

# Understanding healthcare inequalities in BNSSG

**2025 Annual Report –  
Interim**



# Understanding healthcare inequalities in BNSSG 2025.

Welcome to the presentation on "Understanding Healthcare Inequalities in BNSSG 2025."

This annual report aims to shed light on the disparities in healthcare access and outcomes within the Bristol, North Somerset, and South Gloucestershire (BNSSG) region.

Our goal is to provide a comprehensive overview of the current state of healthcare inequalities, identify key areas of concern, and highlight the steps being taken to address these issues.

Throughout this presentation, we will explore various domains of healthcare, including elective recovery, urgent and emergency care, cancer, mental health, maternity and neonatal care, learning disabilities and autism, and conditions such as respiratory, cardiovascular disease, diabetes, and oral health. We will examine how factors such as deprivation, ethnicity, and demographic characteristics influence healthcare usage and outcomes in our community.

By understanding the root causes and extent of these inequalities, we can work together to develop targeted interventions and policies that promote equity and improve the health and well-being of all residents in BNSSG.

Dr Joanne Medhurst CMO BNSSG ICB August 25

# Definitions, methodology, and limitations

## Definitions

- IMD = Index of Multiple Deprivation, a measure of deprivation based on where people live. The UK population is grouped into fifths (quintiles), with quintile 1 being the most deprived, and quintile 5 the least deprived. For this report, we have then grouped the BNSSG population into 5 local quintiles, to adjust for the difference between the deprivation of the population nationally and the specific makeup of the BNSSG population.
- Ethnicity groups = a list of ethnic groups commonly used when collecting and collating data <https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups/>

## Methodologies used

- Rates per 1000 of the population – volumes are controlled for the number of people in the population in each group
- Age and sex standardised rates – in addition to controlling for the number of people, this approach also controls for the variation in age and sex within these groups which are known contributors to healthcare usage and outcomes.
- Absolute values – no adjustments are made for population size, age, sex, or any other factor

## Limitations

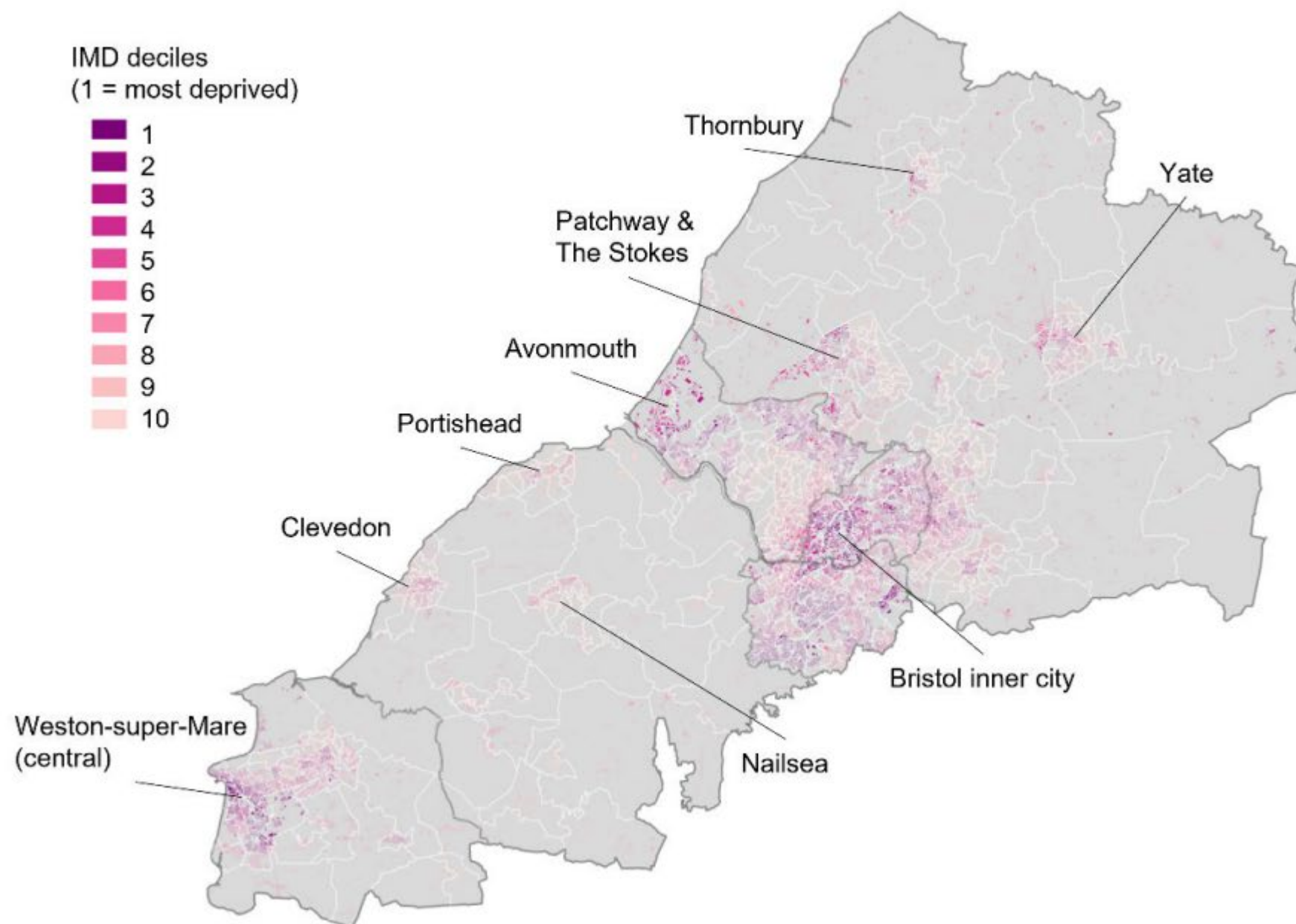
- The following analysis is a high-level aggregation, presented in line with national requirements. This set of indicators alone does not always appropriately represent the complexity of our healthcare system and characteristics of our population. These initial interpretations are based on the data presented and in many cases more detailed analysis of factors indicating health need across BNSSG population would enable more understanding of significance of findings in these charts. This analysis is intended to provide an initial high-level view to prompt further review and analysis.

Additionally, there are other demographic characteristics, such as first spoken language and disability that are known significant factors influencing people's use and experience of healthcare, but we do not currently have sufficient data to be able to report on these.

The available data includes large numbers of records without an ethnicity code recorded. This limits the usefulness of some of the analysis as significant numbers of the population will not be included in the analysis. A programme of work is underway to improve this position.

# How deprivation clusters in BNSSG

This map and the choice of labels was designed to show the natural geography of our 'patch' - deprivation by Index of Multiple Deprivation (IMD) national deciles (1 = most deprived - darker shading), by lower super output areas (LSOAs). LSOAs (white outlines) contain on average 1,500 people. Shading indicates where people actually live (buildings). Locality borders in grey.<sup>[15]</sup>





# Around one million people live across BNSSG

AROUND ONE MILLION PEOPLE  
LIVE ACROSS BNSSG

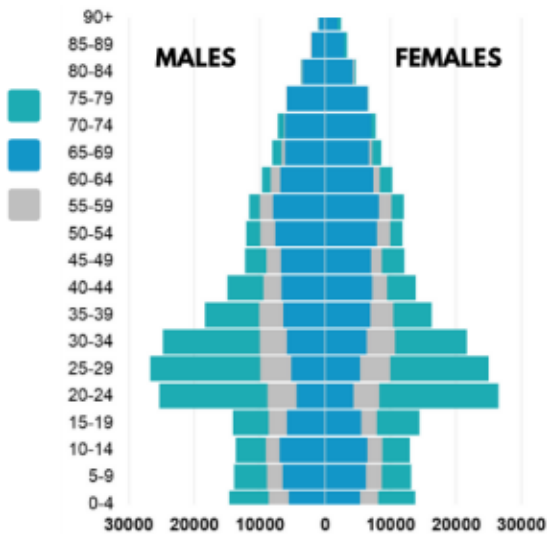
1 ICS

3 Places

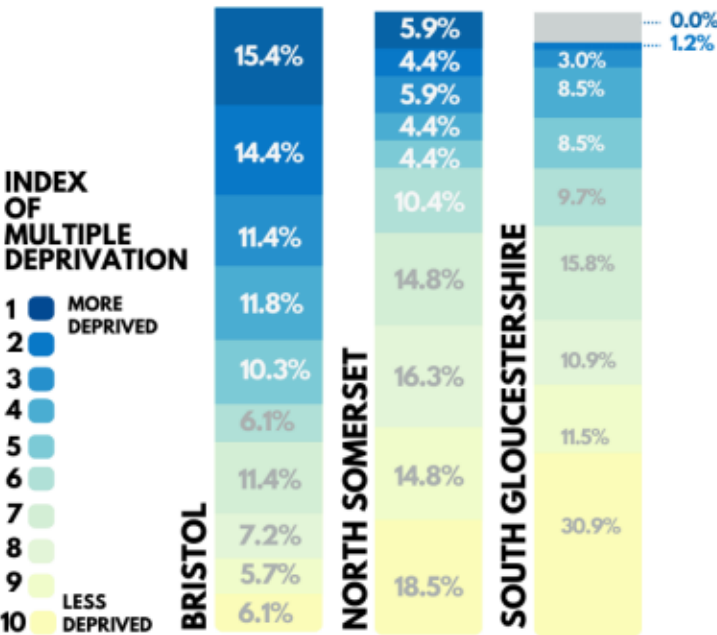
6 Localities

THE POPULATION IN BRISTOL IS YOUNGER WITH  
AN AVERAGE AGE OF 30 COMPARED TO 46 IN  
NORTH SOMERSET AND 40 IN SOUTH  
GLOUCESTERSHIRE

BRISTOL  
NORTH SOMERSET  
SOUTH GLOUCESTERSHIRE



THERE ARE WIDE VARIATIONS IN  
DEPRIVATION



BLACK AND MINORITY  
ETHNIC GROUPS

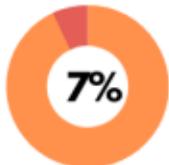
BRISTOL



NORTH  
SOMERSET



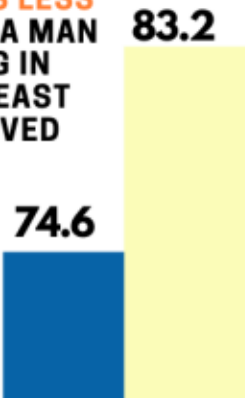
SOUTH  
GLOUCESTERSHIRE



THERE ARE LARGE DIFFERENCES IN LIFE  
EXPECTANCY BETWEEN THE MORE  
DEPRIVED AND LESS DEPRIVED AREAS

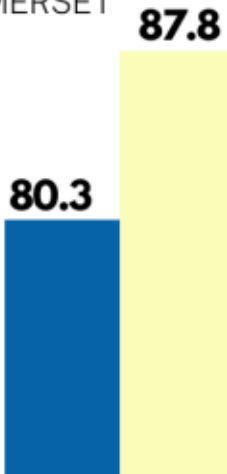
A MAN LIVING IN THE  
MOST DEPRIVED  
AREA OF BRISTOL

LIVES 9.9  
YEARS LESS  
THAN A MAN  
LIVING IN  
THE LEAST  
DEPRIVED  
AREA



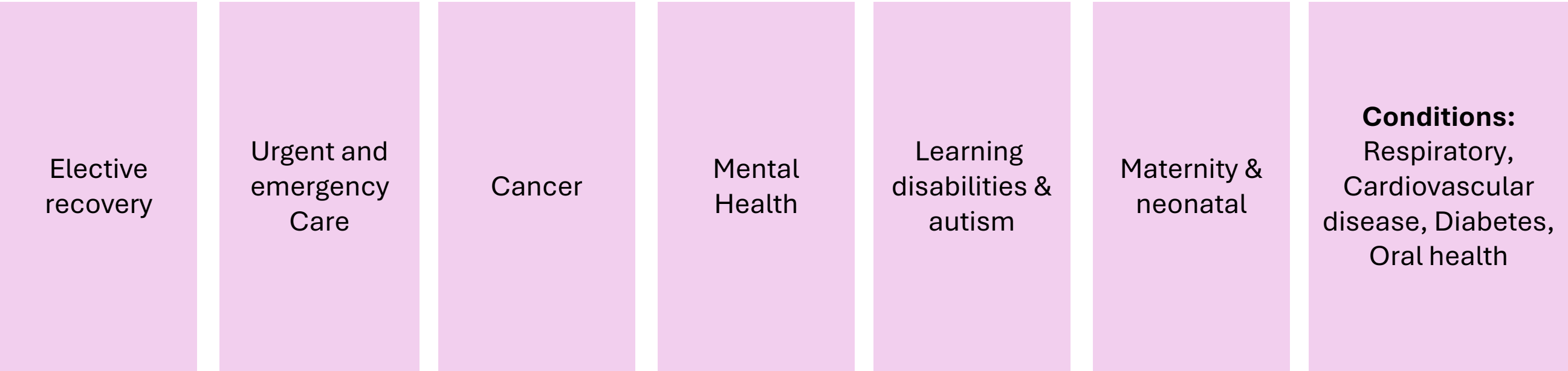
A WOMAN LIVING IN  
THE MOST  
DEPRIVED AREA OF  
NORTH SOMERSET

LIVES 7.9  
YEARS LESS  
THAN A  
WOMAN  
LIVING IN  
THE LEAST  
DEPRIVED  
AREA



## Healthcare domains

A selection of metrics grouped into the following domains



## Demographic characteristics

The above metrics are analysed by these population characteristics



## Healthcare domains

**Urgent and  
emergency  
Care**

Elective  
recovery

Cancer

Mental  
Health

Learning  
disabilities &  
autism

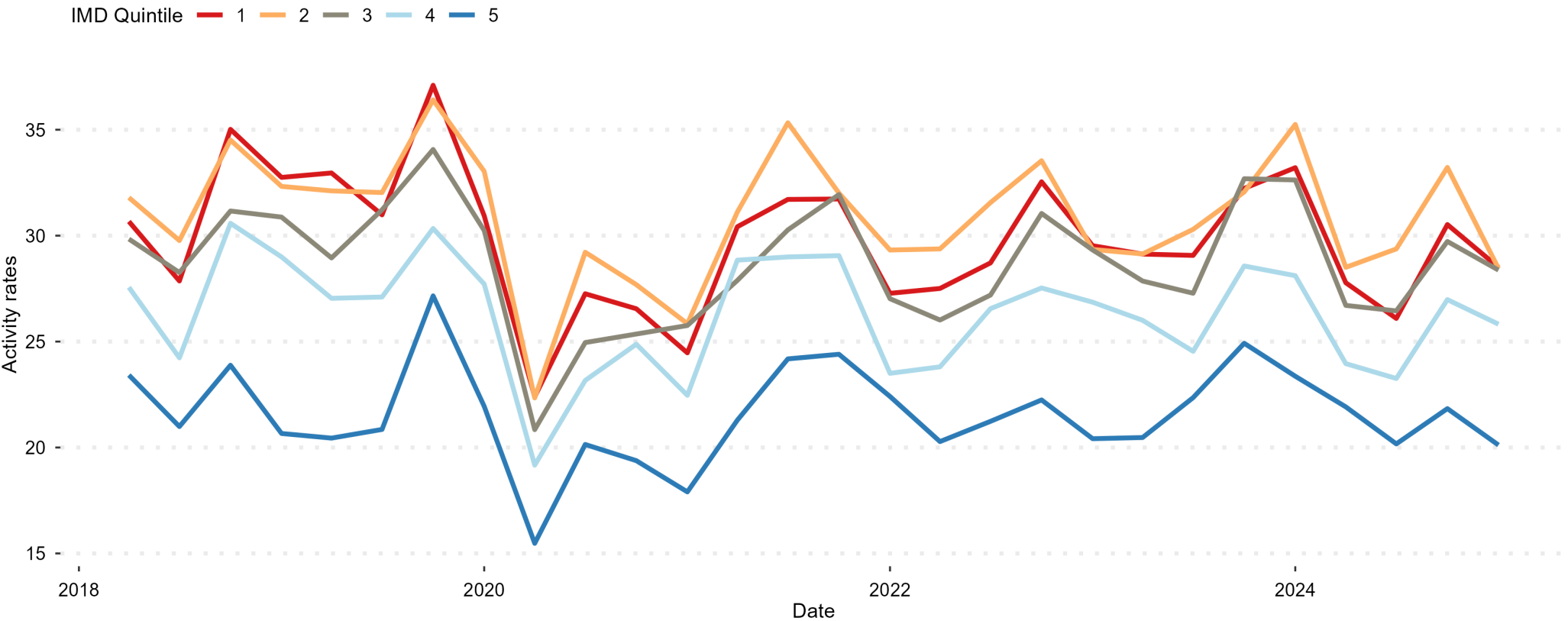
Maternity &  
neonatal

**Conditions:**  
Respiratory,  
Cardiovascular  
disease, Diabetes,  
Oral health

# Domain 1: Urgent & Emergency Care

## Emergency hospital admissions for children by IMD quintile

Quarterly rates per 1000 of the population



Source: Secondary use services. April 2018 to March 2025

### Why are we looking at this?

Approximately 35% of all admissions in the NHS in England are classified as emergency admissions. Admitting a patient to hospital as an emergency case is sometimes preventable, yet the number of emergency admissions to hospital has been rising for some time. Emergency admissions data gives an indication of wider determinants of poor health, linked to issues such as housing and transport<sup>1</sup>.

### What does the chart tell us?

Emergency hospital admissions are lower among children living in our least deprived areas (IMD5 and 4 ) compared with children in other parts. The most deprived areas (IMD1) tend to have the highest rates of emergency hospital admissions. There has been no change in this gap by deprivation in recent years.

Children and young people from our more deprived areas are more likely to have emergency hospital admission than those from our least deprived areas. The reasons behind this are complex and influenced by other factors as well as overall health for example, access to health services outside of hospital.

### What are we doing?

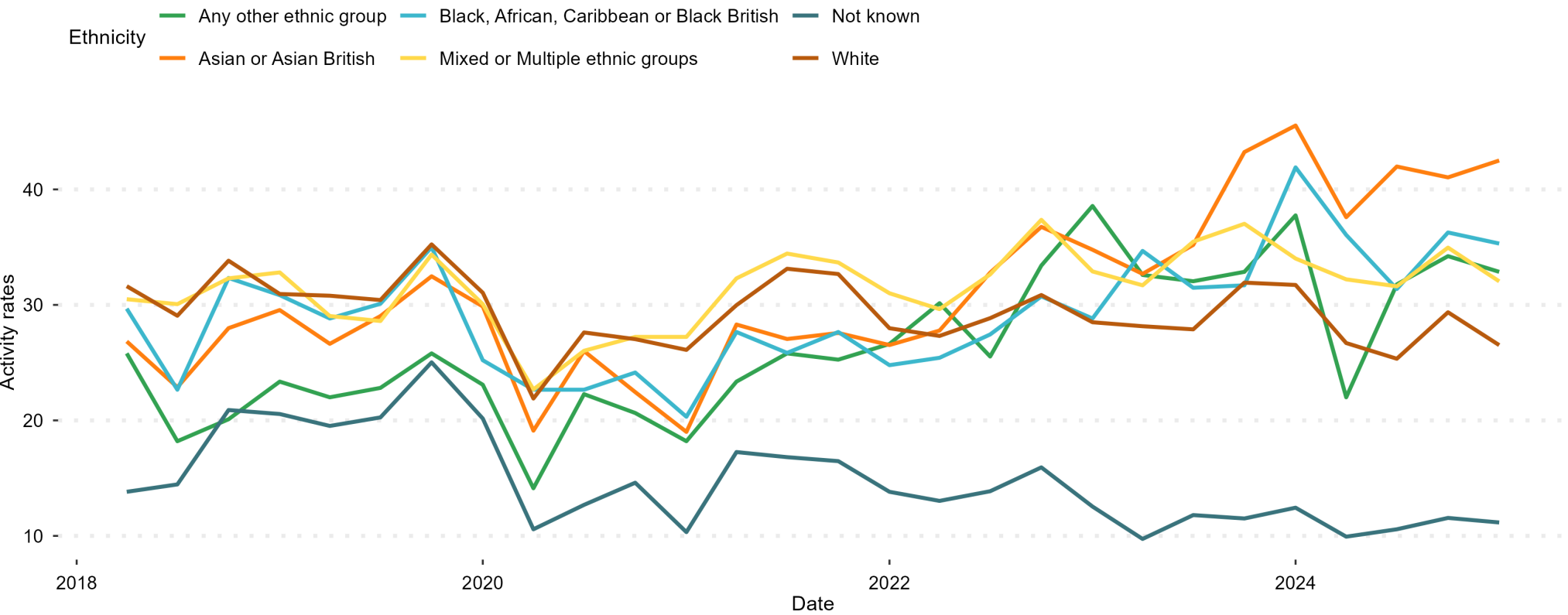
**Data source:** Secondary Use Services (SUS)  
**Date range:** April 2018 to March 2025

**Definition:** The number of times a child (0-17) has been admitted to an acute hospital bed, per 1000 of the population  
**IMD:** A measure of deprivation based on a person's postcode, 1 = most deprived fifth (quintile) of the population



## Emergency hospital admissions for children by ethnicity

Quarterly rates per 1000 of the population



Source: Secondary use services. April 2019 to March 2025

### Why are we looking at this?

Approximately 35% of all admissions in the NHS in England are classified as emergency admissions. Admitting a patient to hospital as an emergency case is sometimes preventable, yet the number of emergency admissions to hospital has been rising for some time. Emergency admissions data gives an indication of wider determinants of poor health, linked to issues such as housing and transport.

There are variations in healthcare use by population group and by domains of inequality such as socioeconomic deprivation.

### What does the chart tell us?

Emergency admission rates for children are highest in Asian/ Asian British and Black, African, Caribbean or Black British ethnic groups. They are lowest in the white group ( apart from the not known category). There has been a reduction in ‘not known’ ethnicity, which may indicate improvements in recording of data. The differences between ethnic groups seem to be getting bigger, and overall rates for hospital admissions are increasing.

The gaps between different groups have widened compared to before the Covid-19 pandemic. Overall rates are increasing.

