Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board Response:

NHS England Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

Introduction

To drive forward the NHS focus on health inequalities, NHS England published a Statement on Information on Health Inequalities in November 2023. The Statement set out a description of the powers available to relevant NHS bodies to collect, analyse and publish information. NHS England has a statutory duty to conduct an annual assessment of Integrated Care Boards (ICBs) including the extent to which they have fulfilled their statutory obligations regarding health inequalities, adhering to this Statement supports this annual statement.

Derby and Derbyshire Integrated Care Board (ICB) and Integrated Care System (ICS) recognise that good quality, robust data enables the NHS and wider system partners to understand more about the populations we service. The ICB and ICS are supported by a Strategic Analytics Intelligence Unit that has the skills and expertise to allow for effective reporting and analysis to identify groups that are at risk of poor access to healthcare, have poor experiences or outcomes from care and as a result take targeted action to reduce health inequalities.

NHSE have provided a list of key metrics for monitoring that are the focus of the Statement. The metrics align with the national five strategic health inequality priorities alongside the clinical areas in the Core20+5. Actions are supported by the Derby and Derbyshire Joint Forward Plan.

Ongoing the data and information provided in the Appendix to this Statement will be used by the ICS to shape and monitor improvement activity to further reduce healthcare inequalities, fulfilling the Statement's aim to help drive improvement in the provision of good quality services.

What are Health Inequalities?

Health inequalities refer to the unfair and avoidable differences in people's health across the population and between different groups in society. In England, some people live longer, healthier lives while others experience poor health and die younger, often due to factors beyond their control.

These differences are not just about personal choices or genetics—they are closely linked to social, economic, and environmental conditions. For example, where a person lives, how much money they make, their education level, the kind of work they do, and their access to healthcare can all have a big impact on their health.

Health inequalities are most often seen in areas such as life expectancy, infant mortality, mental health, and long-term conditions like heart disease or diabetes. A key example of this is the "health gap" between rich and poor areas. People living in the most deprived parts of England may live up to 10 years less than those in the wealthiest areas, and they spend more of their lives in poor health.

Key Groups Affected by Health Inequalities

Some groups in society are more affected by health inequalities than others. These include:

<u>People living in deprived areas</u>

People in poorer neighbourhoods tend to have worse health outcomes. For instance, rates of smoking, obesity, and alcohol use are higher, and access to healthy food or safe places to exercise is often lower. Hospital admissions for preventable conditions are more common, and life expectancy is shorter.

Ethnic minority groups

Some ethnic minority communities face higher risks of certain health issues. For example, Black and South Asian people in England have higher rates of type 2 diabetes and heart disease. Additionally, these communities sometimes face barriers such as language differences, cultural misunderstandings, and discrimination in healthcare settings.

People with disabilities

Individuals with physical or learning disabilities often face significant health challenges. They may have difficulty accessing services, experience poorer treatment, or have health needs that go unmet. This group also has a lower life expectancy than the general population.

Older people

Older adults are more likely to suffer from long-term health conditions, and those who are poor or socially isolated often have worse outcomes. Access to social care is also unequal, with many older people not receiving the support they need.

Children from low-income families

Health inequalities start early. Children born into poverty are more likely to be underweight at birth, have developmental delays, and experience mental health issues. Poor housing and limited access to nutritious food or recreational activities contribute to these problems.

LGBTQ+ people

While not always highlighted, people from LGBTQ+ communities can also face health inequalities. Mental health issues, including depression and anxiety, are more common, partly due to stigma, discrimination, and lack of understanding within some healthcare services.

The Role of Healthcare Services in Reducing Health Inequalities

The NHS and other healthcare providers play a crucial role in helping reduce health inequalities. While the root causes of health inequality—such as poverty, education, and housing—are outside the direct control of healthcare services, they can still make a big difference through the way they deliver care. Healthcare services can:

Provide equal access to care

Making sure that everyone, regardless of their background, can access high-quality health services is essential. This includes reducing waiting times, offering services in different languages, and ensuring facilities are accessible to people with disabilities.

Focus on prevention

Preventative care is vital for reducing long-term inequalities. Services like free health checks, vaccination programmes, stop smoking clinics, and weight management support can help people avoid serious illness in the future.

Tailor services to community needs

Healthcare organisations are increasingly working to understand the specific needs of local populations. This might mean setting up clinics in communities where certain conditions are more common, offering culturally sensitive services, or partnering with local charities and community groups.

Improve data and research

Collecting and using data about patient outcomes, ethnicity, and geography helps healthcare organisations identify where the biggest health gaps are and take targeted action. For example, if a particular group is less likely to attend cancer screenings, services can be adjusted to improve access and uptake.

Train staff in equality and inclusion

Ensuring that NHS staff are trained to understand cultural differences and the barriers some groups face can help create a more inclusive and respectful healthcare environment. This helps reduce unconscious bias and improves the overall experience of care.

How Healthcare Services Influence Health Inequalities

Healthcare services have a wide range of ways to influence health inequalities, even beyond treatment itself. Here are a few key approaches:

Integrated care systems (ICSs)

England now uses integrated care systems to bring together NHS services, local councils, and other partners. These systems are designed to look at the bigger picture and address the social factors that affect health. By working together, they can plan services around what communities really need—whether it's better mental health support, improved housing, or easier access to GPs.

Outreach and community engagement

Health services can go out into communities rather than waiting for people to come to them. This is especially important for reaching groups who may not trust the system. Mobile clinics, pop-up vaccination centres, and community health workers are all ways of reaching underserved groups.

Using 'proportionate universalism'

This idea means that everyone should get help, but those who are most in need should get more support. Healthcare services can use this approach to make sure resources are directed where they will have the biggest impact. For example, offering longer GP appointments in areas with high deprivation or putting more funding into mental health services in local areas experiencing high levels of anxiety, depression and psychosis.

Focusing on the early years

Supporting families from pregnancy through early childhood can have long-lasting effects on health. NHS services like health visitors, maternal mental health teams, and early screening can help identify and address problems early, giving children a better start in life.

Partnership with public health

Healthcare services often work closely with public health teams to improve the wider determinants of health. This can include tackling issues like air pollution, unhealthy diets, or poor housing. When healthcare and public health work together, they can influence change on a broader scale.

Using their role as large employers

The NHS is one of the biggest employers in the country. By offering good jobs, apprenticeships, and fair wages—especially in poorer areas—it can help reduce poverty and boost local economies. This, in turn, helps reduce health inequalities over time.

Key Local Messages on Health Inequalities from local data analysis

- The Derby & Derbyshire NHS serves a registered population of 1.24 million people.
- There is a relatively even distribution of people in each of the deciles of deprivation with 29.3% of people in the three poorest deciles.
- 79.4% of the population served by the NHS are recorded as being from a white ethnic background.
- 11.4% of the population served by the NHS are recorded as being from a non-white ethnic background.
- We are missing data on the ethnicity of 9.2% of the population served by the NHS.
- There are clear differences in the Health Service Utilisation between those people living in poorest and richest areas in Derby and Derbyshire:
    - people living in our poorest communities are admitted to hospital with an urgent or emergency condition more commonly than those in our richer communities;
    - people living in our poorest communities access health services through out-patient settings less commonly than those in our richer communities;
    - there is inequality in the delivery of elective inpatient services to those in our poorest communities when compared with our richer communities;
    - there is a clear inequality in the delivery of some preventative healthcare services (e.g. Immunisation) between our poorest and our richer communities;
    - there is evidence that in specific services such as those to identify hypertension and atrial fibrillation that we have successfully identified more people with those conditions in our poorer communities. However, the wider evidence base around those conditions suggests that there remains far more people in our more deprived communities that are yet to be identified. Therefore, there remains a likely hidden inequality even in these services;
    - there is variation in access and utilisation of healthcare services by different ethnic groups; and
    - it would be invaluable to better understand demographic differences between people in our deprivation deciles in Derby & Derbyshire and the impact of those demographic differences could have on how local NHS services are designed and delivered.

Summary

Health inequalities in England are a major issue, with some people living significantly shorter and less healthy lives than others due to factors like poverty, ethnicity, and disability. Groups such as people in deprived areas, ethnic minorities, and people with disabilities are

especially affected. In Derby and Derbyshire we see a similar pattern and distribution of health inequalities to the rest of England.

While healthcare services alone cannot solve all the root causes, they play a vital role in reducing the gap through fair access, tailored support, preventative care, and partnerships. By focusing on those most in need and addressing the wider causes of ill health, the NHS and other services can help build a fairer, healthier society for everyone. The local analysis indicates that there is significant opportunity for local health services to address health inequalities by:

1. improving equal access to care;
2. increasing the alignment of local health service provision with the delivery of increased preventative measures; and
3. tailoring local health services to community needs with particular attention given to the variation in needs that can be identified on a neighbourhood footprint.

