Somerset ICB Statement on Health Inequalities

2025/26

V1

Health Inequalities Legal Statement Requirements

NHS Somerset

- Health inequalities refer to the preventable and unfair differences in health outcomes and access to healthcare experienced by different groups within a population. These inequalities can be influenced by a variety of factors, such as socioeconomic status, geographical location, ethnicity, education, gender, and employment. Health inequalities manifest in disparities such as differences in life expectancy, the prevalence of certain health conditions, and the quality of care people receive. These disparities are often rooted in the wider social, economic, and environmental conditions in which people live, which are known as the wider determinants of health.

- "Health inequalities are avoidable, unfair and systematic differences in health between different groups of people that arise because of the conditions in which we grow up and live, the environment or area we live in, the group we belong to or the opportunities we have to lead healthy lives." Health inequalities in a nutshell | The King's Fund

- All ICBs have a statutory responsibility to improve population health, tackle health inequalities, support wider socio-economic development and enhance value for money and our vision within Somerset continues to be to increase the healthy life expectancy of the population we serve, with a focus on reducing health inequalities

- NHS bodies must publish annual reports that review the extent to which NHS England's steers on inequalities information have been addressed. This Statement is designed to support ICBs and Trusts to fulfil their legal duties and inform an evidence-led improvement approach to tackling health inequalities, aligned with the Core20PLUS5 approach for adults and children and young people (CYP)

- It provides guidance on how health inequalities information should be used to inform local action and how this should be reflected in annual reports

- NHSE first published its Statement in November 2023 and committed to it being reviewed every 2 years; the revised Statement was published in November 2025 and provides the framework for the Health Inequalities report 2025/26

- **ICBs, Trusts and Foundations Trusts must report on three key reporting categories: Operational priorities, Core20PLUS5** and **Data Quality**
  - **Operational priorities:** Elective care, Urgent and emergency care
  - **Core20PLUS5 - Adults:** Maternity, Mental health, Respiratory disease and smoking cessation, Cancer, Cardiovascular disease, Vaccines, Learning disability & autism
  - **Core20PLUS5 – CYP:** Asthma, Diabetes SEND, learning disability, autism and epilepsy, Oral health & Mental health

- **Guidance:** NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

Health Inequalities Legal Statement Requirements

NHS Somerset

- This Health Inequalities Appendix to the Annual Report for 25/26 provides a clear and evidence-based account of how the ICB has discharged its statutory duty under section 14Z35 of the Health and Care Act 2022 to exercise its functions with a view to securing continuous improvement in the quality of services, including their effectiveness, safety and the experience of people who use those services. Somerset ICB demonstrates that quality improvement is embedded as a core principle across commissioning, service delivery and system oversight throughout this report; it is evidenced through the systematic use of population health and inequalities data (see specific programme updates) to inform decision-making, ensuring that resources and interventions are targeted towards areas of greatest need and unwarranted variation

- Robust governance and assurance arrangements are in place to oversee this work, including Board-level scrutiny and the role of system groups such as the Population Health Transformation Board, ensuring that quality improvement is monitored, evaluated and continuously strengthened. This group during 25/26 was chaired by the ICB's Director of Population Health and Inequalities

- The Board has reviewed the evidence presented within this Annual Report and is satisfied that the ICB has discharged its duty under section 14Z35 of the Health and Care Act 2022 and is assured that Somerset ICB has exercised its functions with a clear and consistent focus on securing continuous improvement in the quality of services, including their effectiveness, safety and the experience of people who use them. This assurance is supported by comprehensive evidence demonstrating that quality improvement is systematically embedded within commissioning, service delivery and performance oversight

- The Board recognises the strength of the ICB's approach in:
  - the routine use of population health and health inequalities data to inform decision-making and prioritisation;
  - delivery of targeted improvement programmes aligned to national priorities, including Core20PLUS5 and key clinical pathways
  - a clear focus on reducing unwarranted variation in access, experience and outcomes for underserved populations; and
  - robust governance and assurance arrangements that provide effective oversight of quality and continuous improvement

- Board has a high level of confidence that Somerset ICB is meeting its statutory duty to improve quality and is delivering measurable and sustained improvements for the population it serves. There is a breadth of evidence presented within this Appendix to the Annual Report and demonstrates a systematic and continuous approach to improving quality and provides assurance that the ICB has effectively discharged its duty under section 14Z35 during 2025/26. The Board will continue to monitor this duty closely and is satisfied that appropriate arrangements (under the proposed new Cluster structure) will be in place to sustain and further strengthen quality improvement in future years.

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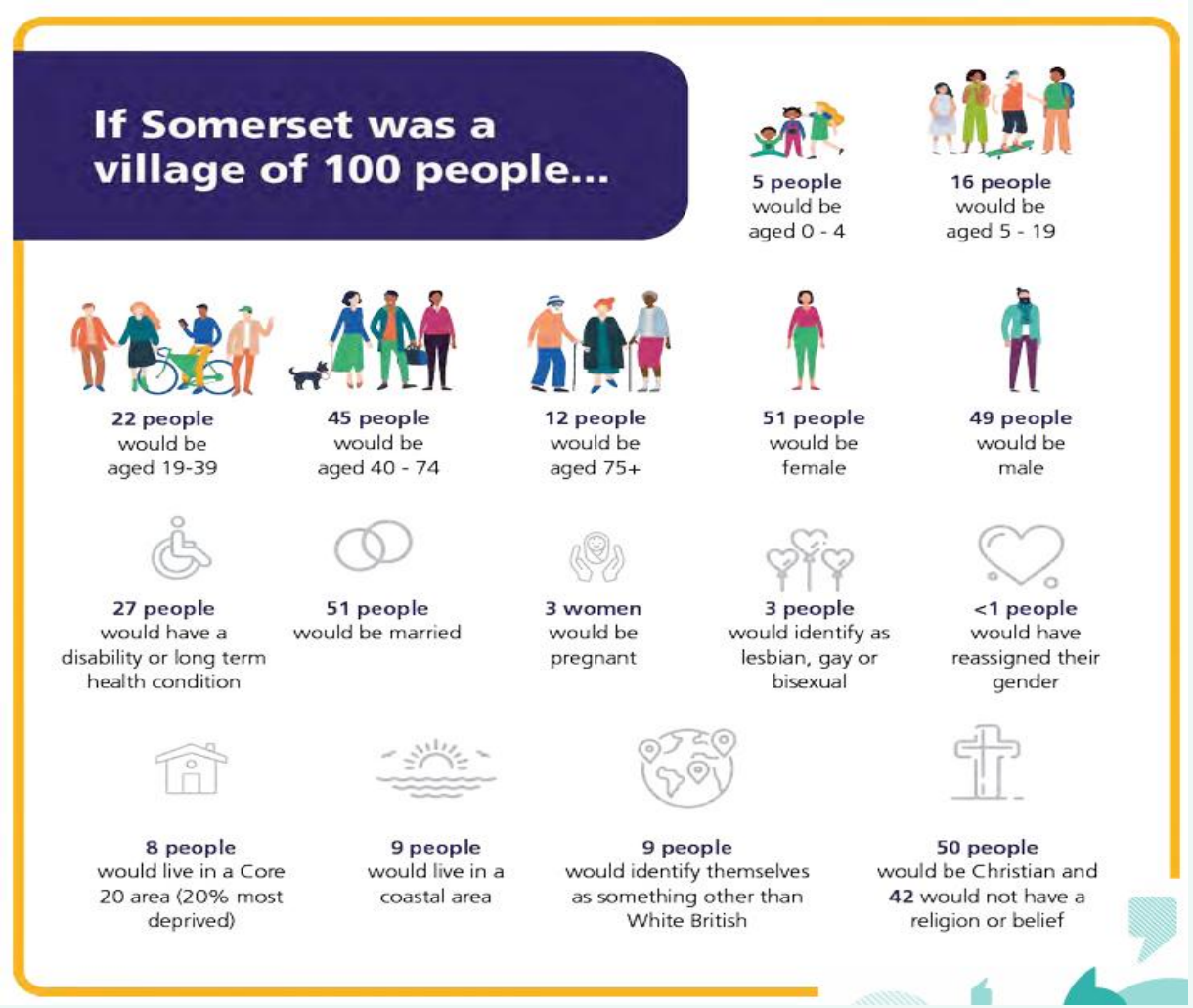
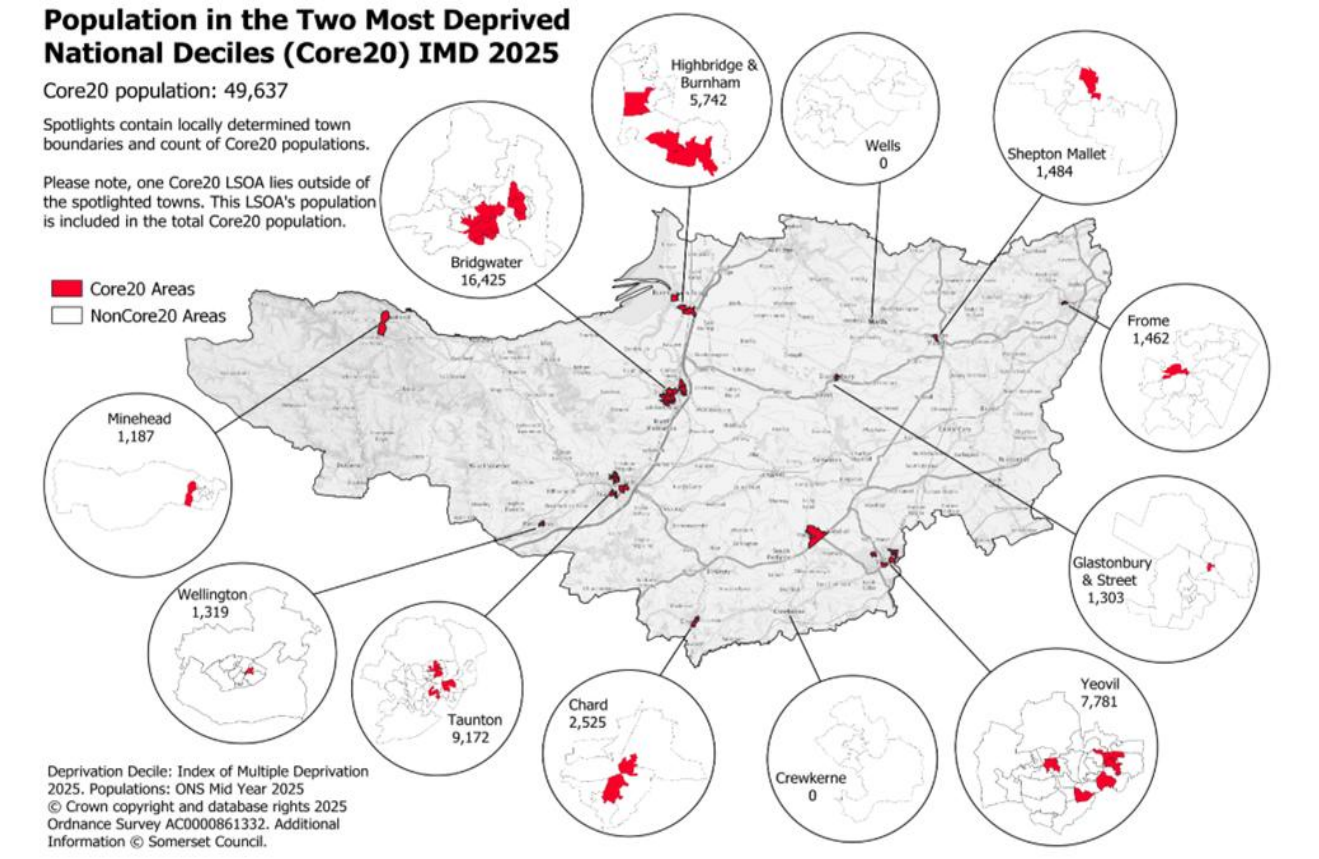
Somerset Population Overview

Somerset Population

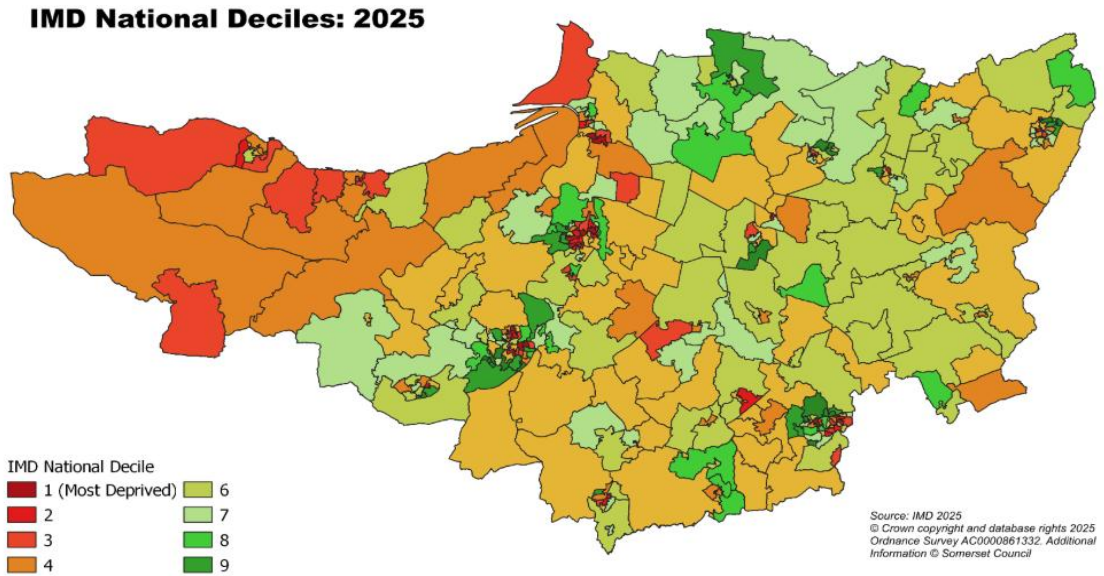


- Somerset covers 3,452 square kilometres (1,333 square miles), one of the largest counties in England and much of Somerset's distinctiveness comes from its rurality, with 48% of the population living in areas described as 'rural' by the Office for National Statistics compared to 18% in England
- 8.5% of the Somerset population reside in the most deprived deciles (deciles 1 & 2) and 9.1% in the least deprived deciles (deciles 9 & 10)
- Census 2021 data shows Somerset remains predominantly White, but diversity is increasing. The majority, 96%, identified with a White ethnic group (with 2% Asian, 1% Mixed, 0.5% Black and 0.5% Other
- 8.5% of Somerset population were born outside the UK, and about half identify as Christian. Within our school aged population, Polish, Portuguese and Romanian are leading non-UK origins and languages
- For a group of 100 people in Somerset, this illustration gives an indication of the proportion with various protected and other important characteristics
- Somerset has less deprivation than the England average. Approximately 10% of the Somerset population fall into the England Core 20 most deprived group
- There is a lot of rural deprivation which is not as extreme and tends to be within an older population but exacerbated by those issues of poor transport, access to services and digital exclusion, especially in the west of Somerset and coastal areas

Somerset Population by Deprivation Deciles



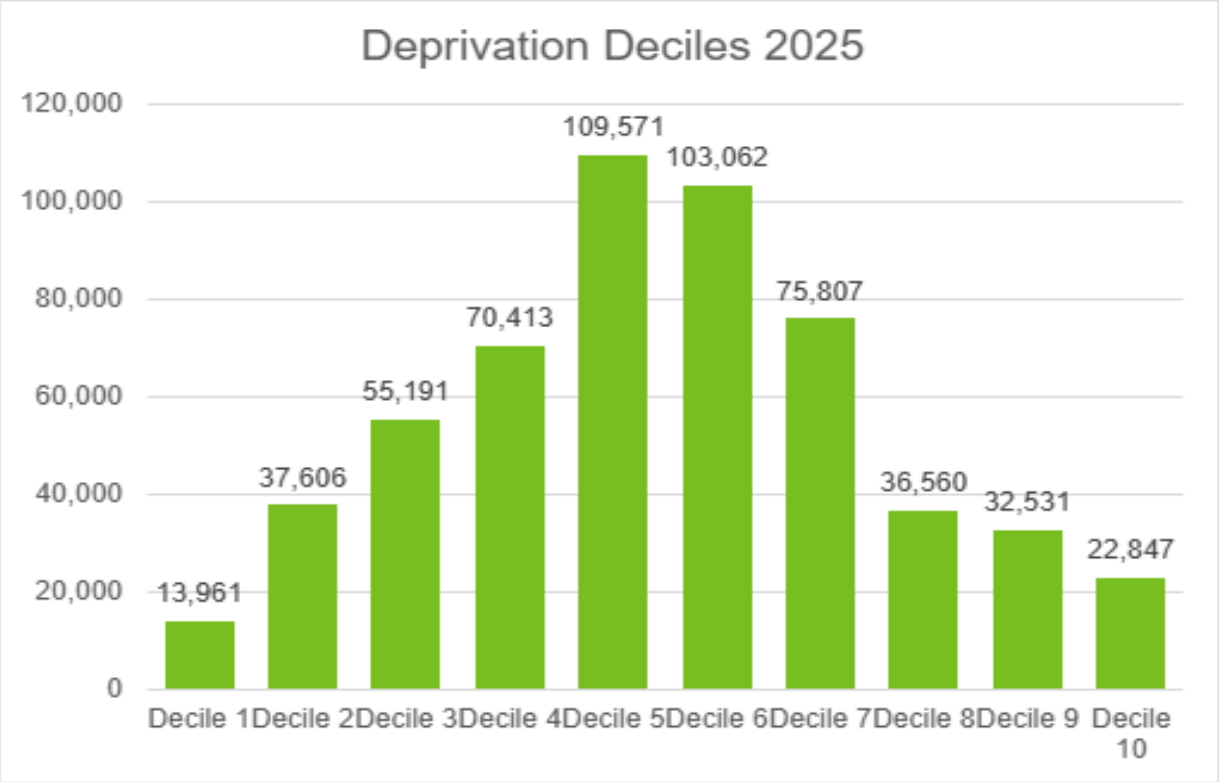
- CORE 20 areas are defined as the 20% most deprived areas in England
- People living in a CORE 20 tend to have worse health outcomes, have poorer access to health services and have a lower life expectancy than people who don't live in a CORE 20 area.
- Certain health conditions and health behaviour are more common in CORE 20 areas. These include: smoking, obesity, cardiovascular disease and diabetes



- Since 2015, the number of people in Somerset living in a CORE 20 area has increased by 31% from 37,894 in 2015 to 49,637 in 2025 compared to 7.5% in the other deciles (deciles 3-10)

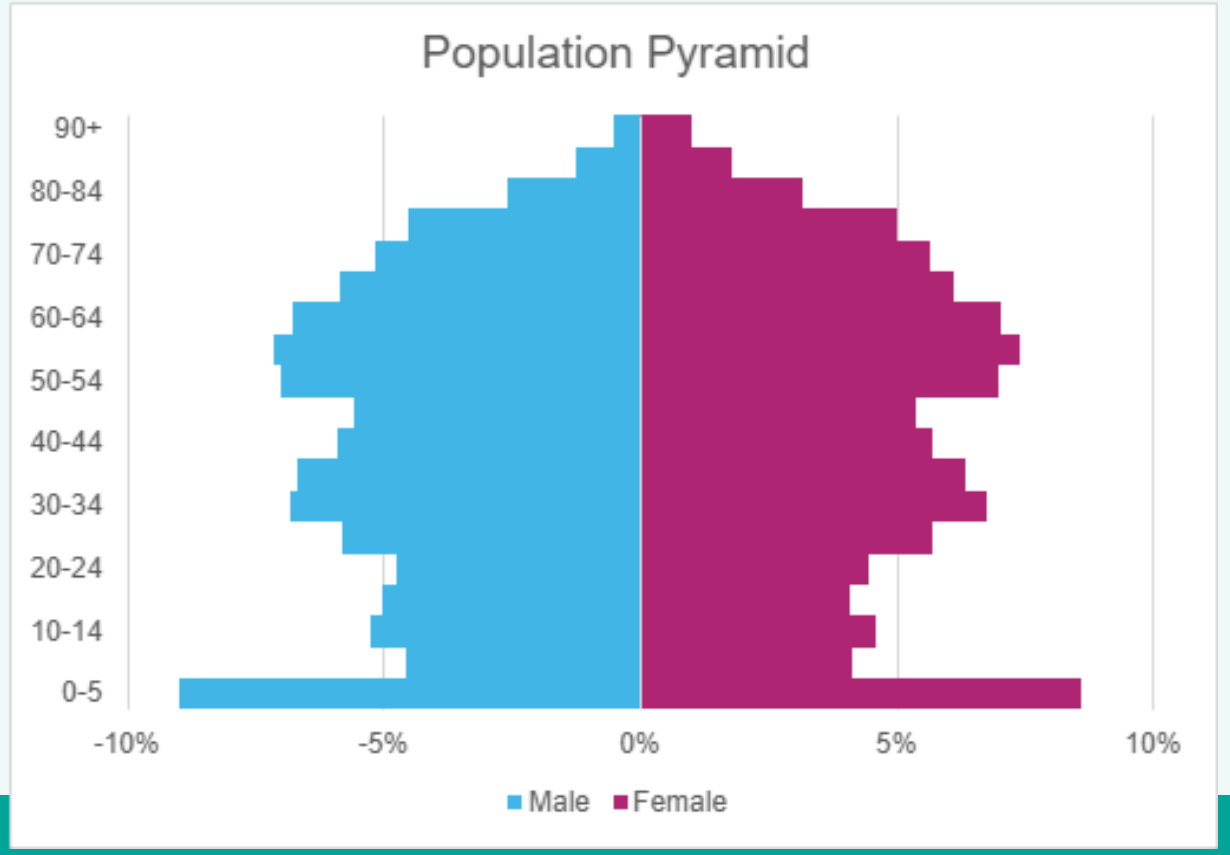
Note: Map from Microsoft Power BI

Somerset Population



- 8.5% of Somerset population is in the most deprived deciles (deciles 1 & 2) and 9.1% in the least deprived deciles (deciles 9 & 10)

- Somerset's total population is 606,201 of which 49% is male and 51% female
- The age breakdown of our population is 21% are aged under 18, 58% aged 18-64 and 21% aged 65 and over



Somerset Population

- The major conditions which impact Somerset residents are similar to the rest of England and are driven by behavioural factors or conditions with good potential for avoidance through adoption of healthier lifestyles, early detection and treatment. However, it is also clear that those in CORE20 groups are carrying a greater burden of those risk factors. We need efforts in Somerset to co-produce support for those in more deprived areas like parts of Bridgwater, Highbridge, Yeovil, Taunton and Minehead addressing barriers to access and ensuring these populations receive equitable healthcare.