### What are we doing?

**Data source:** Secondary Use Services (SUS)  
**Date range:** April 2018 to March 2025

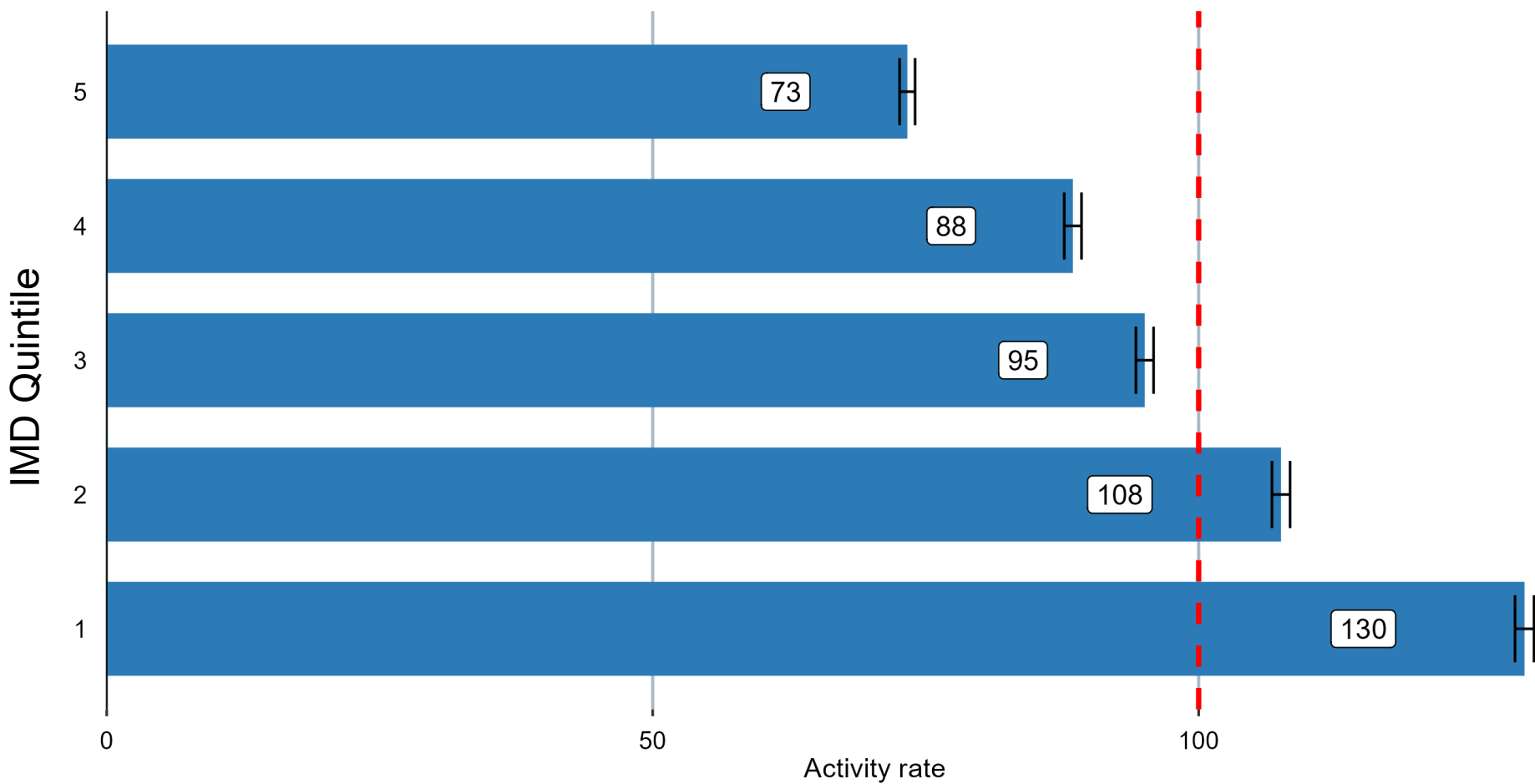
**Definition:** The number of times a child (0-17) has been admitted to an acute hospital bed, per 1000 of the population

# Domain 1: Urgent & Emergency Care

## A&E activity by IMD Quintile

Age and sex standardised activity rates (100 = the BNSSG average),

Is the variance statistically significant? ■ Yes



### Why are we looking at this?

People living in more deprived areas tend to be in poorer health and have a higher number of deaths per 100,000 people per year<sup>2</sup>. They are more likely to get help or care later, spend longer on waiting lists and have poorer health outcomes overall<sup>3</sup>. They are also more likely to attend A&E for conditions classed as not severe or urgent<sup>5</sup>. An Office for National Statistics analysis found that there is evidence to suggest this may be related to people having trouble getting appointments or services from their general practice<sup>4</sup>.

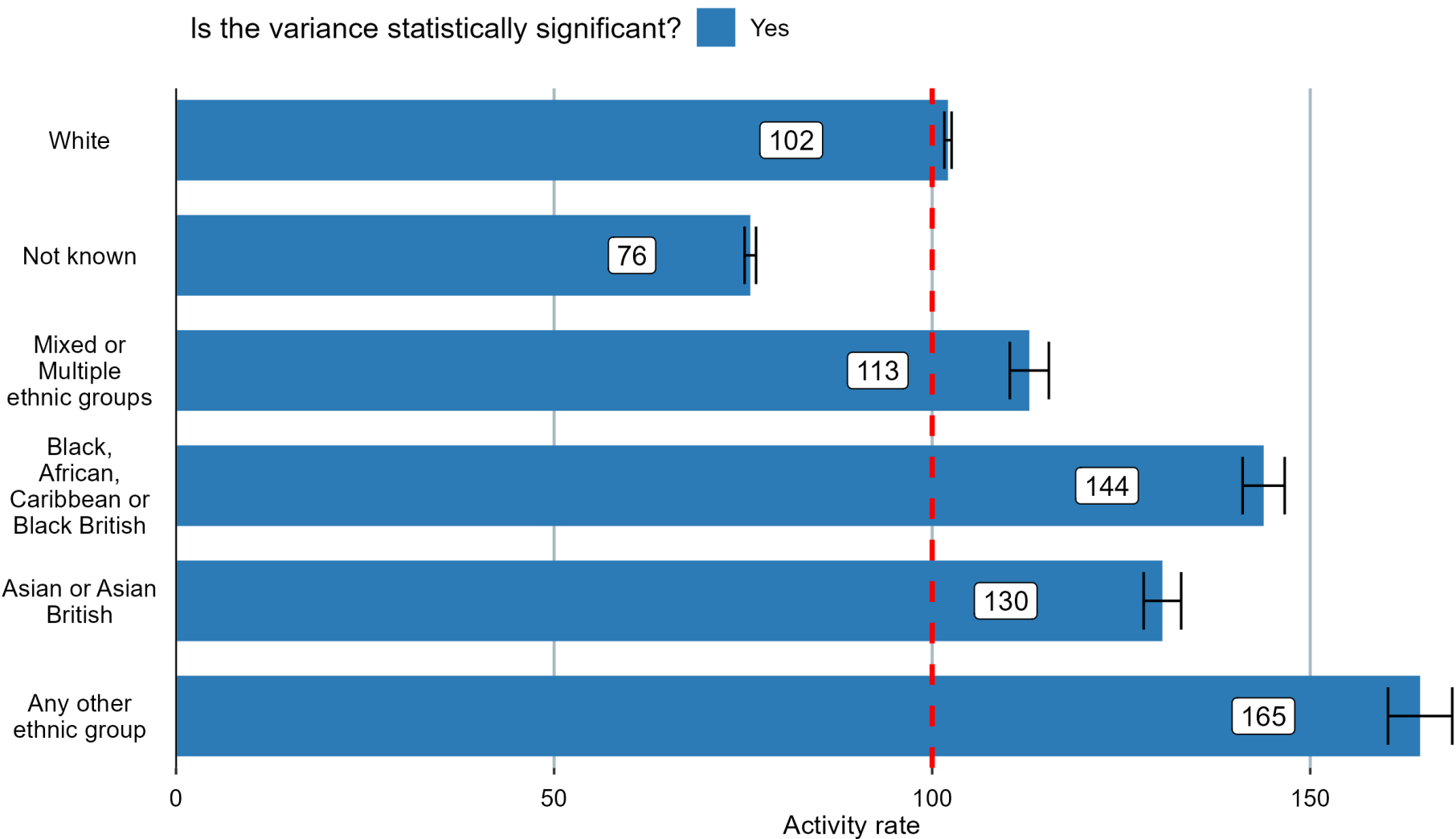
### What does the chart tell us?

Adults living in the most deprived areas (IMD1) are 1.3 times more likely to attend A&E compared to the overall BNSSG population and are almost twice as likely to attend A&E compared to the least deprived areas (IMD5). There is a clear pattern of higher A&E attendance rates with higher deprivation.

### What are we doing?

## A&E activity by Ethnicity group

Age and sex standardised activity rates (100 = the BNSSG average),



**Why are we looking at this?**  
There are variations in healthcare use by population group and by domains of inequality including by deprivation and across different ethnicity groups.

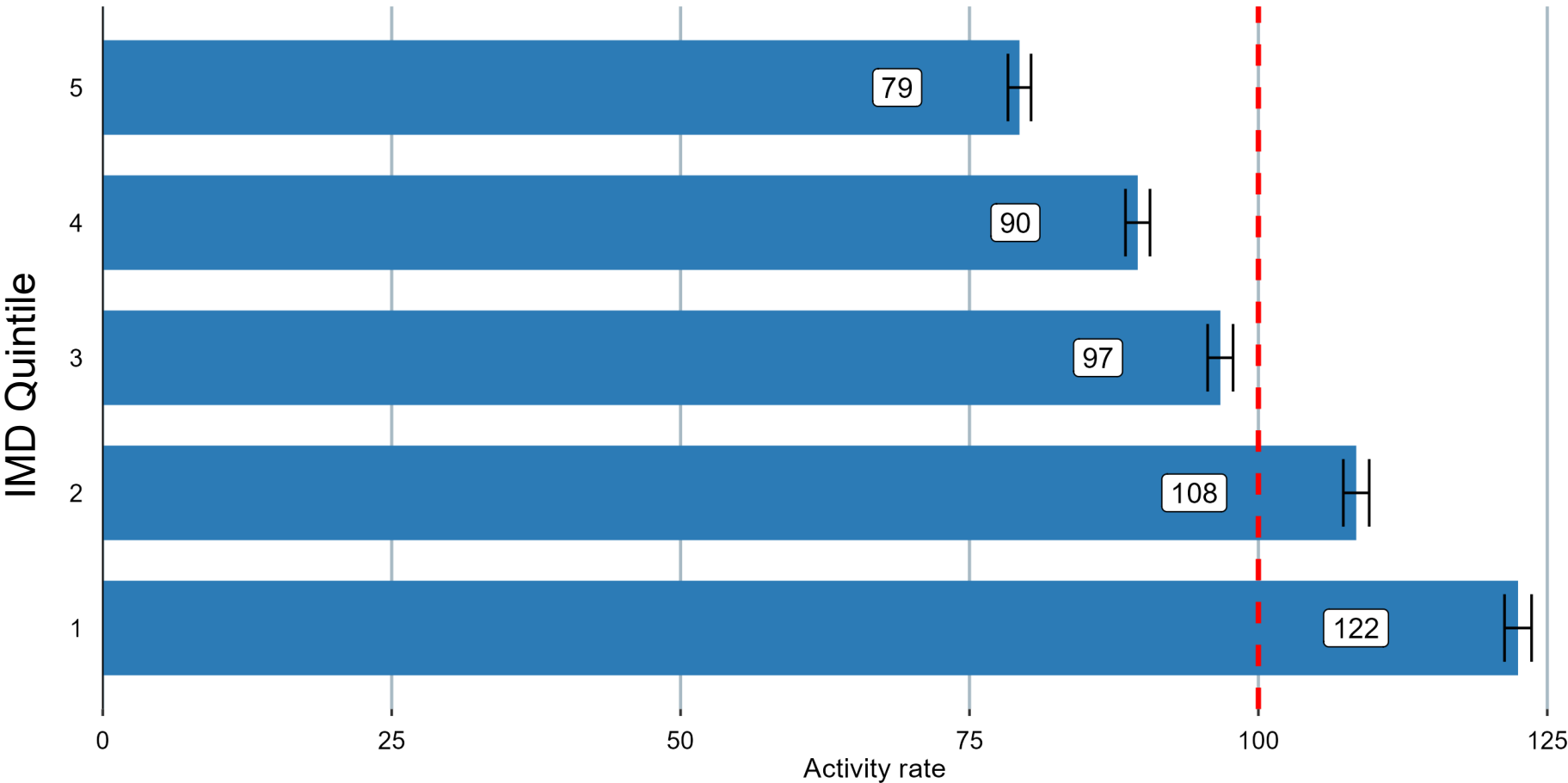
**What does the chart tell us?**  
Adults in the white ethnic groups (or where ethnicity is not recorded) have significantly lower A&E attendance rates than those from all other ethnic groups.

**What are we doing?**

## Emergency admissions by IMD Quintile

Age and sex standardised activity rates (100 = the BNSSG average),

Is the variance statistically significant? ■ Yes



### Why are we looking at this?

Approximately 35% of all admissions in the NHS in England are classified as emergency admissions. Admitting a patient to hospital as an emergency case is sometimes preventable, yet the number of emergency admissions to hospital has been rising for some time. There are variations in healthcare use between groups and communities across our population, including between broad ethnic groups. Emergency admissions data gives an indication of wider determinants of poor health, linked to issues such as housing and transport<sup>1</sup>.

### What does the chart tell us?

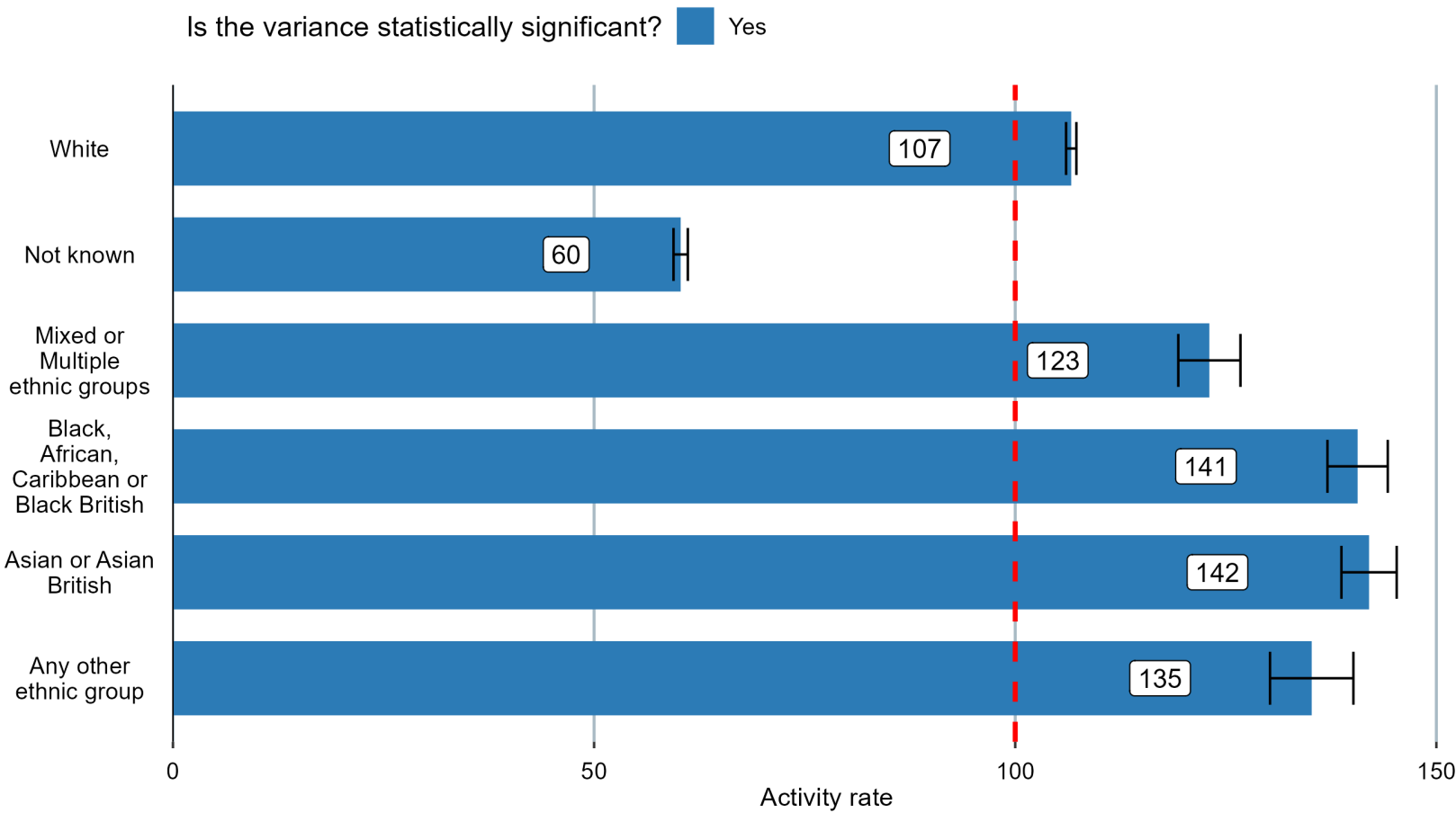
Adults living in the most deprived areas (IMD1) are significantly more likely to have an emergency hospital admission in comparison to others in our population.

People living in the least deprived areas (IMD5) are significantly less likely to have an emergency admission. There is a clear pattern of higher emergency admission rates from areas of higher deprivation.

### What are we doing?

## Emergency admissions by ethnicity

Age and sex standardised activity rates (100 = the BNSSG average),



### Why are we looking at this?

Approximately 35% of all admissions in the NHS in England are classified as emergency admissions. Admitting a patient to hospital as an emergency case is sometimes preventable, yet the number of emergency admissions to hospital has been rising for some time. There are variations in healthcare use between groups and communities across our population, including between broad ethnic groups.

### What does the chart tell us?

Emergency admission rates are significantly lower for the white ethnic group (and the group where ethnicity is not recorded) than for all the other ethnic groups.

### What are we doing?



## Healthcare domains

**Elective  
recovery**

Urgent and  
emergency  
Care

Cancer

Mental  
Health

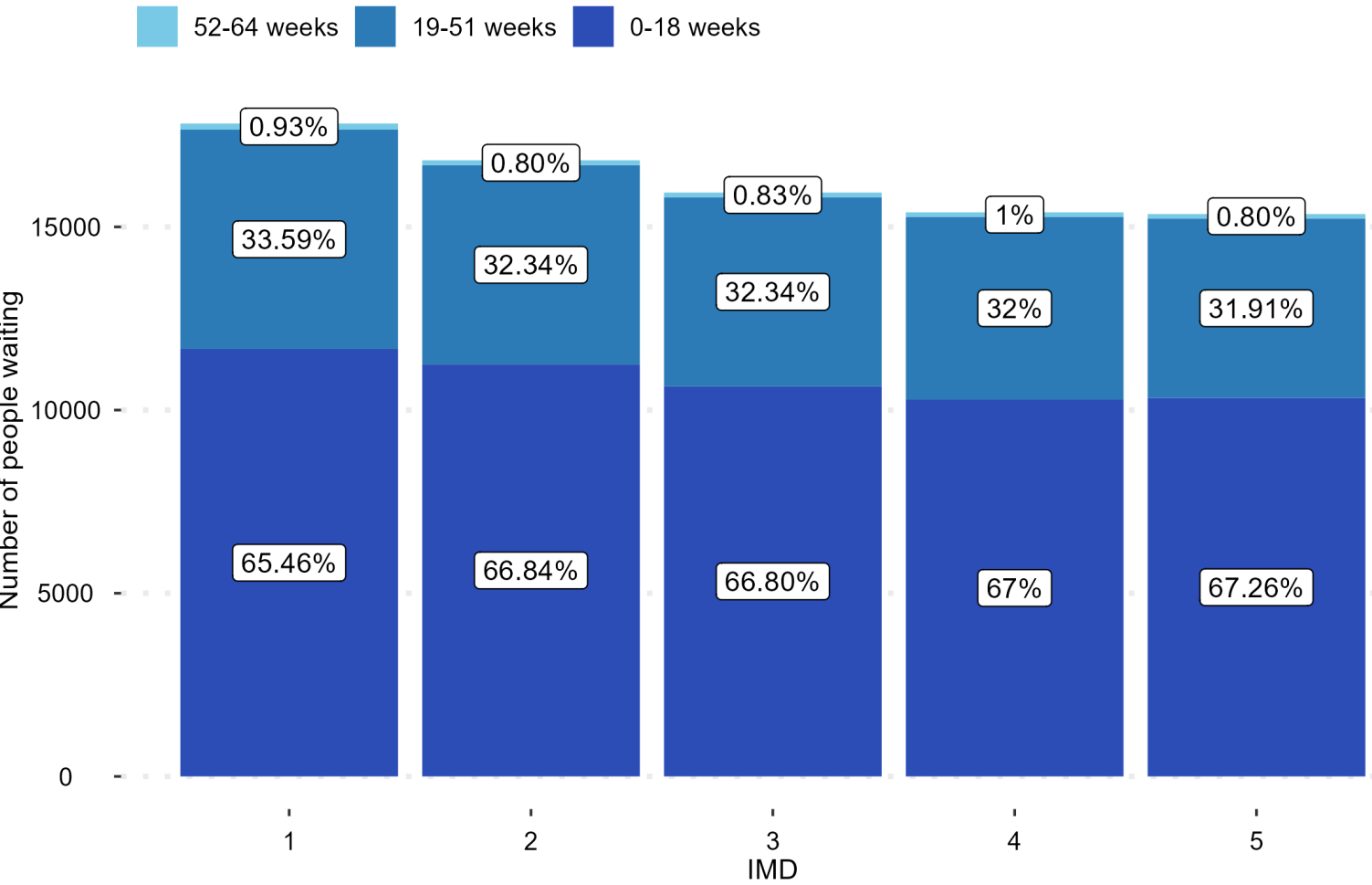
Learning  
disabilities &  
autism

Maternity &  
neonatal

**Conditions:**  
Respiratory,  
Cardiovascular  
disease, Diabetes,  
Oral health

## Size and shape of the elective waiting list by IMD quintile

Number of waiters and percentage split by waiting time



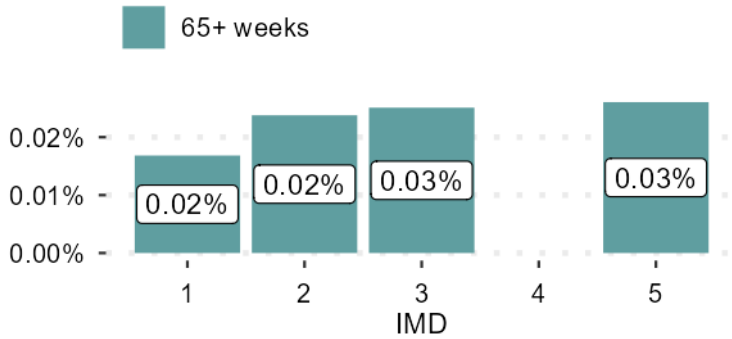
### Why are we looking at this?