Health Inequalities in Derby & Derbyshire Healthcare Services Utilisation

Key Messages- Population

- The Derby & Derbyshire NHS serves a registered population of 1.24 Million people
- There is a relatively even distribution of people in each of the deciles of deprivation with 29.3% of people in the three poorest deciles
- 79.4% of the population served by the NHS are recorded as being from a white ethnic background
- 11.4% of the population served by the NHS are recorded as being from a non-white ethnic background
- We are missing data on the ethnicity of 9.2% of the population served by the NHS.

Key Messages- Health Service Utilisation

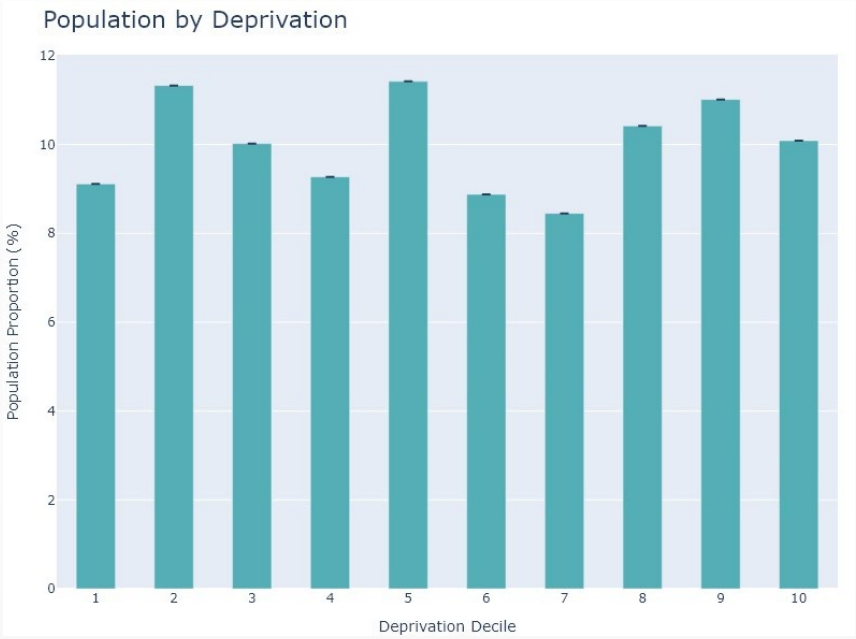
- There are clear differences in the Health Service Utilisation between those people living in poorest and richest areas in Derby & Derbyshire:
  - People living in our poorest communities are admitted to hospital with an urgent or emergency condition more commonly than those in our richer communities
  - People living in our poorest communities access health services through out-patient settings less commonly than those in our richer communities
  - There is inequality in the delivery of elective inpatient services to those in our poorest communities when compared with our richer communities
  - There is a clear inequality in the delivery of some preventative healthcare services (e.g. Immunisation) between our poorest and our richer communities
  - There is evidence that in specific services such as those to identify hypertension and atrial fibrillation that we have successfully identified more people with those conditions in our poorer communities. However, the wider evidence base around those conditions suggests that there remains far more people in our more deprived communities that are yet to be identified. Therefore, there remains a likely hidden inequality even in these services.
- There is variation in access and utilisation of healthcare services by different ethnic groups.
- It would be invaluable to better understand demographic differences between people in our deprivation deciles in Derby & Derbyshire and the impact of those demographic differences could have on how local NHS services are designed and delivered.

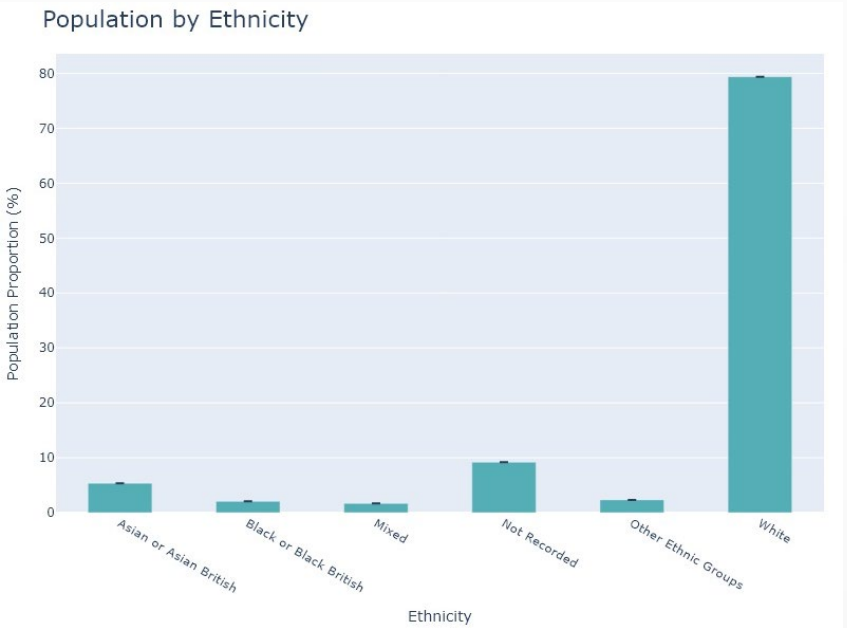
Population Structure

Total Population
1.24m

Proportion living in bottom 3 deciles:
29.3%

Proportion of White Ethnicity:
79.4%





The ICB has a registered population of **1.24 million**, with variations in socioeconomic and ethnic composition.

Socioeconomic Distribution:

- **29.3%** of the population live in the areas that are in **bottom three deprivation deciles of England**, highlighting a significant segment experiencing socioeconomic disadvantage.
- Population proportions across deciles range from **8.4% to 11.4%** suggesting there is no concentration of population on either side of deprivation dimension.

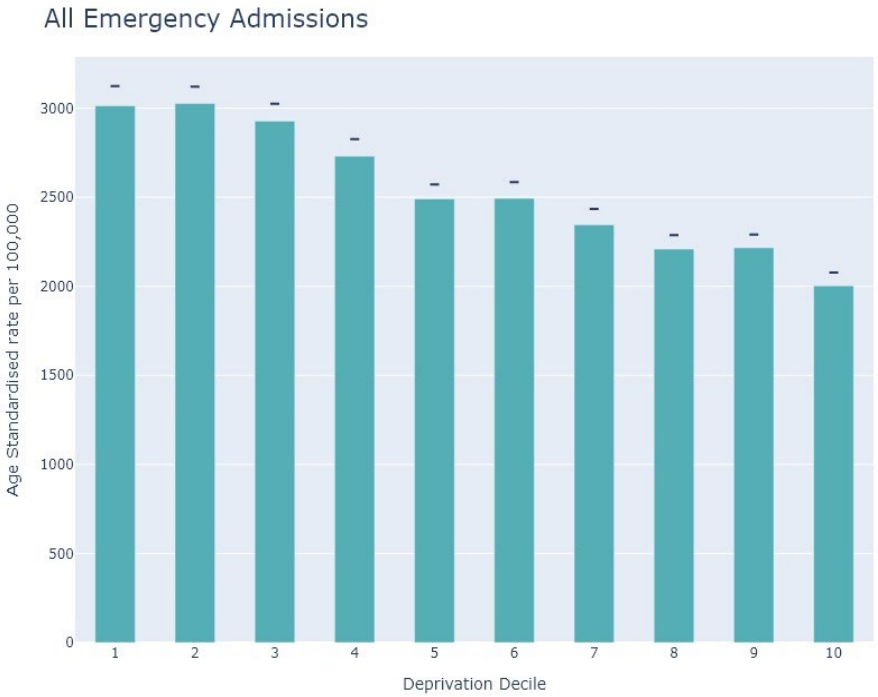
Ethnic Composition:

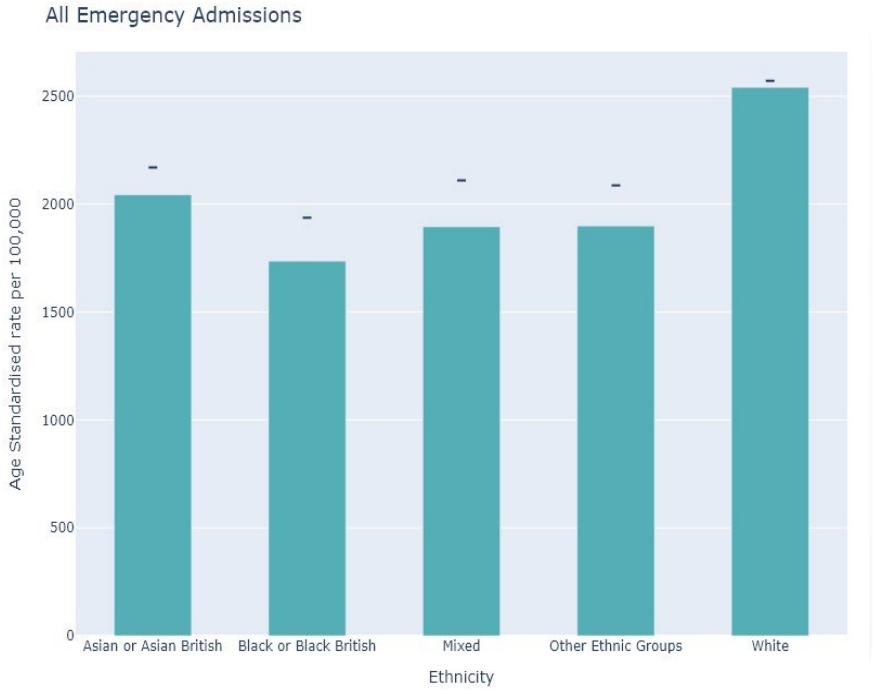
- **79.4%** of the population identifies as **White** and **11.4**% recorded as any of the non-white ethnic backgrounds. This underscores the importance of culturally tailored healthcare strategies to address varying health needs.

