and patients from ethnic minorities are more likely to experience the most restrictive forms of mental health provision, including detention under the Mental Health Act and use of restrictive interventions in inpatient settings. These metrics and supporting information should be used to identify and deliver progress on the recommendations of the Independent Review of the Mental Health Act and the principles of the government's White Paper, Reforming the Mental Health Act, with patients treated in the least restrictive way and setting possible with the maximum therapeutic benefit.
- **NHS Talking Therapies (formerly IAPT) recovery** – NHS Talking Therapies, for anxiety and depression (formerly IAPT) recovery rates for certain ethnic minority populations and more deprived populations are below the national expectation. This metric should be used to identify and monitor opportunities for improvement, supported by the considerations set out in The NHS Talking Therapies manual and Black Asian and Minority Ethnic Service User Positive Practice Guide.
- **Children and young people's mental health access** – The NHS Long Term Plan committed to increase the number of children and young people accessing help from NHS-funded mental health services. High levels of unmet need and unwarranted variation remain and addressing inequalities for ethnic minority populations and

more deprived children and young people remains a priority. This metric and supporting information should be used to demonstrate increased access and reduced inequalities in early access to support.

Cancer

Making improvements across different cancer types and for different population groups is critical to helping achieve the NHS Long Term Plan ambition of diagnosing 75% of patients at stage 1 or 2 by 2028.

ICBs should monitor and report the percentage of cancers diagnosed at stage 1 or 2.

Early cancer diagnosis is a specific priority within the NHS’s wider Core20PLUS5 approach to reducing healthcare inequalities. On average, early diagnosis rates in the most deprived areas are around 8 percentage points lower than in the least deprived areas.

When delivering approaches to achieve our NHS-wide early diagnosis ambition, ICBs, NHS trusts and NHS foundation trusts should work in collaboration with Cancer Alliances to ensure activities are targeted at the most deprived population groups and other groups facing inequalities. Local level data on deprivation is available through the Health Inequalities Improvement Dashboard and OHID Fingertips.

Future analytical work by NHS England is planned to make early diagnosis data available at ICB level by deprivation and ethnicity.

Cardiovascular disease

The indicators in Appendix 1 will help to understand progress around the NHS Long Term Plan and NHS England 2023/24 priorities and operational planning guidance in relation to prevention and health inequalities on cardiovascular disease (CVD).

Data should be used to target case finding activities to improve outcomes for groups with poorer cardiovascular health outcomes.

The information examined could be used to inform the ICS’s integrated care strategy; the ICB and its partner trusts/foundation trusts’ joint forward plan; more local plans including health and wellbeing strategies (produced by health and wellbeing boards); and needs assessments for prevention, CVD, respiratory diseases, diabetes and progressing the Core20PLUS5 approach.

People with a learning disability and autistic people

Relevant NHS bodies are expected to use inequalities data on people with a learning disability or autistic people to:

- Support the delivery and quality of learning disability annual health checks and the health action plans that accompany them, with a particular focus on young people with a learning disability and on people from ethnic minority communities.
- Increase the number of people with a learning disability on the GP learning disability register, reflecting the demographics of the local population.
- Support culturally appropriate, reasonable adjustments across all health services to enable people to access care more equitably and improve their experience of care.
- Deliver service improvements to reduce premature mortality, improve accessibility and enable people with a learning disability and autistic people to live longer, healthier lives.
- Understand and apply learning about particular groups of people with a learning disability and autistic people at risk of admission to a mental health inpatient unit, as they experience particular health inequalities in a mental health inpatient setting.
- Inform workforce plans for the workforce that support people with a learning disability and autistic people.
- Gain a better understanding to inform service planning and delivery about the needs of people with a learning disability and autistic people across and between ethnic minority groups, and to address the impact of intersectionality on health outcomes.

Maternity and neonatal services

As set out in the Three year delivery plan for maternity and neonatal services, NHS England has co-produced robust Equity and equality guidance for local maternity and neonatal systems (LMNS) to ensure that women and babies, no matter what their ethnic group or where they live, get safe, personalised and equitable care. The guidance asked LMNSs to co-produce and publish equity and equality action plans. These action plans set out how the guidance will be implemented locally.

The 2023/24 priorities and operational planning guidance asked systems to implement their LMNS equity and equality action plans so as to reduce inequalities for those from Black, Asian and mixed ethnic groups and those living in the most deprived areas.

Saving Babies Lives Care Bundle (SBLCB) is a package of interventions designed to reduce stillbirth, neonatal brain injury, neonatal death and preterm birth, which is set out in the Three year delivery plan. Each element in SBLCB version 3 has been reviewed to include actions to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

The indicator in Appendix 1 will help systems assess progress in addressing these inequalities.

A2.2 Specific expectations for using data not included in the Statement

Due to current limitations in data availability, it has not been possible to include information on health inequalities for all priorities in this Statement at this time, including for primary care and community care. Expectations on how information should be used within these areas is set out below.

Knowledge and information on health inequalities that is not included in this Statement, but is available, can be used by relevant NHS bodies to inform action.

Primary care

NHS England is developing a draft Primary Care Balanced Scorecard, which following internal review will be shared with regions and ICBs. This product is intended to incorporate a broad range of primary care indicators, and will also include a health inequalities view of some of these indicators. When the product becomes available, ICBs are encouraged to engage with the data presented and help further develop the product, the intention being that in the longer term the data it presents can be used to support ICBs' approach to monitoring health inequalities and included in their annual reports.

Community care

All ICBs and providers should ensure they:

- are capturing and recording high quality health inequalities data about all NHS commissioned community health services
- have regard to community health services data in line with fulfilling statutory duties on health inequalities.

Appendix 3: Other data sources

The key nationally available sources of data for relevant NHS bodies that contribute to analysis of health inequalities include:

- National Healthcare Inequalities Improvement Programme – Data and Insight information
- Datasets published by NHS England (formerly NHS Digital)
- Inequality tools – Office of Health Improvement and Disparities (OHID)
- Public health profiles – OHID
- Office of National Statistics (ONS) data