We know that there is a strong relationship between deprivation and waiting times. National data shows that people who live in the most deprived areas are twice as likely to wait more than a year for treatment compared to people living in the least deprived areas, which has been exacerbated by COVID-19 pandemic<sup>6</sup>. There may be a number of structural, economic and social factors that can lead to inequalities in elective waiting lists, including challenges in attending appointments, difficulty navigating the NHS, entering the waiting list at different health states, deteriorating more rapidly and individual circumstances such as work or caring responsibilities<sup>27</sup>.

### What does the chart tell us?

The charts show that there are more people waiting for planned hospital treatment in the most deprived areas (IMD1&2). The proportion of those on the witing list in each quintile that are waiting longer than 18 weeks is slightly higher in the most deprived quintile.

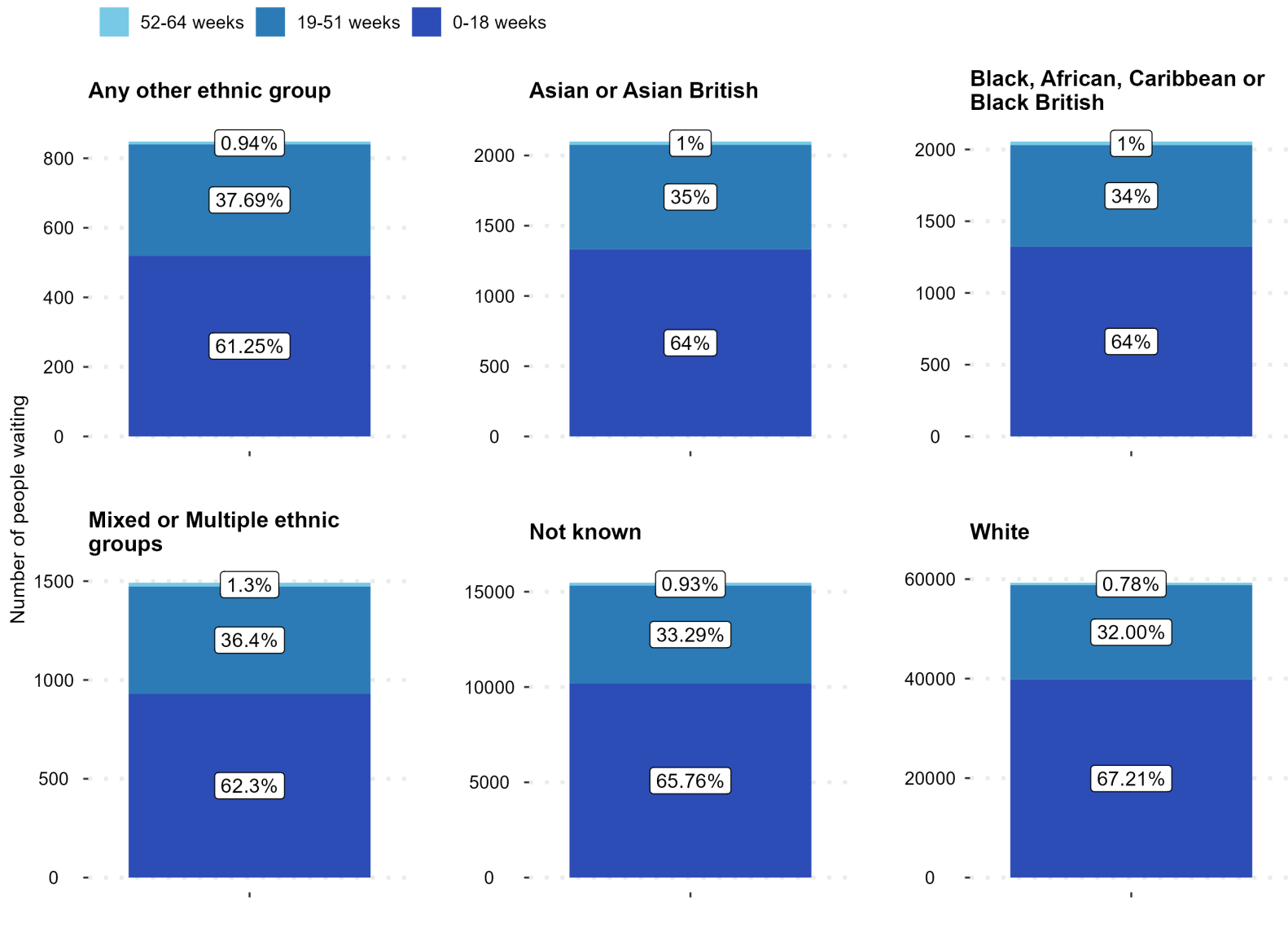
### What are we doing?



# Domain 2: Elective recovery

## Size and shape of the elective waiting list by ethnicity group

Number of waiters and percentage split by waiting time



### Why are we looking at this?

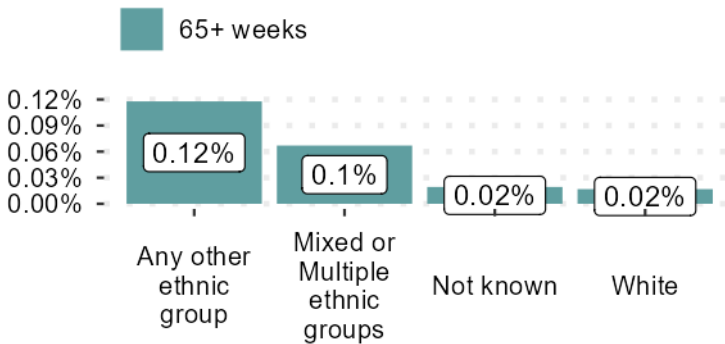
Evidence shows that the impact of the COVID-19 pandemic on the elective waiting list was not felt equally across different ethnic groups. There are many reasons why access to elective care may have varied between ethnic groups during the pandemic. Ethnic differences may reflect demand factors (such as the level of need or changes in health care-seeking behaviour) or supply factors (such as pressure on services), but the extent to which this is the case is unclear. The drivers for differences may also be related to the effects of factors such as deprivation, occupation and geography, rather than primarily ethnicity<sup>7</sup>.

### What does the chart tell us?

The charts show that waiting times across ethnic groups are broadly similar when looking at proportions in each waiting time group. The exception to this is that the proportion of people waiting 65+ weeks is much higher in the Mixed or Multiple ethnic groups and Other ethnic groups.

( It should be noted that numbers waiting over 65 weeks are much smaller, which limits confidence as to whether the differences seen are significant).

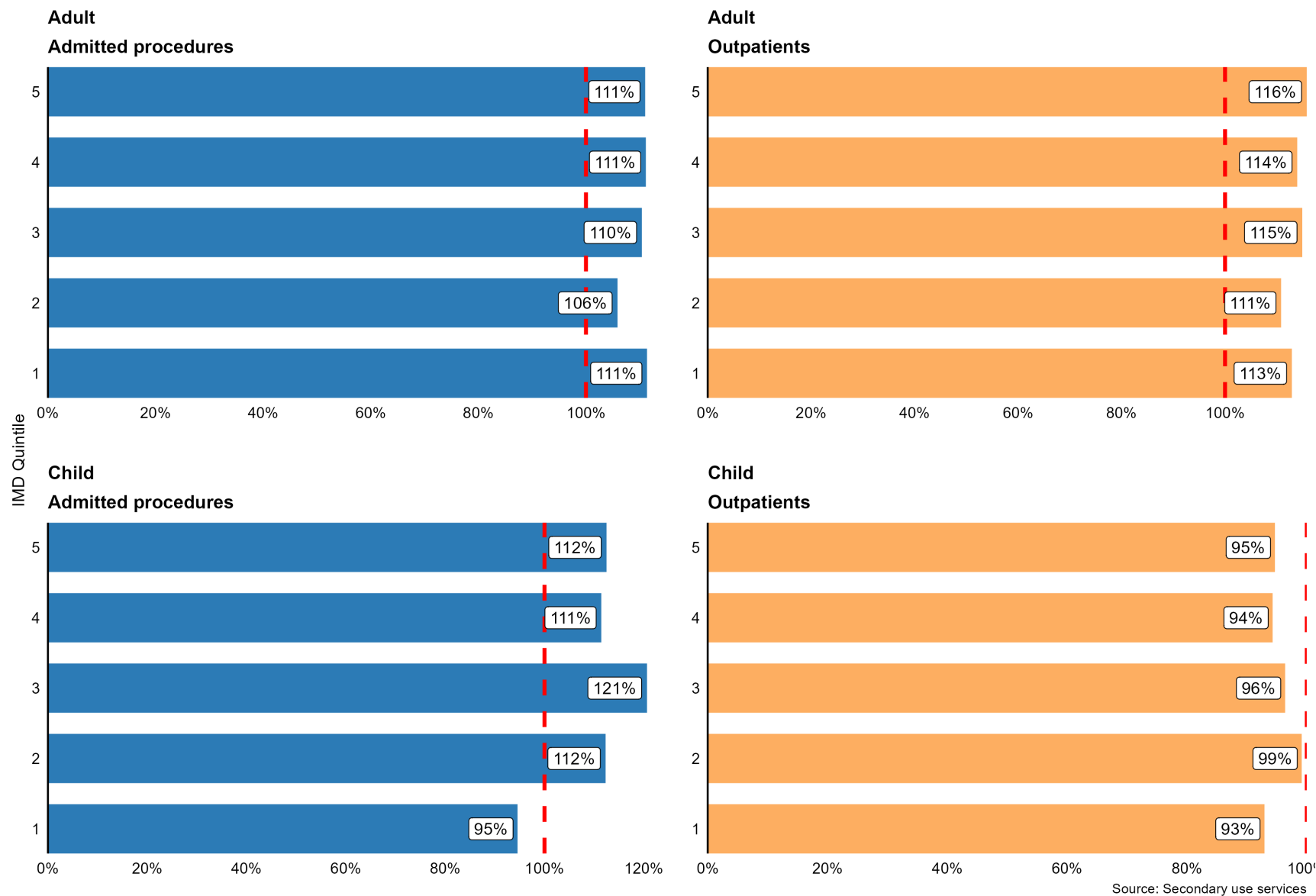
### What are we doing?



# Domain 2: Elective recovery

## Recovery of elective activity rates since Covid lockdowns by IMD Quintile

2024/25 activity volumes as a percentage of 2018/19 volumes



### Why are we looking at this?

Post pandemic there were long waiting times for elective care and the NHS set up a three year elective recovery plan to reduce waiting times<sup>27</sup>. A key objective for the NHS in 2023/24 was to recover elective activity levels to above those seen in the pre-COVID period, to address the growing elective care waiting list<sup>8</sup>.

### What does the chart tell us?

These charts show that for adults, recovery in elective rates for admitted procedures and for outpatients has been broadly similar across the deprivation quintiles. All quintiles show an increase in activity compared with 2019.

For children, outpatient activity remains below pre-pandemic levels. For admitted procedures, recovery has been noticeably slower in the most deprived quintile.

### What are we doing?

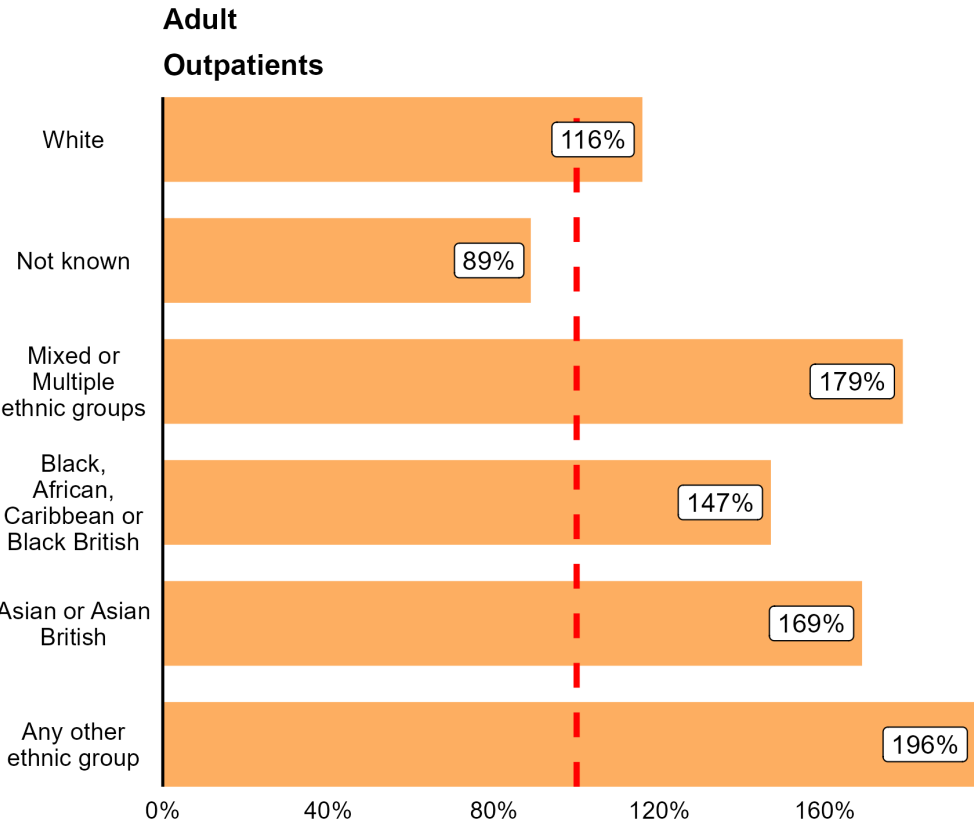
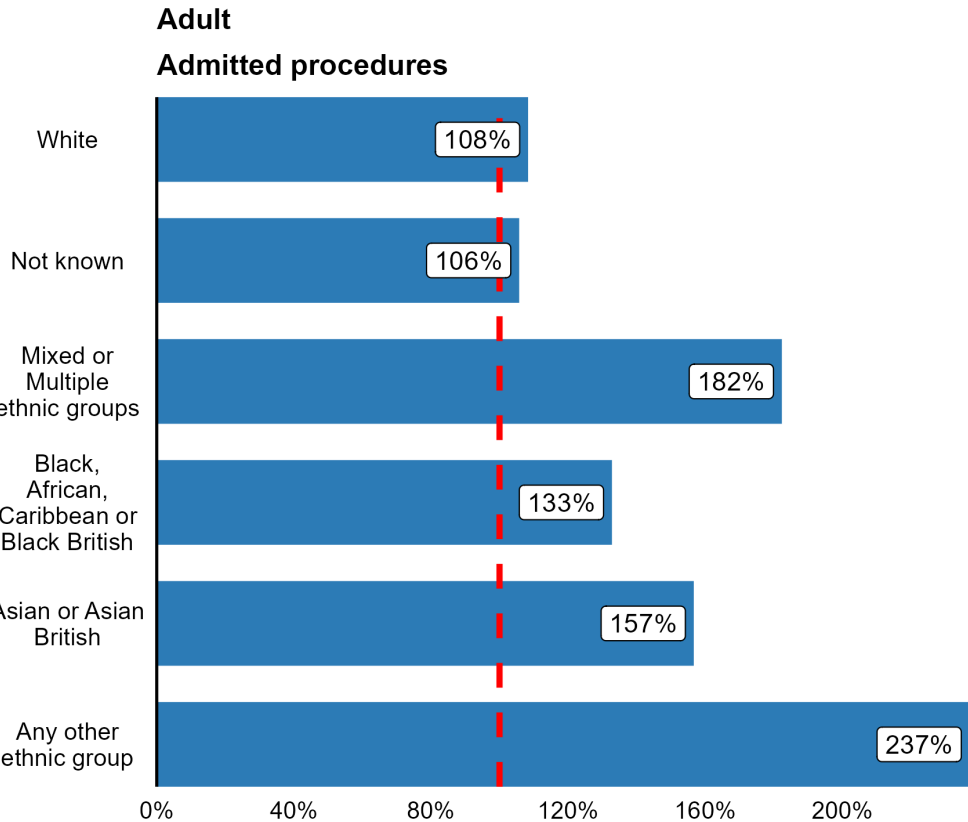
**Data source:** Secondary Use Services (SUS)  
**Date range:** April 2018 – March 2025

**Definition:** BNSSG Volumes of elective hospital activity  
**IMD:** A measure of deprivation based on a person's postcode, 1 = most deprived quintile of the population

# Domain 2: Elective recovery - Adults

Recovery of elective activity rates since Covid lockdowns by ethnicity group

2024/25 activity volumes as a percentage of 2018/19 volumes



**Why are we looking at this?**

Evidence shows that the impact of the COVID-19 pandemic on the elective waiting list was not felt equally across different ethnic groups.

There are many reasons why access to elective care may have varied between ethnic groups during the pandemic. Ethnic differences may reflect demand factors (such as the level of need or changes in health care-seeking behaviour) or supply factors (such as pressure on services), but the extent to which this is the case is unclear. The drivers for differences may also be related to the effects of factors such as deprivation, occupation and geography, rather than primarily ethnicity<sup>7</sup>.

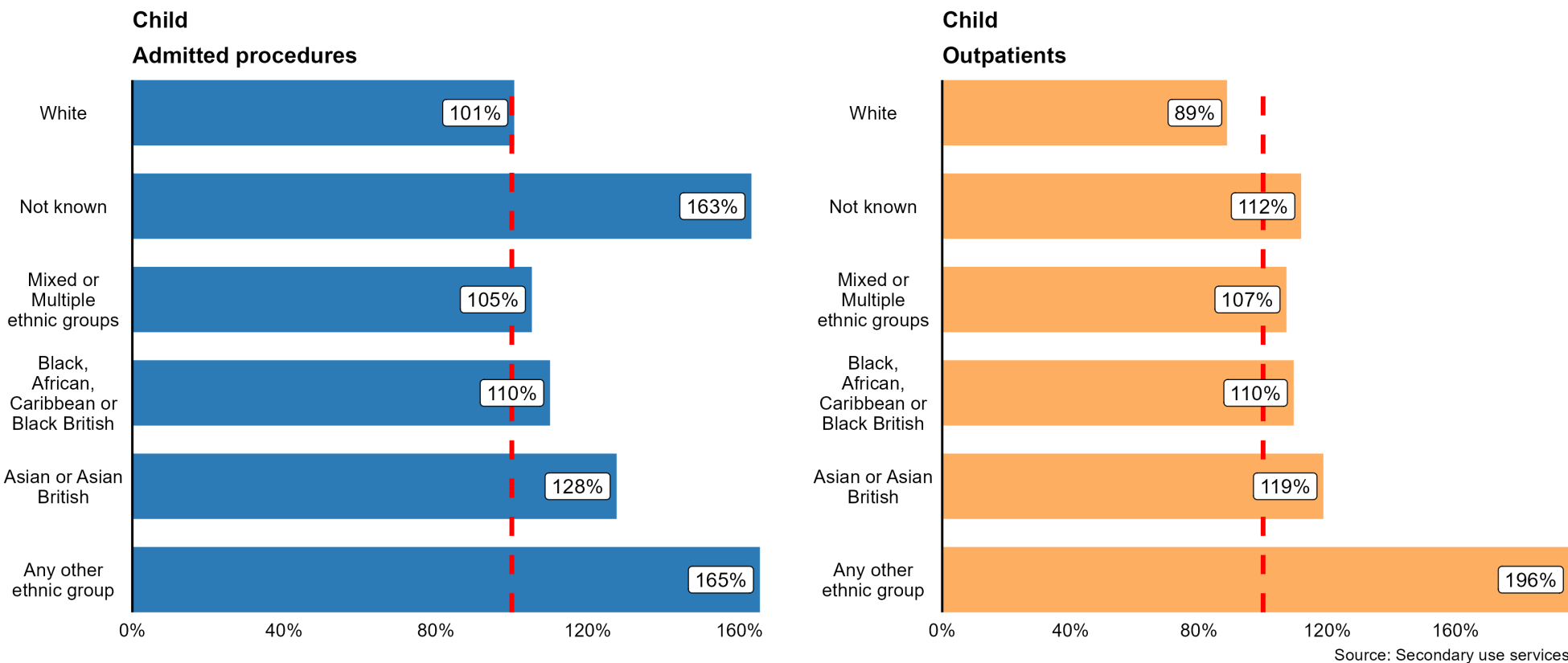
**What does the chart tell us?**

The charts show that elective activity in 2024/5 has been higher across all ethnic groups compared to pre-pandemic, (with the exception of outpatient activity where ethnicity is not known). Mixed or multiple ethnic groups, and those in the any other ethnic group category show the greatest increase compared to pre-pandemic levels. The increase in elective procedures and outpatients since the pandemic has been lower for the white group than all other groups (apart from where ethnicity is not known).



## Recovery of elective activity rates since Covid lockdowns by ethnicity group

2024/25 activity volumes as a percentage of 2018/19 volumes



### Why are we looking at this?

Evidence shows that the impact of the COVID-19 pandemic on the elective waiting list was not felt equally across different ethnic groups.

There are many reasons why access to elective care may have varied between ethnic groups during the pandemic. Ethnic differences may reflect demand factors (such as the level of need or changes in health care-seeking behaviour) or supply factors (such as pressure on services), but the extent to which this is the case is unclear. The drivers for differences may also be related to the effects of factors such as deprivation, occupation and geography, rather than primarily ethnicity<sup>7</sup>.