Emergency Admissions

All Emergency Admissions

Slope Index of Inequality	Rate per 100,000 for the population	% unrecorded
-1156.8	2489.5	Deprivation: 1.9% Ethnicity: 9.9%





Socioeconomic Distribution:

- Clear linear trend in rate of emergency admissions between deprivation deciles. Negative Slope Index of Inequality suggests Rate decreases as the deprivation decreases. The absolute gap between the most and least deprived is -1156.8 emergency admissions per 100,000 population.

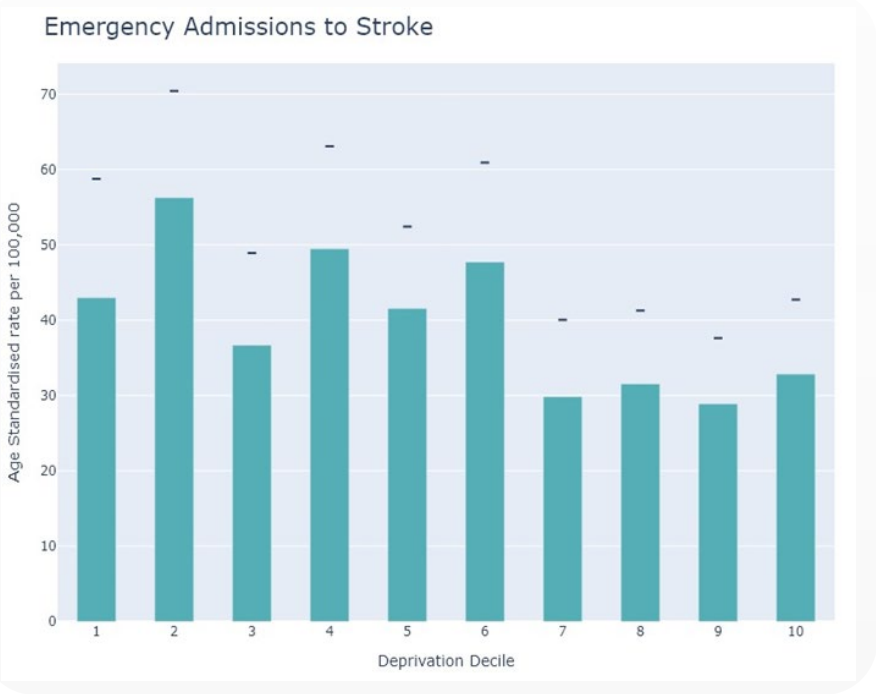
Ethnic Composition:

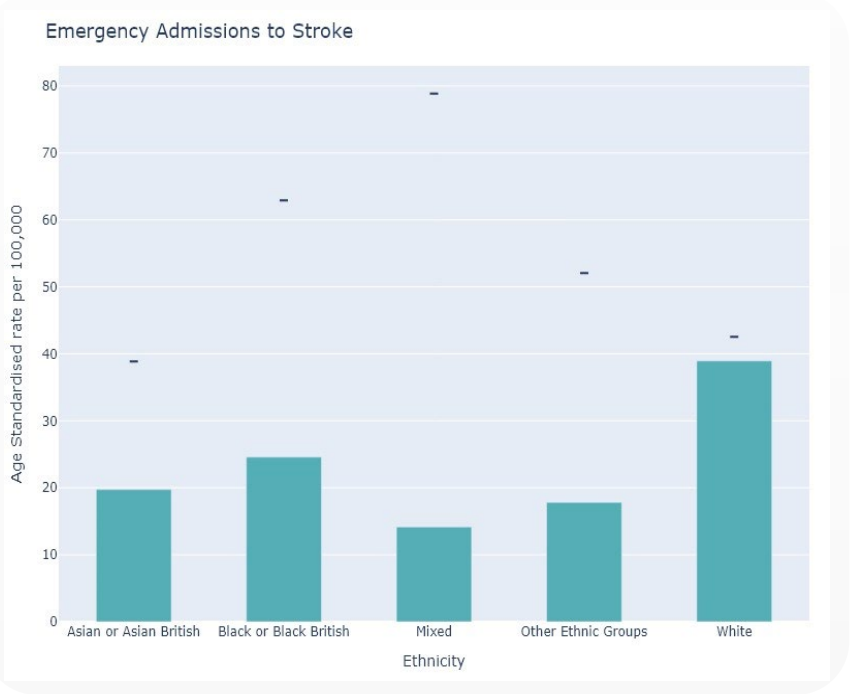
- Population belonging to White ethnicity appear to have higher rate of emergency admissions compared to others. For 100,000 population

Emergency Admissions

Emergency Admissions to Stroke

Slope Index of Inequality	Rate per 100,000 for the population	% unrecorded
-18.4	38.5	Deprivation: 1.21% Ethnicity: 11.8%





Socioeconomic Distribution:

- There seems to be a gap in bottom 6 and top 4 deciles. SII of **-18.4** suggests inequality. There appears to be a gap between top 4 deciles and the rest.

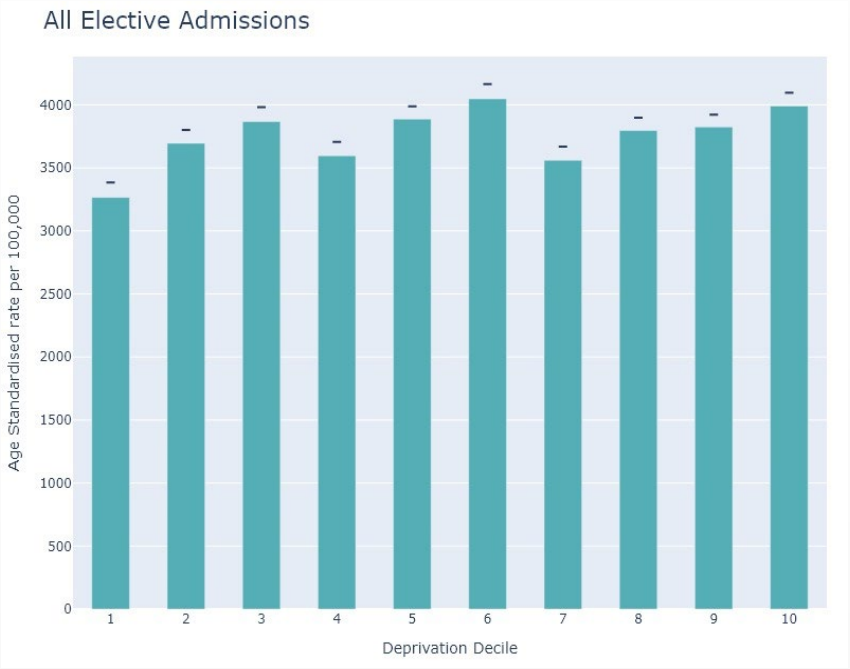
Ethnic Composition:

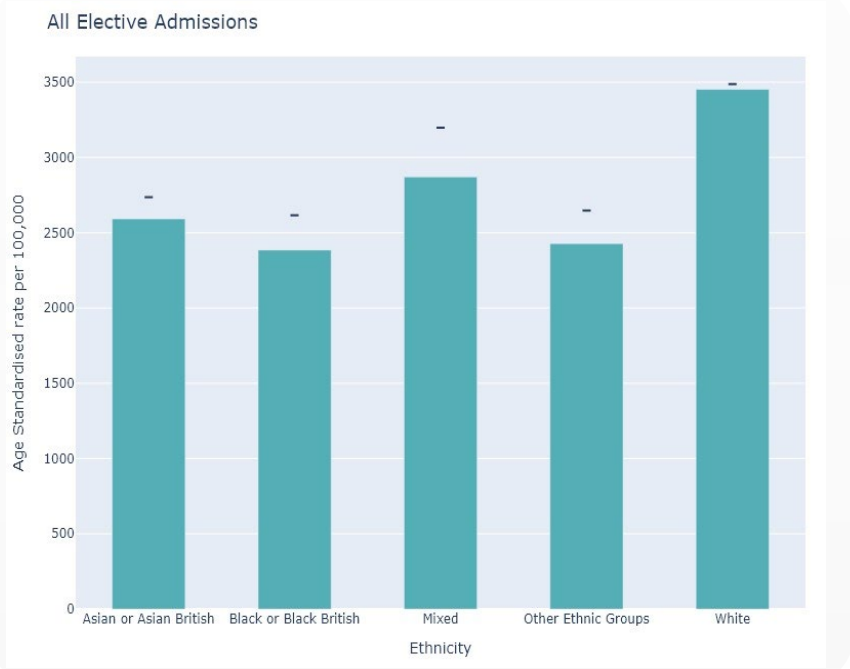
- White population have higher rate compared to other ethnicities. However, wide confidence intervals require caution while interpreting the variance.