- Somerset has an older population profile, which is already associated with higher levels of chronic and age-related conditions. However, available data suggests that a significant proportion of these conditions remain undiagnosed. As the population aged 65 and over continues to grow, there is likely to be a substantial increase in the number of people living with age-related conditions such as dementia, frailty and falls. This will place greater emphasis on how the system identifies and manages multi-morbidity, and how it supports people to live well with ill health in later life. Earlier detection of existing conditions can enable timely treatment and help to reduce complications. This issue is particularly pronounced in West Somerset and South Somerset West, where the population is older than the county average.

- Homogeneity of the population in terms of languages spoken and cultural background pose less of a demand on service design than geographic spread of the population across the rural setting. There is a pattern of younger urban deprivation along with poorer mental health and older more affluent but isolated residents with more physical older age-related conditions which impacts on understanding health outcomes, service design and delivery. There is a need to invest in housing both to address fuel poverty but also explore technology adaptations and remote delivery where appropriate which may enable to older rural population to live independently for longer.

- This report provides an overview of health inequalities in Somerset focusing on the 3 reporting priorities (Operating Priorities, Core 20 plus 5 and Data Quality) together with a detailed update across the Somerset Population Health Transformation Board priorities namely: Smoking, Homelessness, Cardiovascular disease, Diabetes, Coastal Communities and Ethnicity recording.

Somerset Health Inequalities Priorities

Review of the Entire Population Health Programme ("Trivial Pursuit" breakdown)

NHS Somerset

Treatment to Prevention Shift (Orange Segment)

Includes: primary care new funding framework, SFT population health strategy, influencing strategies.

- Primary care commissioning is expected to stay at Place level.
- SFT work will remain within SFT's own governance.
- Strategic elements related to treatment–prevention will move under the cluster ICB.

Tackling Health & Healthcare Inequalities (Blue Segment) - Includes:

- Inclusion Health / Homeless Health Service
- Maldaba digital exclusion project
- Highbridge & Burnham navigator work
- Elective care inequalities
- Core20PLUS5 (Adults & CYP)

Recommendations:

- Homeless Health → commissioned at cluster level, delivered at place.
- Maldaba, Highbridge/Burnham, Coastal Navigators → remain Somerset place-based.
- Elective Care Inequalities → move into SFT's BAU portfolio.
- Core20PLUS5 → Strategic oversight at cluster ICB → Delivery across all places via Place Boards

Workforce & Culture ("Changing Hearts and Minds" – Yellow Segment)
Includes:

- Population Health e-learning
- Population Health Ambassador Programme (50 sign-ups in one month)
- System-wide comms on prevention and inequalities

Recommendations:

- This work is best delivered at Place level, not cluster level.
- The ambassador model is viewed as essential to sustaining behaviour change and should be retained.

Major Conditions (Green Segment)
Includes: hypertension (case finding + optimisation), smoking cessation, liver disease early detection.
Key Points:

- Hypertension case finding to be stepped down; focus now on optimisation to reach national targets.
- Smoking cessation remains led by Public Health and the Tobacco Alliance - but should remain monitored by a population health governance mechanism.
- Early Liver Disease Identification (SFT led) to move into SFT BAU as a strong secondary care population health programme.

Data, Intelligence & Digital (Purple Segment) - Includes:

- Integrated Data Platform (IDP) development
- Data governance
- DiiS links to Dorset & BSW work

Recommendation:
Governance and platform development must sit at the cluster ICB, but use of the data tools must be embedded at Place level.

Neighbourhood Development (Red Segment) - Includes:

- Optum PHM pilot
- Neighbourhood PHM methodology
- Development of neighbourhood contracts and outcomes

Recommendation:
This sits with the Somerset Place Board, as neighbourhood architecture is place specific.
Data tools like Optum will support neighbourhood team design.

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Operational Priorities

Operational Priorities

Domain	Measure	Core or Supporting Metric	Included in Report		Basis of Reporting
Elective care and community services	Inequalities in percentage of people waiting 18 weeks or less for elective treatment	Core	☑	Pages 11-16	Waiting times across Somerset, and reported by Deprivation, Age and Gender. Data source: WLMDS Feb-25 vs Jan-26
	Inequalities in percentage of people waiting over 52 weeks for elective treatment	Core	☑		
	Inequalities in annual change in size of waiting list	Core	☑		
	Inequalities in percentage of people waiting over 18 weeks, over 52 weeks, over 104 weeks for community services	Core	☑	Page 19	Community waiting times at Somerset FT, and reported ny Gender and Deprivation Decile. Data Source: local waiting list reporting
	Inequalities in rates of did not attends/was not brought across elective services	Supporting	☑	Page 18	Somerset, and reported by age group, gender and deprivation. Data Source: OP SUS YTD 25/26 vs 24/25
	Inequalities in rates of did not attends/was not brought across community health services	Supporting			Work underway to report via the Community Services Dataset in 26/27
	Inequalities in access to community health services	Supporting			Work underway to report via the Community Services Dataset in 26/27
	Inequalities in access to community health services for people who are frail	Supporting			Work underway to report via the Community Services Dataset in 26/27
Urgent and emergency care	Inequalities in mean time in emergency department	Core	☑	Pages 17-22	Departments, and reported by Deprivation, Age and Gender and presented as an average (mean) time (in hours). Data source: ECDS Data for 2025/26 YTD (Apr25-Mar26).
	Inequalities in the proportion of ambulance patients in cardiac arrest that receive a post-ROSC care bundle	Core			Data source to be identified to report upon this indicator
	Inequalities in the proportion of ambulance patients with a ST-elevation myocardial infarction (STEMI) that receive the appropriate care bundle	Core			Data source to be identified to report upon this indicator
	Inequalities in rates of ambulance calls across different patient groups	Supporting			Ambulance services monthly dataset - work underway to report during 26/27

Elective Care – Waiting list

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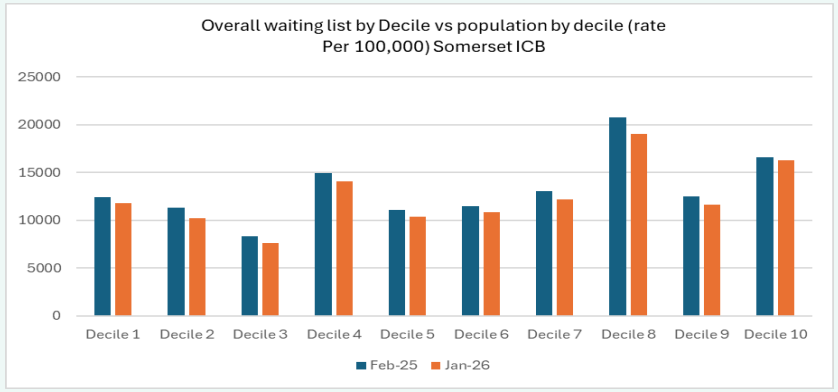

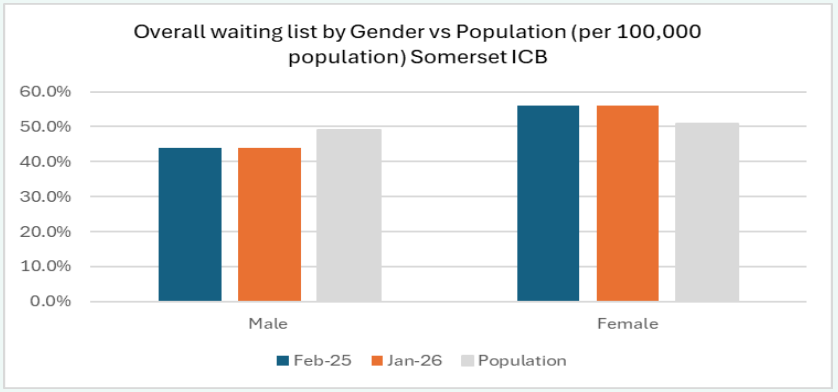

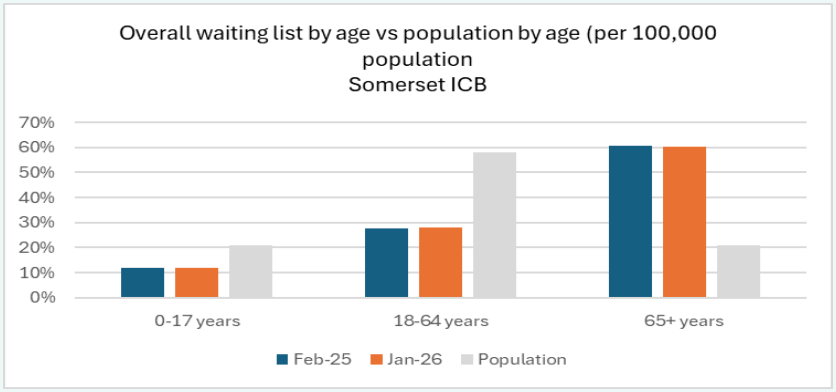

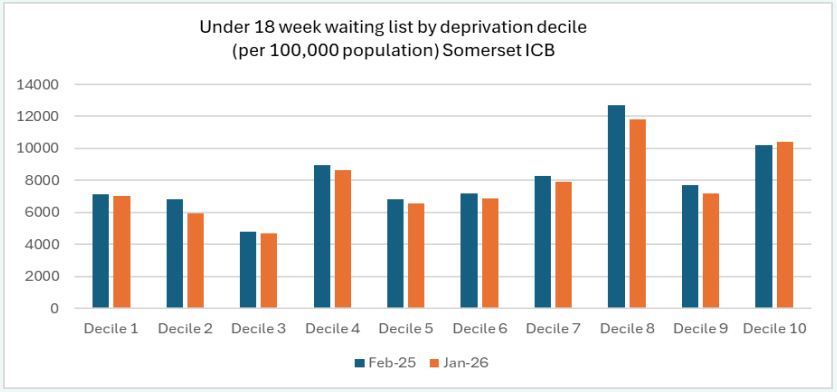

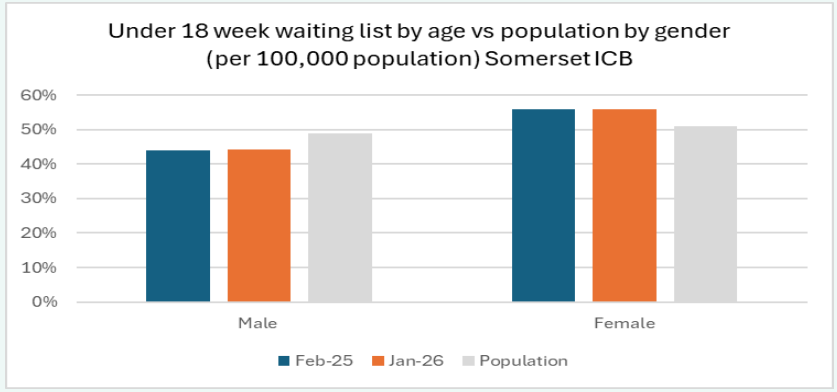

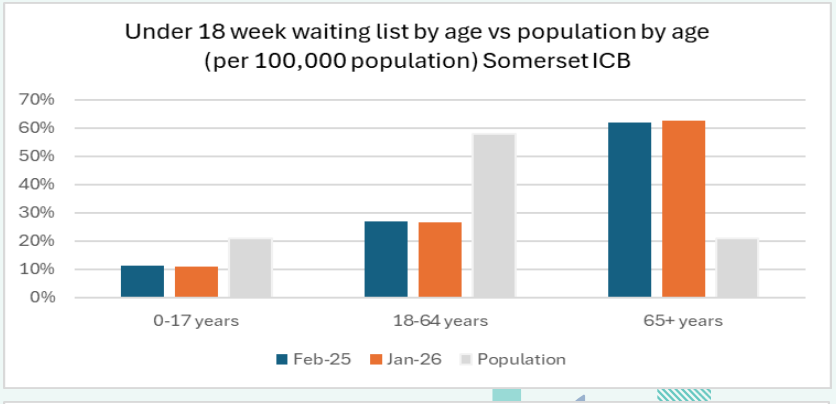

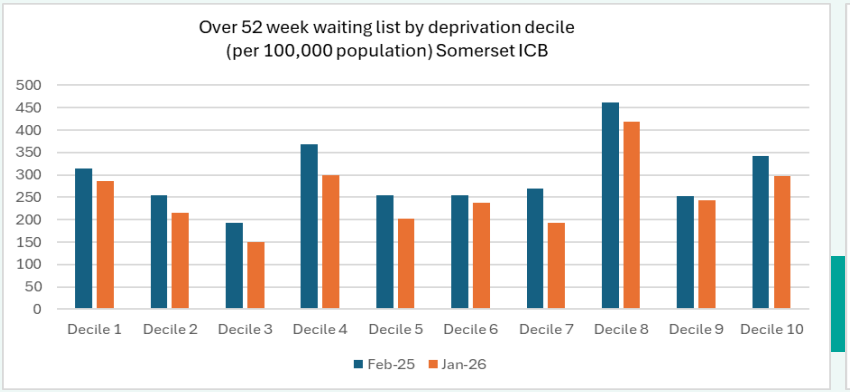

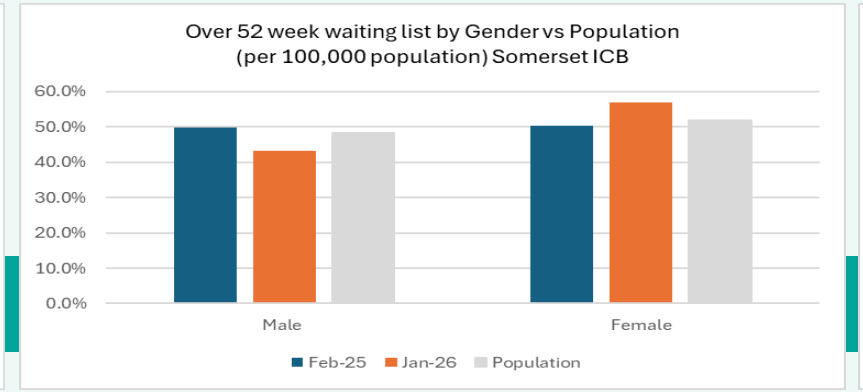

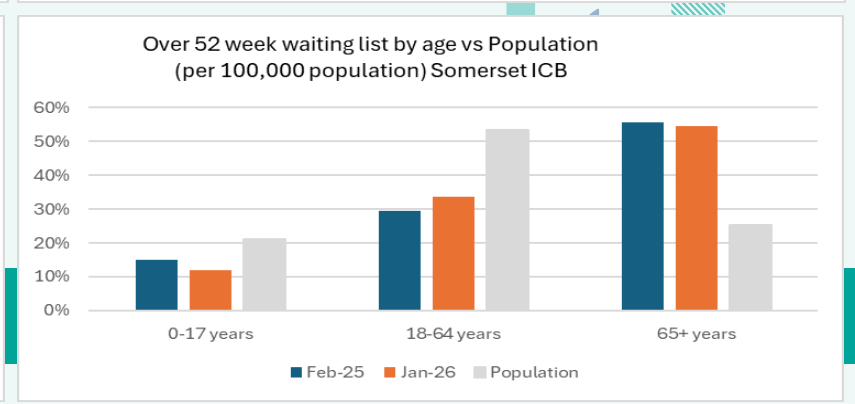

Elective Care – Waiting Lists, Adults

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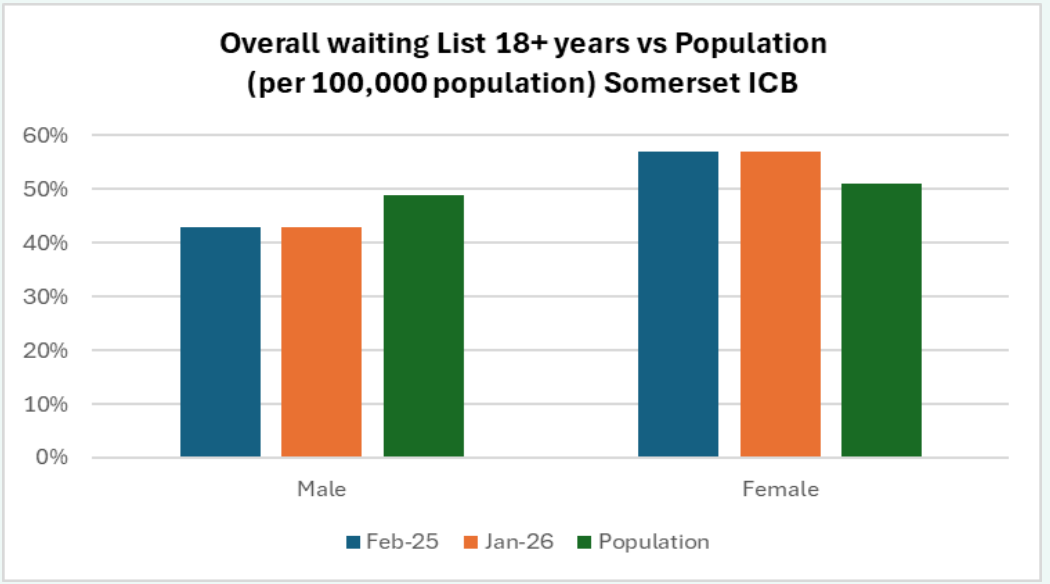
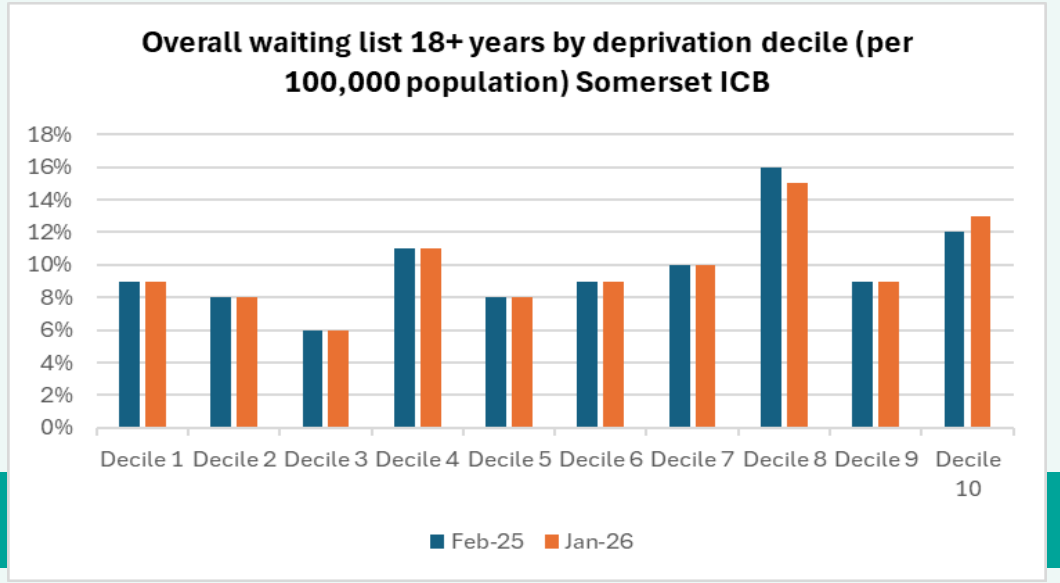
- Somerset FT introduced a targeted prioritisation system in 2022 to speed up elective care for adults and children at highest risk of deterioration whilst waiting. Using a structured, points-based model, the Trust identifies patients with learning disabilities, current mental health referrals or high levels of social deprivation - groups chosen because of their markedly lower life expectancy and heightened vulnerability to delays. Applied to the acute Referral to Treatment (RTT) waiting list, the system flags only around 1.35% of patients, yet its impact has been significant. Since January 2023, 883 outpatients have been upgraded to urgent, reducing average waits from six months to 8.4 weeks and enabling enhanced support from learning-disability liaison teams. Surgical specialties such as gynaecology, orthopaedics and urology have also seen meaningful gains, with prioritised patients receiving surgery 6 to 8 weeks sooner.

- Specific support for patients with learning disabilities has been put in place. Patients with learning disabilities are also flagged to the Learning Disabilities Liaison Teams (both acute and community) so that additional support can be put in place if patients require it when they attend for their appointments. Patients will frequently decline the offer of support, but the phone call itself can highlight specific needs that can be sorted in advance e.g., the need for an interpreter or specialist equipment.

- Overall, the programme has created a robust, evidence-based framework that improves access, reduces inequalities and enhances patient experience, while affecting only a very small proportion of the total waiting list and offering clear potential for further expansion.

- The national focus in 2026/27 is to continue to recover referral to treatment waiting times (those waiting less than 18 weeks as per the NHS constitution). The aim is to improve performance by a minimum of 7 percentage points over the next 12 months, relative to the March 2026 plan. In 2025/26 there was significant focus on reducing the numbers of patients waiting over 65 weeks. There are expected to be fewer than ten over 65 weeks waiters as of the end of March 26.