### What does the chart tell us?

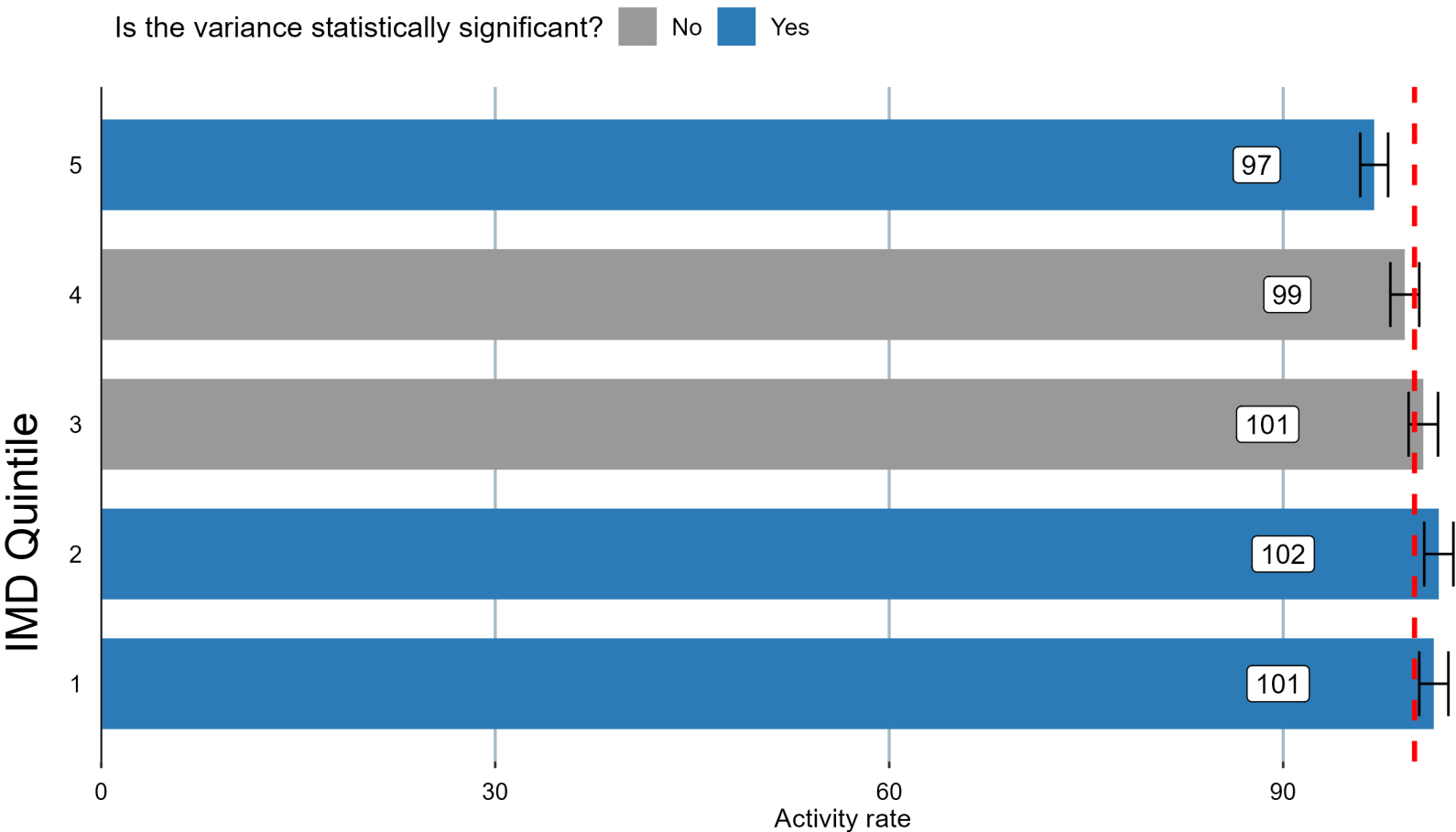
2024/5 elective activity rates for children were higher across all ethnic groups compared to pre-pandemic, with the exception of children's outpatient activity in the white ethnic group which remains lower than in 2018/19.

The increase in elective procedures and outpatients since the pandemic has been lower for the white group than all other ethnic groups.

### What are we doing?

## Elective inpatient activity by IMD Quintile

Age and sex standardised activity rates (100 = the BNSSG average),



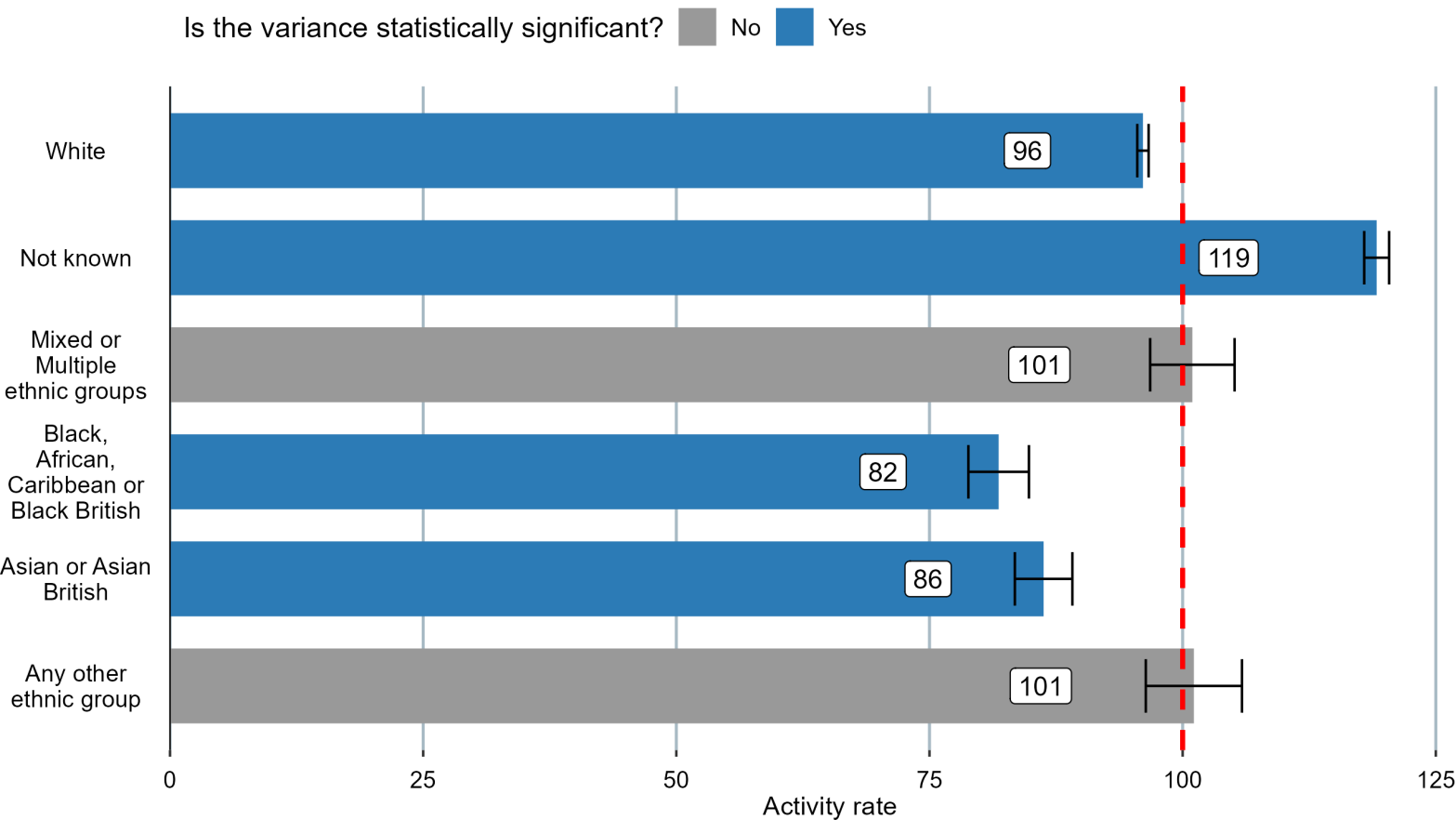
**Why are we looking at this?**  
We know that there is a strong relationship between deprivation and waiting times. National data shows that people who live in the most deprived areas are twice as likely to wait more than a year for treatment compared to people living in the least deprived areas, which has been exacerbated by COVID-19 pandemic<sup>6</sup>. There may be a number of structural, economic and social factors that can lead to inequalities in elective waiting lists, including challenges in attending appointments, difficulty navigating the NHS, entering the waiting list at different health states, deteriorating more rapidly and individual circumstances such as work or caring responsibilities<sup>27</sup>.

**What does the chart tell us?**  
The chart shows that recent inpatient activity rates are broadly similar across the deprivation quintiles. There is slightly lower inpatient activity in the 20% least deprived of the population (IMD5), with the more deprived quintiles showing significantly higher rates than BNSSG overall.

**What are we doing?**

## Elective inpatient activity by ethnicity

Age and sex standardised activity rates (100 = the BNSSG average),



### Why are we looking at this?

Evidence shows that the impact of the COVID-19 pandemic on the elective waiting list was not felt equally across different ethnic groups. There are many reasons why access to elective care may have varied between ethnic groups during the pandemic. Ethnic differences may reflect demand factors (such as the level of need or changes in health care-seeking behaviour) or supply factors (such as pressure on services), but the extent to which this is the case is unclear. The drivers for differences may also be related to the effects of factors such as deprivation, occupation and geography, rather than primarily ethnicity<sup>7</sup>.

### What does the chart tell us?

The chart shows that there are significant variations in planned hospital admission rates between ethnic groups.

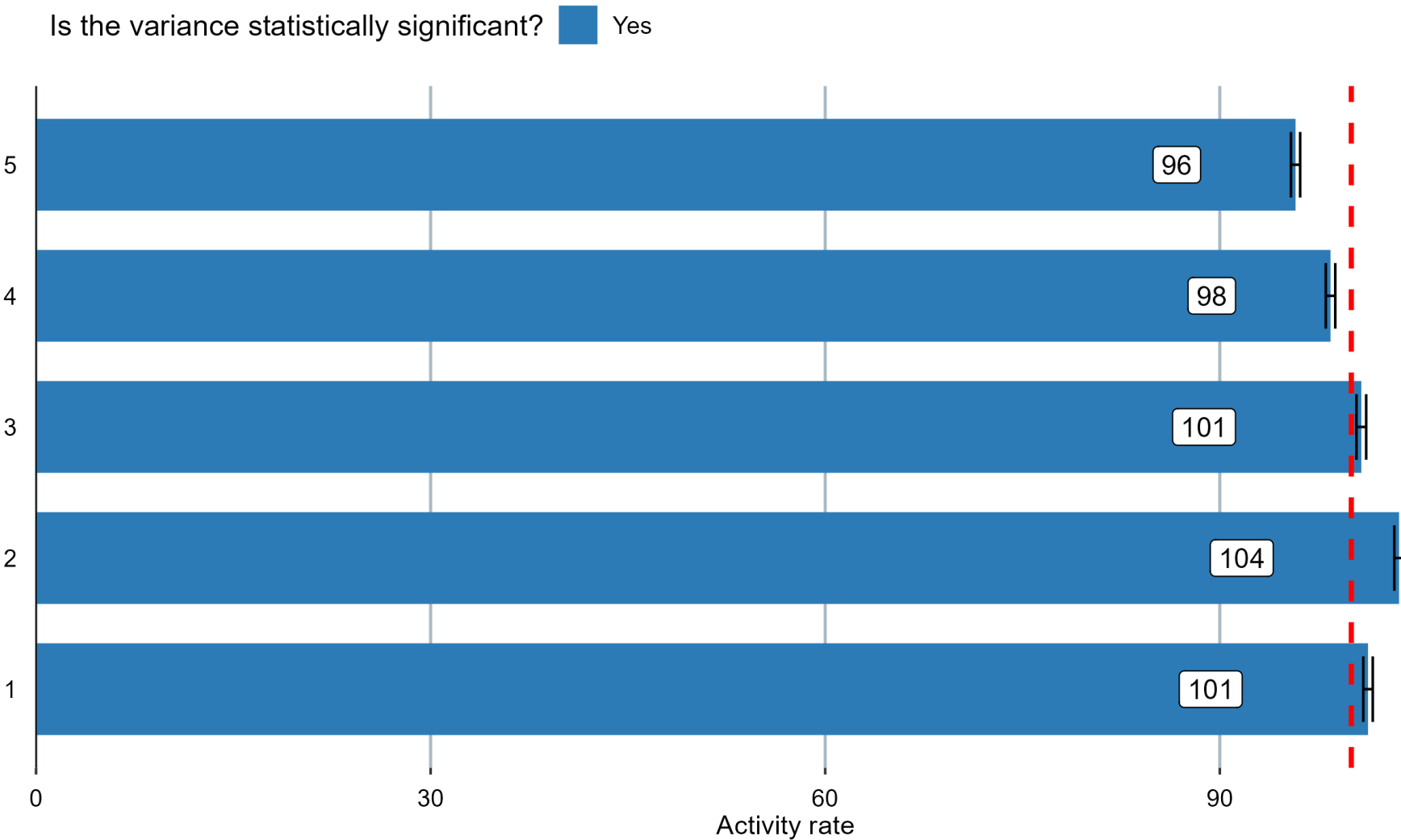
Planned admission rates are significantly lower in Black African, Caribbean or Black British groups and Asian or Asian British than the other groups and lower than BNSSG overall .

The highest rate is for the group where ethnicity is not recorded (not known category)

### What are we doing?

## Outpatient activity by IMD Quintile

Age and sex standardised activity rates (100 = the BNSSG average),



**Why are we looking at this?**

Post pandemic there were long waiting times for elective care and the NHS set up a three year elective recovery plan to reduce waiting times<sup>27</sup>. A key objective for the NHS in 2023/24 was to recover elective activity levels to above those seen in the pre-COVID period, to address the growing elective care waiting list<sup>8</sup>. Access to outpatient appointments is a key part of the pathway for elective care.

**What does the chart tell us?**

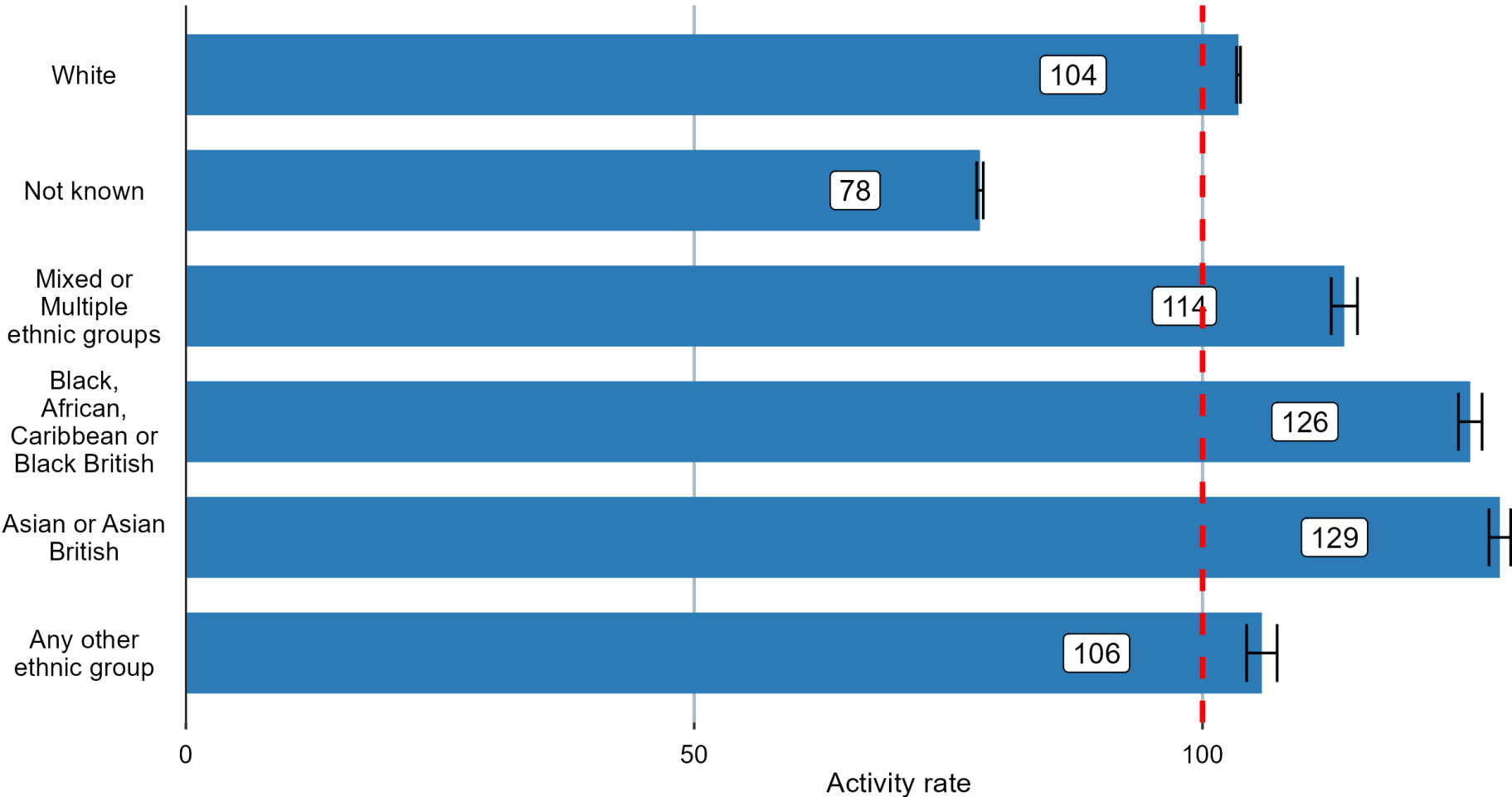
The chart shows that current outpatient activity is higher in the most deprived areas compared to the least deprived areas .

**What are we doing?**

## Outpatient activity by ethnicity

Age and sex standardised activity rates (100 = the BNSSG average),

Is the variance statistically significant? ■ Yes



### Why are we looking at this?

Post pandemic there were long waiting times for elective care and the NHS set up a three year elective recovery plan to reduce waiting times<sup>27</sup>. A key objective for the NHS in 2023/24 was to recover elective activity levels to above those seen in the pre-COVID period, to address the growing elective care waiting list<sup>8</sup>. Access to outpatient appointments is a key part of the pathway for elective care.

### What does the chart tell us?

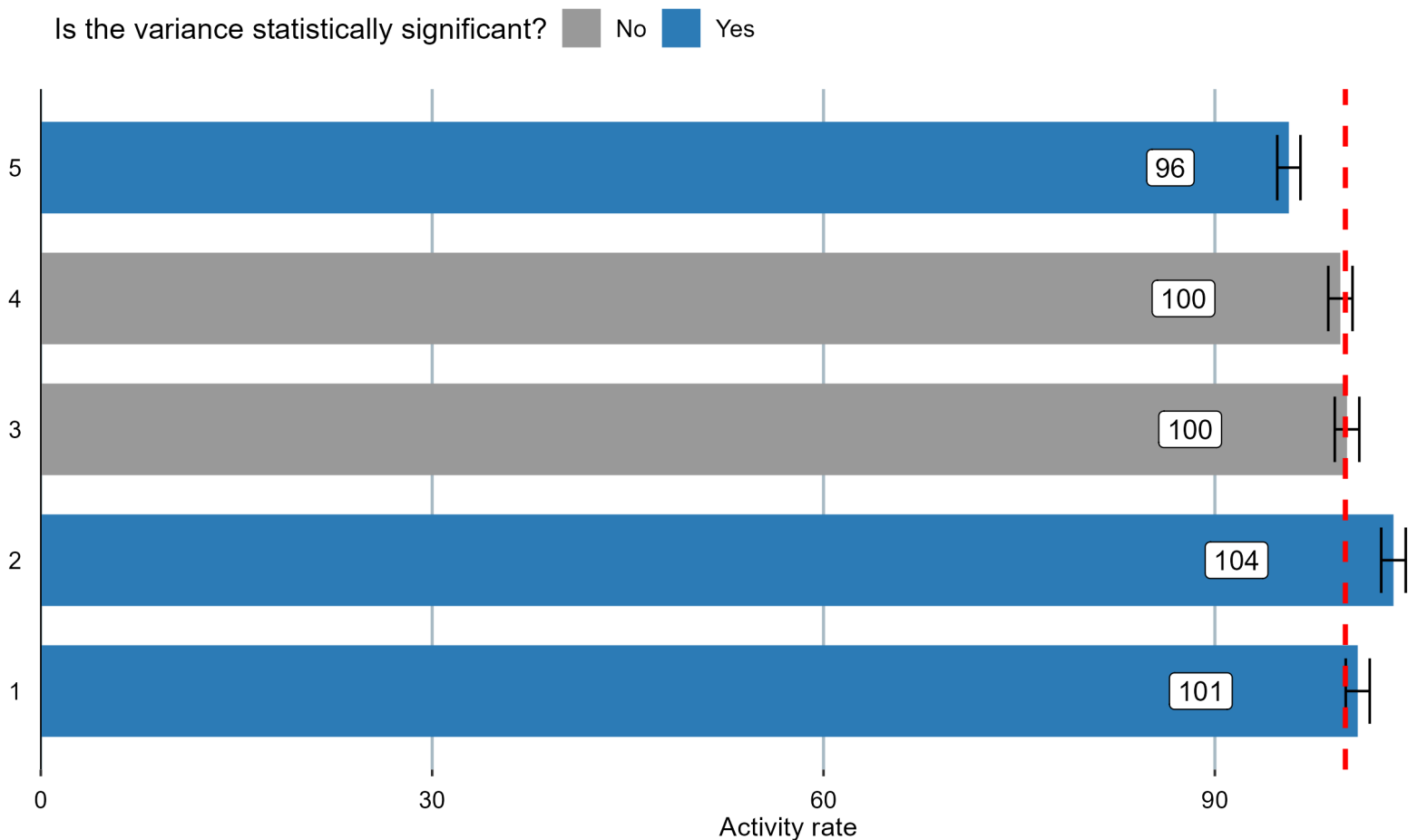
There is significant variation in outpatient activity by ethnic group. Black African, Caribbean or Black British and Asian or Asian British ethnic groups, along with the mixed or multiple ethnic group have significantly higher outpatient activity rates compared to other ethnic groups.

