Health inequalities

Introduction

Health inequalities are systematic, avoidable and unfair differences in health outcomes between different groups of people. These disparities arise due to social, economic and environmental factors, which influence people's ability to live a healthy life. Health inequalities are revealed in life expectancy, disease prevalence, access to healthcare and health outcomes.

Health inequalities lead to shorter life expectancy, higher disease rates and poorer health outcomes in disadvantaged communities. People in lower-income or marginalised groups experience higher rates of chronic illness, mental health issues and preventable diseases.
Limited access to healthcare, poorer housing and lower health literacy exacerbate disparities, resulting in higher emergency admissions and lower treatment adherence. These inequalities increase the burden on
the NHS, reduce workforce productivity and contribute to widening social and economic divides. Addressing these issues through targeted interventions, data-driven strategies, and community partnerships is essential for improving health equity.

Our duties

The NHSE statement on information on health inequalities, published in November 2023, underlines that the NHS Act 2006 (as amended, by the Health and Care Act 2022) places a range of health inequalities duties on the NHS, including provider trusts. It also outlines the powers available to NHS organisations
to collect, analyse and publish information on health inequalities.

The purpose of this duty is to encourage NHS board of directors to use the data to shape and monitor improvement activity. The statement is intended to help drive improvement in the provision of services and in reducing healthcare inequalities, helping to ensure equitable access, experience and outcomes for all. The statement also incentivises collaboration between NHS board of directors on information collection and analysis, to better understand the health and wellbeing needs of their local communities. The aim of highlighting the legal duties and powers of NHS organisations regarding health inequalities is
to increase the importance and profile of the health inequality agenda.

In publishing relevant data and analysis, the Trust has sought to exercise its functions in accordance with the NHSE statement on health inequalities.

The Trust's role

NHS trusts have a crucial role in addressing health inequalities by providing equitable healthcare, fostering partnerships and acting as anchor institutions. While challenges remain, strategic investment in data, workforce diversity, community engagement and preventative care can help create a more inclusive and fairer healthcare system for all.

In 2024, the Trust board approved the first health inequalities strategy. This set out the Trust's contribution to tackling health inequalities through its role as a care provider, partner and anchor institution.

Over the last year, the Trust has made good progress in implementing the strategy:

- **As a provider**: The Trust has made significant progress in developing the data foundations needed to support targeted intervention on health inequalities. This includes developing the 'Closing the Gap' programme, which uses the social determinants module in our electronic patient record – Epic – to improve data and risk stratification for our patients. Good progress has
  also been made in developing a health inequalities dashboard, and robust evaluation methodology and metrics.
- **As a partner**: Trust representatives make significant contributions to developing and continuing local care partnership forums across Northern and Eastern Devon. The programmes of work, supported through delegated funding
  from the Integrated Care Board to support health inequalities and population health, are proving effective, and some projects have shown a return on investment.
- **As an anchor**: The Trust is embedding an approach to tackling health inequalities across all areas - it is contained within key committee
  terms of reference, quality impact assessments and project mandates.

Health inequalities data

Robust data is essential for understanding our populations and ensuring fair access, positive experiences and better outcomes for all. It supports place-based approaches and population health management techniques, such as Core20Plus5, to narrow the inequality gap. Advances in data collection and analysis are helping us make more informed,

targeted decisions. Five key data sources are used to deliver the health inequalities strategy:

1. Population health data – integrates health and care data to identify at-risk groups, assess health inequalities and guide targeted interventions
2. National data platforms – NHS England's health inequalities dashboard provides Core20Plus5 insights to help trusts analyse and act on disparities
3. Local data – the Trust's Epic electronic patient record (EPR) tracks risk factors and patient demographics, helping prioritise health inequality interventions
4. Partner data – collaborating with police, councils and charities, the Trust uses data on housing, fuel poverty and social issues to better target support
5. Neighbourhood insights – engaging directly with communities helps understand lived experiences and shape inclusive, responsive services.

The Trust is embedding health inequalities data into service planning through:

- Improved data collection – ensuring ethnicity and deprivation data are routinely recorded and used for service improvement
- Health inequalities dashboard – tracking population trends and aligning actions with Core20Plus5 priorities
- Targeted interventions by identifying those impacted, segmenting the population using health and partner data, stratifying and prioritising, and implementing interventions, followed by evaluating the impacts and outcomes.