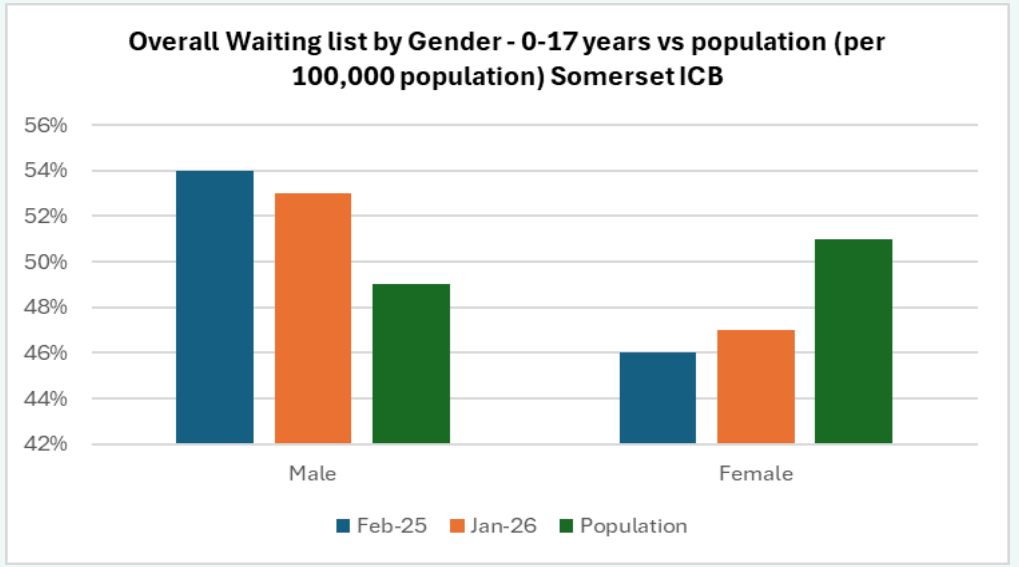


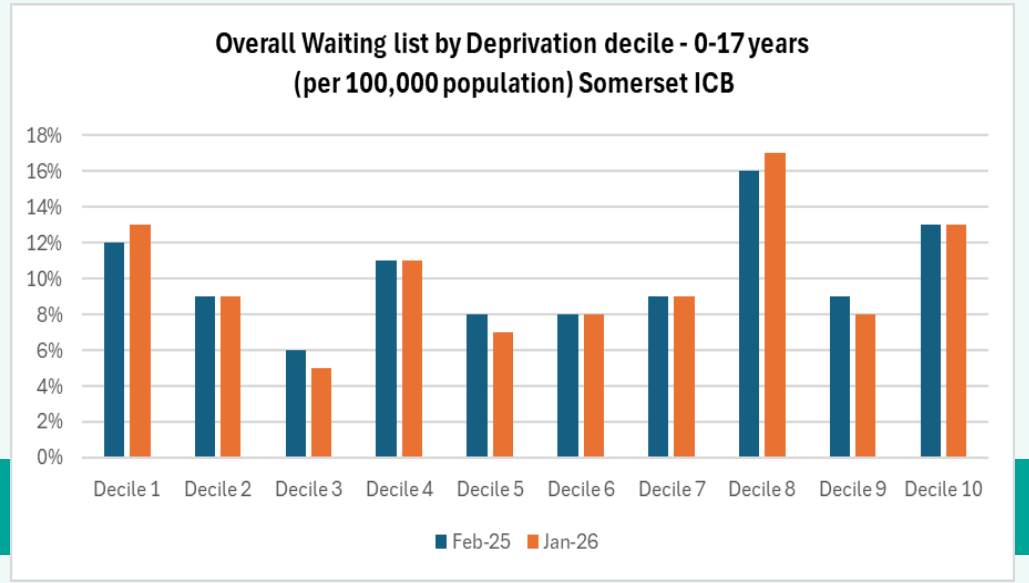


Elective Care – Waiting Lists, Children & Young People

- Children Looked After, paving the way for the adoption of elements of the new national Health Inequalities in Children (HIC) Tool. This tool assesses deprivation, wellbeing, additional needs and the proportion of life spent waiting, specifically for children. Work in 2025 focussed on evaluating the feasibility of full implementation and on rolling out the original vulnerable-patient policy to the Yeovil waiting list, which is now complete.

- Future developments for Children & Young People (CYP) will build on existing safety-netting processes to gather richer information from parents, drawing on principles from the HIC Tool. This will involve collecting information by contacting the parents/carers on a regular basis, on factors which might indicate a CYP patient is not able to participate in school, is not sleeping well, is showing behavioural problems, or withdrawing from activities that would form a normal part of their development. The information we collect will enable us to flag to the clinician responsible for their care, that a clinical review might be required to determine whether the patient's care needs to be expedited. Full implementation is temporarily paused pending increased ENT capacity, as this specialty has a particularly high proportion of children awaiting routine surgery.





Elective Care – Cancer, Early Diagnosis

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- Somerset ICS continues to work to identify and address discrepancies in cancer outcomes, with the aim of increasing the proportion of patients diagnosed at an early stage (i.e., stage 1 or 2). The ICS continues to support the expansion of targeted lung health checks and other initiatives to improve the proportion of patients with lung cancer diagnosed at stage 1 or 2. Patients with Learning Disabilities and other groups who do not access screening, a powerful tool in early diagnosis of cancer, are being targeted for additional support with this process to try and boost engagement. We also continue to use the system's suspected cancer referral and treatment data to explore the full range of inequalities in patients by demographics, geographic areas, and other relevant factors.

- Somerset Foundation Trust's approach to supporting the earlier diagnosis of cancer is also to target populations which our analysis of patients diagnosed with cancer suggests, present with later stage cancers and/or receive a diagnosis following attendance as an emergency rather than being referred by their GP. We continue to develop ways which makes it easier for patients to come forward and have any tests they need. Self-referral is a way in which people can have quick access to any diagnostic tests they need and complements the more 'traditional' route of going to a GP, which some patients might find is difficult because of a range of reasons, including work patterns, where they live, they can't take time off work, or they have childcare commitments.

- Following the successful establishment of one-stop community clinics across Somerset, for people referring themselves with bleeding after menopause, which is a potential symptom of endometrial cancer, we have in the last year piloted and rolled-out across the majority of Somerset, self-referral for particular groups of the population who have symptoms of bowel cancer. The Somerset Bowel Service accepts referrals from people in the 40–49-year-old age group. Since 2021, more than 54% of bowel cancer diagnoses has been in individuals under 50 not made through urgent suspected cancer routes. Bridgwater was initially chosen as a pilot site because our analysis of the data we collect indicates that patients from this part of the county are more likely to be diagnosed with a more advanced stage of bowel cancer, and present via the Emergency Department, than people living in many other areas of Somerset. Following the successful pilot this has been rolled out to the majority of Somerset, with work being undertaken in the remaining areas that face other providers. Patients self-referring are asked to complete a questionnaire, so that we can more fully understand their symptoms, and if the symptoms suggest they could potentially have a cancer, they will be sent a Faecal Immunochemical Test (FIT) kit. Those patients with a positive FIT are then fast-tracked for a further investigation within Somerset Foundation Trust (SFT). As of the end of February 26 we had received 596 bowel cancer self-referrals, with 14% of these having a positive FIT and needing further investigation at SFT and 35% of these either having a cancer diagnosed or needing future surveillance due to being at high risk of developing a bowel cancer in the future.

Elective Care – Cancer, Early Diagnosis

- Somerset ICS has also been piloting alternative options for patients with potential symptoms of breast cancer. Women over 30 who have concerning breast symptoms are able to self-refer directly to a local breast diagnostic clinic using 111 online, the NHS App, or the Somerset NHS Foundation Trust website. Previously, women needed a GP appointment for referral; now, a short online triage identifies eligibility and enables direct referral to secondary care, streamlining access to specialist assessment and easing pressure on GP services. The digital pathway has helped more than 400 women so far to complete self-referral, resulting in faster diagnoses, with 6.94% of referrals confirming cancer compared to the national average of 5%. The initiative has also led to a 23% reduction in GP referrals, freeing up vital clinical resources.

- In the last year Somerset ICS has also piloted and rolled-out the Somerset Chest X-Ray service which allows people aged 40 or over, to check if they need an x-ray to rule-out lung cancer. So far there have been 61 referrals, 20% having a suspicious chest x-ray and 3 cancers being diagnosed.

- In total, just under 2,900 self referrals have been through these self and direct referrals services, since the original 'Go Live' of the bleeding in menopause service in September 24, with 116 cancers found and the equivalent of 3.2 months of GP time saved.

- The strategy for the next three years for cancer services is to continue to address health inequalities and late cancer diagnoses by expanding the range of access options to patients, through self referral, direct referral through NHS 111 and community pharmacists and case finding to identify high risk patients for screening. This innovative access to cancer diagnostic services enables more patients to come forward to promote earlier diagnosis, including from some of the harder to reach communities who may find accessing their GP more challenging. It also reduces the waiting times for patients, both for those for whom the tests rule-out cancer, but also those receiving a cancer diagnosis who then need treatment.

- We will also continue to identify opportunities to improve cancer pathways through the introduction of medical technologies and innovations. In March 2026 we commenced a pilot of WID-Easy, a high vaginal swab to rule-in or rule-out endometrial cancer within 72 hours of the swab being taken. This has the potential to revolutionise the diagnostic pathway for patients referred with a suspected endometrial cancer, making it easier for them to access a test.

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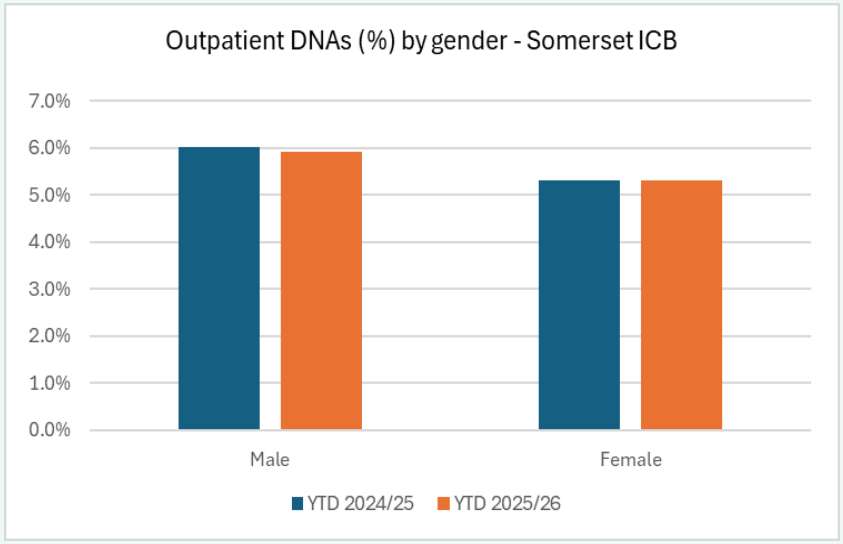
Elective Care – Cancer, Early Diagnosis

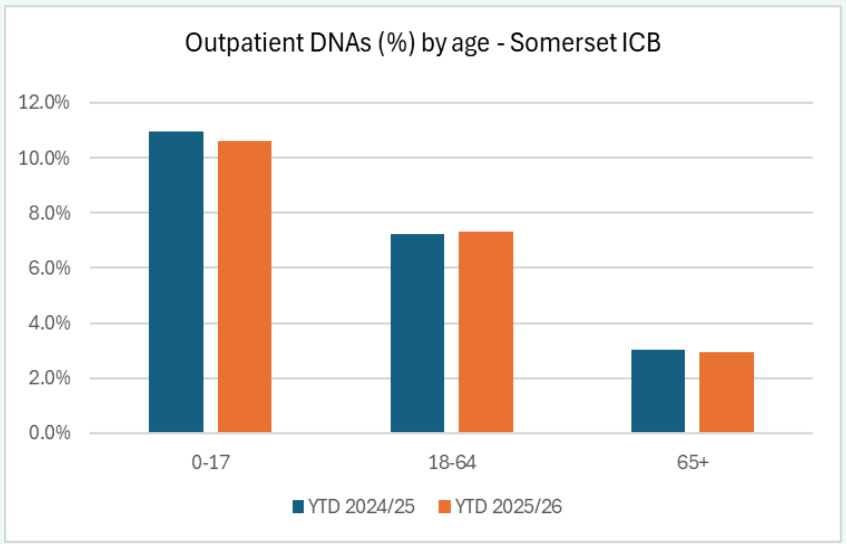
- We have recently also commenced a pilot of using capsule sponge for screening high risk patients for potential Oesophageal cancer, this case finding approach will identify those patient at a risk of developing an oesophageal cancer. Oesophageal cancers are frequently diagnosed at a relatively late stage with a poor prognosis, and due to the risk factors more often diagnosed in people from areas of high social deprivation. So ease of access and early identification is critical. Patients identified through the case-finding approach will be invited to attend a clinic appointment, where the capsule, which has a string attached, is swallowed. The capsule then expands in the stomach and when retrieved with the aid of the string, contains a sample of cells from the oesophagus which is then analysed using an antibody test, to identify pre-cancerous cells. The use of capsule sponge for triaging patients with reflux symptoms waiting for gastroscopy and patients under surveillance with Barrett's oesophagus is also under consideration, because it will help reduce the need for patients to undergo an endoscopy, and again make services more accessible.

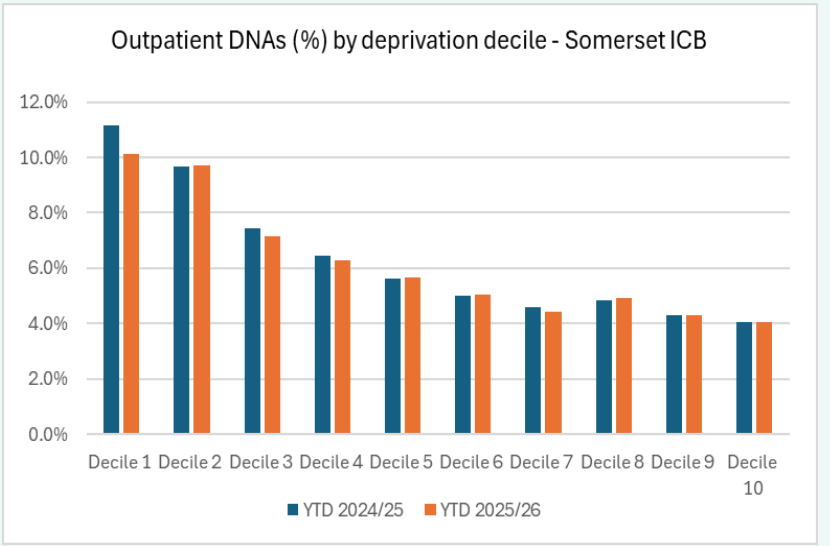
- In 2026/27 we similarly have plans to establish self-referral services for patients with potential bladder cancer, and people at higher risk of developing prostate cancer. The latter will include black men or men with a family history of prostate cancer, aged 45 to 65 years old.

Other Data Insights

Inequalities in Rates of 'Did Not Attend'

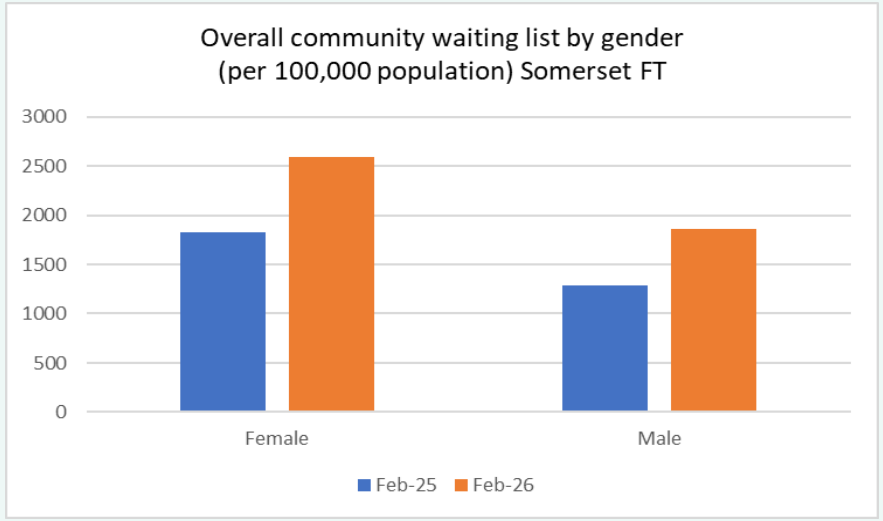


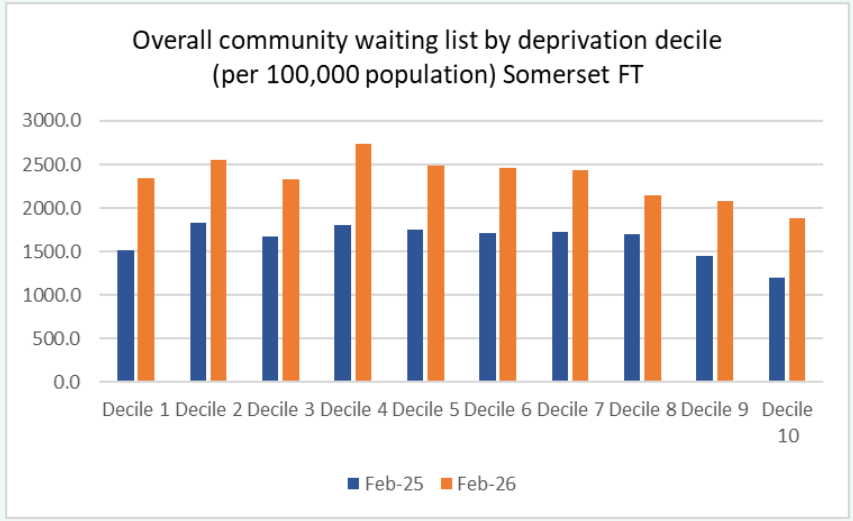


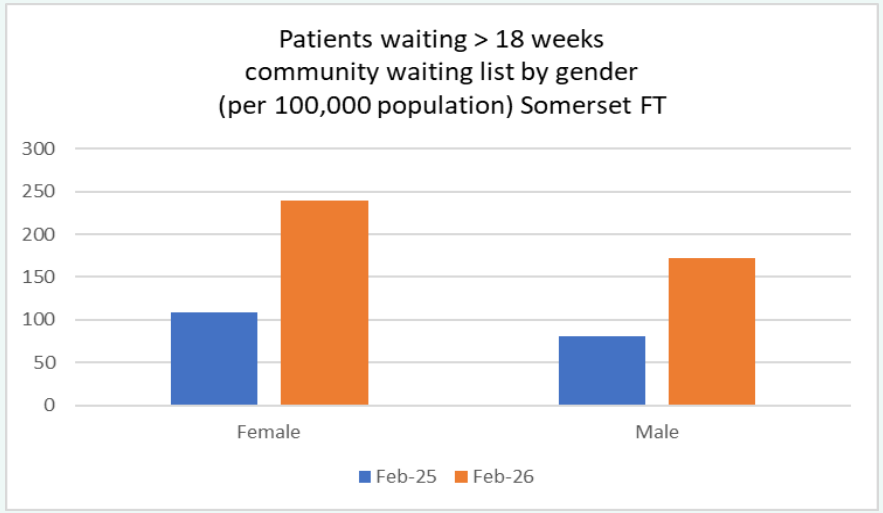


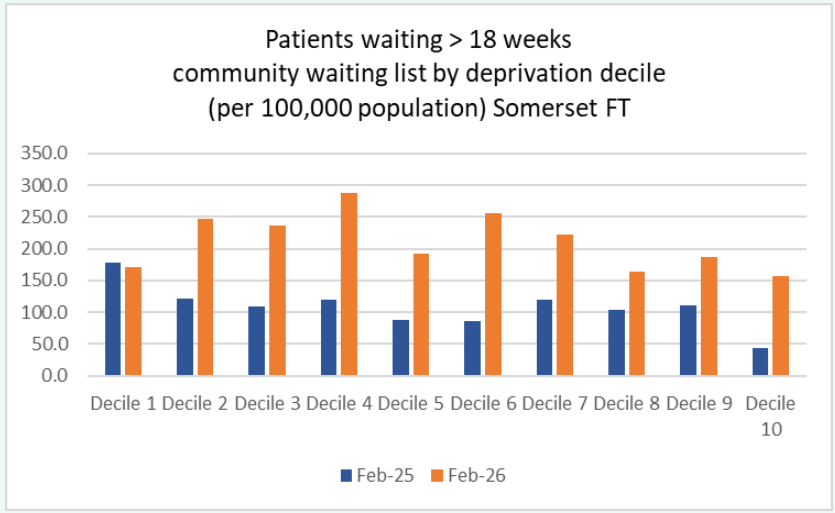
- The above charts report outpatient appointments where the patient did not attend (DNA) with no advanced warning across Somerset and broken down by Gender, Age and Deprivation Deciles.
- Males have a slightly higher rate of DNA than females (5.9% vs 5.3%).
- The under 17-year cohort of patients have a much higher DNA rate at 10.6% (2025/26 YTD) vs 7.3% in ages 18-64 yrs and 2.9% in 65+ years. A high proportion of patients under the age of 17 from the most deprived deciles see a higher DNA rate than the least, 10.1% in the most deprived decile vs 4.1% in the least deprived decile.
- The most deprived deciles have a much higher rate of DNA vs the least deprived decile with decile 1 (most deprived) at 10.1% in 2025/26 YTD vs 4.1% in decile 10 (least deprived) in 2025/26 YTD.