### What are we doing?



## Virtual outpatient activity by IMD Quintile

Age and sex standardised activity rates (100 = the BNSSG average),



**What does the chart tell us?**

Virtual appointments have the potential to reduce health inequalities by improving access to care for a wide range of people who would otherwise face barriers accessing services. Some evidence has shown that virtual care has a lower rate of missed appointments compared with in-person appointments and makes it more likely people will take their medication. Online appointments can also better support people who live in areas where public transport is less available, and people who have lower incomes but are above the threshold to qualify for travel reimbursements.

However, virtual appointments pose a number of challenges and for some already marginalised groups there is evidence that they may limit, rather than improve, access to care<sup>25</sup>. Other barriers include lack of skills, age, disability, lack of trust and language barriers<sup>26</sup>

**What does the chart tell us?**

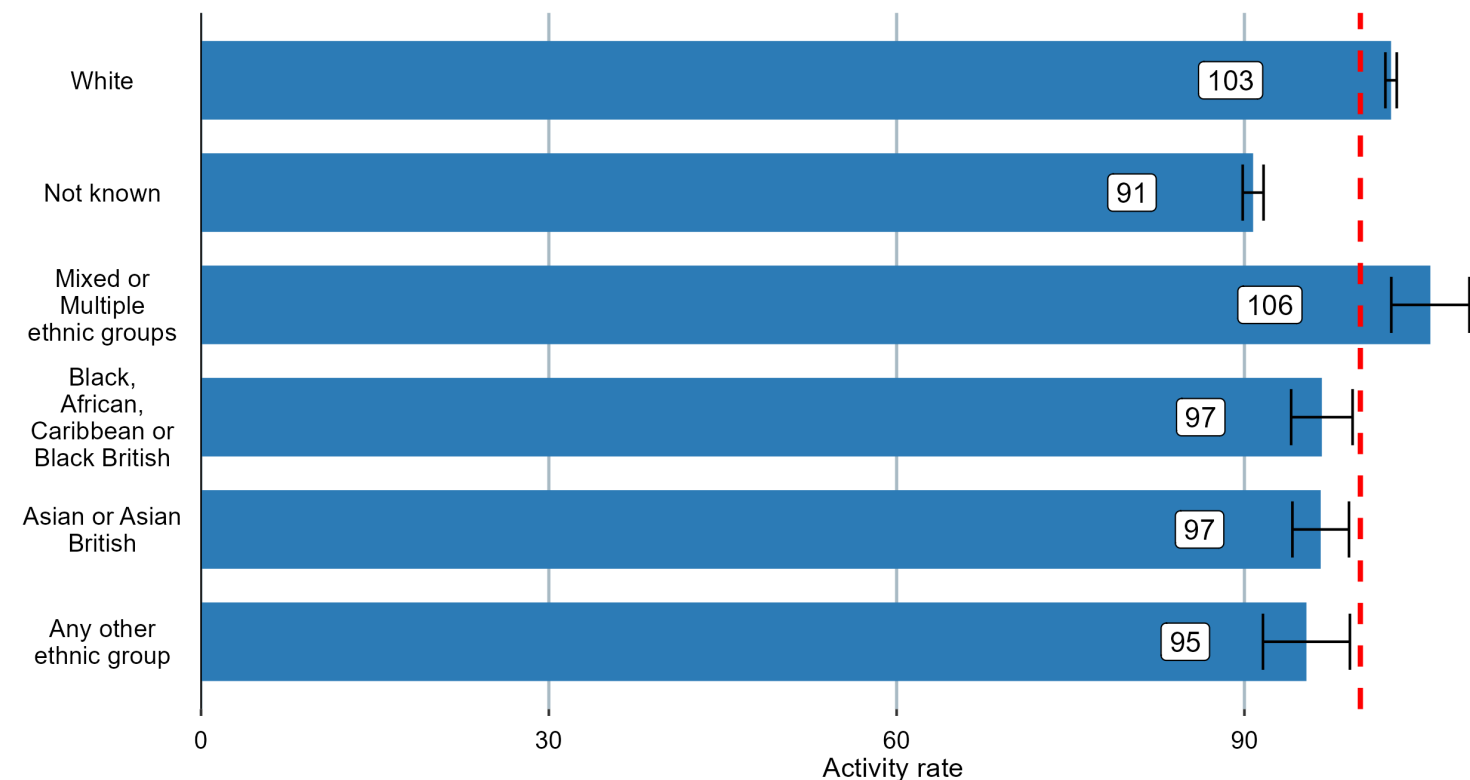
The chart shows that rates of virtual outpatient appointments are slightly but significantly higher for more deprived areas compared to the least deprived fifth of areas, and higher than BNSSG as a whole.

**What are we doing?**

## Virtual outpatient activity by ethnicity

Age and sex standardised activity rates (100 = the BNSSG average),

Is the variance statistically significant? ■ Yes



### Why are we looking at this?

Virtual appointments have the potential to reduce health inequalities by improving access to care for a wide range of people who would otherwise face barriers accessing services. Some evidence has shown that virtual care has a lower rate of missed appointments compared with in-person appointments and an increased retention rate for medication adherence. Online appointments can also better support people who live in areas where public transport is less available, and people who have lower incomes but are above the threshold to qualify for travel reimbursements.

However, virtual appointments pose a number of challenges and for some already marginalised groups there is evidence that they may limit, rather than improve, access to care<sup>25</sup>. Other barriers include lack of skills, age, disability, lack of trust and language barriers<sup>26</sup>

### What does the chart tell us?

Rates of virtual outpatient appointments are significantly lower in Black African, Caribbean or Black British, Asian or Asian British, other and unknown ethnic groups than BNSSG overall. Mixed or multiple ethnic groups and white groups are significantly higher.

### What are we doing?

## Healthcare domains

Elective  
recovery

Urgent and  
emergency  
Care

**Cancer**

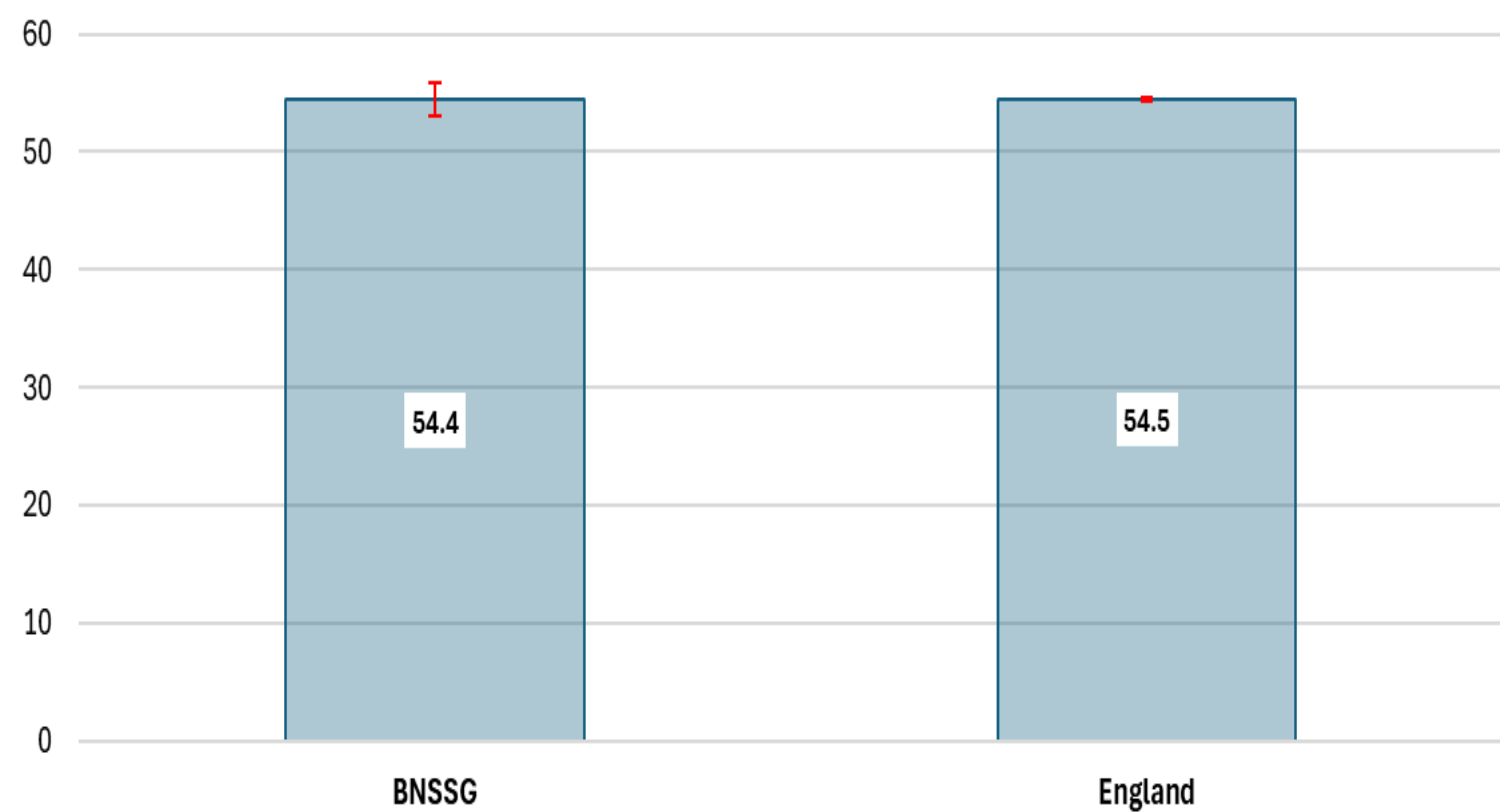
Mental  
Health

Learning  
disabilities &  
autism

Maternity &  
neonatal

Conditions:  
Respiratory,  
Cardiovascular  
disease, Diabetes,  
Oral health

Percentage of cancers diagnosed at stage 1 and 2 - case mix adjusted



**Why are we looking at this?**

Screening, early presentation, and referral are important for getting the best outcomes following a diagnosis of cancer. The NHS long-term plan has a target for 75% of cancers to be diagnosed by Stage 1 and 2<sup>9</sup>.

We know that people from the most deprived areas are more likely to get cancer and receive a diagnosis at a later stage and this is a key driver of inequalities in life expectancy<sup>9</sup>.

In BNSSG, we know that there is variation in diagnosis at stage 1 and 2 by type of cancer with Breast cancers more likely to be diagnosed early and lung cancer at the latest stages<sup>10</sup>

**What does the chart tell us?**

The percentage of cancers diagnosed at stage 1 or 2 in BNSSG is similar to the England average. The proportion of cancers diagnosed at stage 1 and 2 has fallen from 56.4% to 55.6% from 2013-15 and 2019-21 and this trend has also been observed nationally.

**What are we doing?**

## Healthcare domains

Elective  
recovery

Urgent and  
emergency  
Care

Cancer

**Mental  
Health**

Learning  
disabilities &  
autism

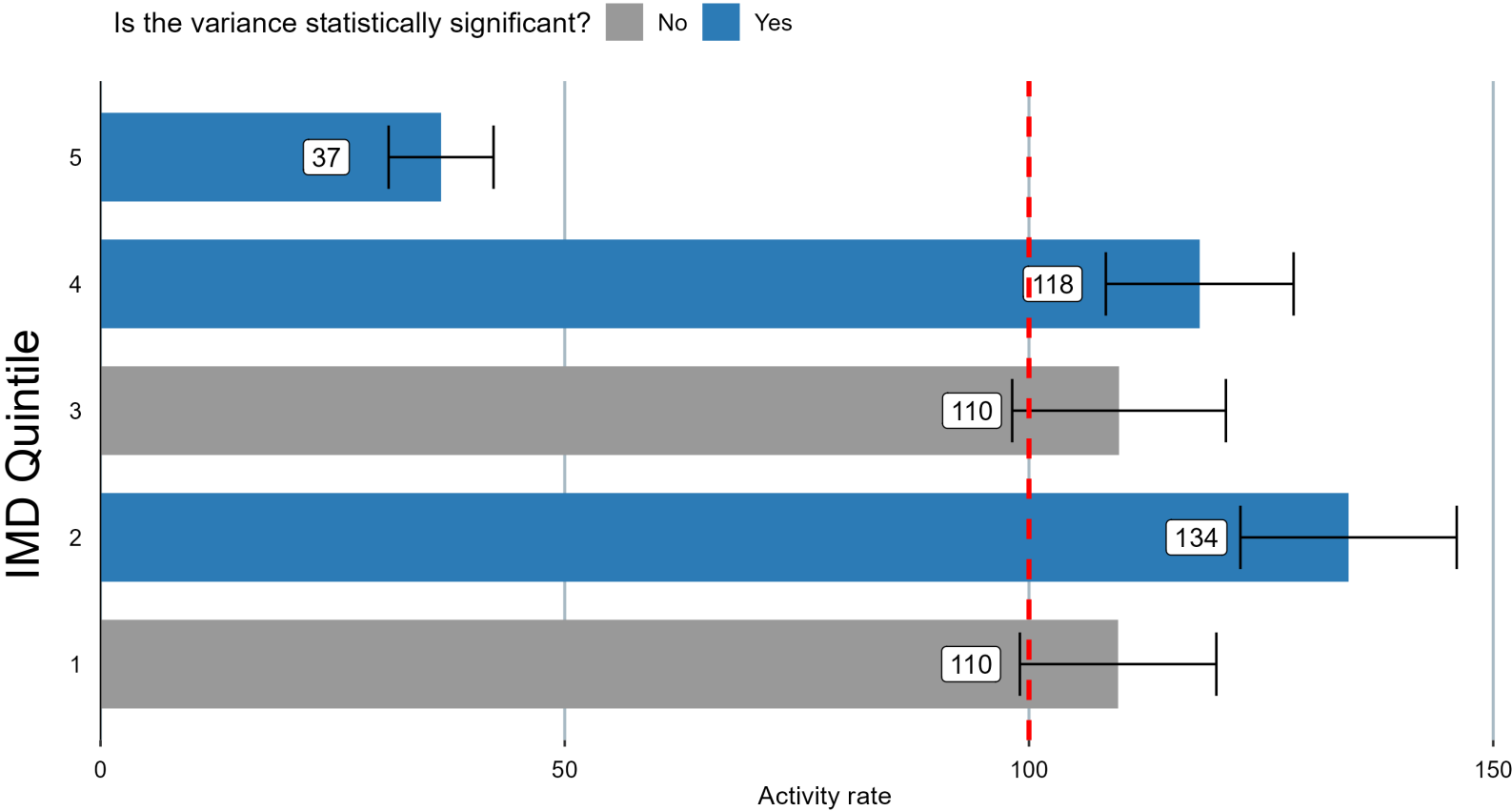
Maternity &  
neonatal

Conditions:  
Respiratory,  
Cardiovascular  
disease, Diabetes,  
Oral health



## Restrictive Interventions by IMD quintile

Age and sex standardised activity rates (100 = the BNSSG average),



### Why are we looking at this?

Restrictive interventions (see definition below) are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and to staff.

This indicator will underpin measures that will need to be put in place to implement the Mental Health Units (Use of Force) Act 2018 that came into force in 2022. The Act, also known as Seni’s Law, is named after Olaseni Lewis, who died as a result of being forcibly restrained whilst he was a voluntary patient in a mental health unit.

The Statutory Guidance supporting the Act is clear on the need for accurate recording of interventions. High quality data is a crucial building block to allow focus and reflection on the use of restrictive practices and consequently reduce the need for those practices<sup>11</sup>

### What does the chart tell us?

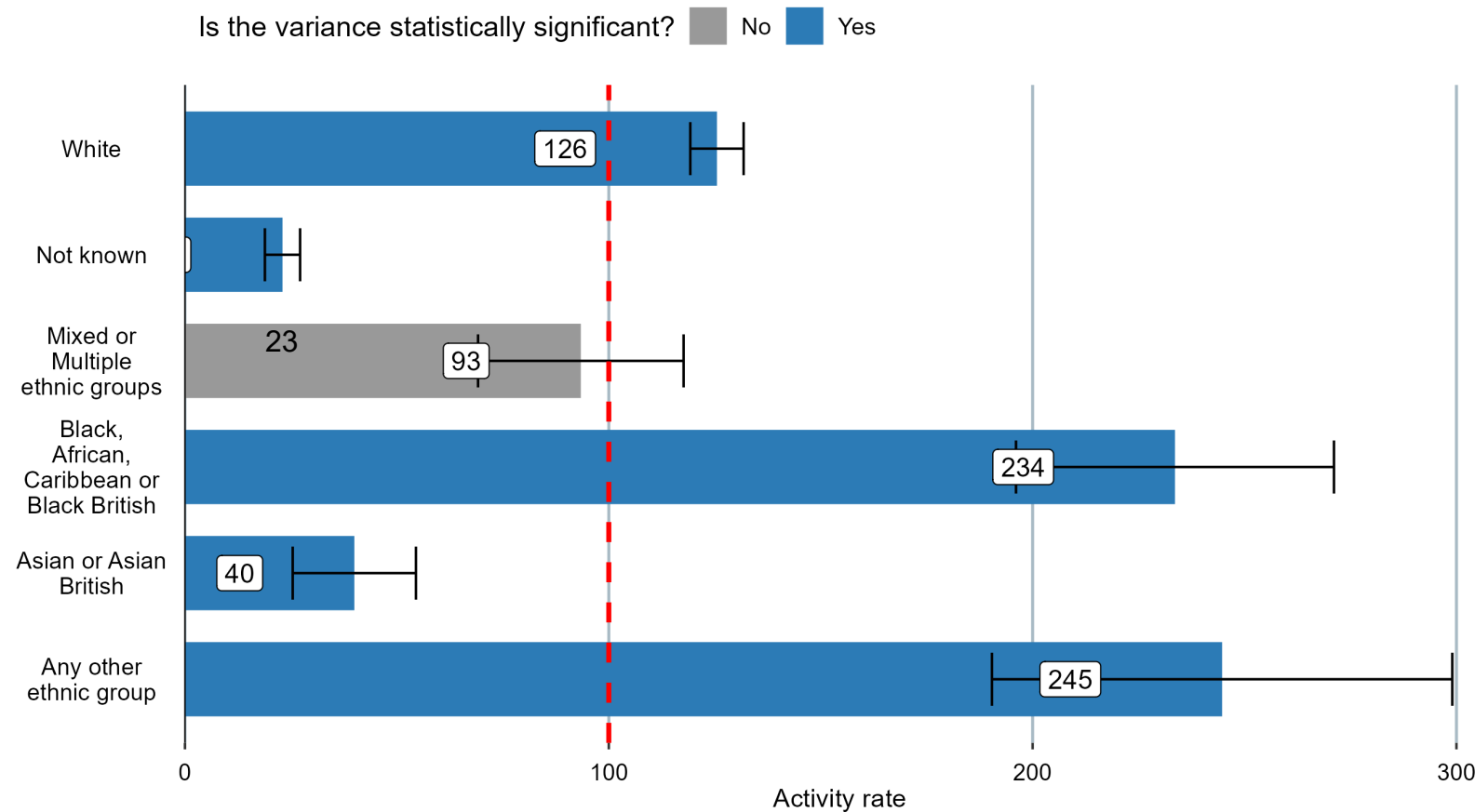
There are significantly lower rates of restrictive interventions for patients from the least deprived areas of BNSSG (IMD5) than the other 4 quintiles.

(note: these figures are population rates)

### What are we doing?

## Restrictive Interventions rates by ethnic group

Age and sex standardised activity rates (100 = the BNSSG average),



### Why are we looking at this?

Restrictive interventions (see definition below) are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and to staff.

This indicator will underpin measures that will need to be put in place to implement the Mental Health Units (Use of Force) Act 2018 that came into force in 2022. The Act, also known as Seni’s Law, is named after Olaseni Lewis, who died as a result of being forcibly restrained whilst he was a voluntary patient in a mental health unit.