Elective Admissions

All Elective Admissions

Slope Index of Inequality	ICB Rate per 100,000	% unrecorded
452.9	3718.5	Deprivation: 1.6% Ethnicity: 17.6





Socioeconomic Distribution:

- There appears to be a **weak linear relation** in access to elective care between deprivation deciles. Absolute gap between least and most deprived population is **452.9** admissions per 100,000. Due to non-linearity, the gap should be carefully interpreted as some of the least deprived deciles (e.g. decile 7) have relatively lower access as well.

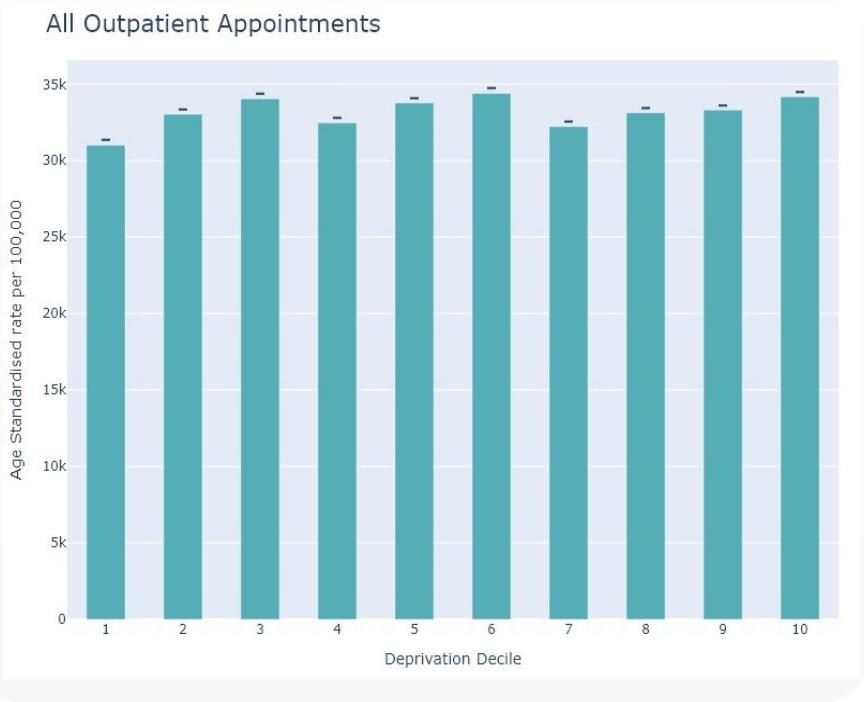
Ethnic Composition:

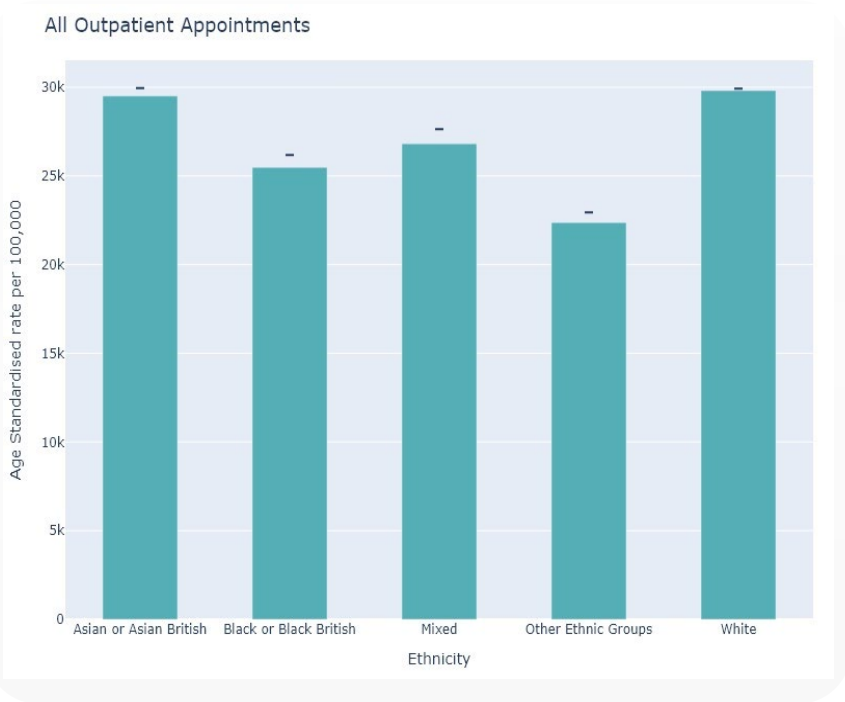
- White ethnicity has significantly higher rate of admissions compared to others.

Outpatient Appointments

All Outpatient Appointments

Slope Index of Inequality	ICB Rate per 100,000	% unrecorded
1706	32681.9	Deprivation: 1.8% Ethnicity: 17.8%





Socioeconomic Distribution:
There appears to be relatively weak and linear variation in access to outpatients between deprivation deciles. Absolute difference between least and most deprived population is **1706** attendances per 100,000.

Ethnic Composition:
White and Asian ethnicities seem to have similar rates of attendances, but Black and other ethnicities have lower rates.

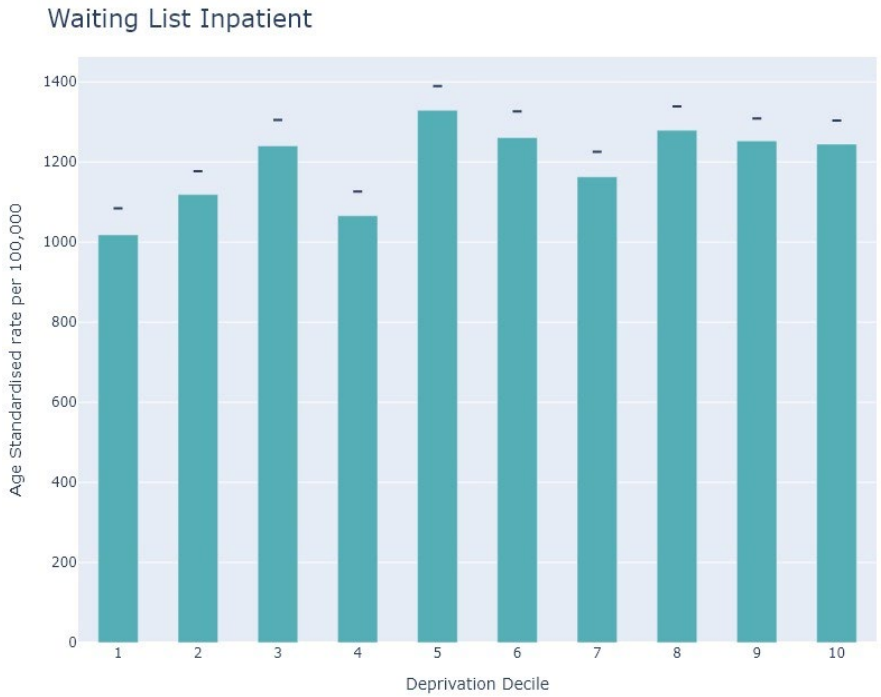
Waiting List

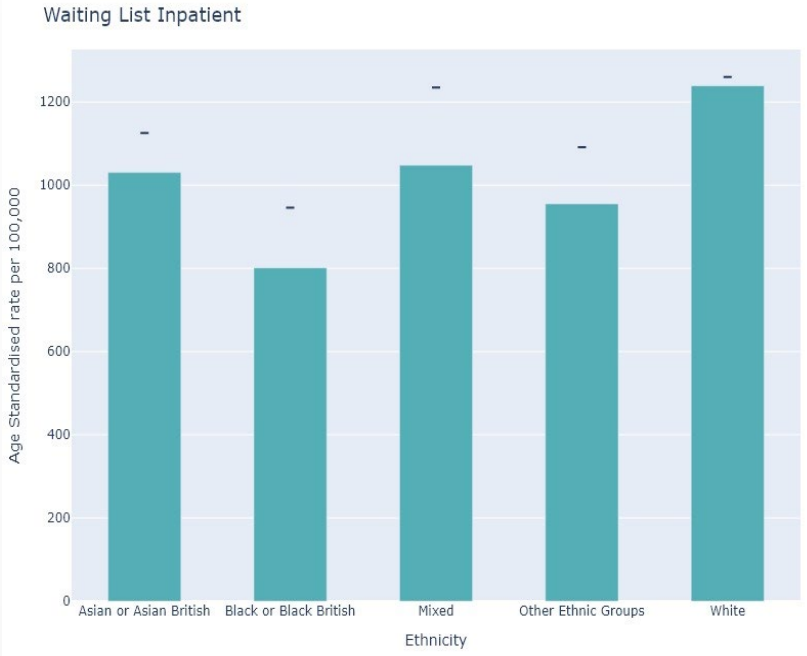
Total Inpatients Clock Stops

Slope Index of Inequality
228.7

ICB Rate per 100,000
1168.1

% unrecorded
Deprivation: 27.8%
Ethnicity: 32.2%





Socioeconomic Inequality:

- The **Slope Index of Inequality (SII) is 228.7**, indicating a measurable disparity in waiting list outcomes between the most and least deprived populations.
- However, there is **no distinct linear relation** between deprivation and waiting list clock stops, suggesting that other factors may influence treatment completion rates beyond deprivation alone.

