

Statement on information on health inequalities

Introduction

NHS England (NHSE) published a [statement on information on health inequalities](#) (duty under section 13SA of the National Health Service Act 2006) on 27 November 2023. The purpose of the statement is to help trusts and Integrated Care Boards (ICBs) identify key data and information on health inequalities and outline how they have responded to this information within their annual reports.

This briefing provides an overview of the statement and highlights the specific actions trusts are expected to take to improve data capture, analysis and reporting on health inequalities. It sets out the powers available to trusts around data, provides a list of data indicators that trusts will be expected to report on, and identifies opportunities for how trusts could make use of these data. Trusts will be expected to report on these data indicators within their annual reports.

This briefing also includes our NHS Providers view of the statement. NHS Providers hosted a roundtable between NHSE and our members on 13 March 2023, which informed the development of the statement. NHSE also conducted broader stakeholder engagement with other relevant stakeholders and organisations.

Overview

The [National Health Service Act \(2006\)](#) states that “NHSE must publish a statement setting out a description of the powers available to relevant NHS bodies [trusts, foundation trusts and ICBs] to collect, analyse and publish information relating to inequalities” (section 13SA). This includes inequalities in accessing healthcare services and within health outcomes.

The overall purpose of the statement on information on health inequalities is to contribute to the reduction of health inequalities. It recognises the benefits of robust data in understanding the inequalities experienced by patients and communities. It is expected that the duty on trusts to include information on health inequalities within their annual reports will encourage better quality data,

completeness, increase transparency, and provide a tool to monitor improvements in reducing inequalities.

The statement covers the period between 1 April 2023 to 31 March 2025 and it will be periodically reviewed and updated by NHSE.

The statement outlines how powers around collecting and using information on health inequalities should be exercised by trusts. In their annual reports (for 2023/24 and 2024/25), trusts will be required to review and report on the extent to which their organisation has exercised its functions in accordance with the statement. The statement does not create any new legal duties or responsibilities for trusts outside of those already set out in the [National Health Service Act \(2006\)](#).

NHSE has a statutory duty to review the progress ICBs have made to reduce health inequalities and adherence to the statement will strengthen this annual assessment process.

Powers available to trusts to collect, analyse and publish information about health inequalities

The statement outlines the legal powers and responsibilities of NHS bodies, as outlined in the NHS Act (2006). NHS trusts and foundation trusts largely share the same responsibilities, with additional powers for trusts around providing efficient, effective and economical functions, and for undertaking research.

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

NHS England's view on how powers should be exercised

The statement provides NHSE's view on how NHS bodies should use information on health inequalities.

NHS bodies are expected to work collaboratively on information collection and analysis to better understand the health and wellbeing needs of their local communities. This involves increasing shared understanding of the demographic profile and geographic distribution of disadvantaged groups, the health and care needs of those in more deprived places, and the wider social, environmental and economic factors underpinning health inequalities. To achieve this, trusts, ICBs and local authorities could work collaboratively to review [Joint Strategic Needs Assessments](#) (JSNAs), build population health management approaches, make the best use of local analytical capabilities, and provide engagement opportunities with communities.

Information on health inequalities that trusts should collect, analyse and publish

The statement outlines that NHS bodies should collect, analyse and publish specific information on health inequalities. Table 1 - [provided at the end of this briefing](#) - sets out the data indicators to be included, outlining the different data expectations for trust and ICB level reporting.

It is recommended that health inequalities information is published in a report within or alongside the organisation's annual report (at both trust and ICB level). NHSE recommend that the report should distil the key messages in an accessible format, within approximately 10 pages. Alongside publishing the data in the report, trusts are expected to outline their reflections on the inequalities revealed, how

the organisation will use the data and how they intend to improve and make progress to reducing health inequalities.

As a minimum, annual reports should contain a review of the extent to which the organisation has exercised their functions in line with NHSE's views set out in the statement.

Trusts should publish information at the trust level only. ICBs may or may not choose to publish information at the individual trust level. If the trust works with more than one ICB, they will need to discuss with each ICB if and how its data is included in the ICB's publication. Only anonymised data sources should be published.

The statement prioritises a small number of data indicators and a limited number of expectations on how the information should be used - so as not to place a high demand on NHS bodies. These indicators are:

- Aligned to NHSE's five priority areas for addressing healthcare inequalities set out in the [Priorities and Operational Planning Guidance 2023-24](#); and the Core20PLUS5 approach for [adults](#) and [children and young people](#).
- Already available on existing dashboards (or will be within the timeframe of the statement).
- Also to be disaggregated by a limited number of variables (age, sex, deprivation and ethnicity), where available.

It is understood that trusts may be collecting and using other data on health inequalities outside of what is expected in this statement, such as for other national monitoring or for monitoring local priorities. The upcoming NHSE Healthcare Inequalities Improvement Strategy will provide an overview of the indicators that will be used to monitor progress nationally.

NHSE have not included indicators on health inequalities in community care within the statement, stating a lack of available data. In the absence of this, the statement outlines that NHSE expects all community care providers to:

- Capture and record high quality health inequalities about all NHS commissioned community health services.
- Have regard to community health services data in line with fulfilling statutory duties on health inequalities.