The Statutory Guidance supporting the Act is clear on the need for accurate recording of interventions. High quality data is a crucial building block to allow focus and reflection on the use of restrictive practices and consequently reduce the need for those practices<sup>11</sup>

A review of studies into restrictive practices in mental health inpatient settings showed that certain ethnic minorities are more likely to experience restrictive practices than other groups<sup>30</sup>

### What does the chart tell us?

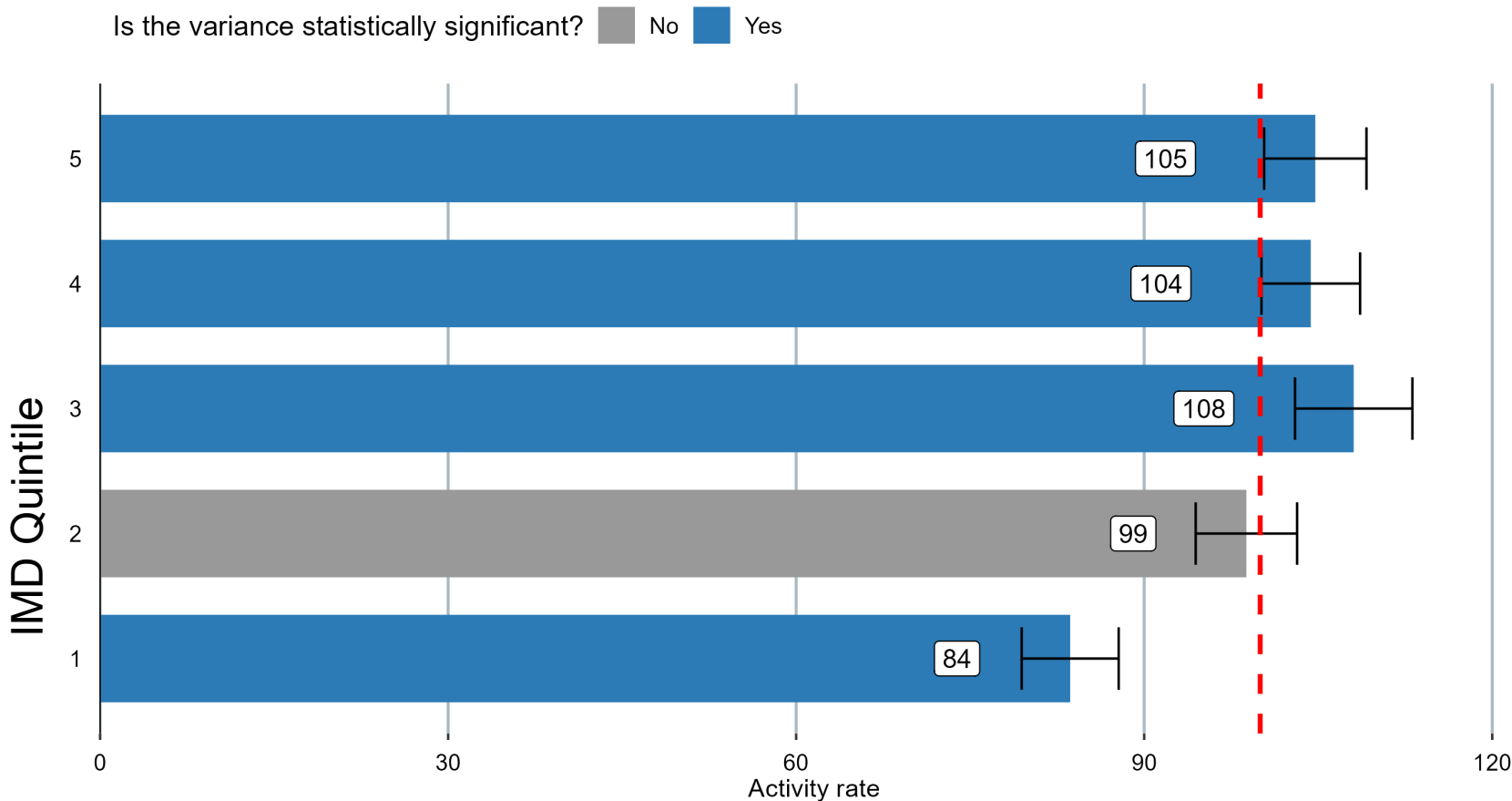
The chart shows that the rate of restrictive interventions is significantly higher for people in the Black African, Caribbean or Black British ethnic group, and other ethnic groups than in White, Asian or Asian British groups or mixed groups.

(note: these figures are population rates)

### What are we doing?

## Talking therapies rates by IMD quintile

Age and sex standardised activity rates (100 = the BNSSG average),



### Why are we looking at this?

The NHS Talking Therapies programme is centred around particular treatments for depression and anxiety disorders, as recommended by NICE. In routine monthly NHS Talking Therapies reporting, patient outcomes are measured in terms of three measures: reliable improvement, recovery, and reliable recovery.

There are differences in experience and outcomes across domains of inequality. Different groups access services differently, with underrepresentation in some services and overrepresentation in others<sup>13</sup>.

People in lower income households are more likely to have unmet mental health treatment requests compared with the highest. Talking therapy recovery rates are generally poorer in the most deprived localities compared to the least deprived<sup>14</sup>

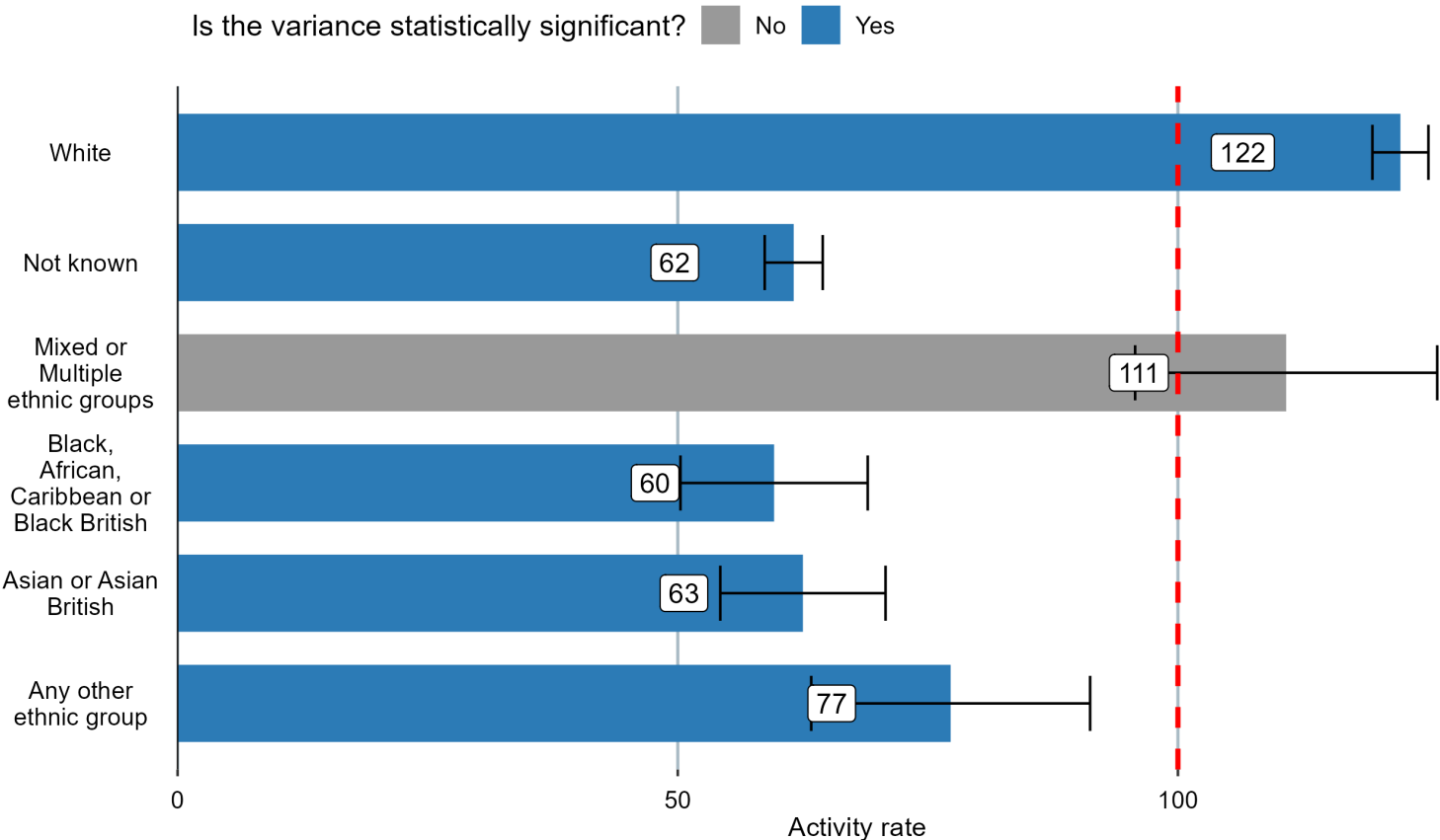
### What does the chart tell us?

Talking therapy intervention rates are significantly lower in BNSSG most deprived populations compared to other groups.

### What are we doing?

## Talking therapies rates by ethnic group

Age and sex standardised activity rates (100 = the BNSSG average),



### Why are we looking at this?

We know that there are barriers to accessing and engaging with talking therapies.

Research shows that people from Black and minoritised ethnic backgrounds have experienced poorer access to, and outcomes from, NHS talking therapies. They are less likely to access services, wait longer for treatment and have longer waits to access treatment and have poorer outcomes from treatment once they receive a referral.

Reasons for this can include lack of culturally sensitive therapy, issues around trust, use of clinical language and understanding of cultural issues such as taboos or interpretation<sup>12</sup>.

Many minoritised communities face additional socioeconomic barriers (plus structural racism) that may impact access, engagement, and outcomes<sup>15</sup>.

### What does the chart tell us?

Rates of talking therapies interventions are significantly lower than the BNSSG average for all ethnic groups other than White and Mixed or Multiple ethnic groups. The white group shows the highest rate and a significantly higher rate than BNSSG overall.

### What are we doing?

The NHSE statement guidance includes:

- Overall number of severe mental illness (SMI) physical health checks by ethnicity
- Rates of Mental Health Act detentions by deprivation and by ethnicity
- Children and young people's mental health access by deprivation and by ethnicity

We have been unable to access this information and will continue to work to address this information gap.

Interim

# Domain 5: Learning disabilities & autism

## Healthcare domains

Elective  
recovery

Urgent and  
emergency  
Care

Cancer

Mental  
Health

**Learning  
disabilities &  
autism**

Maternity &  
neonatal

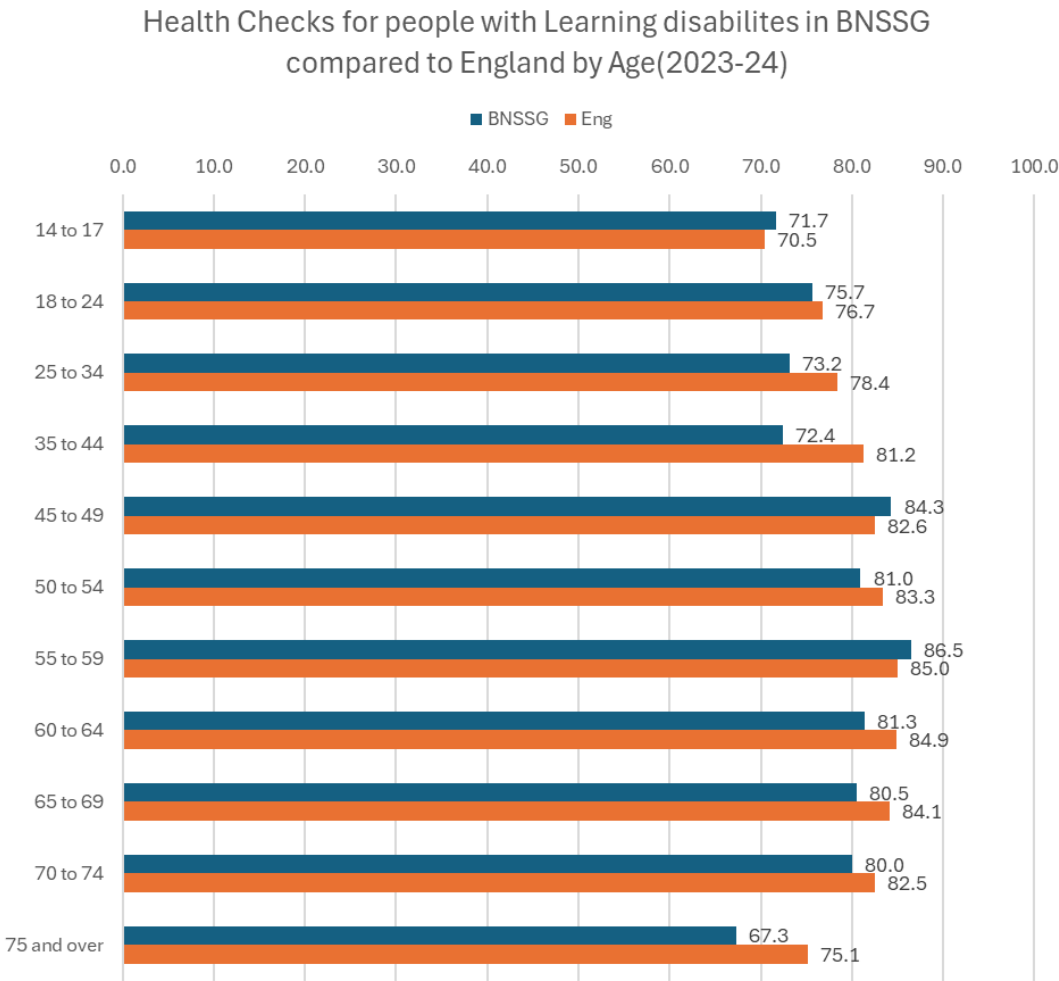
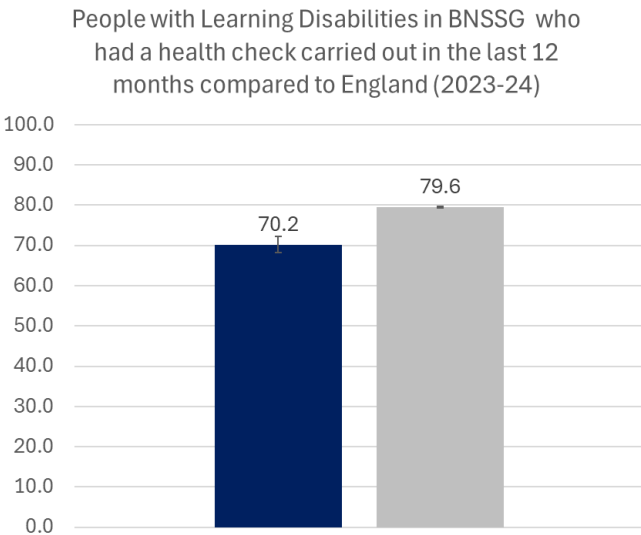
Conditions:  
Respiratory,  
Cardiovascular  
disease, Diabetes,  
Oral health

# Domain 5: Learning disabilities & autism

## Learning disability health checks completion

[Health and Care of People with Learning Disabilities - NHS England Digital](#) - Data at ICB level is available [here](#).

-



### Why are we looking at this?

Evidence suggests that providing health checks to people with learning disabilities in primary care is effective in identifying previously unrecognised health needs, including those associated with life-threatening illnesses. Learning disability annual health checks are different from the NHS health checks programme for cardiovascular disease prevention. Learning disabilities health checks are designed to pick up a wider range of unmet health needs <sup>29</sup>.

### What does the chart tell us?

In BNSSG there is a significantly lower proportion of people with Learning Disabilities who have had a health check carried out in the last 12 months compared to England.

The proportion of older people in BNSSG who've had their health check carried out is lower than the England average especially among over 75s. It is also lower among 25-44 years olds in BNSSG.

### - What are we doing?



## Healthcare domains

Elective  
recovery

Urgent and  
emergency  
Care

Cancer

Mental  
Health

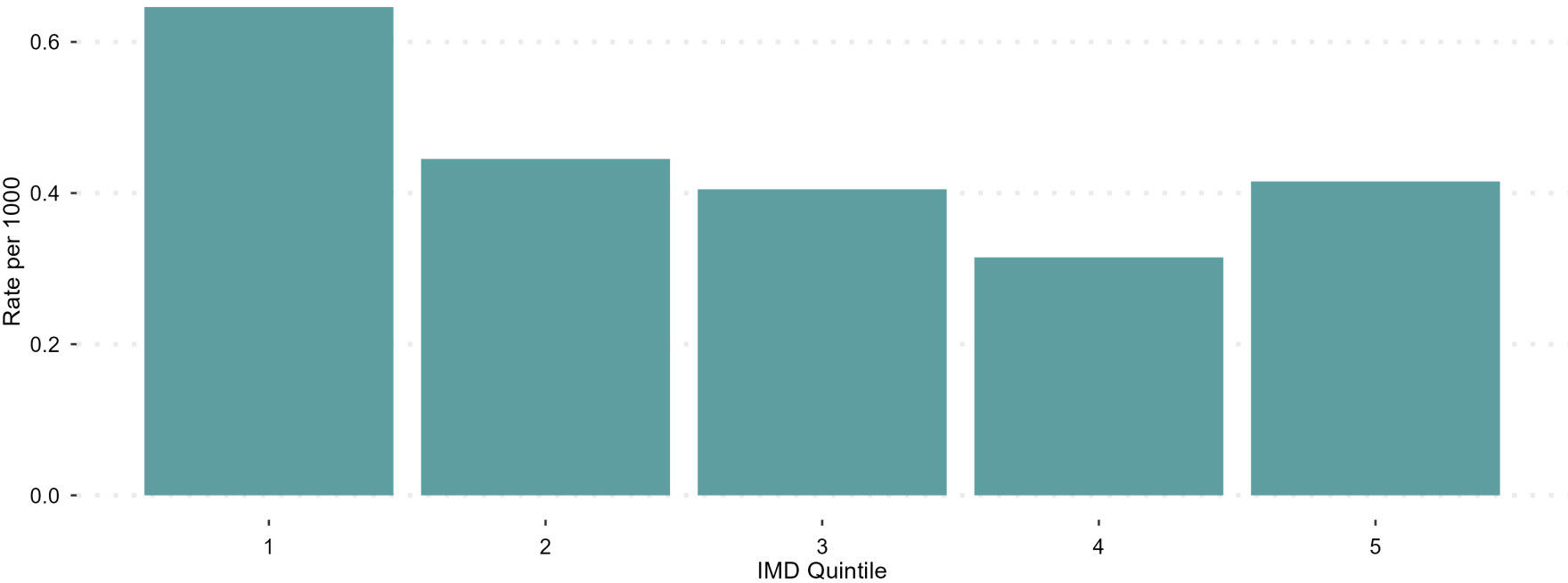
Learning  
disabilities &  
autism

**Maternity &  
neonatal**

Conditions:  
Respiratory,  
Cardiovascular  
disease, Diabetes,  
Oral health

## Pre-term births by IMD quintile

Apr-24 to Mar-25, BNSSG residents. Rates per 1000 population



Source: Maternity Services Dataset

### Why are we looking at this?

Globally premature birth (less than 37 weeks gestation) is the leading cause of death for children under the age of 5. There is substantial evidence that smoking during pregnancy and exposure to second-hand-smoke can lead to premature birth among many other adverse health effects including complications during labour, low birth-weight at full term and increased risk of miscarriage and stillbirth<sup>16</sup>.

In BNSSG, we know that deprivation is linked to poorer maternity outcomes. People living in deprived areas are more likely to be booked in late for care with a midwife, more likely to smoke and more likely to have a BMI >30<sup>17</sup>.

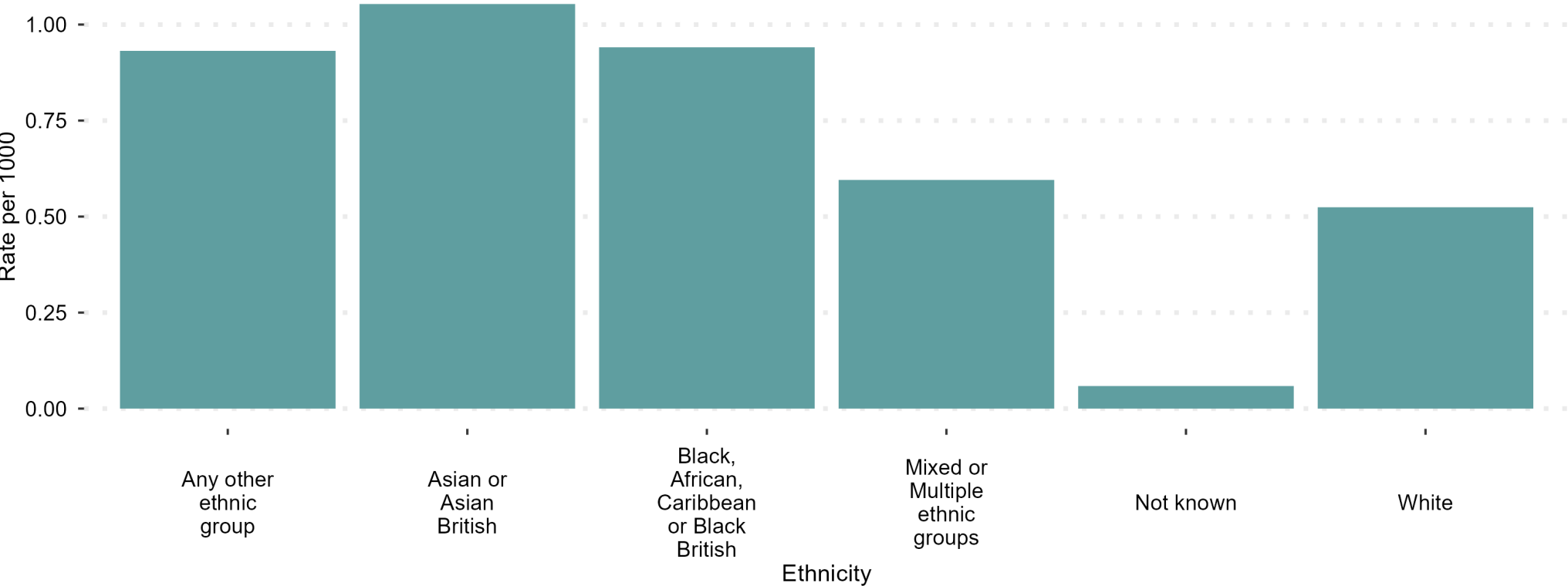
### What does the chart tell us?

The rate of preterm births is highest for the most deprived quintile. Note: it is difficult to provide further interpretation as birth rates may vary across different IMD groups.

### What are we doing?

## Pre-term births by ethnicity

Apr-24 to Mar-25, BNSSG residents. Rates per 1000 population



Source: Maternity Services Dataset

### Why are we looking at this?

Globally premature birth (less than 37 weeks gestation) is the leading cause of death for children under the age of 5. There is substantial evidence that smoking during pregnancy and exposure to second-hand-smoke can lead to premature birth among many other adverse health effects including complications during labour, low birth-weight at full term and increased risk of miscarriage and stillbirth<sup>16</sup>.

In BNSSG, we know that there are there are variations by ethnicity in maternity outcomes - Asian mothers have higher rates of low birth weight (term) births and premature births and Black mothers have higher rates of late bookings<sup>17</sup>.

### What does the chart tell us?

Pre term birth rates are higher for all ethnic groups other than the white group.

Note: it is difficult to provide further interpretation as birth rates may vary across the different ethnic groups.