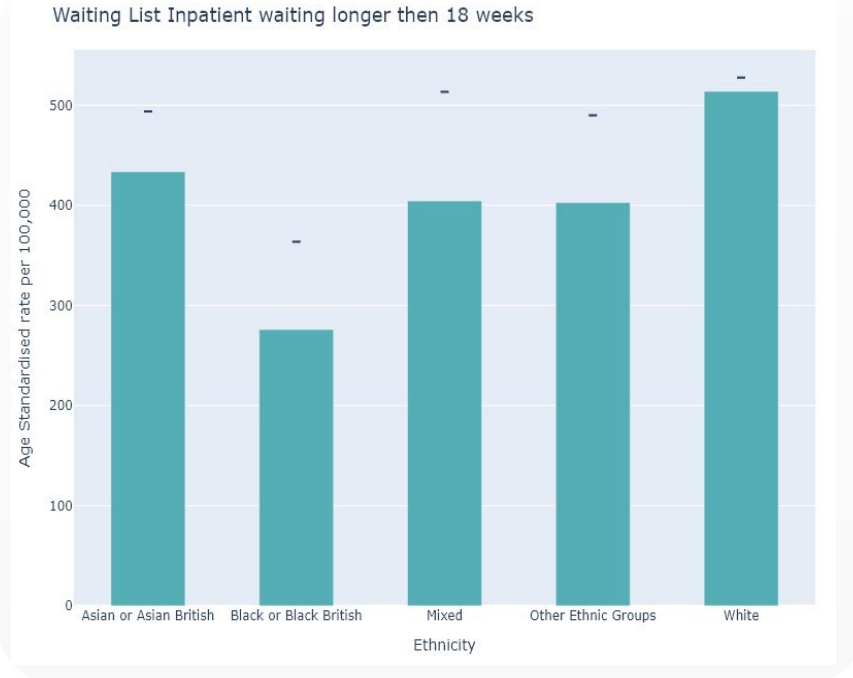
Ethnic Disparities:

- There are **notable differences in waiting list clock stop rates between White and other ethnic minority groups**, with **'Black and Black British' populations having lower rates**.
- These disparities may reflect variations in awareness, referral patterns, healthcare access, or other structural factors affecting treatment pathways.

Waiting List

Inpatients Clock Stops with18+ weeks waits

Slope Index of Inequality	Rate per 100,000 for the population	% unrecorded
49.4	451.3	Deprivation: 32.3% Ethnicity: 31.5%



Socioeconomic Inequality:

- The **Slope Index of Inequality (SII) is 49.4**, indicating some disparity in long-waiting patients between the most and least deprived populations.
- People living in some deprivation deciles have higher rate than ICB rate of 451.3 per 100,000. However, there is **no linear relation** between deprivation and waiting list clock stops, suggesting that delays in treatment are influenced by factors beyond deprivation alone.

Ethnic Disparities:

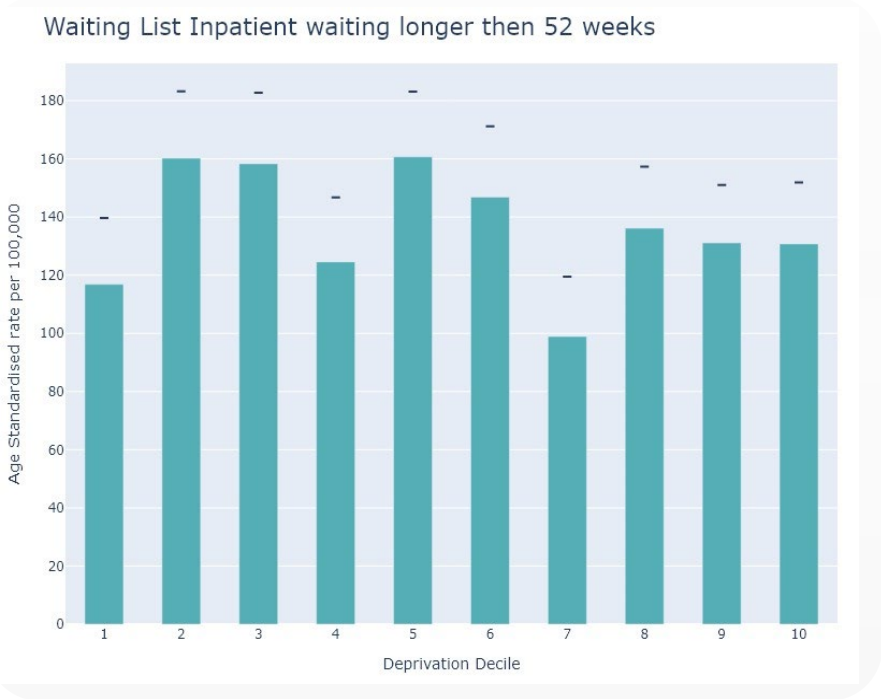
- **Black and Black British groups, in particular, experience significantly lower clock stop rates** compared to White or Asian populations, indicating longer waits or differences in treatment pathways.
- These differences may be linked to variations in healthcare access, referral patterns, or other structural factors affecting timely treatment.

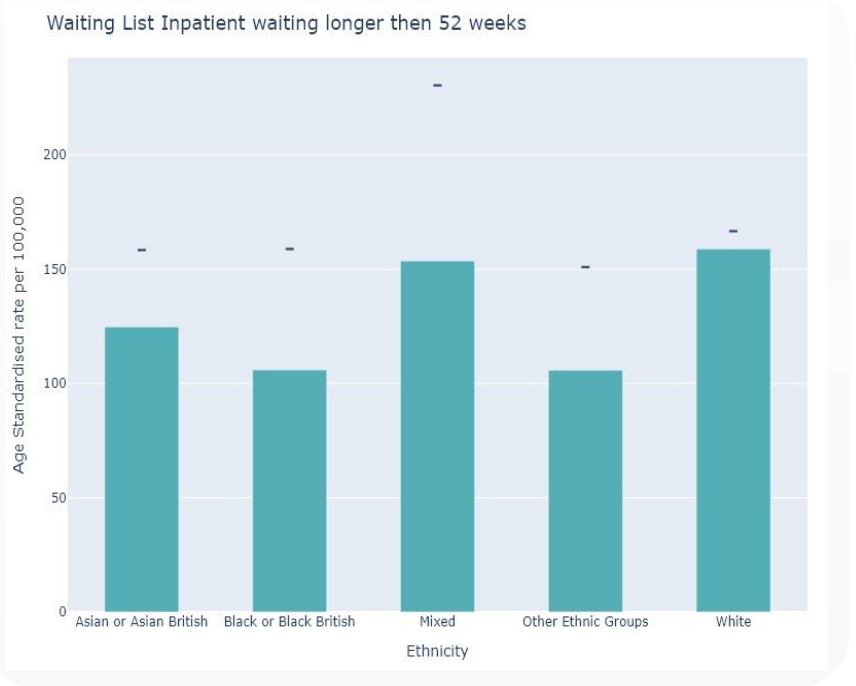
Note: Waiting list date has significant data quality issues for both dimensions reported here. This adds potential bias to the conclusions.

Waiting List

Inpatients Clock Stops with 52+ weeks waits

Slope Index of Inequality	Rate per 100,000 for the population	% unrecorded
2.2	133.7	Deprivation: 33.7% Ethnicity: 30.5%





Socioeconomic Inequality:

- The **Slope Index of Inequality (SII) is 2.2**, indicating a relatively small disparity in long-waiting patients between the most and least deprived populations.
- There is **no clear linear relationship** between deprivation and waiting list clock stops, but certain **deprivation deciles exhibit higher wait times than others**, suggesting influence of other factors.