Waiting Times for Community Services









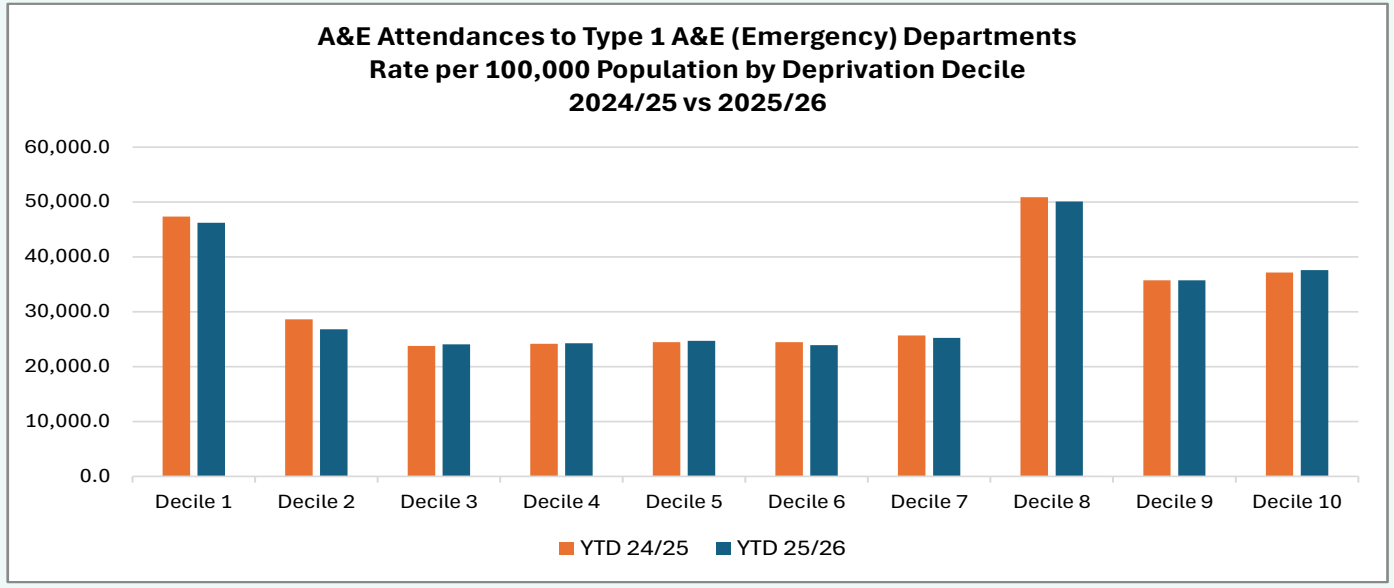
NHS Somerset

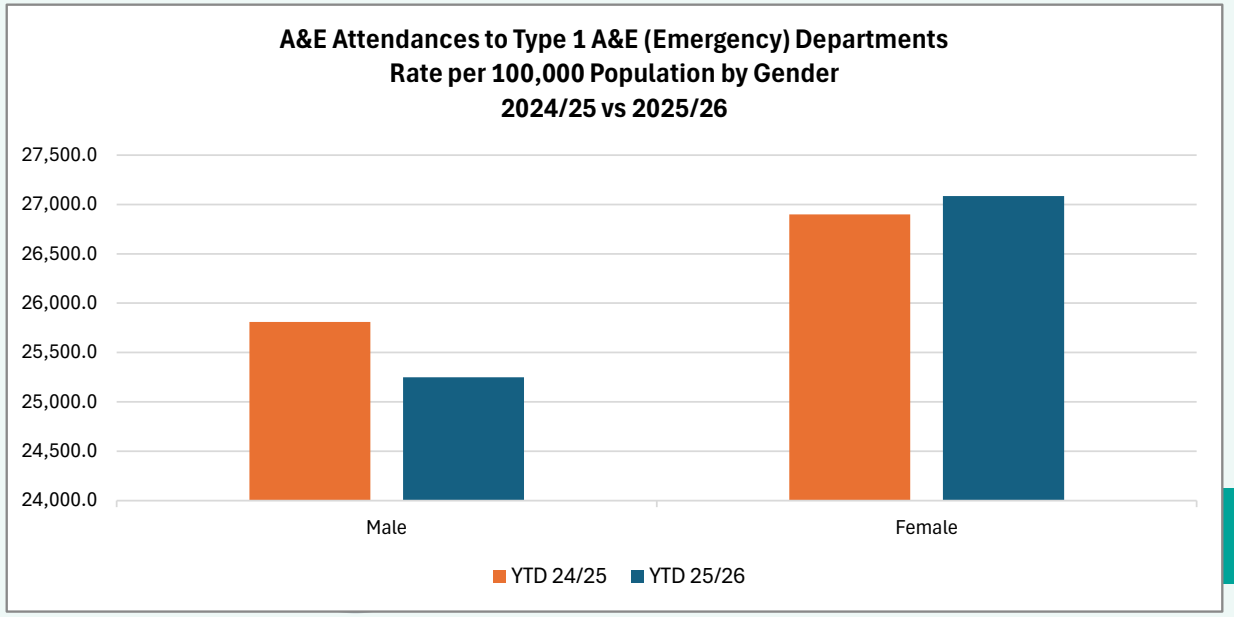
- The charts report inequalities in percentage of people waiting over 18, 52 and 104 weeks for community services
- Please note, this summary excludes any patients awaiting a Neurodiverse (ASD/ADHD) assessment
- There are no patients waiting over 52 weeks on the Community Services waiting list
- There is no evidence of a difference in access when comparing the most to the least deprived population. However, there is an increase in waiting list size per 100,000 population due to inclusion of additional services as a result of adherence to national guidance. There are similarities in pattern when comparing February 2025 to February 2026. This also can be seen in the > 18 week chart and should not be interpreted as patients waiting longer to access services.
- There is higher number of female children on the waiting list

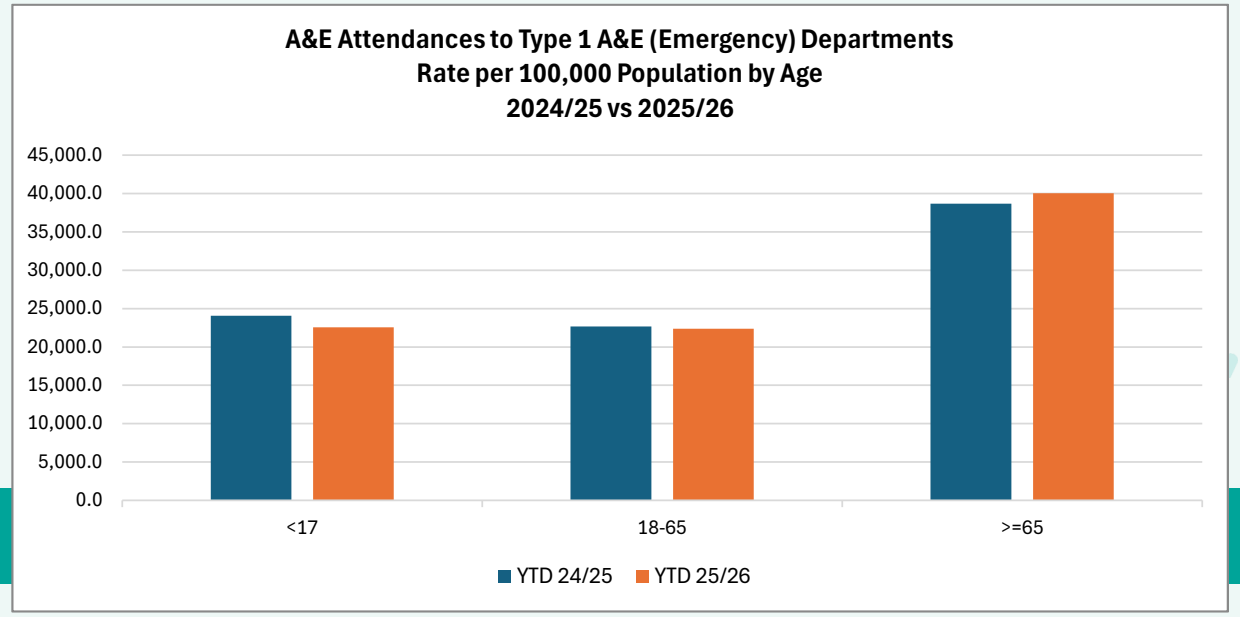
Urgent and Emergency Care – A&E Attendances

Type 1 (Emergency Departments)

NHS Somerset



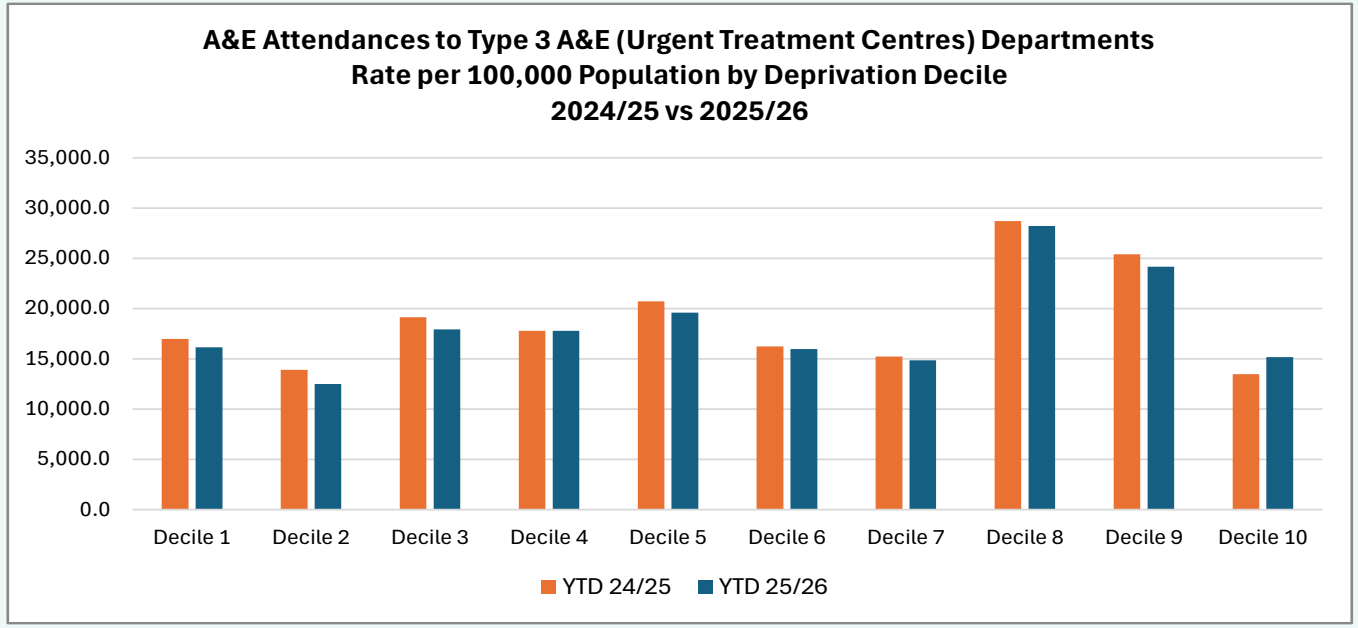


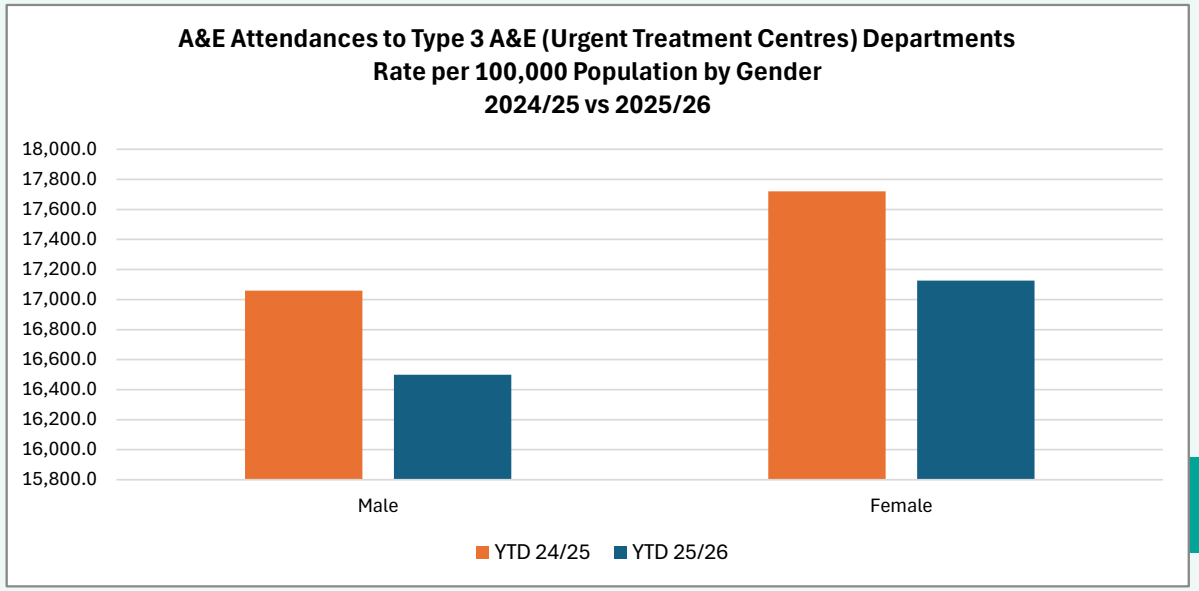


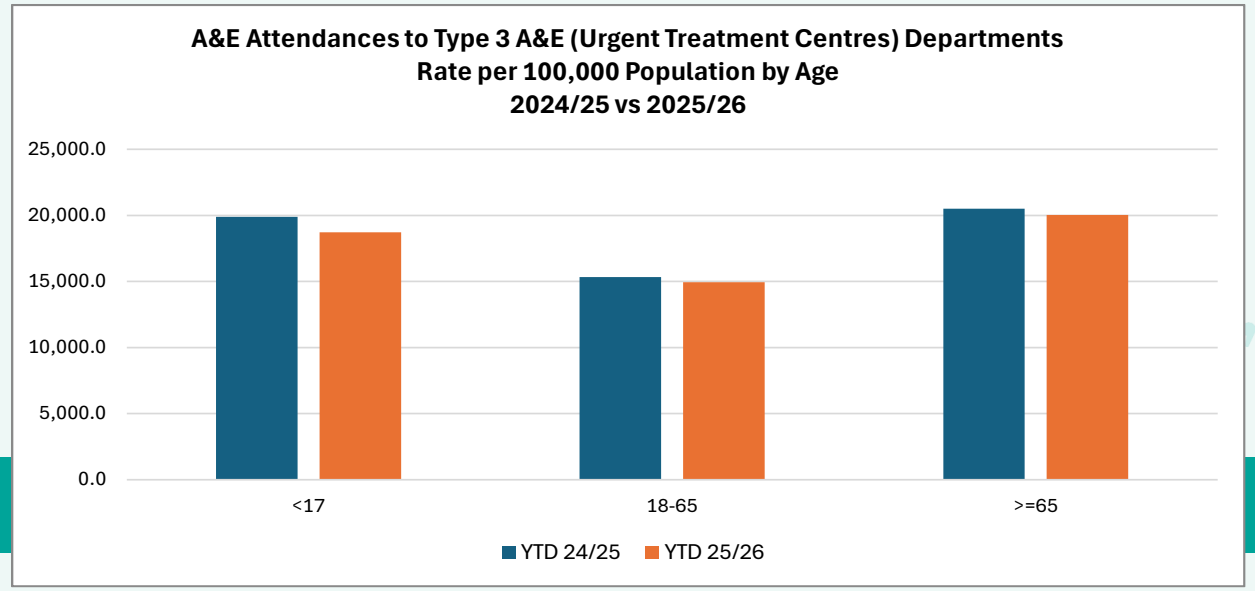
Urgent and Emergency Care – A&E Attendances

Type 3 (Urgent Treatment Centres / Minor Injuries Units)

NHS Somerset







Urgent and Emergency Care – A&E Attendances

Type 1 (Emergency Departments and Type 3 (Urgent Treatment Centres / Minor Injuries Units)

- The Office of National Statistics quotes that people living in the most deprived 10% of areas in England are roughly twice (1.9) as likely to attend A&E compared to those living in the least deprived areas (deciles 2-10) with the rate in Somerset being 1.7 times higher. When comparing the most and least deprived deciles patients in Somerset from the most deprived decile (decile 1) are 1.3 more likely to attend A&E than those patients in the least deprived decile (decile 10). This pattern persists across all ages, with the highest attendance rates for the older population (>65 years) and among the most vulnerable groups, driven by lower health status and limited access to alternative service.

- In times of increased pressure across primary and secondary care, it is important to consider whether patients are attending the most appropriate site for their care and whether there are inequalities in access and outcomes. Work is underway and regularly presented to the Urgent and Emergency Care Delivery Group to gain further understanding of any inequalities that exist within the Somerset system and to consider actions to address these.

- In summary:

  - Overall, there has been a 1.0% reduction in A&E attendances to Type 1 Emergency Departments (ED) and a 4% reduction in Type 3 Urgent Treatment Centres (UTC)/Minor Injury Unit (MIU) attendances when compared YTD (to Feb) 24/25 to 25/26

  - The population with the highest rate of A&E Type 3 (UTC/MIU) attendance is Decile 8 & 9 (in the least deprived quintile)

  - There is some evidence of an increased rate of attendance when comparing the highest and lowest areas of deprivation (absolute or rate of attendance per 100,000 population)

  - Females attending Type 1 A&E (ED) departments have increased by 1% whereas males attending have reduced by 2%, and across UTCs/MIUs attendances have reduced by 4% respectively

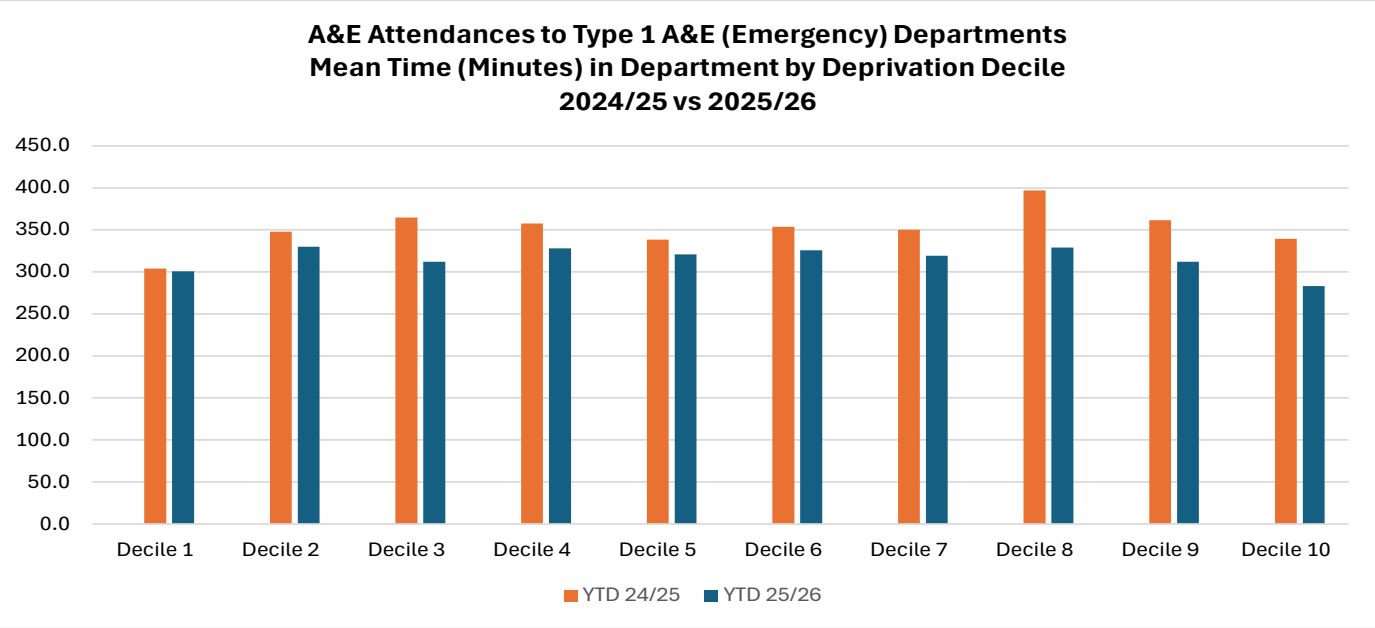
  - Children & Younger Persons (<18) attendances to Type 1 A&E (ED) departments have reduced by 6% in comparison to a 4% increase of people aged >65 years

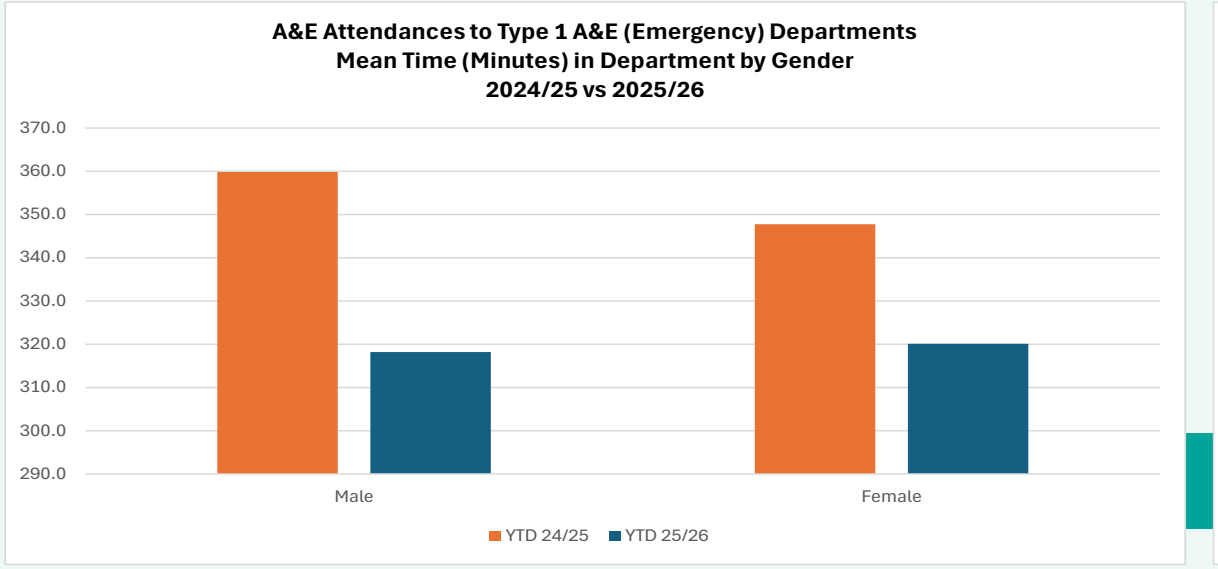
  - At Type 3 A&E (UTC/MIU) the <18 attendances have reduced by 7% and 16-<65 and >65 years have reduced by 3% and 2% respectively

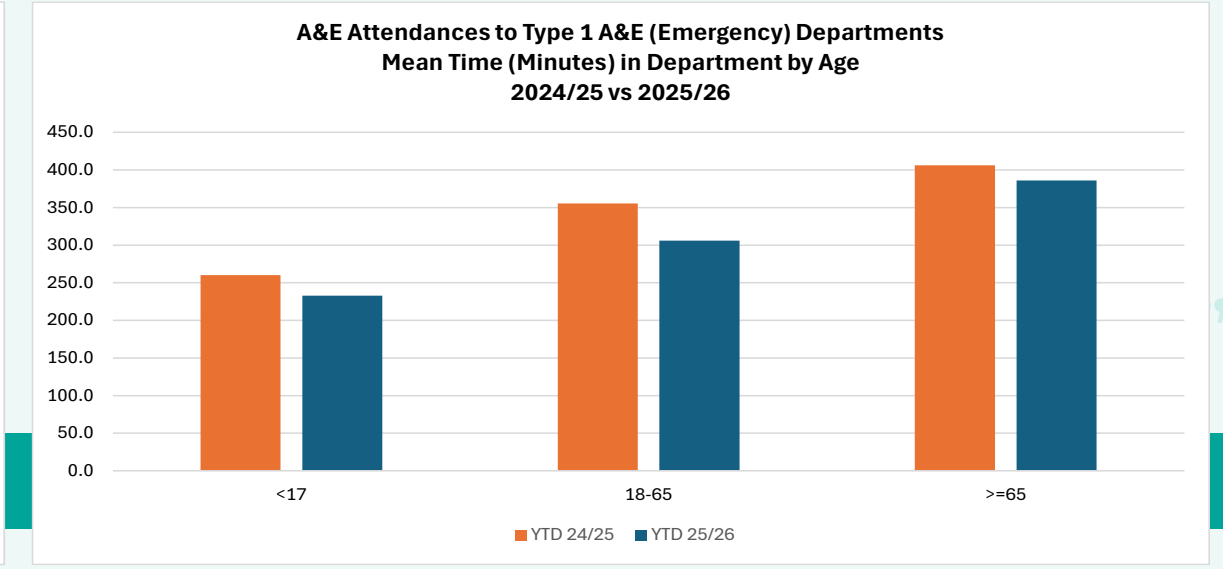
Urgent and Emergency Care – A&E Mean Time in Department