### What are we doing?

## Healthcare domains

Elective  
recovery

Urgent and  
emergency  
Care

Cancer

Mental  
Health

Learning  
disabilities &  
autism

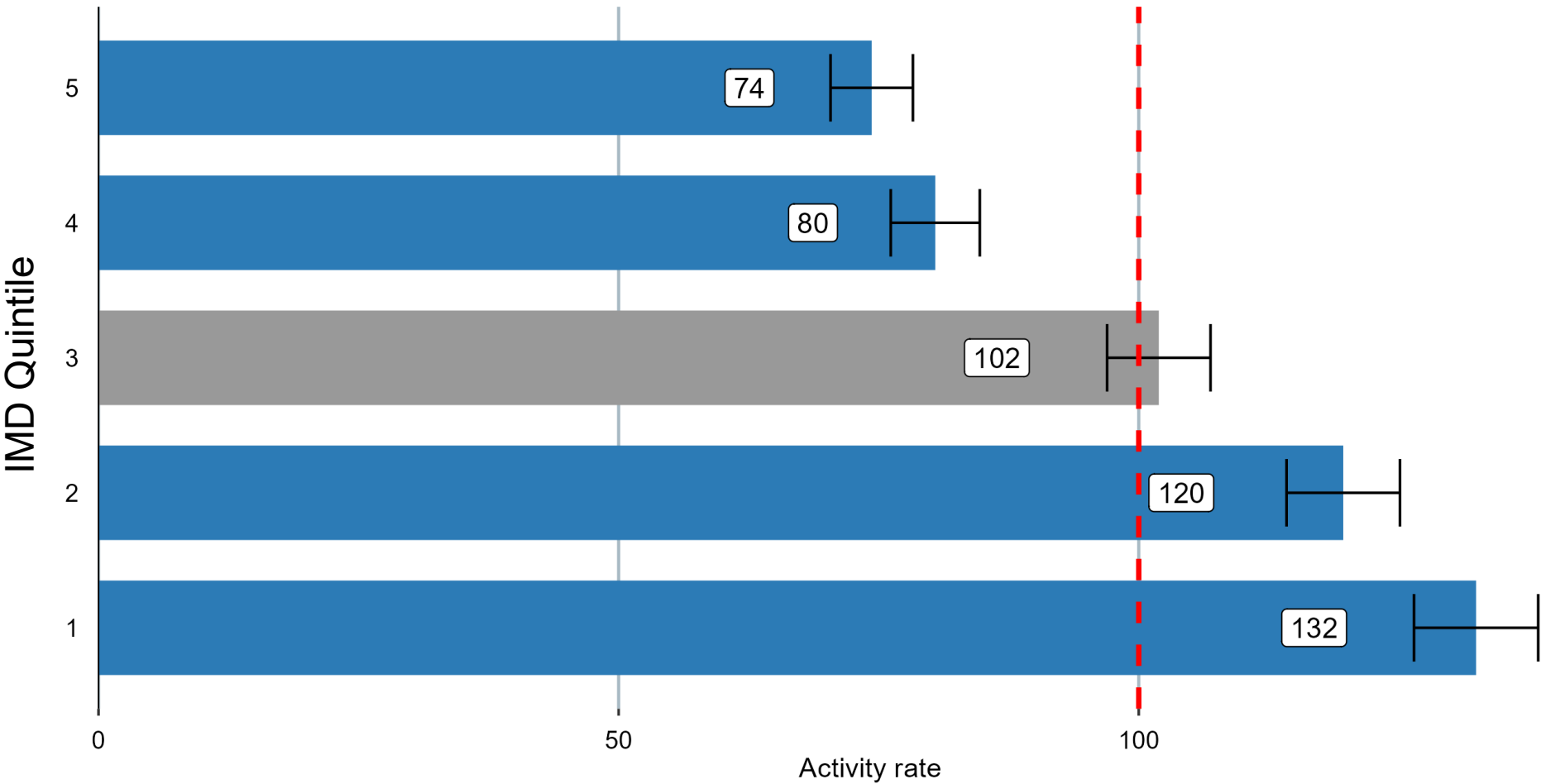
Maternity &  
neonatal

**Conditions:**  
Respiratory,  
Cardiovascular  
disease, Diabetes,  
Oral health

## Non-elective admissions for myocardial infarction by IMD quintile

Age and sex standardised activity rates (100 = the BNSSG average),

Is the variance statistically significant? No Yes



### Why are we looking at this?

People living in the most deprived communities have higher prevalence of heart and circulatory disease. They are more likely to die earlier from cardiovascular disease (CVD) and they are less likely to access healthcare services. The reasons for this are complex. People living in deprived areas are more likely to smoke and to be overweight or obese, which increase risk of developing CVD. People living in deprived areas have a greater need for treatment but may have less access to it. Emergency admissions for CVD are higher in areas of high deprivation<sup>18</sup>

### What does the chart tell us?

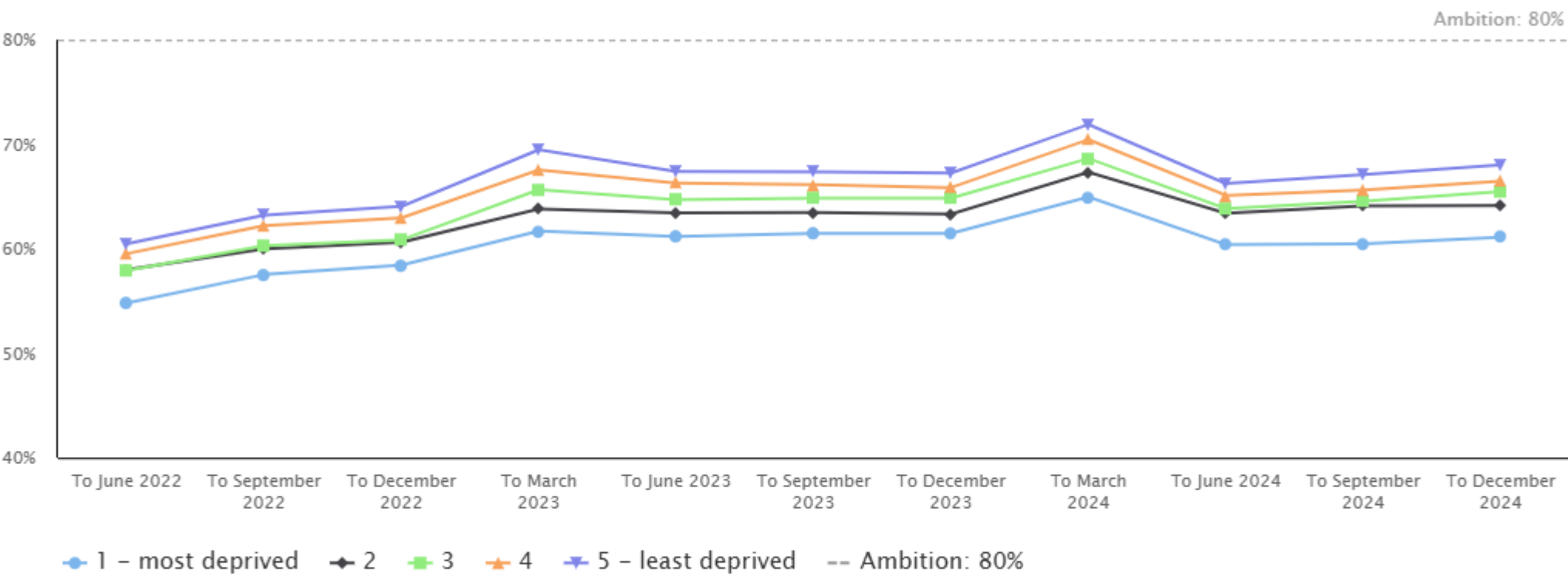
Emergency admissions for MI are significantly higher for people living in the 40% most deprived areas (IMD1 and 2 ), and significantly lower for the less deprived 40%. There is a clear trend of higher rates of admission for MI with higher deprivation.

The rate of emergency admissions for MI among people living in the most deprived areas (IMD1) is almost double the rate for people in the least deprived areas (IMD5).

### What are we doing?

# Domain 7: Conditions - hypertension

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.



**Why are we looking at this?**

UCL Partners ‘Size of the Prize’ analysis highlights key opportunities in BNSSG to prevent heart attacks and strokes at scale through better management of two major risk factors –blood pressure and cholesterol [Size of the Prize for high blood pressure](#)

Hypertension case finding and optimal management, and lipid optimal management are also part of the Core 20 Plus 5 NHSE Health Inequalities approach

The Size of the Prize has estimated that if 80% of patients with hypertension had their blood pressure optimised, this would prevent 131 heart attacks, 196 strokes and 105 deaths across BNSSG within the next few years.

**What does the chart tell us?**

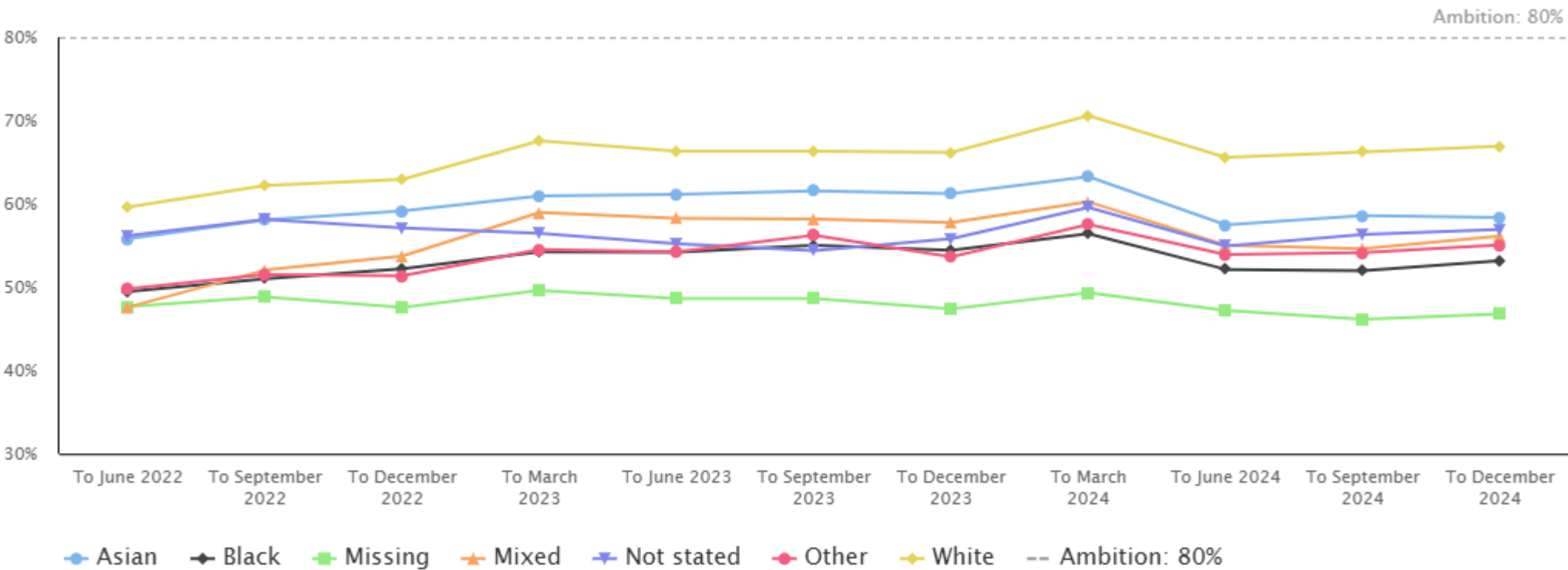
Overall, more patients are achieving blood pressure treatment targets now compared to 2 years ago, but the most deprived areas (IMD1 and 2 ) lag behind the least deprived (IMD4 and 5). This trend of higher achievement of targets among the least deprived had been consistent over the 2 year period shown .

Rates remain below the national ambition.

**What are we doing?**

# Domain 7: Conditions - hypertension

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.



### Why are we looking at this?

In BNSSG, people in the broad ethnic category Black are less likely to be treated to the appropriate treatment threshold for high blood pressure. The gap between ethnic groups in achieving treatment targets is greater than the gap for deprivation.

We’ve also seen in local data that the Caribbean community are less likely to be treated to the appropriate threshold compared to all other ethnicities (24% vs. 5-14%).

### What does the chart tell us?

People in the White ethnic group are more likely to reach treatment targets for blood pressure. People in the Black ethnic group are least likely, except for those where ethnicity recording is missing. The gap between these 2 highest and lowest groups has widened over the 2 year period shown.

Rates remain below the national ambition.

### What are we doing?

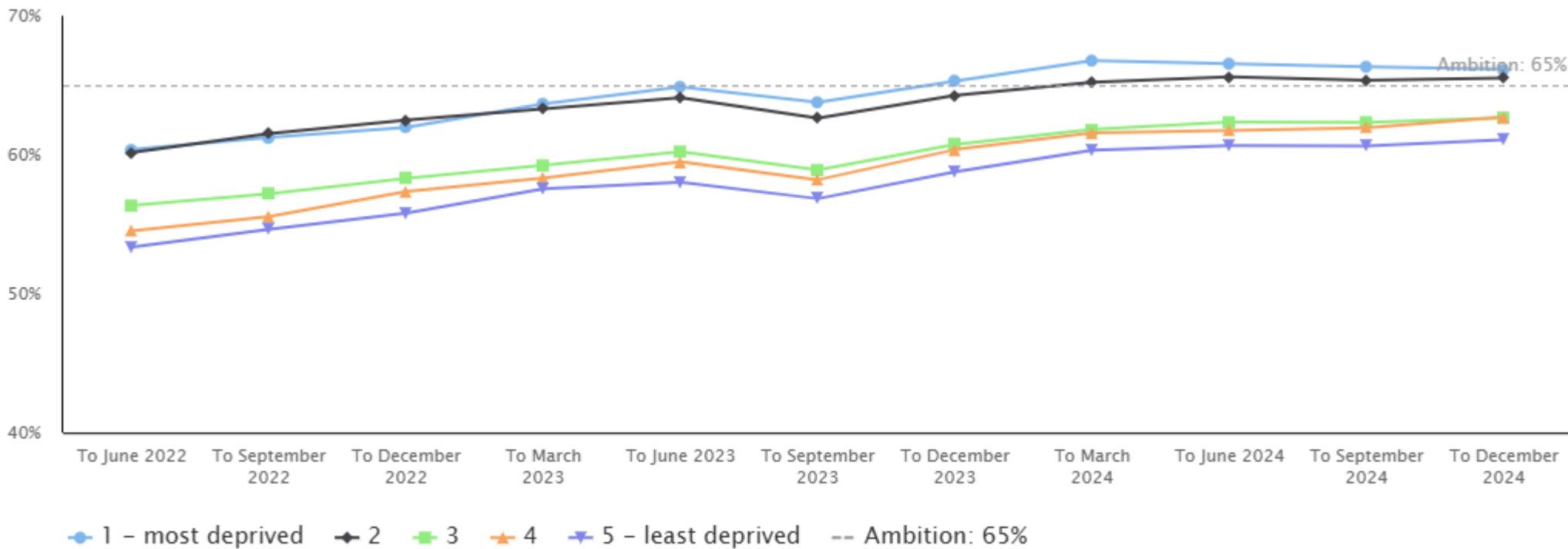
**Data source:** CVD Prevent  
**Date range:** June 2022 to December 2024

**Definition:** Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.



# Domain 7: Conditions – CVD risk

Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy



### Why are we looking at this?

High blood cholesterol (lipid levels) can increase the risk of having a heart attack or stroke. Lipid lowering therapy with statins can reduce cholesterol levels and is a clinically effective treatment option for the primary prevention of CVD.

NICE guidance suggests that adults with a 10-year risk of cardiovascular disease (CVD) of 10% or more (QRISK score) for whom lifestyle changes are ineffective or inappropriate, are encouraged to discuss the risks and benefits of starting statin therapy with their healthcare professional<sup>19</sup>.

### What does the chart tell us?

Overall rates of people at higher risk of CVD being treated with lipid lowering therapy have risen over the 2 year period shown.

People at higher risk of CVD in the most deprived areas have higher levels of treatment with lipid lowering therapy than those in the least deprived areas.

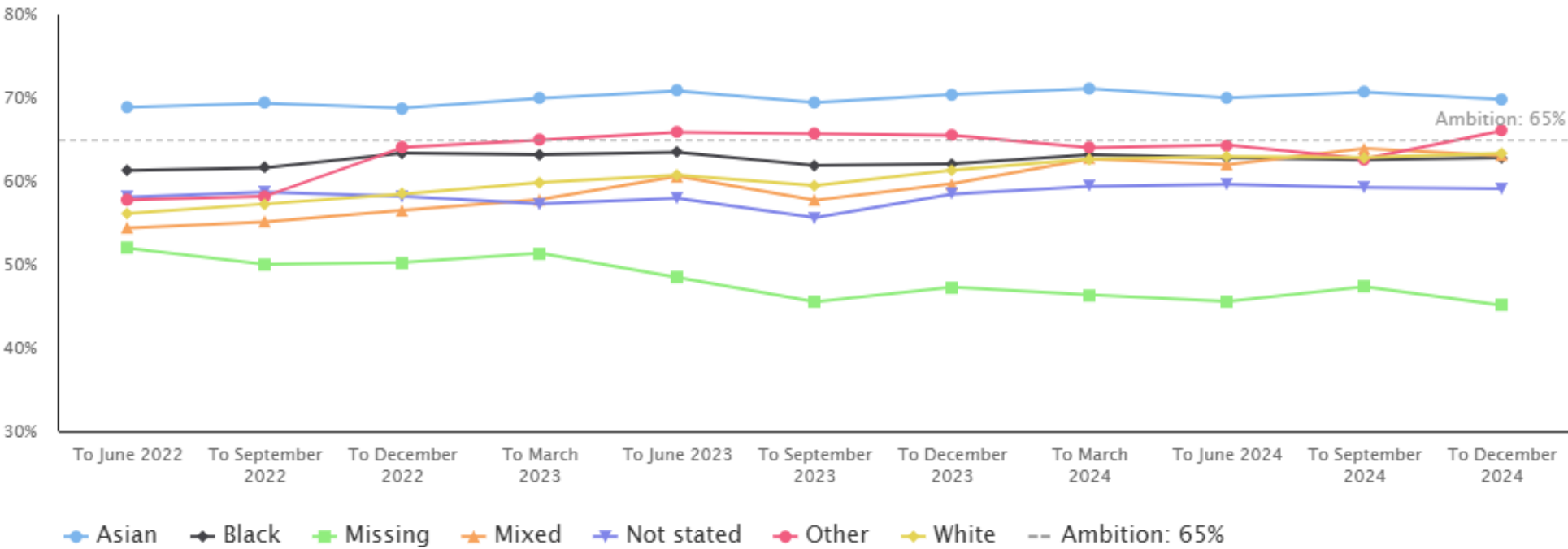
### What are we doing?

**Data source:** CVD Prevent  
**Date range:** June 2022 to December 2024

**Definition:** Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy  
**IMD:** A measure of deprivation based on a person's postcode, 1 = most deprived fifth (quintile) of the population

# Domain 7: Conditions – CVD risk

Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy



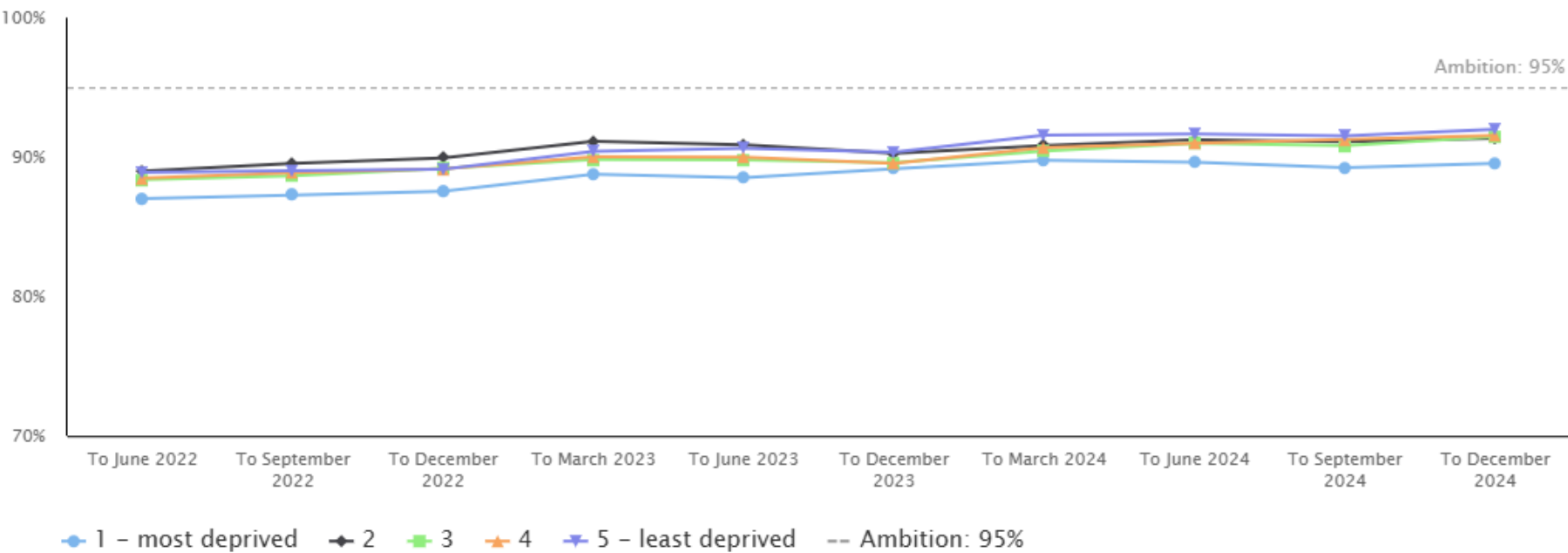
**Why are we looking at this?**  
High blood cholesterol (lipid levels) can increase the risk of having a heart attack or stroke. Lipid lowering therapy with statins can reduce cholesterol levels and is a clinically effective treatment option for the primary prevention of CVD.

NICE guidance suggests that adults with a 10-year risk of cardiovascular disease (CVD) of 10% or more (QRISK score) for whom lifestyle changes are ineffective or inappropriate, are encouraged to discuss the risks and benefits of starting statin therapy with their healthcare professional<sup>19</sup>.

**What does the chart tell us?**  
The proportion of patients at higher risk of CVD who are treated with lipid lowering therapy is highest for people in the Asian ethnic group and lowest in the White and Black ethnic group.