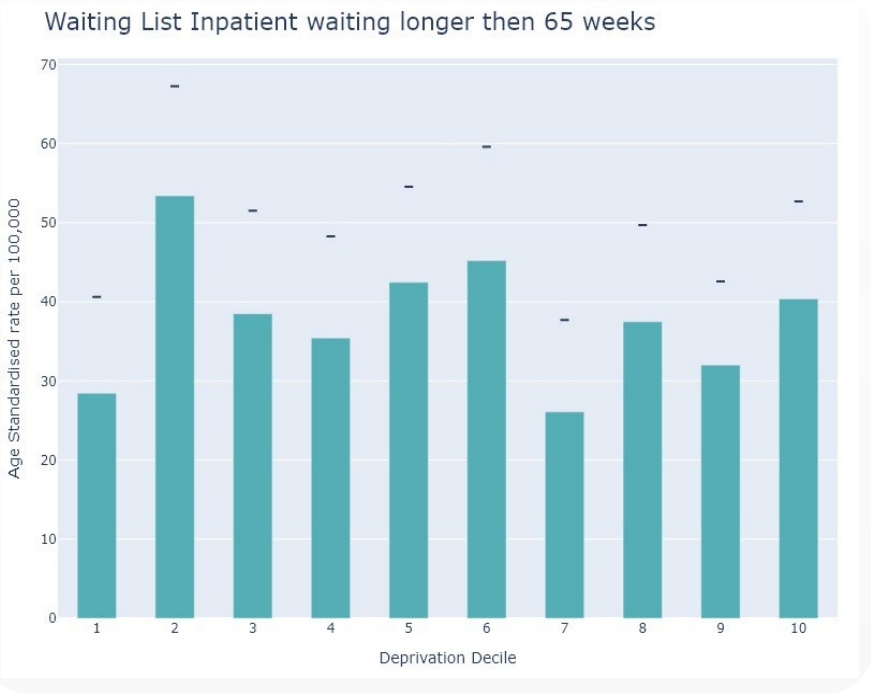
Ethnic Disparities:

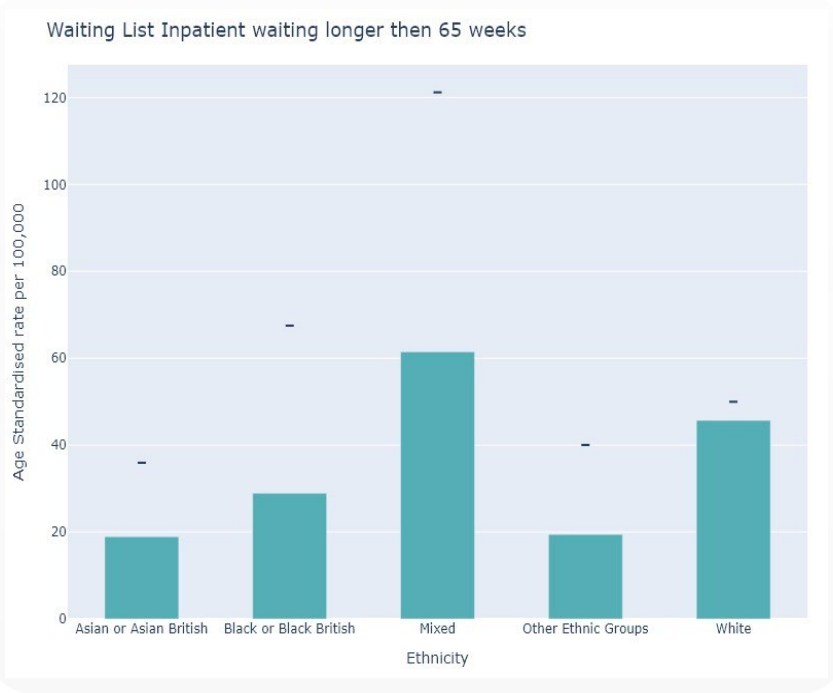
- **White and mixed ethnic groups, in particular, experience higher rates of those waiting 52+ weeks** indicating potential delays in accessing treatment.
- These differences may reflect **barriers in referral pathways, healthcare engagement, or service accessibility**, warranting further investigation.

Waiting List

Inpatients Clock Stops with 65+ weeks waits

Slope Index of Inequality	Rate per 100,000 for the population	% unrecorded
2.7	37.3	Deprivation: 34.9 Ethnicity: 30.9





Socioeconomic Inequality:

- The **Slope Index of Inequality (SII) is 2.7**, indicating a small disparity between the most and least deprived populations.
- There is **no clear linear relationship** between deprivation and waiting list clock stops, but **some deprivation deciles exhibit higher long-wait rates than others**, suggesting further investigation in specific localities.

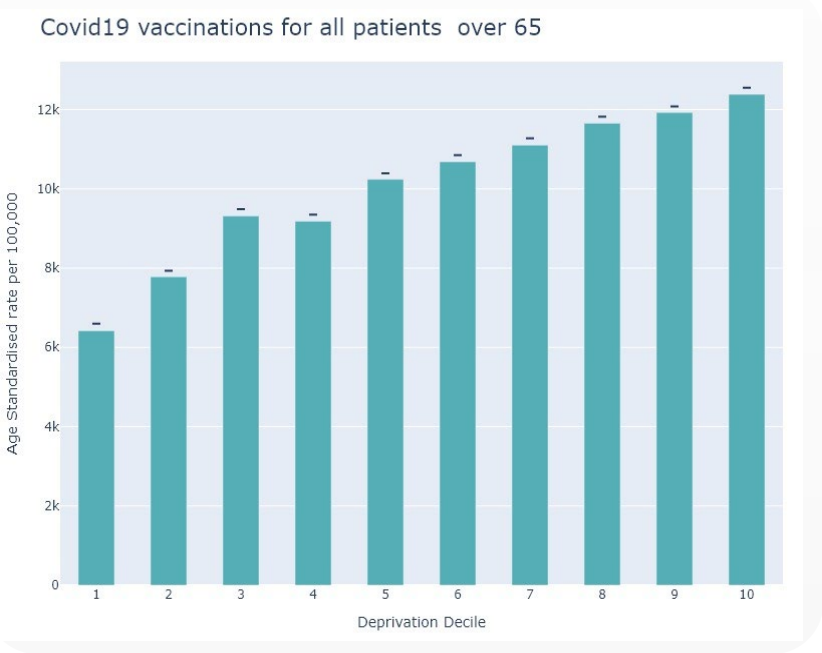
Ethnic Disparities:

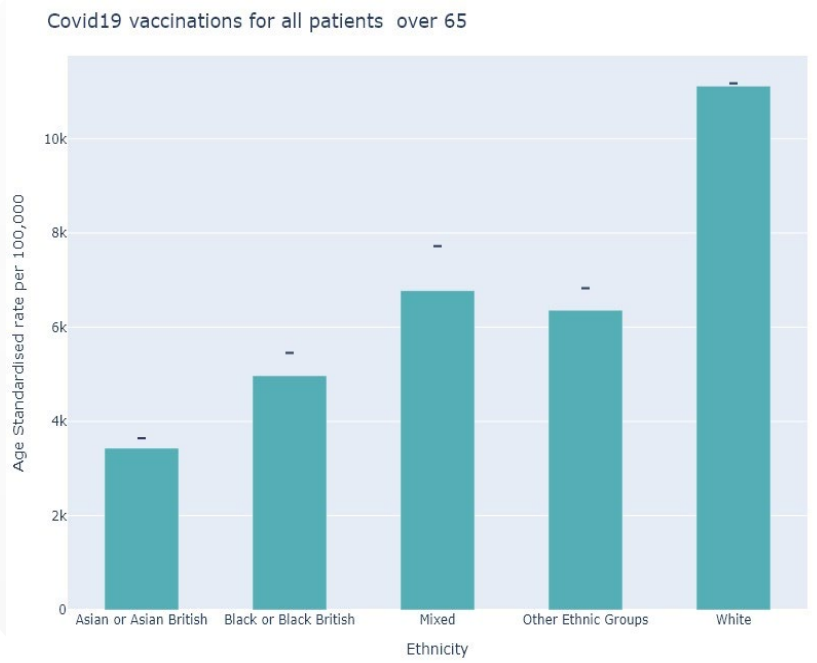
- **Mixed ethnicity groups have the highest rates of long waits**, but **low volumes and wide confidence intervals limit the strength of this finding**.
- These results suggest **insufficient evidence to confirm a significant inequality** in long waiting times by ethnicity, though further monitoring may be needed.

Vaccinations

Covid19 Vaccinations to over 65 population

Slope Index of Inequality	Rate per 100,000 for the population	% unrecorded
5851.9	10,147.6	Deprivation: 0.5% Ethnicity: 4.2%





Socioeconomic Inequality:

- The **ICB-wide vaccination rate is 10,147 per 100,000**, but this masks substantial variation across different population groups.
- The **Slope Index of Inequality (SII) is 5851.9**, indicating a substantial disparity in vaccination uptake between the most and least deprived populations.
- There is a **clear linear relationship** between deprivation and uptake, with **people in the most deprived deciles having much lower vaccination rates** than those in less deprived areas.