Health inequalities data in Devon

Health inequalities in Northern and Eastern Devon reflect a complex interplay of socio-economic, environmental and lifestyle factors, leading to disparities in health outcomes among different communities. The key findings from the current Devon joint strategic needs assessment (JSNA) include:

- Life expectancy: While Devon generally enjoys a higher life expectancy compared to national averages, significant variations exist within the county. For instance, men in the most deprived areas of Devon live, on average, 5.4 years fewer than those in the least deprived areas.
- Deprivation: Pockets of deprivation are present in both Northern and Eastern Devon. These areas often experience higher unemployment rates, lower income levels and reduced access to essential services, all contributing to poorer health outcomes.
- Lifestyle factors: Lifestyle choices significantly impact health inequalities.
  - Smoking – North Devon has a notably high prevalence of smoking, with rates approximately double the national average.
  - Obesity – In Devon, particularly in areas like Plymouth, there is a higher rate of overweight adults compared to national figures.
- Mental health: The suicide rate in Devon is 13.0 per 100,000 people – higher than the England average of 10.3 per 100,000. Teignbridge, within Eastern Devon, is among the districts with rates statistically worse than the national average.
- Access to services: Rurality poses challenges in Northern and Eastern Devon, leading to difficulties in accessing healthcare services, public transportation and other essential amenities. This limited access can exacerbate health inequalities, particularly for vulnerable populations.

NHSE statement on information on health inequalities data reporting and analysis

The following section sets out the data and information that the NHSE 'statement on information on health inequalities' requires foundation trusts to publish in their annual report to help understand and improve health access, experience and outcomes.

A. Elective activity recovery: pre-pandemic 2019/20 vs 2023/24 and current activity levels

This data compares the current numbers of patients routinely accessing elective procedures with activity levels from before the pandemic. The levels of activity indicate whether any previous unmet need is now being met, and if provision is being accessed in the same way by everyone.

Comparative elective pre/post-pandemic activity for under 18s and those aged 18 and over

Total numbers

Under 18 years of age	Total	Year-on-year % change	Pre/post-pandemic % change
2019/20	5035	–	–
2023/24	5165	0.58%	
2024/25 forecast*	5640	9.20%	9.83%
18 years and over			
2019/20	134,207	–	–
2023/24	181,161	34.99%	
2024/25 forecast*	194,081	44.61%	7.13%

Source: Royal Devon BI team* - based *on 2024/25 year to date (Apr 24-Feb 25) totals for under-18s=5170, over-18s=177,908 + 1 month of mean activity*

For the under-18 age group, the number of patients accessing elective procedures has increased year on year and is higher than pre-pandemic levels. In the 18 and over patient group, the number of patients accessing elective procedures has continued to rise significantly above pre-pandemic levels. The increase in 2024/25 is consistent with that observed for 2023/24 and demonstrates that the Trust has continued to focus on reducing backlogs in the waiting list.

i. Ethnicity

	Of stated ethnicity		Not stated		
Under 18 years of age	**White British ethnicity**	**All other ethnicities**	**As a % of the total**		**Total**
2019/20	95.24%	4.76%	11.2%		4,562
2023/24	91.11%	8.89%	7.6%		4,770
2024/25 *	91.64%	8.36%	7.7%		5,640
Over 18 years of age					
2019/20	96.62%	3.38%	4.91%		134,207
2023/24	95.61%	4.39%	5.85%		181,161
2024/25 *	95.49%	4.51%	5.93%		194,081

Source: Royal Devon BI team

**Based on 2024/25 year to date (Apr 24-Feb 25) forecast data*

The elective care patient data shows that there are higher percentages of under-18s from a minority ethnic group than in the 18s and over. There was also a shift in the ethnicity demographics pre and post-pandemic for the under-18 patient group observed in 23/24 data, which has been maintained for 2024/25. This corresponds to sustained lower levels of 'not stated', suggesting that ethnicity demographics may not have changed over the observed period and are likely attributable to improved accuracy in data recording. Ethnicity data in the 18 and over years group is relatively stable, although there is a slight increasing trend in the percentage of 'not stated'.

The Trust will continue to monitor and address data completeness as more becomes available. But it is important to note that data for minority ethnic groups in Devon is based upon comparatively smaller groups of patients, which makes data sensitive to small changes.

ii. Index of multiple deprivation (IMD) IMD:

Under 18 years of age

Under 18s		1	2	3	4	5	Uncoded	Total
2019/20	Total	398	1,196	1,718	1,092	693	38	5,135
	%	7.8%	23.3%	33.5%	21.3%	13.5%	0.7%	
2023/24	Total	227	976	1,704	1,332	882	44	5,165
	%	4.4%	18.9%	33.0%	25.8%	17.1%	0.9%	
2024/25 Forecast*	Total	284	1,187	1,717	1,332	1,075	46	5,640
	%	5.0%	21.0%	30.4%	23.6%	19.1%	0.8%	

Source: Trust business intelligence team

**Based on 2024/25 year to date (Apr 24-Feb 25) forecast data*

The under-18 pre and post-pandemic elective data shows a shifting picture in the IMD profiles of patients accessing care. Noting that the number of patients has increased in 2024/25 compared to pre-pandemic levels, the percentage of patients from IMD 1 has improved from 2023/24 but still remains below pre-pandemic levels, which is a reduction in access since 2019/20.