Type 1 A&E (Emergency Departments)

NHS Somerset



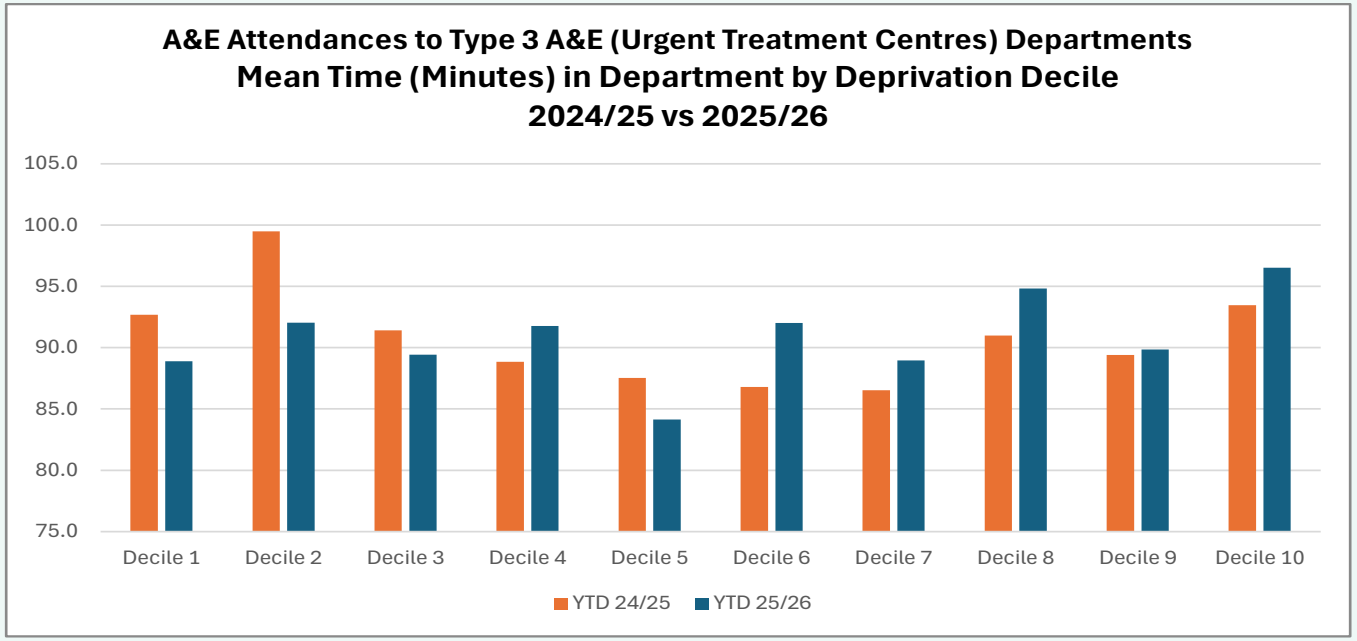


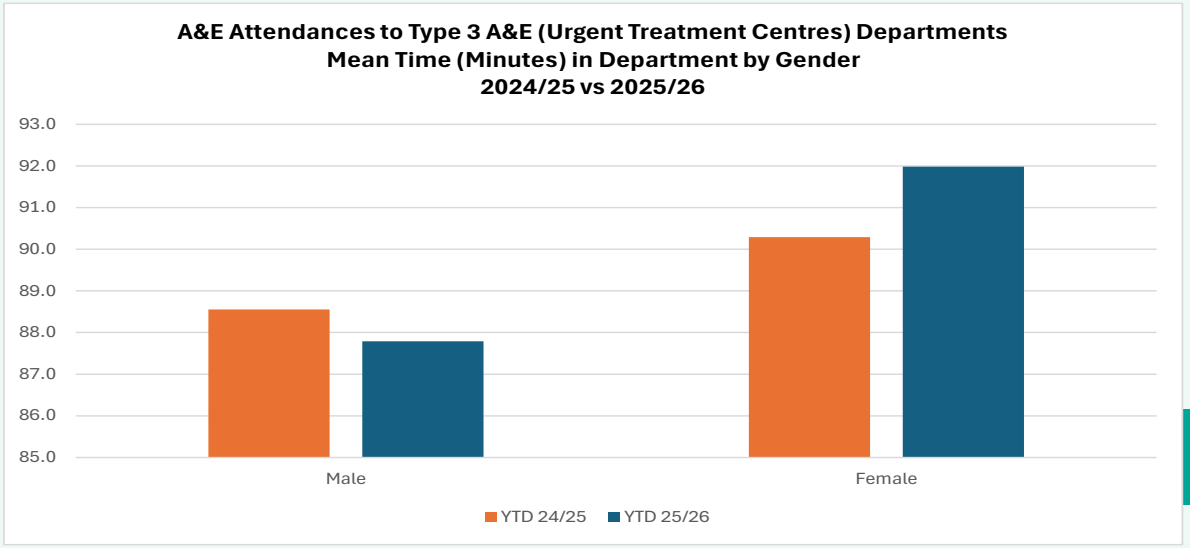


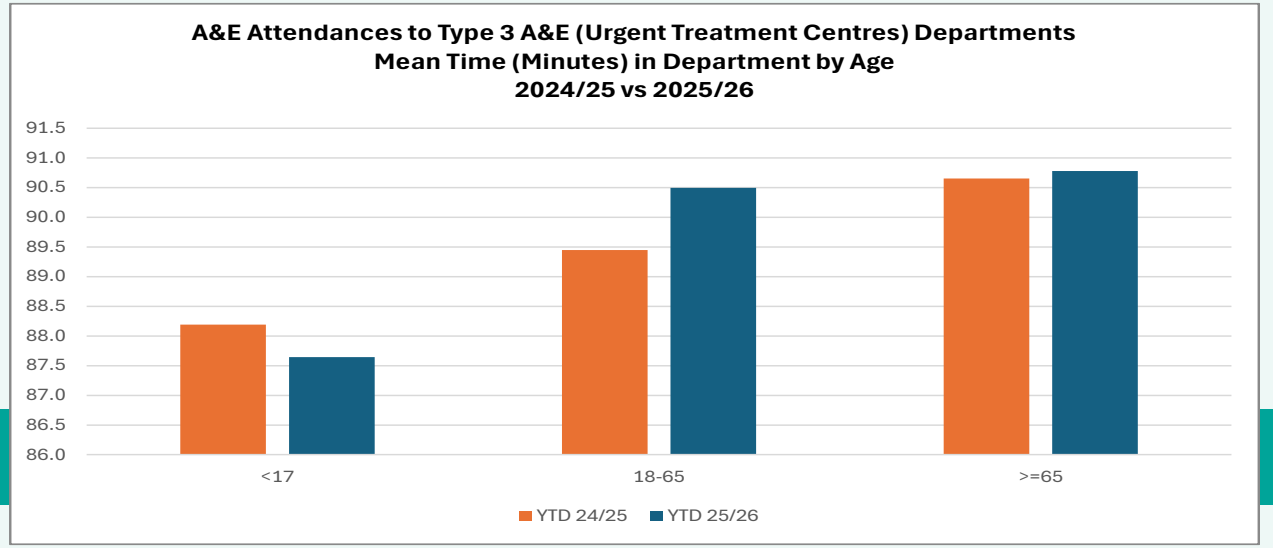
Urgent and Emergency Care – A&E Mean Time in Department

Type 3 A&E (Urgent Treatment Centres / Minor Injuries Units)

NHS Somerset







Urgent and Emergency Care – Mean Time in A&E

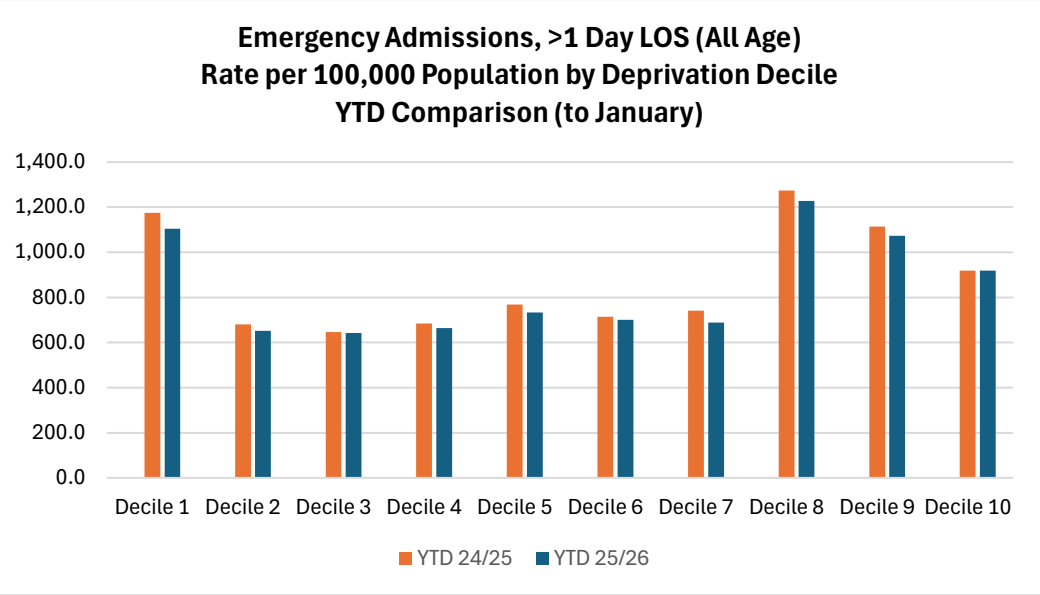
NHS Somerset

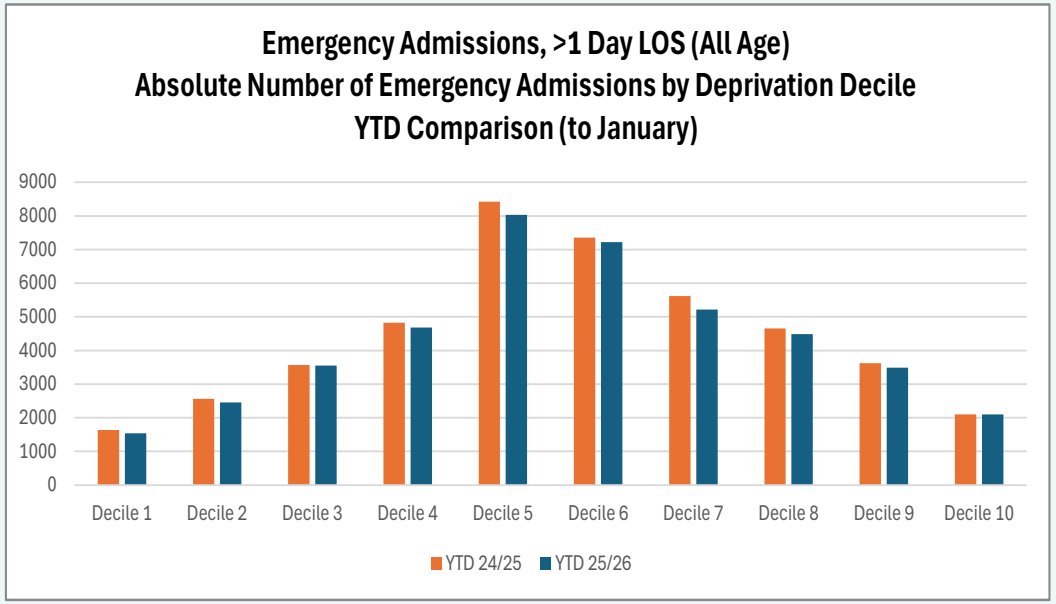
- Long waiting times are a persistent problem for the health service in England, provoking public dissatisfaction and political scrutiny. Reducing these waits remains a top priority for the government, with 78% of patients expected to be seen, treated and either admitted or discharged within 4-hours during 2025/26.
- The Office for National Statistics reports that evidence suggests that patients from more deprived areas experience longer waits in A&E, and patients from the most deprived areas are almost 5% more likely to die within 30 days of attending A&E, partly due to underlying conditions and inequities in care
- During 2025/26 the mean time in Type 1 A&E (ED) departments was 319 minutes (5.3 hours) in comparison to 89 minutes (1.5 hours) across the Type 3 (UTC/MIU) departments - with type 1 departments showing an improvement upon the previous year
- There is no notable variation when comparing the most, least and mid decile areas of deprivation (Most Deprived Deciles (1-2) was 5.2 hours, Least Deprived Deciles (9-10) was 5.1 hours and the mid-Deciles 5.4 hours
- There is no significant gender variation in mean time in the Emergency Department - the mean time for females is only marginally higher than males
- There is evidence that the mean time spent in the Emergency Department increases by age; the age cohort with the longest mean time in Emergency Department was for those patients aged >65 years (6.4 hours) and the <17 cohort experienced the shortest mean time (3.9 hours)
- The longest mean time in an Emergency Department is experienced by White British patients, with those from ethnic minority backgrounds had a shorter mean time. However, it should be noted that 24.6% of A&E attendances had an ethnic category of either “Not Known” or “Not Stated” (10.9% and 13.7% respectively) and therefore skews this assessment

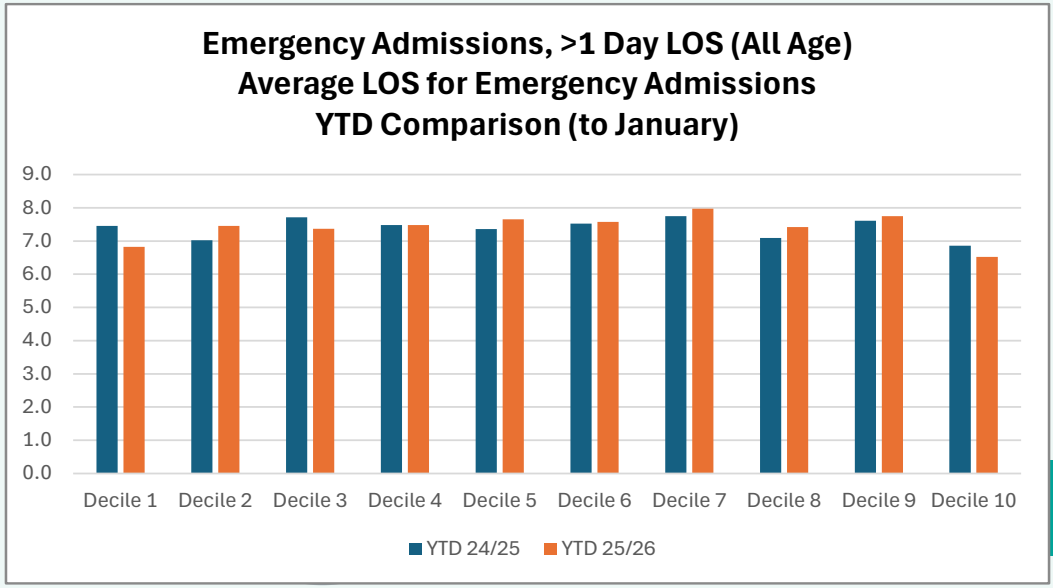
Urgent and Emergency Care

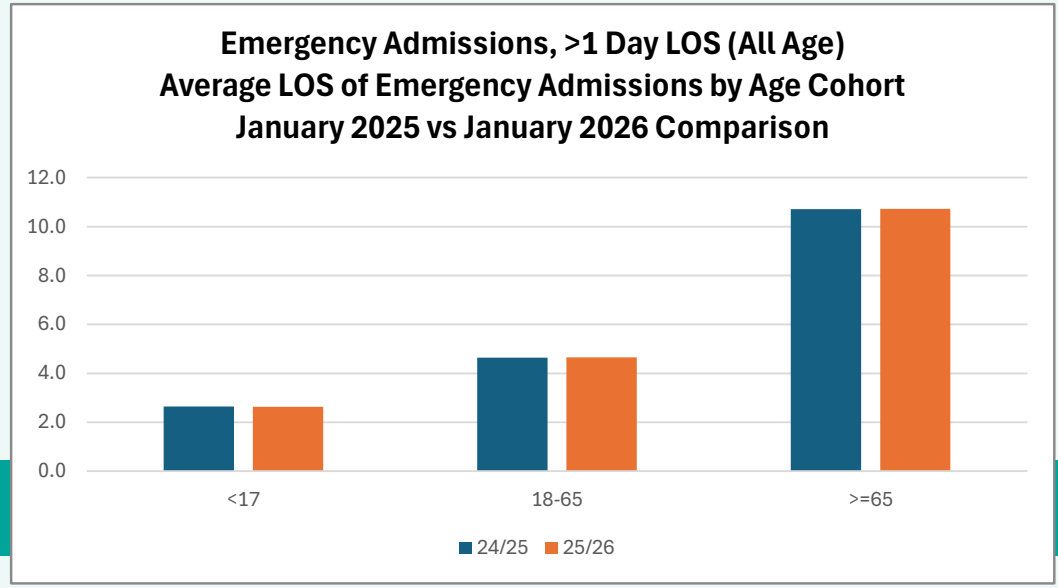
Emergency Admissions with Length of Stay >1 Day by Deprivation Decile

NHS Somerset





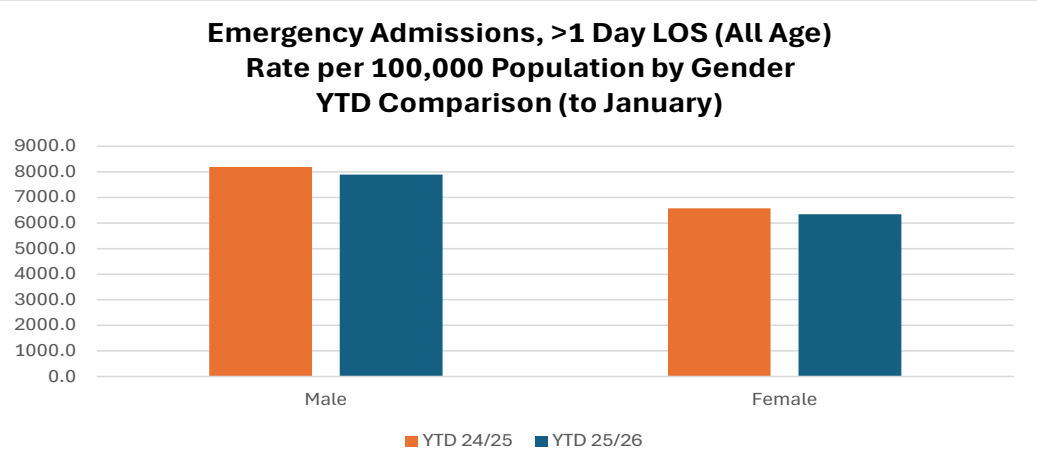


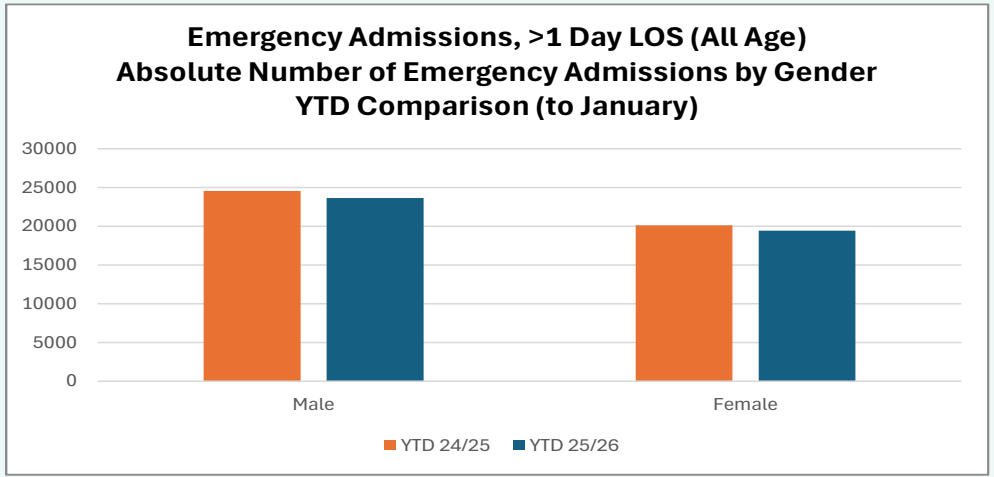


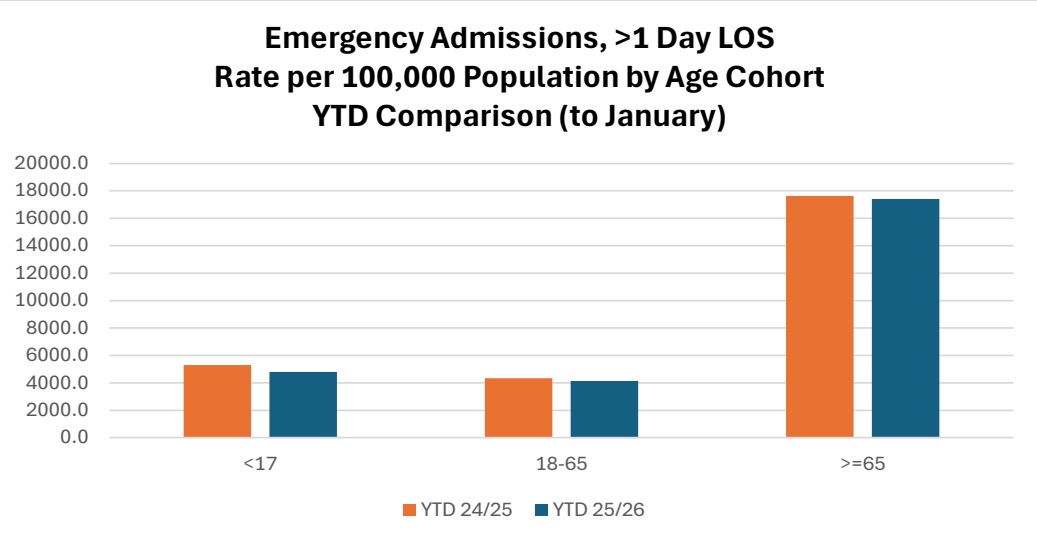
Urgent and Emergency Care

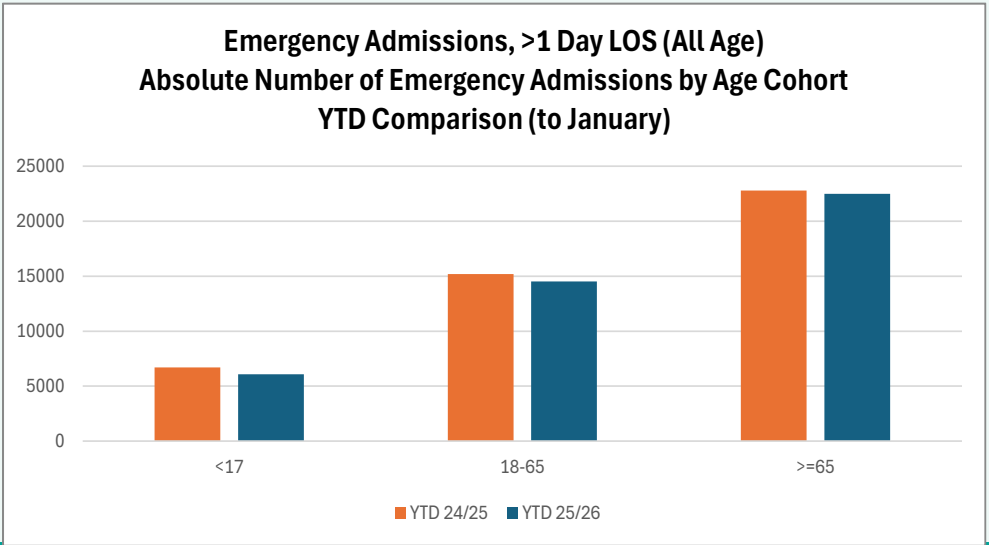
Emergency Admissions with Length of Stay >1 Day by Gender & Age