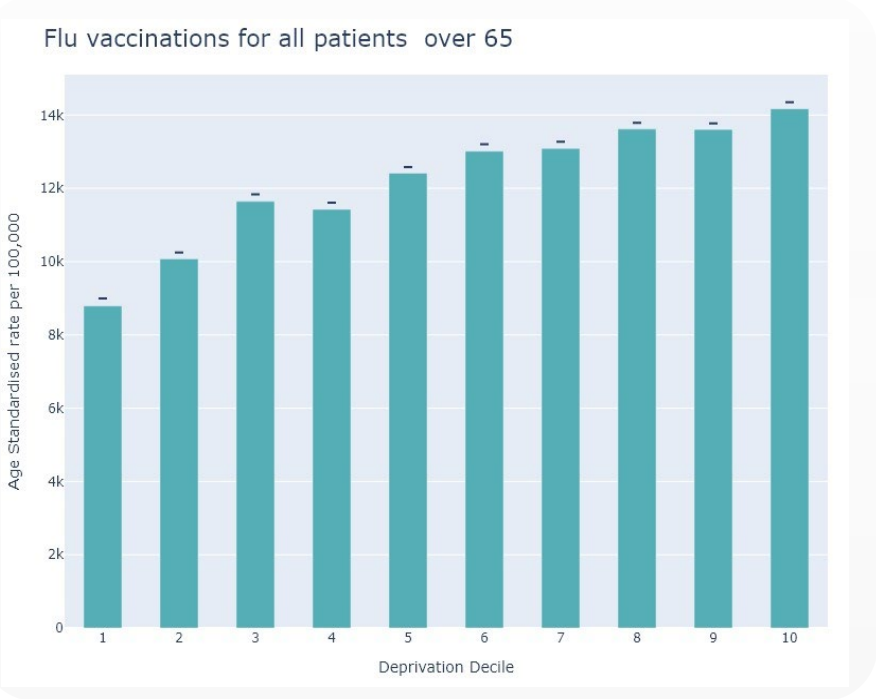
Ethnic Disparities:

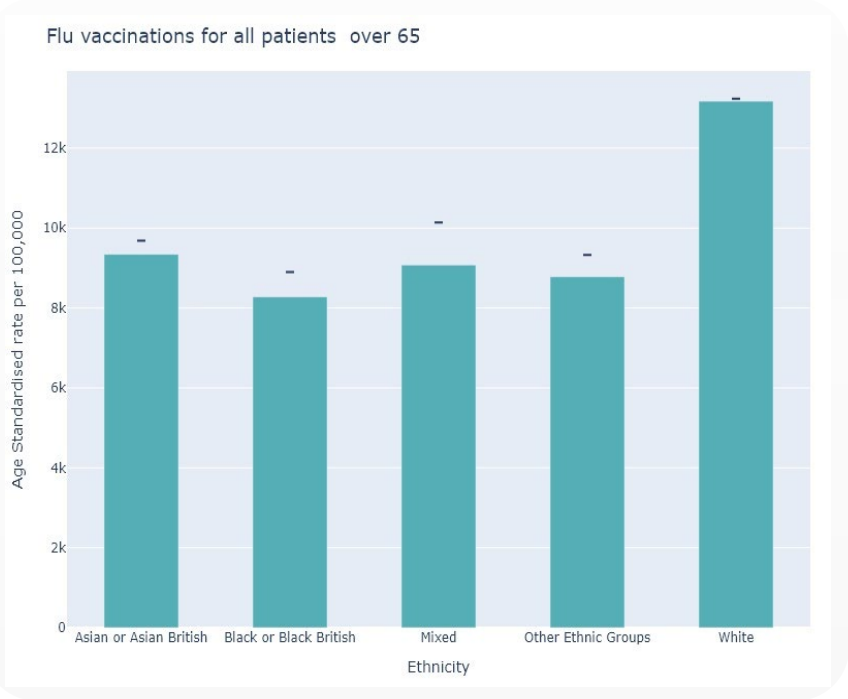
- **White ethnic groups have significantly higher uptake** compared to other ethnic groups.
- Lower vaccination rates in some ethnic groups may be driven by **vaccine hesitancy, accessibility issues, or historical trust barriers in healthcare**.

Vaccinations

Flu Vaccinations over 65

Slope Index of Inequality	Rate per 100,000 for the population	% unrecorded
1215.0	12230.2	Deprivation: 0.5% Ethnicity: 0%





Socioeconomic Inequality:

- The **ICB-wide vaccination rate is 12,230 per 100,000**, but this figure masks significant variation across deprivation levels.
- The **Slope Index of Inequality (SII) is 1215.0**, indicating a measurable disparity between the most and least deprived populations.
- There is a **clear linear relationship** between deprivation and flu vaccination uptake, with **lower rates in the most deprived areas** compared to more affluent populations.

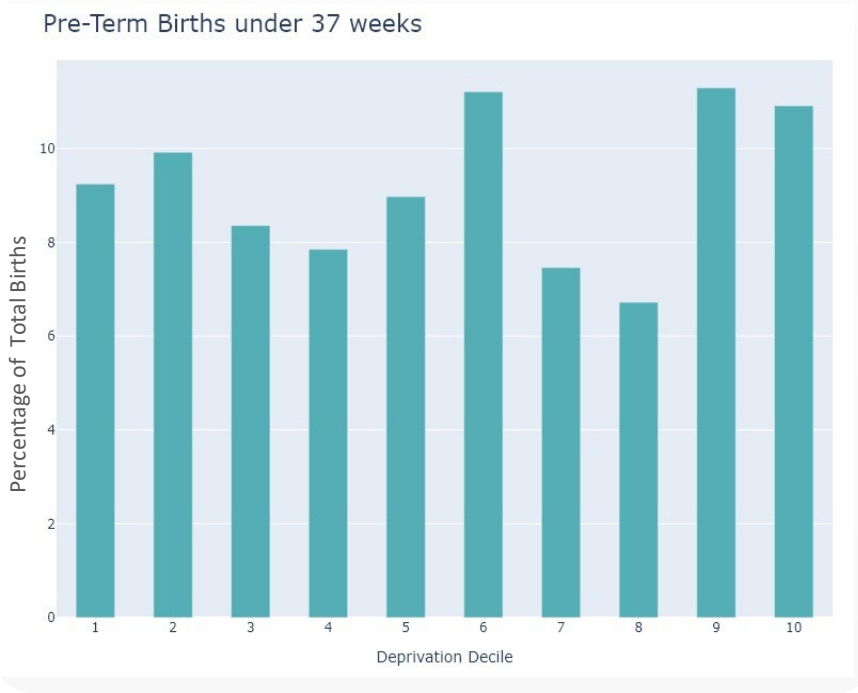
Ethnic Disparities:

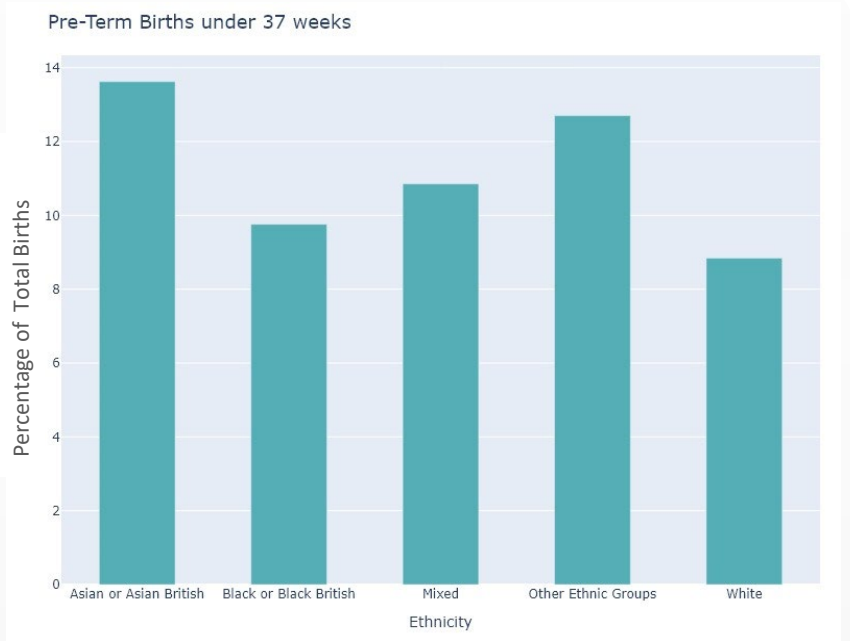
- **White ethnic groups have the highest uptake**, while **all other ethnic groups have significantly lower rates**.
- These disparities may be influenced by **vaccine hesitancy, access barriers, and cultural factors affecting vaccine acceptance**.

Births

Pre-Term Births under 37 weeks

Slope Index of Inequality	ICB Percentage of pre-term births	% unrecorded
1.9	9.5%	Deprivation: 25.5% Ethnicity: 1.5%





Socioeconomic Inequality:

- The ICB has 9.5% of total births under 37 weeks. Although deprivation doesn't appear to be a significant influencing factor on its own, there is an absolute difference of 1.9 points between least and most deprived deciles.