**What are we doing?**

## Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant



### Why are we looking at this?

Atrial Fibrillation (AF) is a heart condition that causes an irregular and often abnormally fast heart rate, in some cases, it can be considerably higher than 100 beats a minute. Atrial fibrillation means there's a risk of blood clots forming in the heart chambers. If these enter the bloodstream, they can cause a stroke. AF is a major risk factor for stroke and contributes to one in five strokes. Anticoagulants reduce the risk of blood clotting and are the main treatment for lowering stroke risk in patients with AF

There are two main types of medications, direct acting oral anticoagulants (DOACs) such as apixaban (this is the preferred option in most cases), or vitamin K antagonists such as warfarin, which are recommended when DOACs are not indicated. The NICE AF guidance suggests that DOACs are a more effective anticoagulation option in patients with high risk AF<sup>19</sup>.

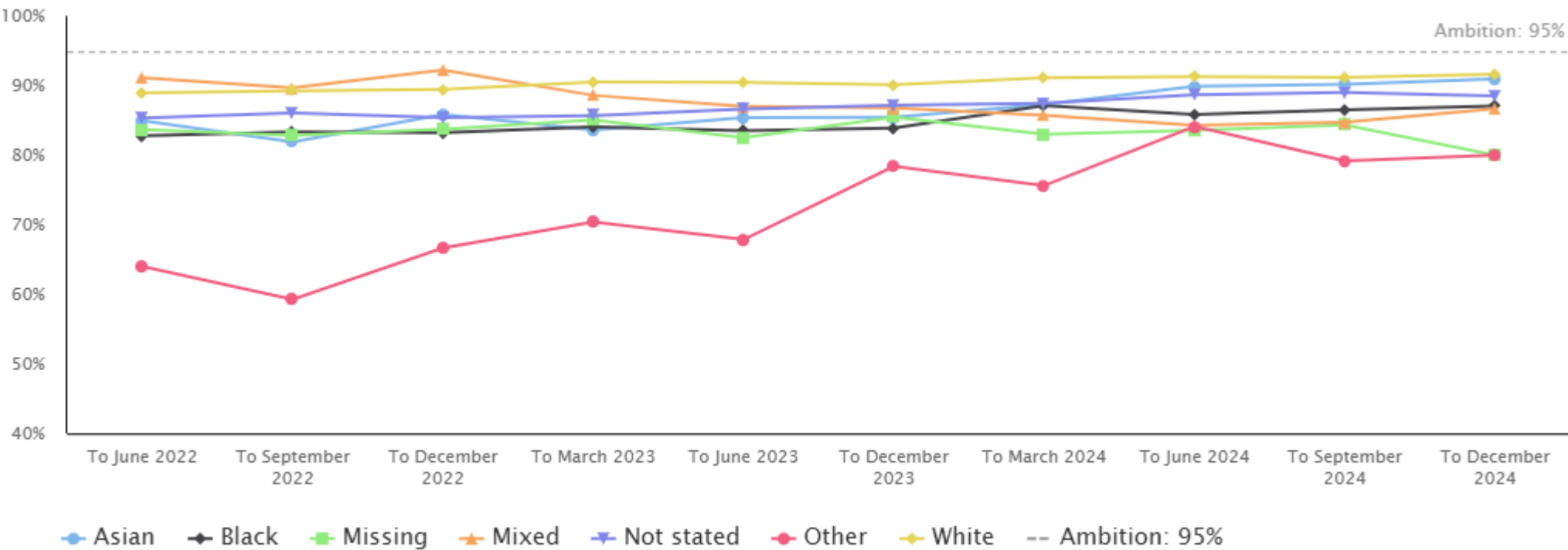
### What does the chart tell us?

Rates of prescribing anticoagulants to reduce stroke risk from AF are lowest in people living in the most deprived areas (IMD1). Rates have been improving across all groups over the 2 year period shown but remain below the national ambition.

### What are we doing?

# Domain 7: Conditions – atrial fibrillation

Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant



### Why are we looking at this?

Atrial Fibrillation (AF) is a heart condition that causes an irregular and often abnormally fast heart rate, in some cases, it can be considerably higher than 100 beats a minute. The way the heart beats in atrial fibrillation means there's a risk of blood clots forming in the heart chambers. If these enter the bloodstream, they can cause a stroke. AF is a major risk factor for stroke and contributes to one in five strokes. Anticoagulants reduce the risk of blood clotting and are the main treatment for lowering stroke risk in patients with AF

There are two main types of medications, direct acting oral anticoagulants (DOACs) such as apixaban (this is the preferred option in most cases), or vitamin K antagonists such as warfarin, which are recommended when DOACs are not indicated. The NICE AF guidance suggests that DOACs are a more effective anticoagulation option in patients with high risk AF<sup>19</sup>.

### What does the chart tell us?

Rates of prescribing anticoagulants to reduce stroke risk from AF are broadly similar across ethnic groups. There has been a significant improvement in the 'Other' ethnic group over the 2 year period shown.

### What are we doing?

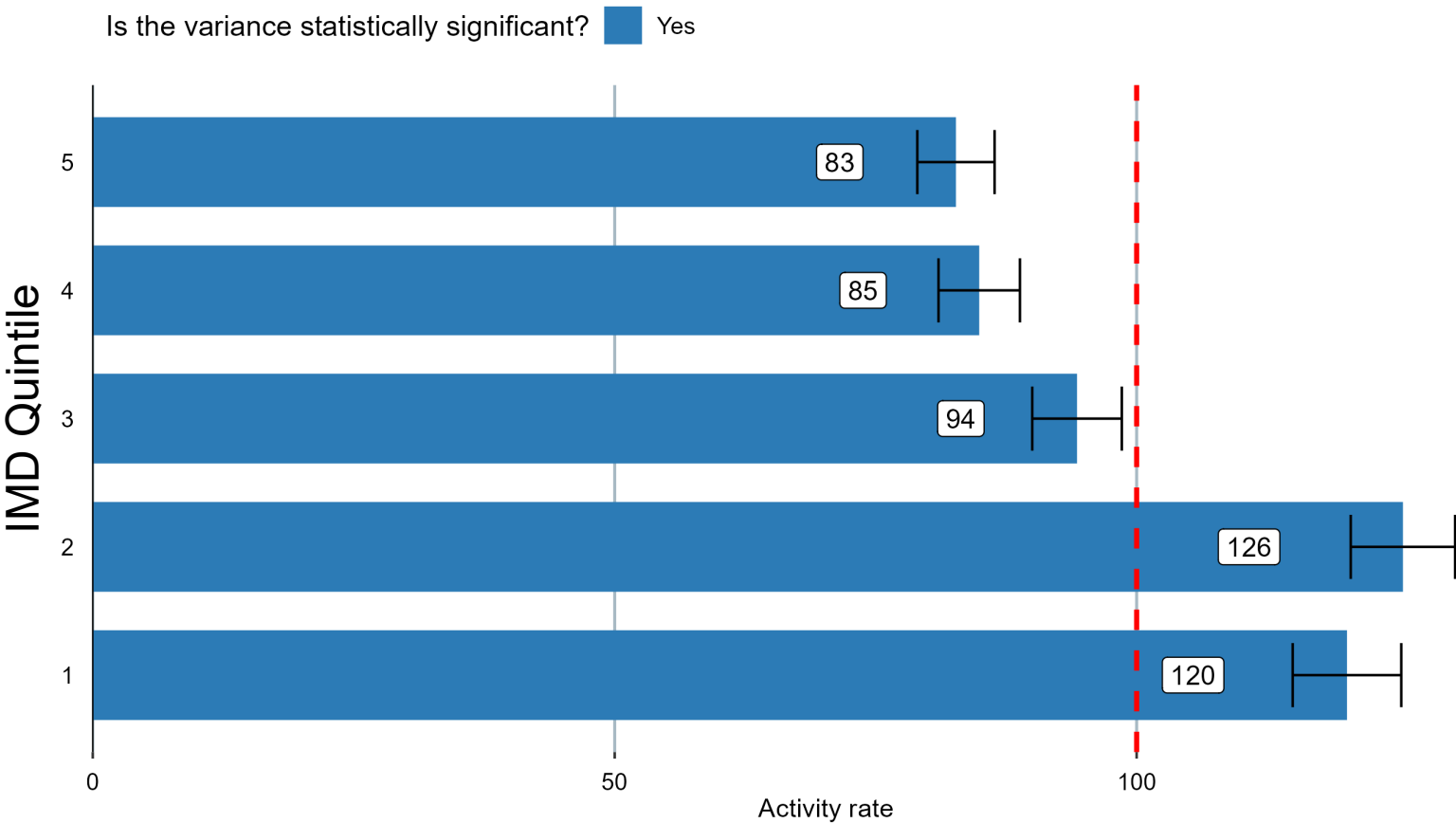
Data source: CVD Prevent  
Date range: June 2022 to December 2024

Definition: Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant

# Domain 7: Conditions - stroke

## Non-elective admissions for stroke by IMD quintile

Age and sex standardised activity rates (100 = the BNSSG average),



### Why are we looking at this?

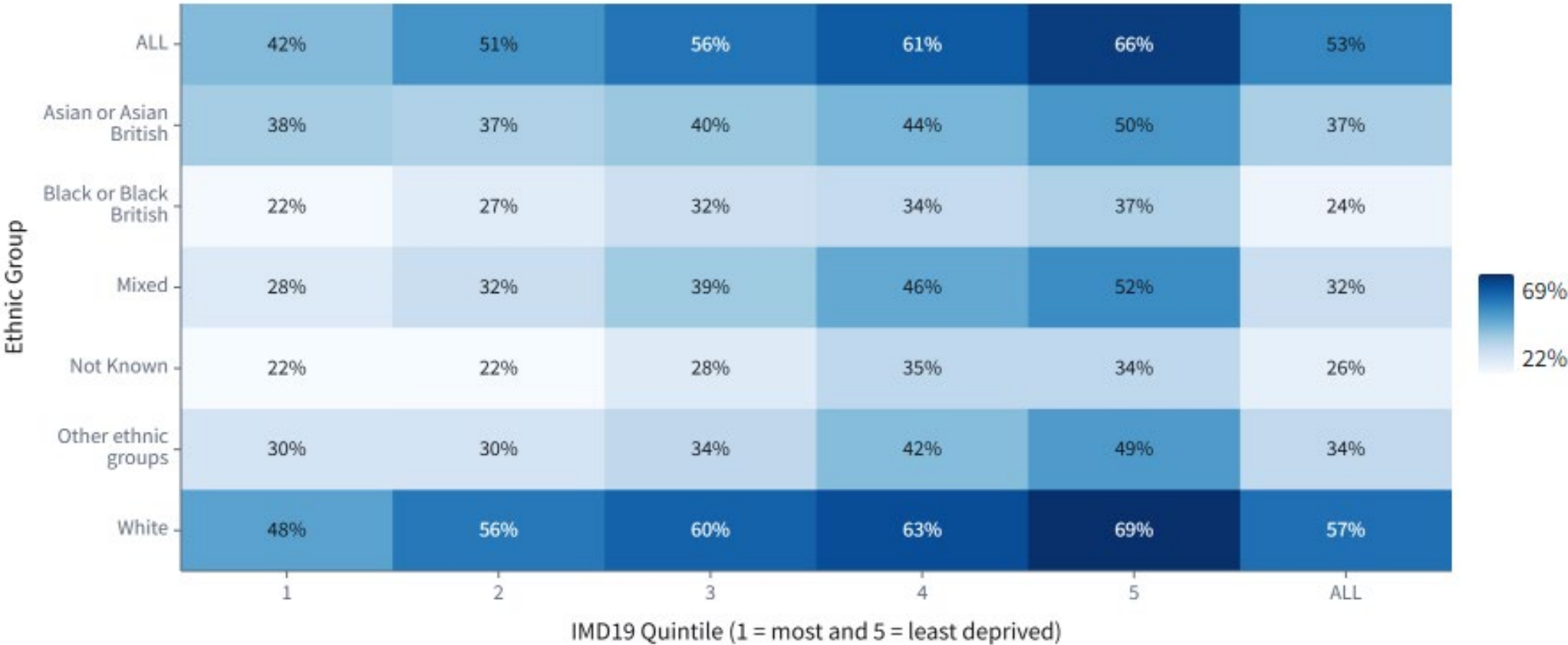
People living in the most deprived communities have higher prevalence of heart and circulatory diseases, including stroke. They are more likely to die earlier from cardiovascular disease (CVD) and they are less likely to access healthcare services. The reasons for this are complex. People living in deprived areas are more likely to smoke and be overweight or obese, which are risk factors for CVD. People living in deprived areas have a greater need for treatment but may have less access to it. Emergency admissions for CVD are higher in areas of high deprivation<sup>18</sup>

### What does the chart tell us?

Rates of admissions for stroke are significantly higher for people living in the most deprived areas (IMD1 and 2) than for those in other areas. Rates are lowest in the least deprived areas.

### What are we doing?

Covid-19 vaccination rates (%) by ethnic group and deprivation quintile



**Why are we looking at this?**  
Research shows that COVID-19 vaccine uptake has been lower amongst most minority ethnic groups compared to the White British group in England. People from Arab, mixed White and Black African, mixed White and Black Caribbean, and all Black or Black British backgrounds were less than half as likely to take up Covid-19 vaccination compared to the White British group. Ethnic inequalities were highest amongst people at the highest risk of severe Covid-19 – older and more clinically vulnerable people, and those living in the most income-deprived areas<sup>21</sup>

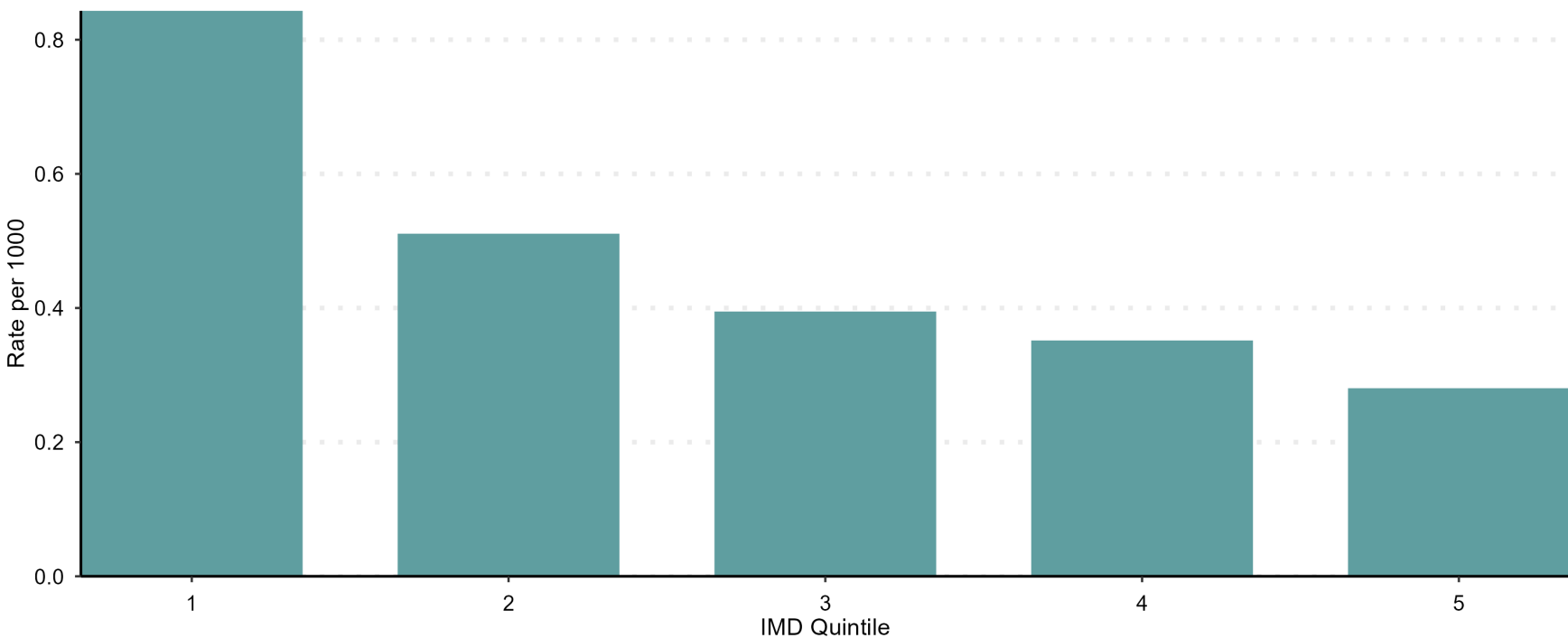
**What does the chart tell us?**  
There is variation in uptake of COVID19 vaccination by deprivation and by ethnic group. People in the most deprived areas (IMD1) are less likely to have a COVID19 vaccination compared to the least deprived areas (IMD5). Rates of uptake are lowest in the Black or Black British ethnic group and rates are lowest in the 40% most deprived areas (IMD1&2).

**What are we doing?**



## Tooth extractions due to decay by IMD quintile

Apr-24 to Mar-25 position for BNSSG residents aged 10 and under. Rates per 1000 population



### Why are we looking at this?

Tooth decay and gum disease are the most common dental health issues in the UK. Tooth decay has become less common over the past two decades, but is still a significant health and social problem. It results in destruction of the crowns of teeth and frequently leads to pain and infection. Dental disease is more common in deprived areas compared to affluent communities. The indicator is a good direct measure of dental health and gives us an idea of children's overall health and diet<sup>22</sup>.

National data shows that decay-related tooth extraction rate for children and young people living in the most deprived communities was nearly 3.5 times that of those living in the most affluent communities<sup>23</sup>.

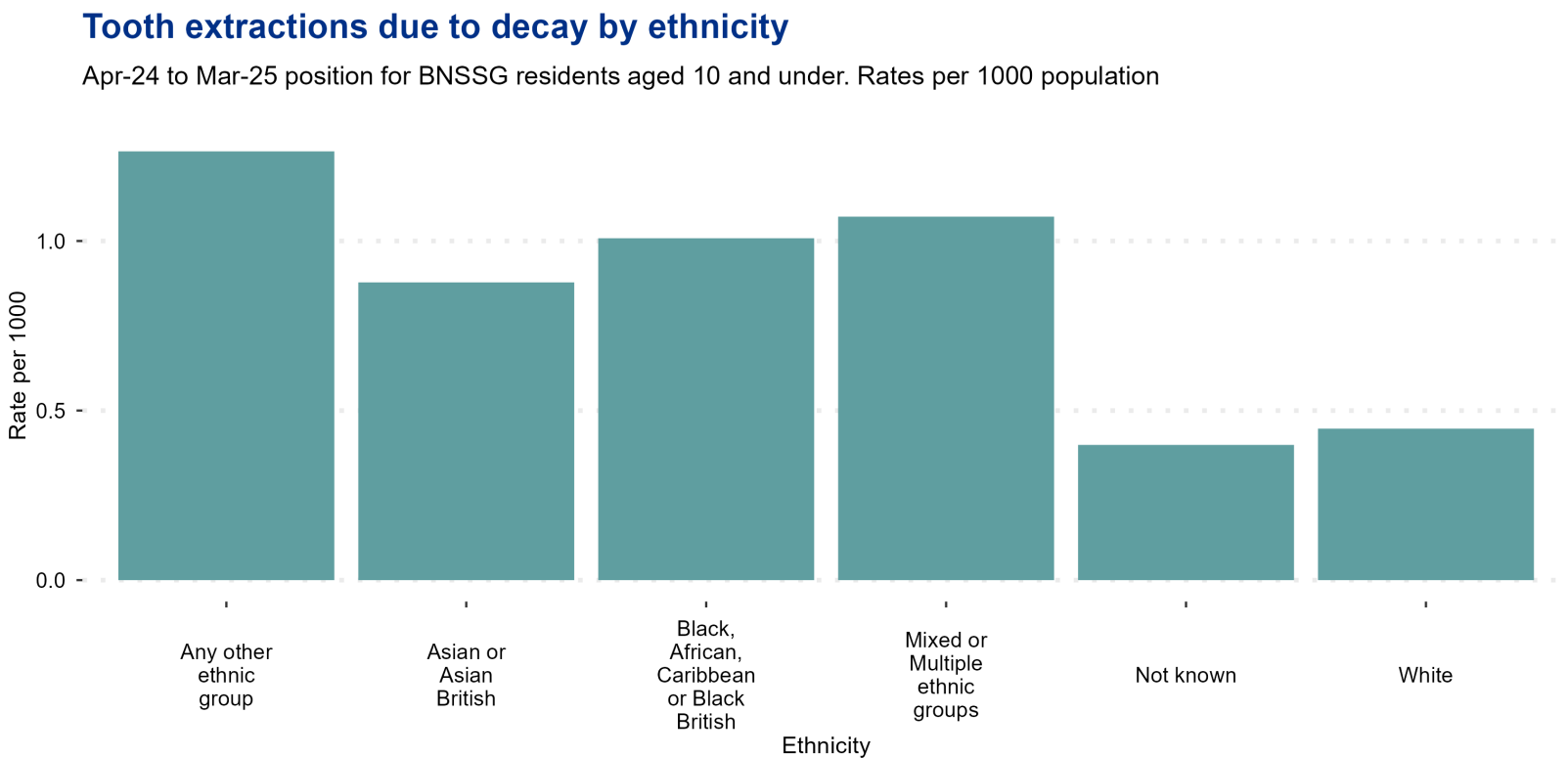
### What does the chart tell us?

The data shows that the rates of children attending hospital for tooth removal are much higher in the most deprived areas (IMD1) compared to other areas.

### What are we doing?



# Domain 7: Conditions – tooth decay



**Why are we looking at this?**

Tooth decay and gum disease are the most common dental health issues in the UK. Tooth decay has become less common over the past two decades, but is still a significant health and social problem. It results in destruction of the crowns of teeth and frequently leads to pain and infection. Dental disease is more common in deprived areas compared to affluent communities. The indicator is a good direct measure of dental health and gives us an idea of children's overall health and diet<sup>22</sup>.

National data shows that decay-related tooth extraction rate for children and young people living in the most deprived communities was nearly 3.5 times that of those living in the most affluent communities<sup>23</sup>.

Children living in areas with the highest proportion of low-income households and those from white Irish, other Asian, Bangladeshi and Pakistani ethnic backgrounds were more likely, and those with excess weight less likely, to require dental extraction<sup>24</sup>

**What does the chart tell us?**

The rates of children attending hospital for tooth removal are lower for those from the white ethnic group and where ethnicity is not recorded, compared to all other ethnic groups.

**What are we doing?**

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