Using information on health inequalities

The main purpose of collecting and analysing information on health inequalities is to drive service improvement to reduce health inequalities. NHSE recommends that trusts could use the information to inform:

- Strategy development
- Policy options review
- Resource allocation
- Service design
- Commissioning and delivery decisions
- Service evaluations.

NHS Providers view

We welcome NHSE's statement on information on health inequalities. Many of the recommendations our members made in a roundtable with NHSE have been incorporated – including suggestions for specific indicators and breakdowns, details on what should be included within annual reporting, and information on data protection.

The statement standardises the approach for collecting, analysing and publishing information on health inequalities by specifying a key set of data indicators that trusts and ICBs will be expected to monitor and report on within their annual reports. We hope that this approach will support trust boards to oversee the progress they are making locally to reduce health inequalities, by providing a key set of indicators where they can track progress and inform the development of improvement initiatives. We hope that the statement also provides a shared understanding of the minimum dataset required to report on health inequalities, enabling comparisons across local systems.

At NHS Providers, we have long recognised the value of data in better understanding the needs of communities served by trusts. Our 2022 briefing [Tackling health inequalities with effective data and insight](#) highlighted the importance of data for identifying and responding to health inequalities. In our 2021 survey [United against health inequalities](#), 49% of trust leaders identified the lack of available data on health inequalities as a major barrier to proactively addressing health inequalities. The statement will not require trusts to collect or analyse additional data sources, but we hope that it will provide transparency at the board level on data that already exist on health inequalities. Yet, we are aware that trusts may face challenges with incomplete or untimely data, limited analytical capabilities and a lack of data sharing/interoperability, which may hamper the effectiveness of the statement. There are also specific challenges around the recording of ethnicity data. Trusts should be supported by NHSE

to invest in data analytic skills within their workforce alongside funding for the digital technology to collect and analyse data, such as electronic patient record systems, which could enable staff to improve data recording and support decision-making.

We welcome the defined set of indicators for monitoring health inequalities in the current version of the statement, which provides a useful prioritisation and focus for trusts, who are experiencing ongoing operational pressures. We also welcome the commitment to reviewing the statement and potentially incorporating more indicators in the future, with signals from NHSE it will include more on children and young people's health, vaccinations, screening and from primary and community care settings. Building the list of indicators over time will enable trusts to get onto a level playing field in terms of data capture, recording and analysis of health inequalities, recognising that some trusts are much further ahead in their capabilities.

Future iterations of the statement could explore further breakdowns of the data indicators. Currently only deprivation, ethnicity and age (where available) are considered. We would welcome a future focus on other protected characteristics such as gender and inclusion health groups, identified as a priority area by NHSE through their [inclusion health framework](#).

While the statement encourages improved quantitative data collection, we also recognise the value of qualitative feedback from listening to and engaging with individuals and communities, particularly from those who are in more marginalised groups who are often not represented within quantitative data sources. We welcome NHSE's guidance on [Working in partnership with people and communities](#) as a useful resource for trusts.

It is important for trust leaders to use the data they collect to inform relevant actions and responses. We recognise that trusts will need to adapt to local circumstances when designing appropriate responses to best meet the needs of their communities.

NHSE are welcoming feedback on the statement to inform the next iteration. If any of our members would like to feedback, please get in touch with us or to the NHSE Health Inequalities team directly: england.healthinequalities@nhs.net

TABLE 1: INFORMATION ON HEALTH INEQUALITIES TO BE COLLECTED, ANALYSED AND PUBLISHED

Domain	Indicator	Indicator source	Variables to be published		Level available		Indicator alignment	
			Deprivation	Ethnicity	ICB	Trust	Healthcare inequalities priority	Core20 PLUS5 approach
Elective recovery	Size and shape of the waiting list; those waiting longer 18 weeks, 52 weeks and 65 weeks	WLMDS: Elective Waiting List – Power BI NCDR and UDAL Elective Recovery Dashboard (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 (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	√	√	√	√		
	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	N/A	N/A	√			√
Cardiovascular disease	Stroke rate of non-elective admissions (rate per 100,000 age-sex standardised)	SUS data	√ (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 (rate per 100,000 age-sex standardised)	NCDR and UDAL	√ (d)		√ (c)			√
	Percent age 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	NHS Benchmarking Data Explorer – CVD Prevent	√	√	√			√
	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		√	√	√			√
Percent age of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASs 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 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 Future NHS 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	Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted)	SUS / HES data	√	√	√	√		√
Learning disability	Learning Disability Annual Health Checks	Future NHS Collaboration Platform: Annual Health Check Data – Mental Health, Learning Disability and Autism Resource Hub				√		Aligned (no indicator)

and autistic people	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	N/A	N/A	√		
Maternity and neonatal	Preterm births under 27 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.cypransformation@nhs.net for access
- (c) Where statistical power allows
- (d) It may be necessary to compare the most deprived and least deprived halves

Abbreviations

- DPP – Diabetes Prevention Programme
- MSOA – Middle Layer Super Output Areas
- NCDR – National Commissioning Data Repository
- N/A – 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