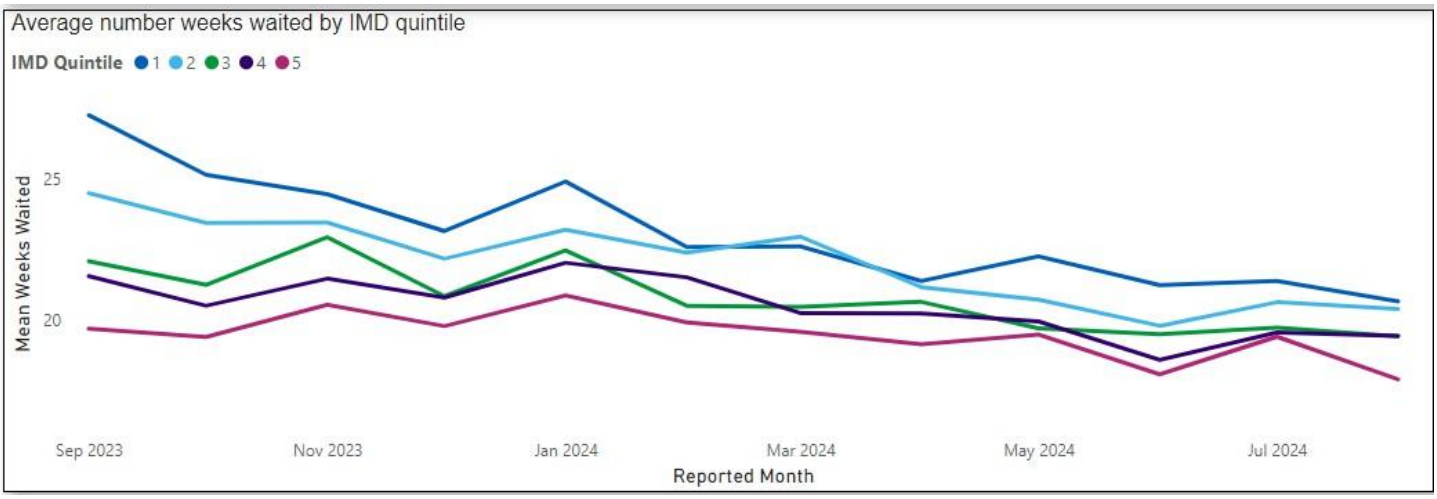
Whilst the data is limited by comparatively small numbers, the largest post-pandemic percentage increases are still being observed in IMD4 and IMD5 patients, albeit with a year-on-year increase in the IMD 1 cohort. Factors affecting recovery are complex and potentially impacted by many underlying variables, and further analysis will be undertaken to ensure equal access for children.

IMD: 18 and over

Aged 18 and over		1	2	3	4	5	Uncoded	Total
2019/20	Total	6,534	30,930	42,826	30,213	21,720	1,984	134,207
	%	4.9%	23.0%	31.9%	22.5%	16.2%	1.5%	
2023/24	Total	11,718	43,209	56,406	40,810	25,703	3,315	181,161
	%	6.5%	23.9%	31.1%	22.5%	14.2%	1.8%	
2024/25 Forecast	Total	12,176	46,105	60,334	43,366	28,478	3,623	194,081
	%	6.3%	23.8%	31.1%	22.3%	14.7%	1.9%	

The IMD1 profile for patients aged 18 and over shows an increase of 6,182 additional patients (nearly doubling the absolute number), meaning a significantly larger share of the IMD1 adult population received elective treatment in 2024/25 compared to five years earlier. The increase is encouraging and appears both statistically and practically significant.

Trust average all waits by IMD



For reference, Trust data for Q3 24/25 shows that all quintiles show a general downward trend in waiting times over the period, reflecting improvements in elective care recovery. It is encouraging to see a significant reduction and improving trend in wait times for those in the lowest IMDs, although despite a narrowing of the gap, they still see higher waiting times on average than the less deprived IMD groups.