NHS Somerset









Urgent and Emergency Care

Emergency Admissions with Length of Stay >1 Day

NHS Somerset

- Overall, there has been a 2.1% reduction in emergency admissions with LOS > 1 days when comparing 2025/26 to the previous year 2024/25
- There is a higher probability of people in Somerset who live within the 20% most deprived areas to be admitted to hospital as an emergency with a length of stay greater than 1 day, than the least deprived areas – there is an observed higher rate of emergency admission in Decile 1 (most deprived) but also in Decile 8 (in the least deprived cohort)
- In absolute number terms, the volume of emergency admissions with a >1 day LOS for patients from Decile 1 represents 3.5% of the overall emergency admissions in 24/25 and 3.3% in 25/26 (and on a rate per 100,000 population this makes up 12.7% of admission in 24/25 and 12.1% in 25/26)
- There is wide variation in average LOS across the deciles, although the average LOS in 25/26 (7.6 days) is higher than in 24/25 (6.9 days)
- For deciles 1-3 the average LOS in 25/26 is 7.2 days in comparison to 7.3 days for the least deprived and 7.5 for the mid decile population
- 55.2% of emergency admissions with a LOS >1 day are for males and 44.8% for females and there is minimal change when compared to the previous year (55.4% and 44.6% respectively)
- 52.8% of emergency admissions with a LOS >1 day are for older adults (>65 years) and make up the biggest proportion of admissions in comparison to 33.8% of admissions for working age adults (18-65 years) and 13.5% for under 18 years. This is comparable to the previous year (<18 14.4%, 18-65 34.1% and >65 years 51.4%)
- When looking at this as a rate per 100,000 population, the >65 years make up the highest proportion of emergency admissions and consume the greatest number of beds - the average LOS for <18 is 2.9 days, 16-65 4.9 days and >65 10.1 days which is comparable to the previous year
- Analysis is periodically presented to the Somerset System Urgent and Emergency Care Delivery Group , and features in deep dives and analytical reviews

NHS Somerset

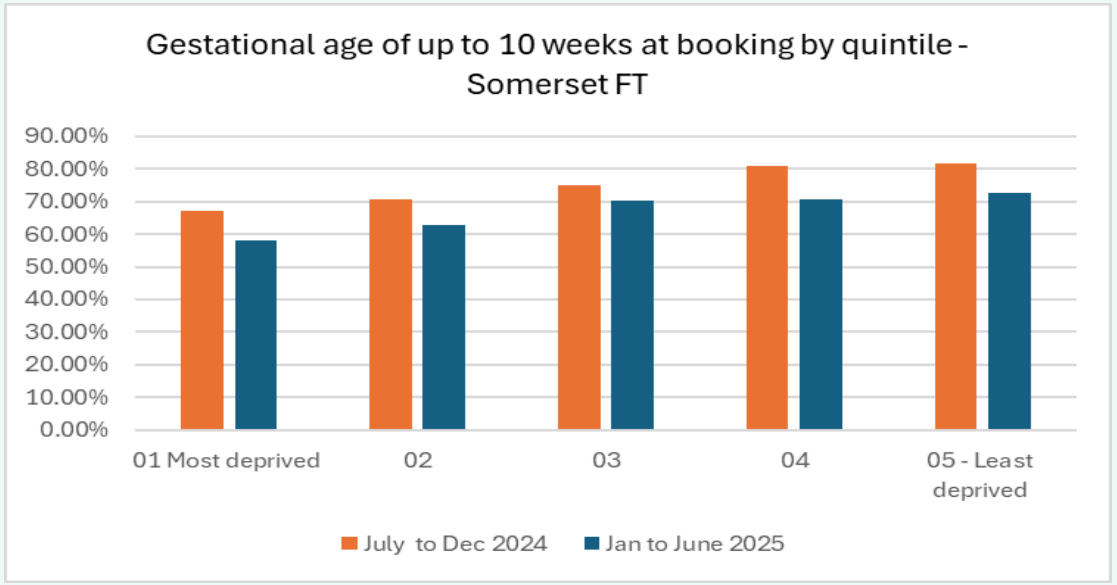
CORE20PLUS5

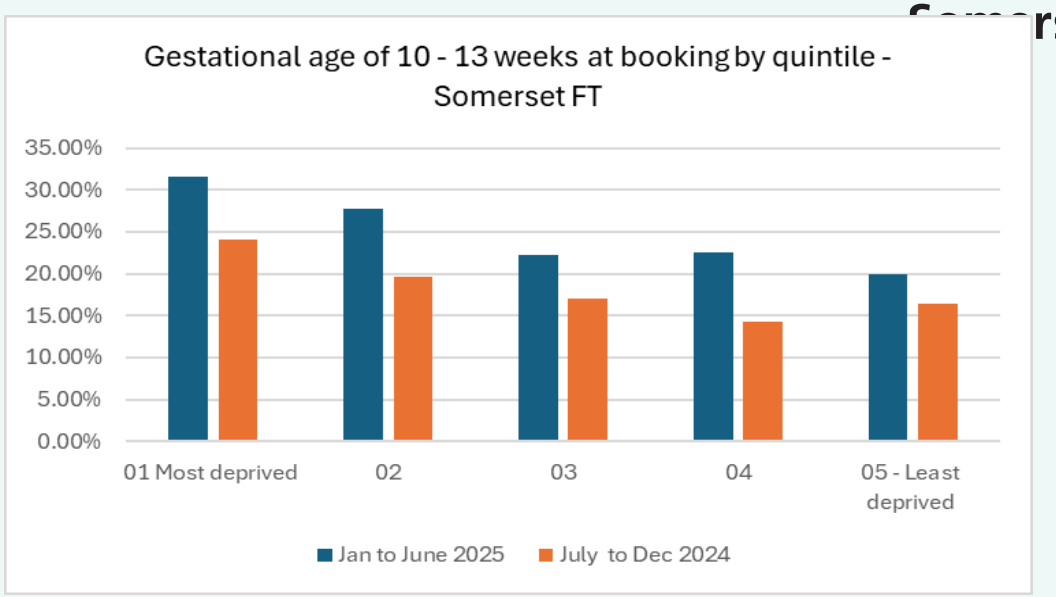
CORE20PLUS5

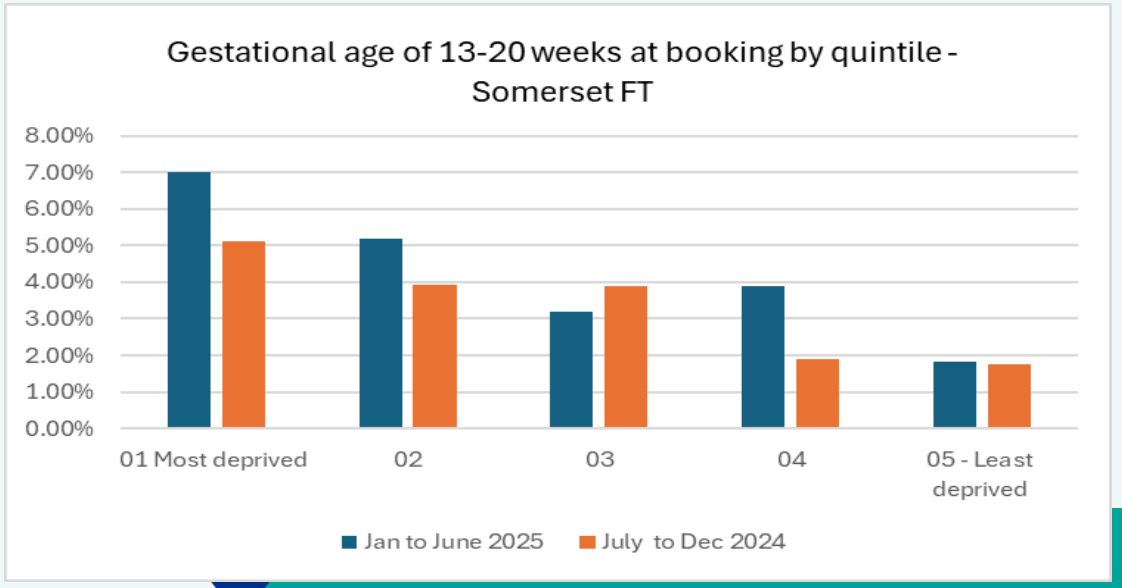
NHS Somerset

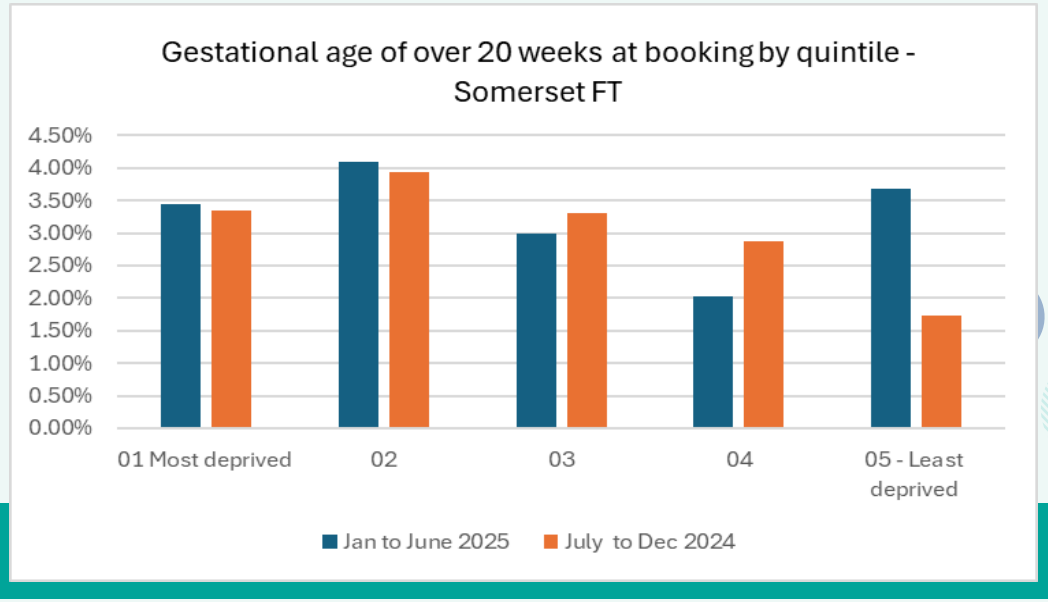
Framework	Domain	Measure	Core or Supporting Metric	Included in Report		Not possible at this time	Not appropriate / applicable	Basis of Reporting
CORE20PLUS5	Maternity	Inequalities in gestational age at booking	Core	☑	Pages 31-34			Maternity & Neonatal Equalities dashboard, reported for Somerset FT comparing Jan-Jun 25 to Jul-Dec 24
		Completeness of ethnicity data in the Maternity Service Date Set (MSDS)	Core	☑				See slide x
		Inequalities in women who have a post-partum haemorrhage	Supporting			☑		Unavailable through national reporting due to data quality issue at NHSE, local data to be reviewed and followed up with Provider(s)
		Pre-term births	Supporting	☑				As per National Guidance for Pre-term births metrics https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-
	Mental health	Inequalities in people achieving access and outcomes for NHS Talking Therapies	Core	☑	Pages 35-37			As per Mental Health Core data pack definition for Access to Talking Therapies: The number of people who enter NHS funded treatment with IAPT Services in the reporting period
		Inequalities in rates of restrictive interventions in inpatient services	Core	☑				Number of restrictive intervention types per 100,000 population
		Inequalities in use of the mental health act including use of community treatment orders (CTOs)	Core			☑		Work underway to report via the Mental health Services Minimum Dataset in 26/27
		Rates of eligible patients with severe mental illness (SMI) receiving an annual physical health check and action plan	Core	☑	Pages 38-39			As per National PHSMI guidance - https://digital.nhs.uk/services/general-practice-extraction-service/physical-health-checks-for-people-with-severe-mental-illness-phsmi
		Inequalities in access to mental health services, including NHS Talking Therapies and other adult community mental health services	Supporting	☑	Page 40			See Inequalities in people achieving access and outcomes for NHS Talking Therapies
		Inequalities in rates of premature mortality for people with severe mental illness	Supporting			☑		Data source to be identified to report upon this indicator
		Inequalities in rates of diagnosed mental health conditions	Supporting			☑		Work underway to report via the Mental health Services Minimum Dataset in 26/27
		Inequalities in the social determinants of health that impact on the prevalence of, acuity and recovery from mental health conditions	Supporting			☑		Work to take place during 2026/27 once the linked dataset is in place
		Inequalities surfaced in patient reported outcome and experience measures recorded in local and national tools	Supporting			☑		Work to take place during 2026/27 once the linked dataset is in place

Maternity and Neonatal Services









Maternity and Neonatal Services

Somerset ICB is not able to report on a Somerset population level therefore this section of the report upon maternity and neonatal services is based on performance at Somerset Foundation Trust. However please note the inpatient maternity services and special care baby unit at Yeovil Hospital (who are part of Somerset Foundation Trust) were temporarily closed from 19th May 2025 following safety concerns raised by the Care Quality Commission regarding paediatric staffing levels and sustainability of special care baby unit. Yeovil Hospital reopened their service on 21st April 2026, therefore the analysis including within this section maybe impacted by this temporary closure.

Delivering Best Practice Care

- Maternity and neonatal services in Somerset continue to embed best practice set out in NHS England's Saving Babies' Lives Care Bundle (SBLCB) and the NHS Resolution Maternity Incentive Scheme. The ICB and LMNS review progress and assure compliance. These programmes help improve safety and aim to reduce preterm birth, and neonatal and maternal deaths.

Inequalities in Gestational Age at Booking

- It is recommended that pregnant women and birthing people have their first maternity appointment before 10 weeks of pregnancy. Early booking ensures access to essential information for a healthy pregnancy and enables timely screening and other key assessments that underpin safe maternity care.

- Somerset's antenatal booking data indicates a reduction in bookings before 10 weeks and an increase in bookings between 10–13 weeks. The most deprived decile shows a slightly higher proportion of bookings between 13–20 weeks. This reflects the wider national picture: women from more socio-economically deprived areas and global majority groups are more likely to enter maternity care later than the recommended 10-week point. National analyses of the Maternity Services Dataset highlight persistent inequalities in early pregnancy access, with Public Health England noting that structural barriers—such as socioeconomic disadvantage, language needs, and limited service accessibility—contribute to delayed booking.

- These delays matter because early appointments enable timely screening and risk assessment. National reviews have also shown that inequalities in access contribute to unequal outcomes. For example, recent MBRRACE-UK data shows Black women are 2.8 times more likely to die during or shortly after pregnancy, and Asian women 1.7 times more likely, compared with white women. This national evidence underscores the importance of Somerset's focus on improving early engagement with maternity services, particularly for communities facing social or structural disadvantage.

- The recent release of the national Maternity Care Bundle and Somerset's Maternity and Neonatal Improvement Plan will support the system to address inequity and inequalities identified in gestational age at booking.

Maternity and Neonatal Services

NHS Somerset

Completeness of Ethnicity Data in the Maternity Services Dataset (MSDS)

- In Somerset, ethnicity recording at the booking appointment is better than the national average, with only 2.5% recorded as unknown as of June 2025. As a next step, and in order to determine Somerset's position regarding maternity outcomes and any impact of learning disability and/or neurodiversity, we are currently working to build a clearer picture of the data available to us.

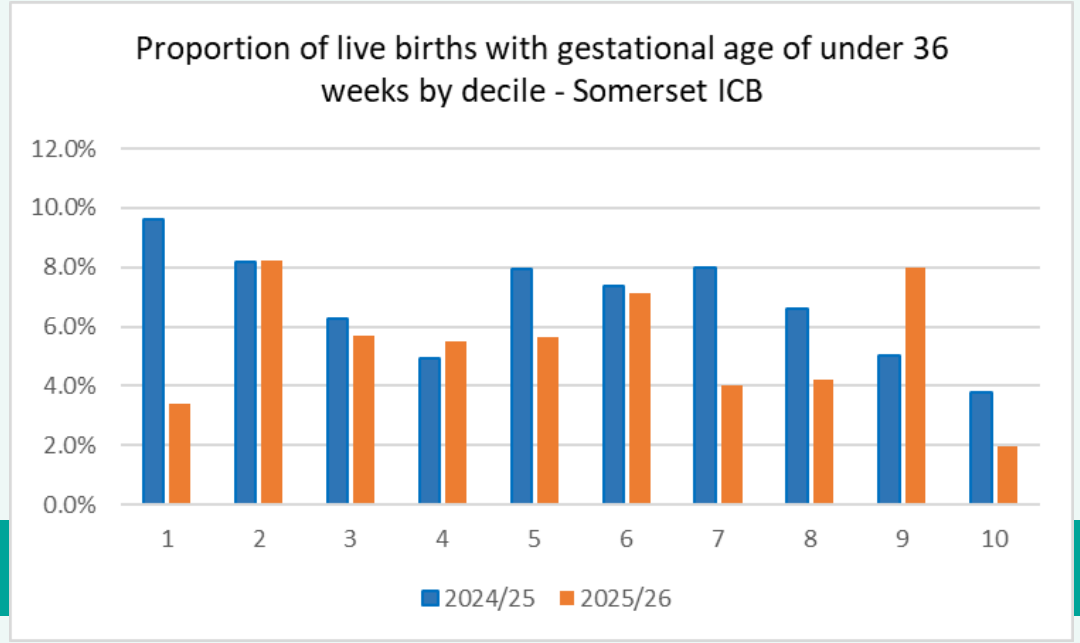
- Inequalities in Women Who Experience Post-Partum Haemorrhage - inequalities in post-partum haemorrhage (PPH) are a significant concern, particularly among women from global majority backgrounds and those living in socially deprived areas. Studies show that these groups are at higher risk of experiencing severe PPH, with a notable percentage of women from global majority backgrounds experiencing PPH of 1000 mL or more. This disparity highlights the need for maternity systems to address inequities not only through clinical care but also through inclusive research and improved data quality.

Pre-term Births

- Pre-term birth is defined as birth before 37+0 weeks gestation. While relatively common, it is the leading cause of mortality in children under five and can have long-term impacts on health. Several factors are known to increase the risk of pre-term birth, including deprivation, ethnicity, maternal age, and lifestyle factors such as smoking.

- The graph shows that pre-term birth percentages range from approximately 5.4% (average for the year) to 8.2% (at its highest) across IMD deciles. Both ends of the deprivation spectrum show lower pre-term rates, while some middle deciles (e.g., 9 and 2) show higher proportions at around 8%.

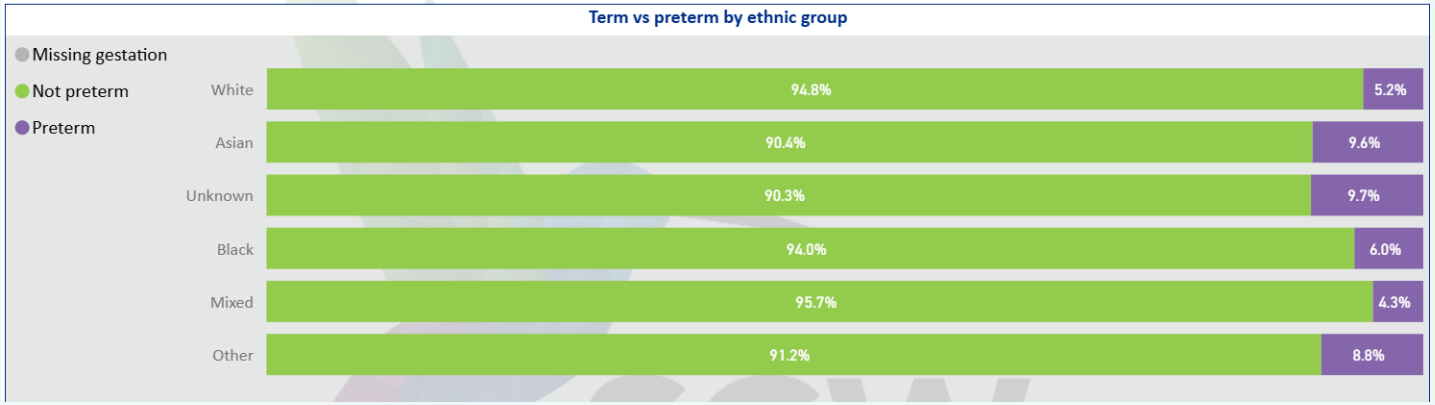
- Somerset's deciles mostly range between 3–8%, with several below national levels. The least deprived areas in Somerset show much lower pre-term rates (around 2%) than the England average (approximately 8%). Even the more deprived Somerset groups (around 3–4%) remain below the national deprivation average (8.8%).