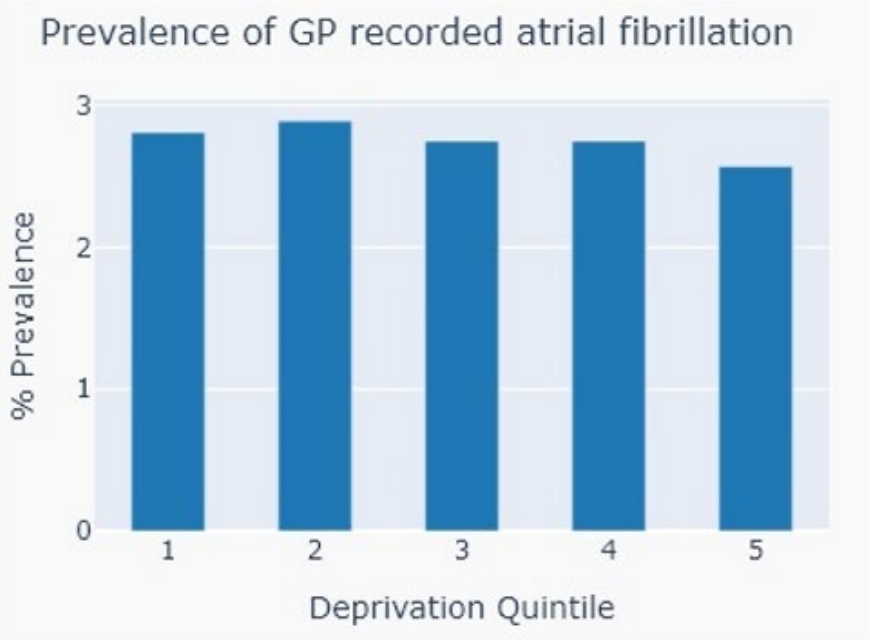
Ethnic Disparities:

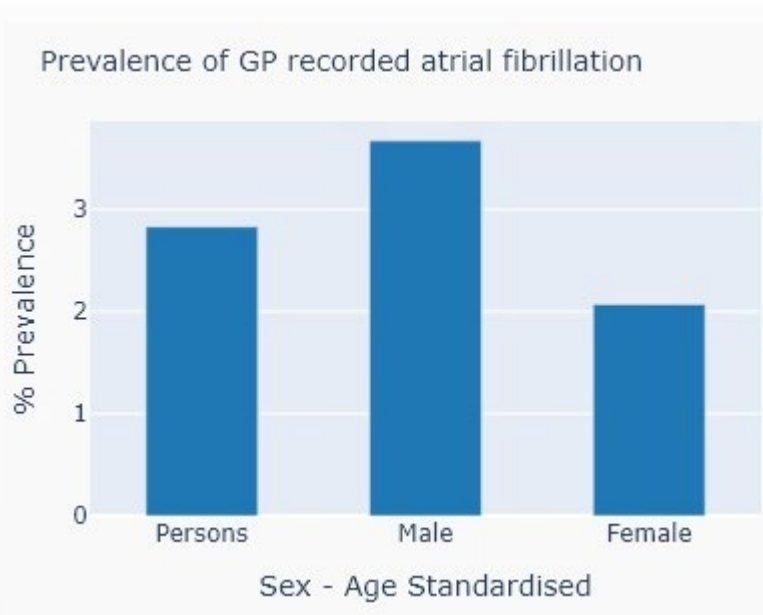
- There are apparent disparities between ethnicities for pre-term births.

Prevalence

GP recorded prevalence of Atrial Fibrillation

Slope Index of Inequality	ICB Percentage	% unrecorded
-0.3	NA	Deprivation: NA Ethnicity: NA





Prevalence figures are sourced from CVD prevent dataset. Therefore, not data is not available for all dimensions.

There appears to be a slight decrease in prevalence as the deprivation decreases and Male prevalence is higher than females.

Prevalence

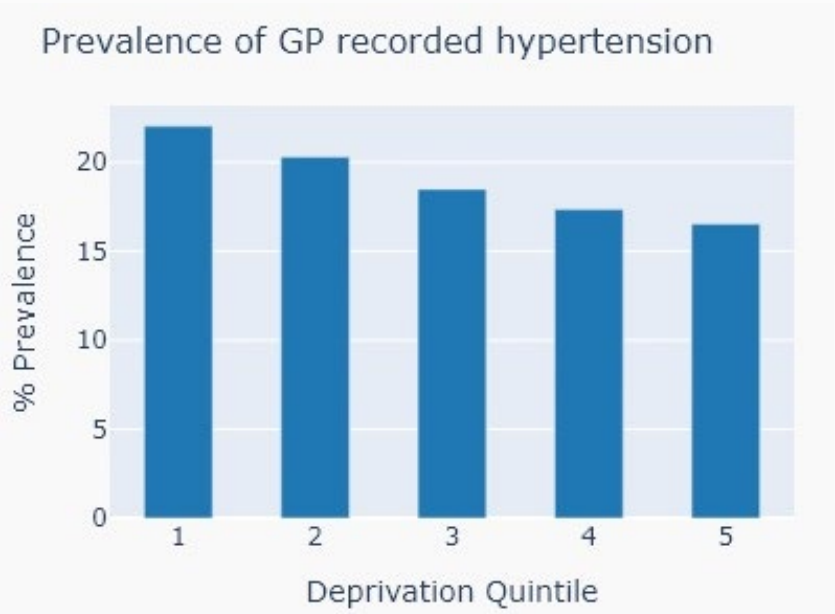
GP recorded prevalence of Hypertension

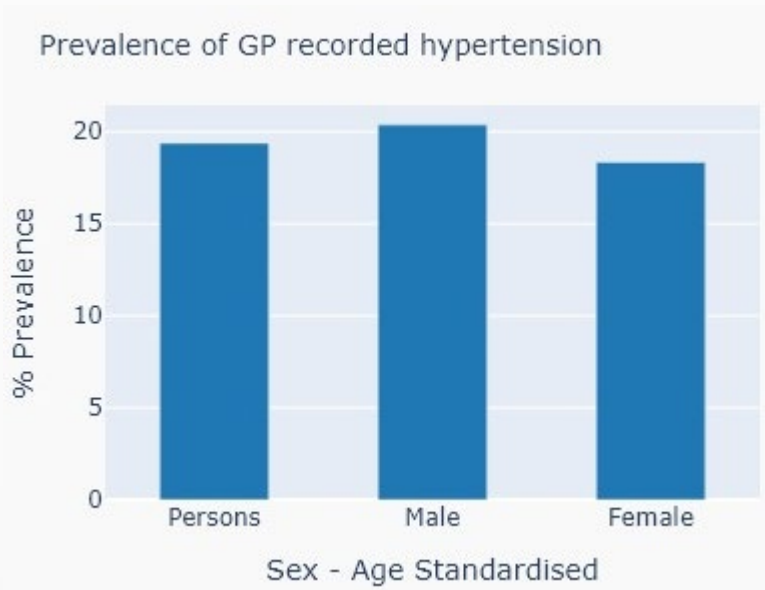
Slope Index of Inequality
-6.98

ICB Percentage
NA

% unrecorded
Deprivation: NA
Ethnicity: NA

There appears to be a slight decrease in prevalence as the deprivation decreases and Male prevalence is higher than females.





Technical Brief

This analysis reports on health inequalities in NHS Derby and Derbyshire ICB using **Directly Age-Standardised Rates (DSR) per 100,000 population and proportions (where rates cannot be calculated)** to account for demographic differences across population groups. The analysis focuses on variations by **deprivation deciles** and **high level ethnic groups**, enabling a clearer understanding of disparities in health outcomes. High-level ethnicity categories were used to ensure statistical robustness. More granular classifications resulted in small sample sizes, leading to unstable rates and wide confidence intervals.

Time period:

- All metrics except Prevalence are calculated for the quarter Oct-Dec 2024. Prevalence figures are a snapshot as at the end of Sep 24

Methodology

- **Direct Age Standardisation**: Standardises rates to a European standard population, allowing for fairer comparisons between groups with different age distributions.
- **Confidence Intervals**: Calculated using the **Dobson method**, providing a measure of statistical uncertainty around estimates.
- **Slope Index of Inequality (SII)**: Used to quantify the gradient of inequality across deprivation deciles, capturing the relative health impact of socioeconomic status.

Data Quality Considerations

While the dataset provides valuable insights, certain limitations must be acknowledged:

- **Missing Deprivation Data**: 3.7% of the population lacks recorded deprivation deciles, which may introduce bias in the analysis.
- **Incomplete Ethnicity Records**: 9.2% of individuals have no recorded ethnicity, potentially affecting the representativeness of ethnic disparities.
- **Small Sample Sizes**: Some subgroups may have small sample sizes, leading to wider confidence intervals and reduced statistical power.