B. Emergency admissions for under-18s i

Emergency admissions by ethnicity

Under 18 years of age	White British ethnicity	All other ethnicity	Not stated	Total emergency admissions
2023/24	85%	15%	4%	**8,635**
2024/25 Forecast	86%	14%	5%	**8,204**

Ii Emergency admissions by IMD

Under 18 years of age		1	2	3	4	5	Uncoded	Total
2023/24	**Total**	439	1,774	2,727	2,203	1,437	55	8,635
	%	5.1%	20.5%	31.6%	25.5%	16.6%	0.6%	
2024/25 Forecast*	**Total**	407	1,769	2,641	2,045	1,293	48	8,204
	%	5.0%	21.6%	32.2%	24.9%	15.8%	0.6%	

The emergency admission data for both ethnicity and IMD is relatively stable over the period covered.

C. Smoking cessation in secondary care: acute and maternity settings

Reducing smoking is key to tackling health inequalities. Smoking is a leading cause of preventable death, with over 64,000 dying annually in England and causing serious illness in many more. Two-thirds of smokers will die from smoking-related diseases (NHS England, 2021). Smoking during pregnancy is the main preventable risk to unborn babies, increasing the risk of miscarriage, low birth weight and neonatal death (NCSCT, 2019). The NHS prioritises tobacco dependency treatment as a critical intervention to prevent avoidable illness.

The Trust has been implementing tobacco treatment pathways since 2022/23 and now has fully established treatment pathways in place. These offer a smoking cessation intervention to all acute inpatients and pregnant women in both the Northern and Eastern Trust sites.

Similar to many other trusts, data reporting remains a challenge, but in 2024/25 the Trust has strengthened existing pathways. And alongside Devon County Council's public health team, it has been exploring approaches to extend the existing pathways to outpatients as well as enhancing the existing maternity offer beyond the support delivered under the national pathway. National evidence shows that the existing maternity support offer is not yet fully meeting the needs of pregnant smokers from more deprived communities where smoking rates are higher, and the Trust is aiming to innovate new and effective additional interventions to help address this. The aim is to integrate a more personalised care approach alongside planned National Smokefree Generation initiatives in 2025/26.

D. Tooth extractions due to decay for children aged 10 years and under admitted as inpatients to hospital (number of admissions, not number of teeth extracted)

Tooth decay is the most common, yet largely preventable, oral disease among children in England (OHID, 2023). In 2019, nearly one in four five-year-olds had tooth decay, affecting three to four teeth on average (NDEP, 2019). Among three-year-olds, 11% had visible decay, often early in life. While 77% of five-year-olds are free of obvious decay, children in the most deprived areas experience more than double the rate compared to the least deprived. Nearly 90% of hospital tooth extractions in children aged up to five are due to preventable decay, and tooth extraction remains the most common hospital procedure for six to 10-year-olds (up to 2019).

The table below shows the number of children aged 10 and under admitted to hospital for tooth decay (dental caries), measured as the number of admissions (finished consultant episodes or FCEs) per 100,000 children. These hospital admissions often involve tooth extractions under a general anaesthetic and are largely preventable with good oral hygiene and access to regular dental care.

In 2019, the way this data was recorded was updated to match the coding used by Public Health England. This included some additional diagnosis codes (from group K04) and removed some from group K02 that wouldn't normally lead to a tooth extraction. Because the age ranges differ, this indicator is not directly comparable with the Public Health England tooth extraction data. Please note that this data counts admissions, not the number of teeth removed.

Rate of Trust admission per 100,000 for children aged 10 and under

Under 18s		1	2	3	4	5	Total
England rates (2020/21)	**Total**	329	230	167	135	95	201
2023/24*	**Total**	310	420	180	120	90	210
2024/25 Forecast*	**Total**	140	100	150	110	40	110

Local SUS - North and East APC (Inpatients).

Admissions for tooth extractions and IMD

Because the number of admissions in some deprivation groups is very low (fewer than eight children), the figures have been rounded to the nearest 10 to protect privacy. This means small changes in the number of cases can have a big effect on the reported rate. As a result, we advise caution when interpreting trends by deprivation level, as the numbers are too small to draw reliable conclusions.

Admissions for tooth extractions and ethnicity

The number of children admitted to hospital for tooth extractions is very low across most ethnic groups.
In many cases, fewer than eight children from each group were admitted, which means a single case could significantly affect the data. There is also a risk that publishing this information could identify individual patients.

Because of this, the Trust is not able to publish tooth extraction data by ethnicity. However, the Trust recommends that this data should be looked and addressed at integrated care board (ICB) level.

[1] Admissions are counted where children had a relevant diagnosis of tooth decay and underwent a dental procedure (e.g. F09 or F10 procedure codes with diagnosis codes K021, K025, K028, K029, K040, K045, K046 or K047), following national NHS guidance.

Population data is based on ONS estimates (2019–22) for East Devon, Exeter, Mid Devon, North Devon and Torridge, covering children aged 10 and under.