Maternity and Neonatal Services

NHS Somerset

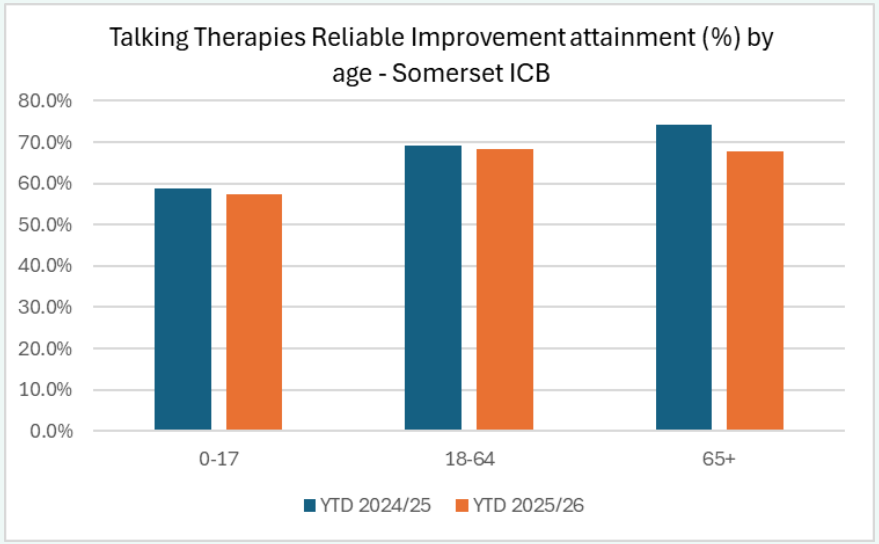
- Ethnicity data shows that white, black, and mixed groups in Somerset have lower pre-term birth rates than national norms. The Asian group (9.6%) is significantly above the national rate (\~6.9%), representing Somerset's most pronounced inequality relative to national expectations. The 'unknown' category (9.7%) is also high, suggesting data completeness issues or unmeasured risk factors. The 'Other' group (8.8%) is elevated and aligns more closely with nationally higher-risk groups.

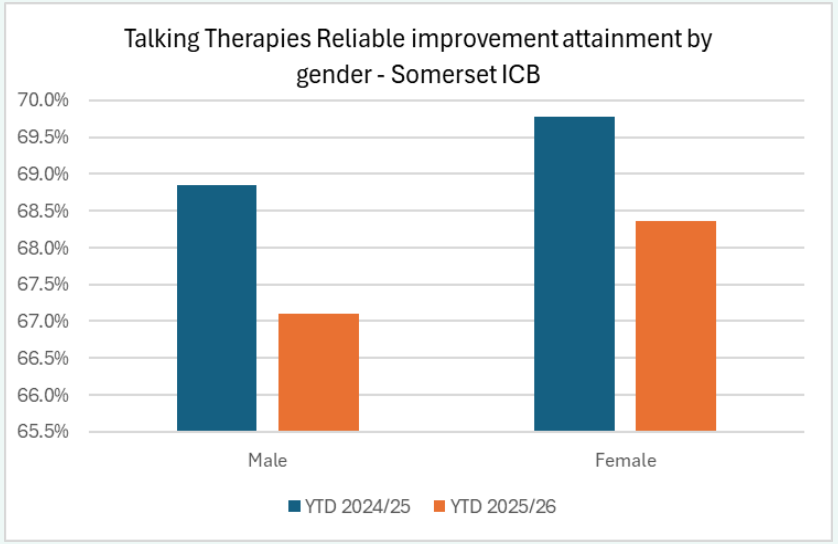


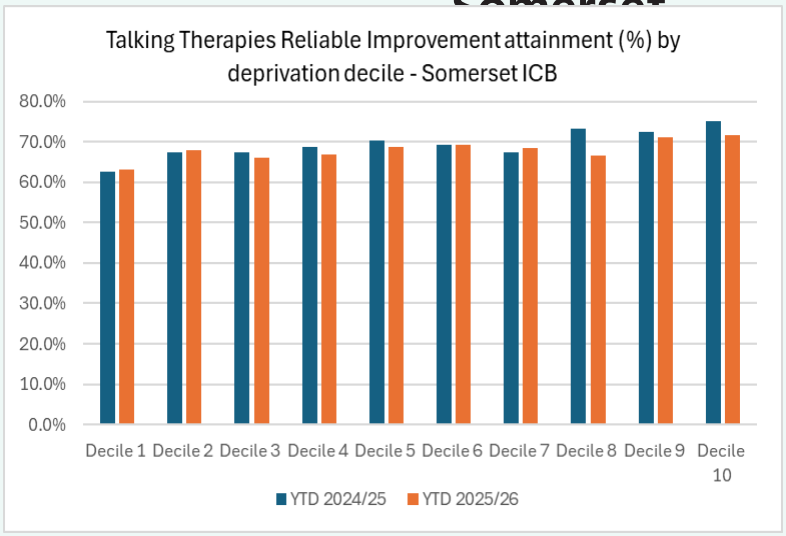
- In Somerset, we aim to continue reducing the number of pre-term births and narrowing health inequalities. Saving Babies' Lives Care Bundle version 3.2 (SBLCBv3.2) Element 5 focuses on pre-term birth, and the Somerset system is working toward compliance through initiatives such as pre-term birth clinics and perinatal optimisation. Additionally, by reviewing and implementing our Maternity and Neonatal Equity and Equality Action Plan and embedding the Maternal Care Bundle, and training such as the Perinatal Equity and Anti-Discrimination Programme we aim to continue improving maternity and neonatal outcomes for all women and birthing people in our communities.

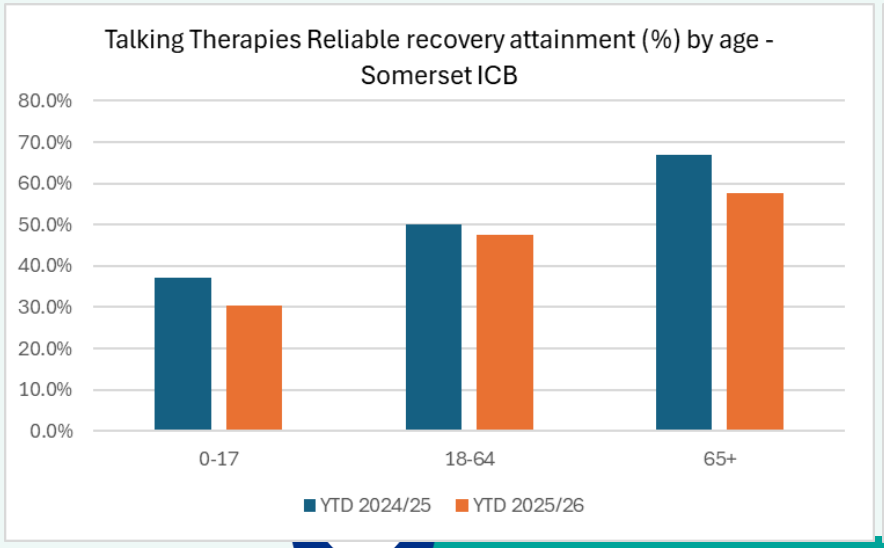
Mental Health (Adults)

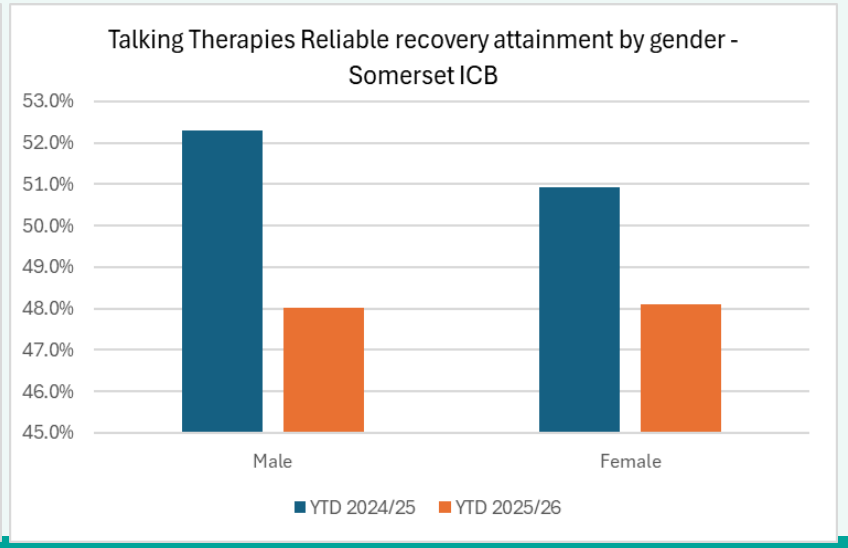
Talking Therapies Reliable Recovery and Reliable Improvement

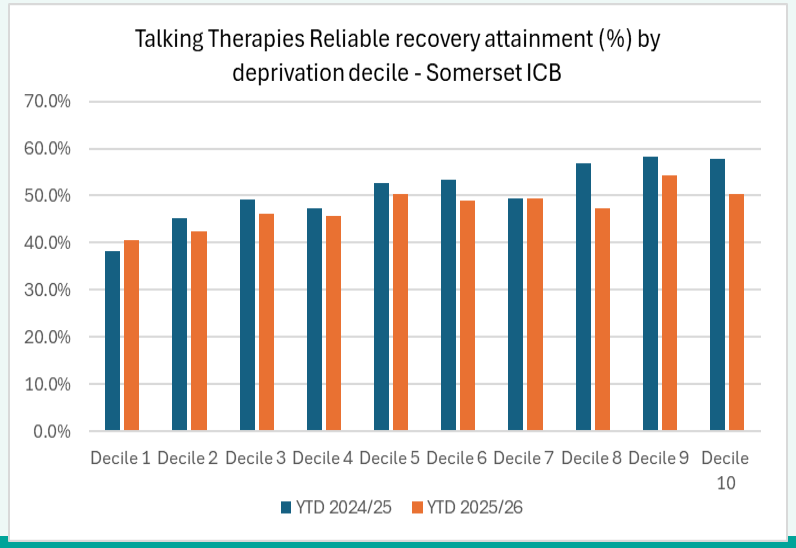








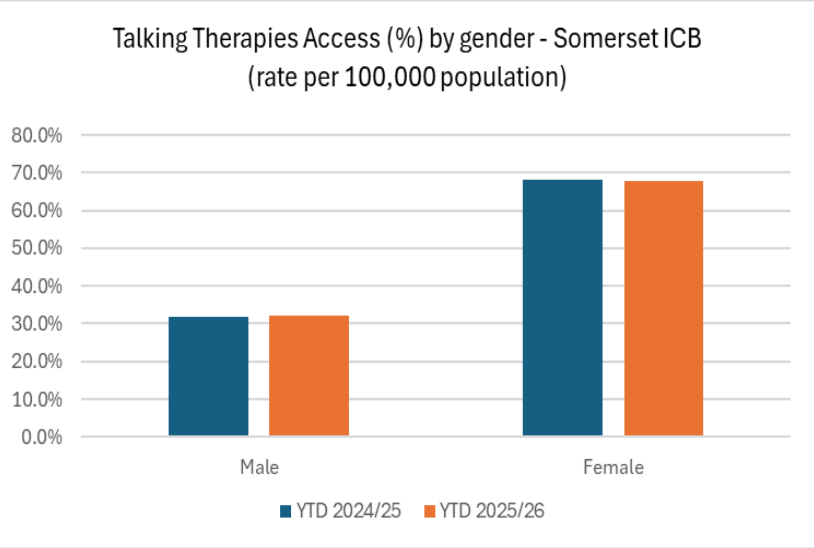


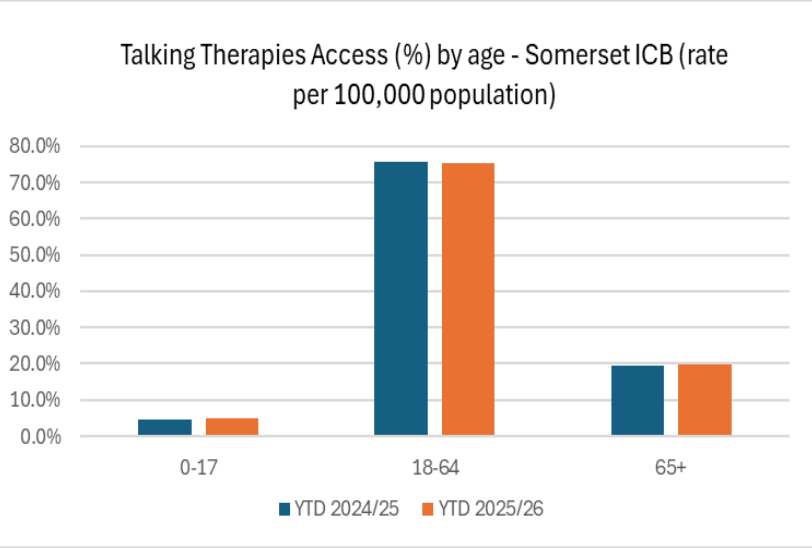


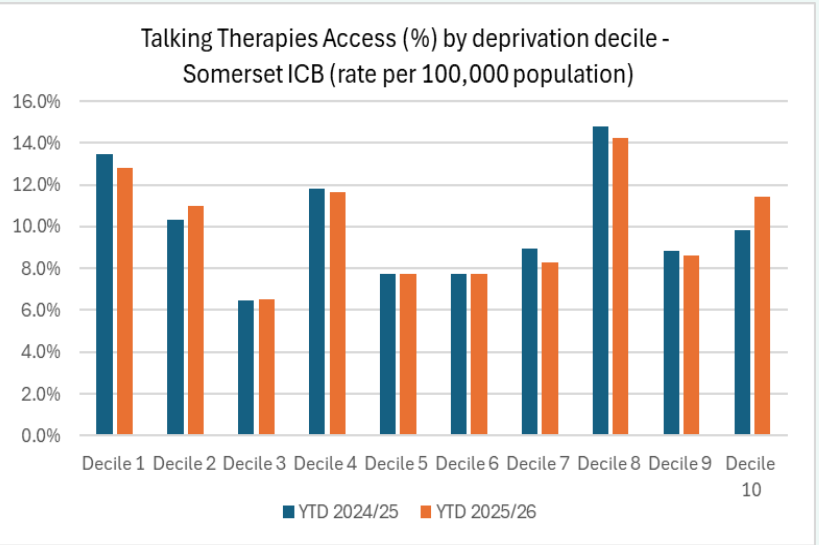
Mental Health (Adults)

Talking Therapies Access

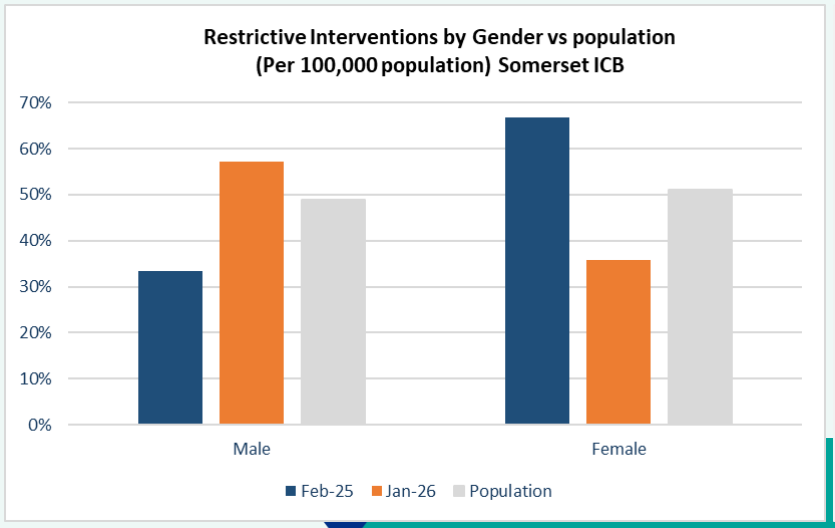
NHS Somerset

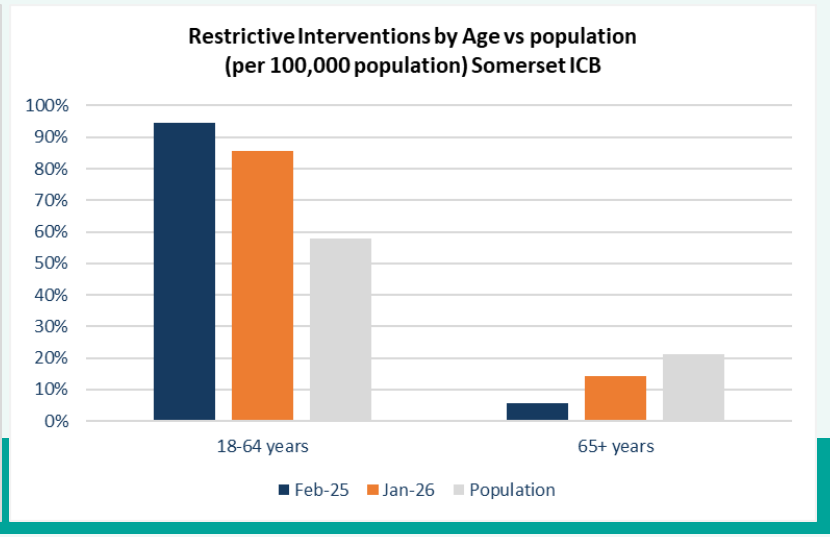


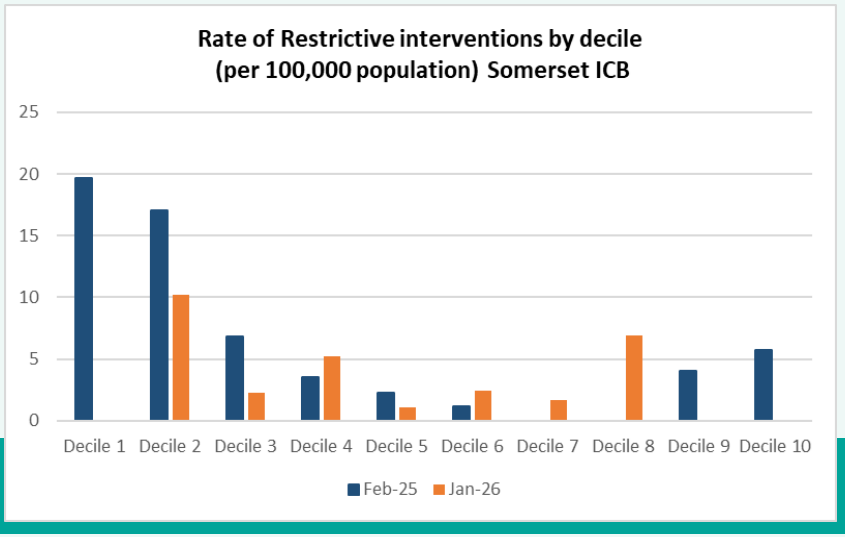




Mental health Restrictive Interventions







Mental Health (Adults)

Inequalities in people achieving access and outcomes for NHS Talking Therapies

- Talking Therapies is a national programme of support for adults experiencing common mental health conditions, such as anxiety and depression. There are two main areas of focus. Firstly, how many people of different demographics access treatment, and secondly, how successful that treatment is for different demographic groups. For 2025/26 services have a nationally set target that 48% of people should recover from anxiety and depression as a result of treatment, and that 67% should show improvement.

- Access: A high proportion of referrals come from people aged 18-64, with only 9% from people over 65 despite this age range representing almost 21% of the Somerset population. National evidence suggests that circa 20% of older people will have anxiety or depression. These rates are higher than national average, but there is still further work to do to engage older people. Women are much more likely to access Talking Therapies than men, representing nearly 70% of all people accessing the service. This is broadly similar to national average. For people with lower intensity needs, most people are able to access treatment within a week. For people with complex needs, that require access to higher intensity support there is a longer wait time in Somerset than the National Average.

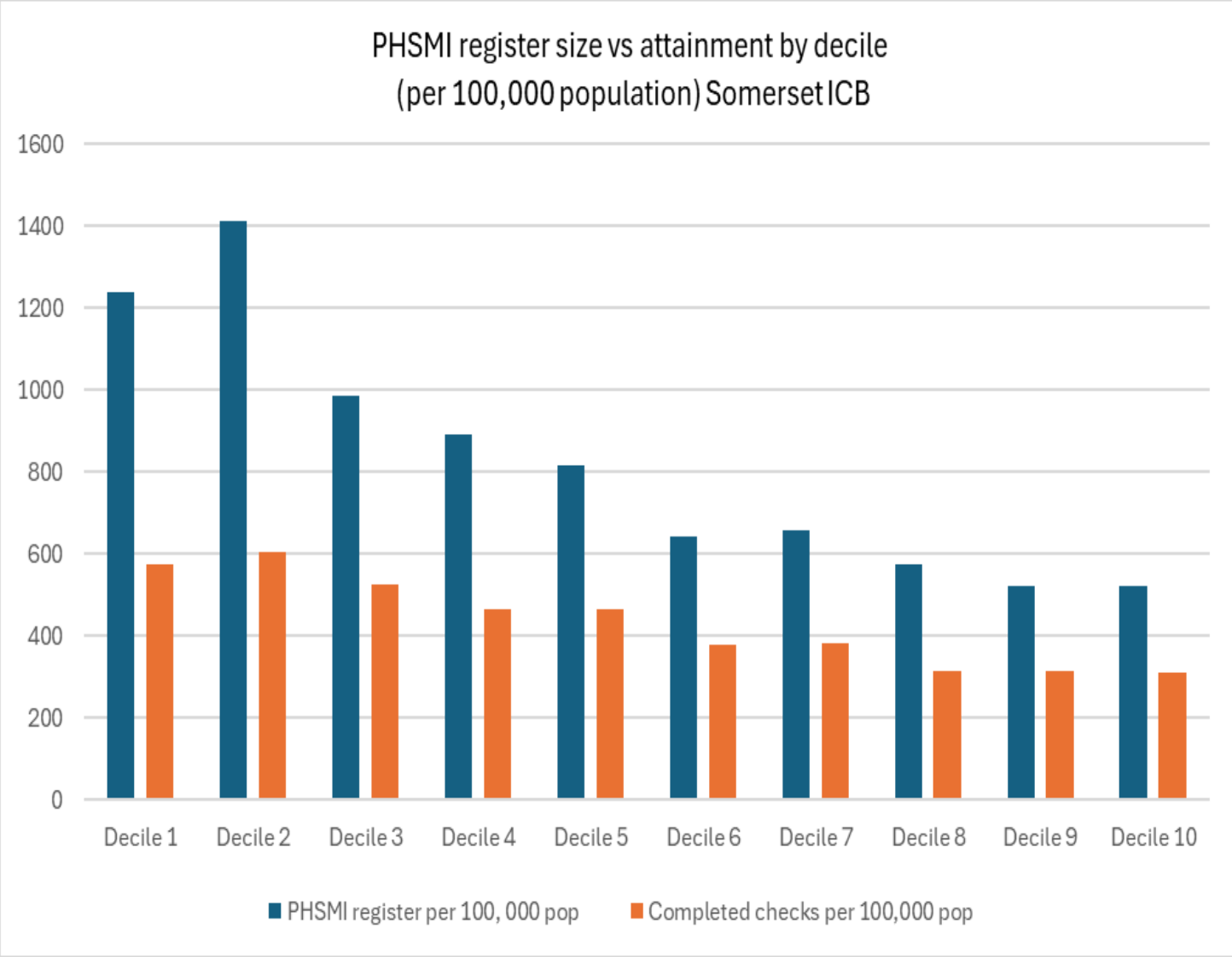
- Outcomes: Overall Somerset's outcomes are broadly in line with the national average. Outcomes for older people are generally better than those in a lower age range, and older people usually need a shorter course of treatment to show improvement. People aged 18-25 years usually show the lowest recovery rates; this is possibly a result of wider socio-economic factors. People from BME communities have slightly lower rates of reliable recovery and reliable improvement than people who identify as White British. People with disabilities have lower rates of reliable recovery and reliable improvement, and people who identify as Gay, Lesbian or Bisexual have higher recovery rates than those who identify as heterosexual. Men show slightly higher rates of reliable improvement and reliable recovery than women.

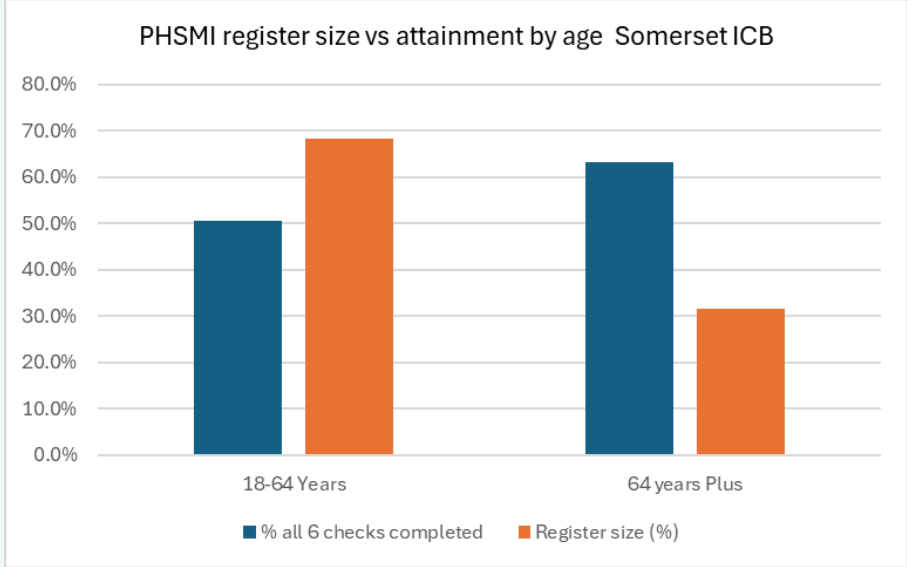
Inequalities in rates of restrictive interventions in inpatient services

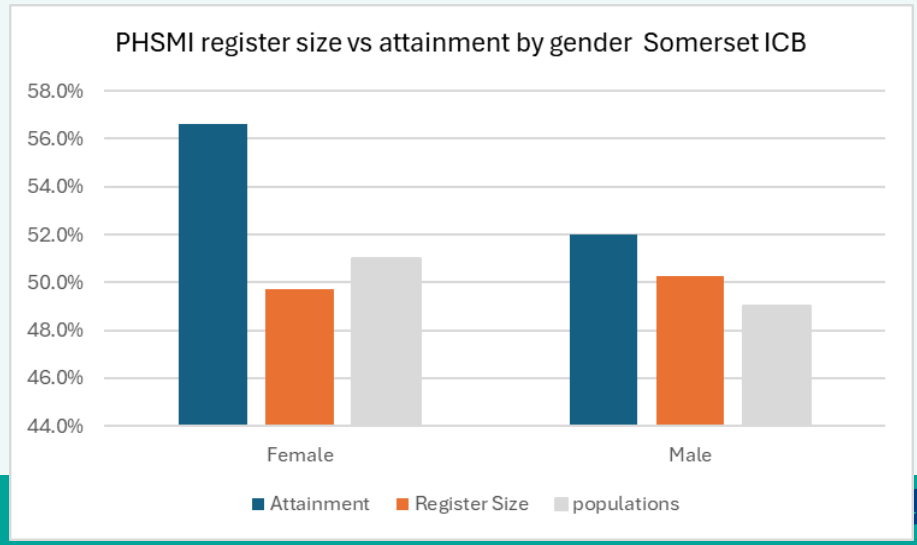
- Restrictive interventions are defined as "planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person's freedom. This could include physical restraint, chemical restraint, seclusion or segregation". The rates of restrictive interventions are broadly aligned to Somerset's demography. Circa 97% of people in Somerset report a white ethnicity, and 98% of restrictive interventions are reported for people of this ethnicity. The Trust reports on this six monthly to the Trust Board. The Trust are committed to undertake further work to improve the recording of ethnicity for this and other measures. Their aim is to build upon this, producing regular updates to the data, introducing trend analyses, and broadening the range of information through the inclusion of further indicators.

Mental Health (Adults)

NHS Somerset







Mental Health (Adults)

Rates of eligible patients with severe mental illness (SMI) receiving an annual physical health check and action plan

- Physical health checks for people with serious mental illness (SMI) are important because people with SMI die on average 20 years earlier than those without. This is largely due to physical health needs. Overall, for Somerset, about 55% of people with an SMI received an annual health check in 2025/26. This is lower than the national average. Physical health checks are delivered either within secondary care services, for people who have been admitted to an inpatient bed or are being treated by the Early Intervention in Psychosis Team (97% of people in these categories will receive a health check), or within primary care. All people with a serious mental illness should be contacted by their registered GP practice to be invited for a health check.

- People in the most deprived deciles are least likely to have received an annual health check, whereas people in the least deprived deciles are most likely to have received an annual health check. People that are British, Irish or any other white background are the least likely to receive a health check, compared to other ethnicities. There is wide variation in age ranges most likely to receive a health check, with people aged between 50 and 84 the most likely to receive a health check. For patients who have not traditionally engaged with the health check, we have commissioned dedicated physical health support workers who work with GP practices and patients to encourage uptake.

- Local Experts by Experience also deliver training to healthcare staff in how best to engage with people with SMI, helping them to tackle some of the significant barriers to access. Experts by Experienced have also been instrumental in developing co-produced written & visual resources, which “de-mystify” health checks, help understanding of why they are important, and what to expect and help people make informed choices.

- From a data quality perspective, there is further work to be done to bring together secondary care and primary care data. There is also a discrepancy between NHS England data and locally collected data. Although the percentage delivery of the health checks is broadly similar at around 55%, local data shows that there are 871 more patients with SMI than in the national data.

Mental Health (Adults)

Inequalities in access to mental health services, including NHS Talking Therapies and other adult community mental health services

- Somerset performs exceptionally well for community mental health services. Access rates for people with a serious mental illness at 540 referrals per 100,000 population are some of the highest nationally, well above the England average of about 190. This is attributable to Somerset's wholesale transformation of services, with statutory services working in partnership with an alliance of VCFSE providers, as part of Open Mental Health. The service has a mantra of "no wrong door" and works to have a tailored offer for every person.

- In terms of the range of people accessing services, 18-year-olds are the most common on caseload, but this is because there is a known cohort of people transitioning from children and young people's mental health services into adult services, but older people are underrepresented. Women are more likely to access than men (56% women, 39% men, 6% not recorded), despite women being slightly less likely to be diagnosed with a serious mental illness. More activity is recorded from people from more deprived backgrounds, which aligns with national evidence which shows that serious mental illness is more common in people from more deprived deciles.

Inequalities in rates of diagnosed mental health conditions

- Inequalities surfaced in patient reported outcome and experience measures recorded in local and national tools. In adult mental health services, most services are now using DIALOG+ to record outcomes. At the current time, data is not sufficiently complete for meaningful assessment. However, further work is profiled for 2026/7 to improve data quality and completeness.

Inequalities in the social determinants of health that impact on the prevalence of, acuity and recovery from mental health conditions

- Actions to address inequalities in mental health - there is significant local and national attention on health inequalities in mental health services. Like other health conditions, there is often significant correlation between poor mental health, personal identity and the wider socio-economic environment. As a result there are a number of local initiatives in place to address systemic barriers to accessing services, as well as improving outcomes.

Mental Health (Adults)

NHS Somerset

Improving Mental Health Access

- **No wrong door:** Our transformed community mental health services model, “Open Mental Health”, which is a partnership between Somerset Foundation Trust and a series of VCFSE providers, operates a “no wrong door” model. This means anyone with a mental health need is able to access services. Somerset is exploring the development a similar model in Children and Young People’s mental health services.

- **Expanding offers:** In line with the national planning framework, Somerset will be looking to further evolve its community offer into a neighbourhood mental health centre model, which will include 24/7 crisis support. By further developing the model we will reduce further barriers to access, such as time of day, offering walk in appointments as well as continuing to offer virtual support.

- **Voices of experts by experience and people with lived experience** are integral to Open Mental Health and support tailored means of increasing access and improving outcomes across all demographics. The range of partners within the Voluntary, Community, Faith, and Social Enterprise (VCFSE) alliance also help to address issues of access. For example, Age UK, 2BU and Young Somerset are organisations that focus on specific demographics. There are also organisations focused on deprivation, such as The Nelson Trust, physical health such as the Somerset Activity and Sports Partnership as well as organisations that operate primarily in some of the most rural and deprived areas of Somerset, helping to bring high quality and easily accessible services to some of the most underserved populations.

- **Improving routes of access:** There is a dedicated work programme looking to develop the relationship between primary care and Open Mental Health, with a conference planned for summer 2026. This will improve access as GP practice is the bedrock of the NHS and a key source of referrals.

- **Communications campaigns**: in Somerset, we also align our local communications campaigns with the national campaigns. For example, in 2026, the latest Talking Therapies campaign is designed to encourage self-referrals from groups known to be under-represented, such as those with obsessive compulsive disorder (OCD), social anxiety disorder, post-traumatic stress disorder (PTSD), panic disorder, body dysmorphic disorder (BDD) or a phobia. There is an additional focus on people aged 30-50, men, Black and South Asian audiences and those aged 65+. It is anticipated that this will drive uptake in access from these underrepresented groups.

Mental Health (Adults)

Improving Mental Health Outcomes

- **Patient and Carer Race Equality Framework** – Somerset Foundation Trust has an established programme in place, working with partners in the VCFSE sector and experts by experience. Part of this work is to undertake regular data collection, monitoring and analysis to determine a local action plan. The latest analysis showed that the ethnicity profile for the majority of the measures is broadly in line with the wider ethnicity profile of the county of Somerset. The Trust has also undertaken a detailed self-assessment against the key domains and is developing an action plan in response. The Patient and carer race equality framework (PCREF) programme reports into the Somerset Equality Partnership Group.

- **Within Talking Therapies in particular, the Trust has a named lead for the BAME Positive Practice Guide, who is working to implement the best practice approaches outlined** to support equality in both access and outcomes for different demographics. In 2026/27, Somerset will be working to improve outcomes for those groups identified as having the poorest outcomes.

- **Inpatient Quality Transformation Programme (IQTP)** – this is a national initiative launched by NHS England to improve the safety, quality, and culture of care in inpatient settings. Addressing health inequalities is a central tenet of the local IQTP. Actions include autism informed training and race equity training for staff, improving the physical environment

- **Outcomes reporting**: in line with national guidance, providers of adult mental health services use patient reported outcome measures and patient reported experience measures. This means that service users and staff can assess whether an individual is improving as well as looking at the data collectively to assess if treatment improvements or adaptations could be made to improve experience and outcomes for certain demographics. The patient reported outcomes measure used is DIALOG+. This captures changes in satisfaction across a range of domains, including physical health, job situation, accommodation and relationships as well as more traditional measures such as medication, mental health and practical help. Again, by looking at ratings across domains cut by different characteristics, we are able to assess which system factors are not working well. Somerset is also looking to expand its Patient Reported Outcome Measures (PROMs) tools to also include either Goal Based Outcomes and/or REQOL10, in line with national guidance. This will give us further information about areas for improvement.

- **Suicide prevention and outreach:** people in certain demographics are at higher risk of taking their own lives. In Somerset, these include middle aged men, people in highly deprived rural communities, and people with gambling addiction. The Somerset Suicide Prevention Partnership (SuPPa) is responsible for delivery against the Somerset Suicide Prevention Strategy. The strategy outlines a number of actions focused on priority groups, which include communications campaigns, a suite of training for statutory and non-statutory providers and developing a standardised evaluation framework to assess effectiveness of any of the suicide prevention services and approaches.

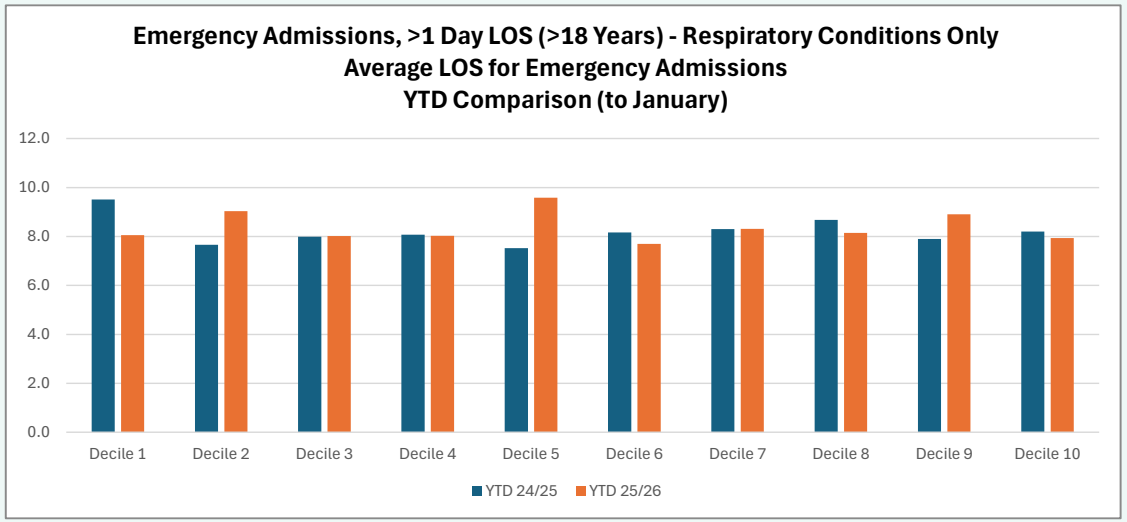
CORE20PLUS5

NHS Somerset

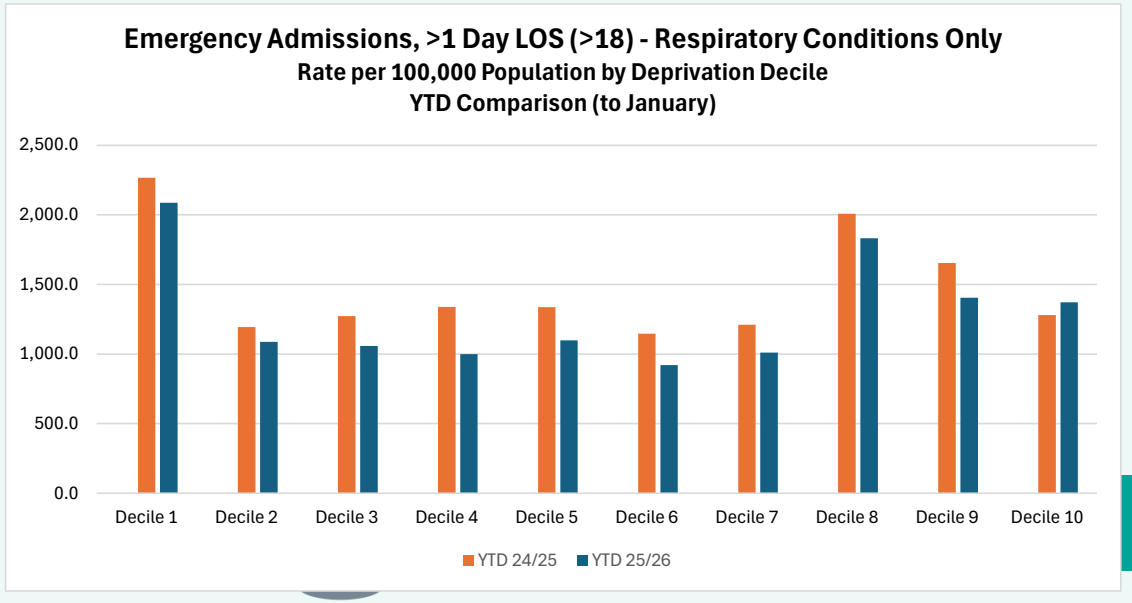
Framework	Domain	Measure	Core or Supporting Metric	Included in Report		Not possible at this time	Not appropriate / applicable	Basis of Reporting
CORE20PLUS5	Respiratory disease	Inequalities in non-elective bed days occupied by asthma, chronic obstructive pulmonary disease (COPD) and community-acquired pneumonia (CAP)	Core	☑	TBC			SUS Data reporting average length of stay for COPD and Pneumonia (via HRG) and reported by deprivation, age and gender)
		Inequalities in pulmonary rehab completion rates	Core			☑		Data source to be identified to report upon this indicator
		Inequalities in access to diagnostic procedures for respiratory disease	Supporting			☑		Work underway to report via the Waiting List Minimum Dataset in 26/27
		Inequalities in under 75 premature mortality rate from chronic lower respiratory disease	Supporting	☑	TBC			fingertips.phe.org.uk/profile/public-health-outcomes-framework
	Smoking cessation	Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Core	☑	TBC			As per Tobacco Dependency dashboard
		Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt	Core		TBC	☑		Data source to be identified to report upon this indicator
		Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks gestation	Core	☑	TBC			As per Tobacco Dependency dashboard
		Inequalities in smoking prevalence in adults	Supporting	☑	TBC			As per Tobacco Dependency dashboard
		Inequalities in smoking at time of delivery (SATOD) status	Supporting	☑	TBC			As per Tobacco Dependency dashboard
	Vaccines	Inequalities in uptake of COVID and flu vaccines	Core	☑	TBC			Data as per the COVID Datastore - Numbers of vaccinations per 100,000 population

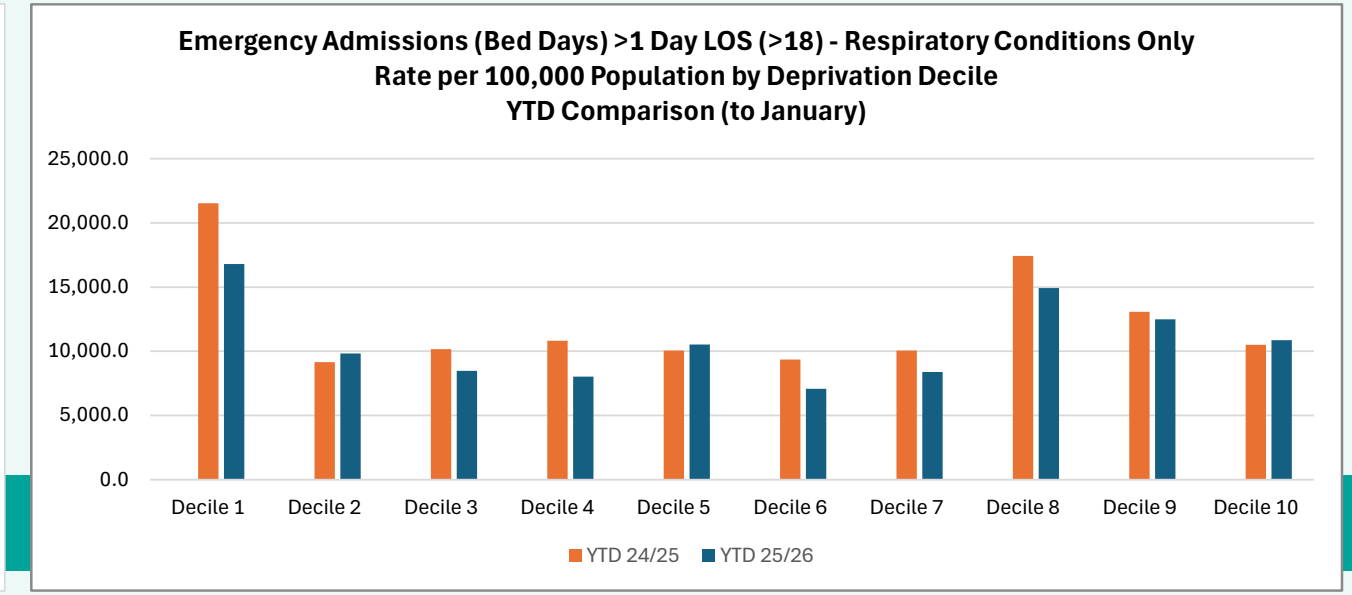
Emergency Admissions (Bed Days) – Respiratory Conditions
Patients Aged >18 Years

NHS Somerset

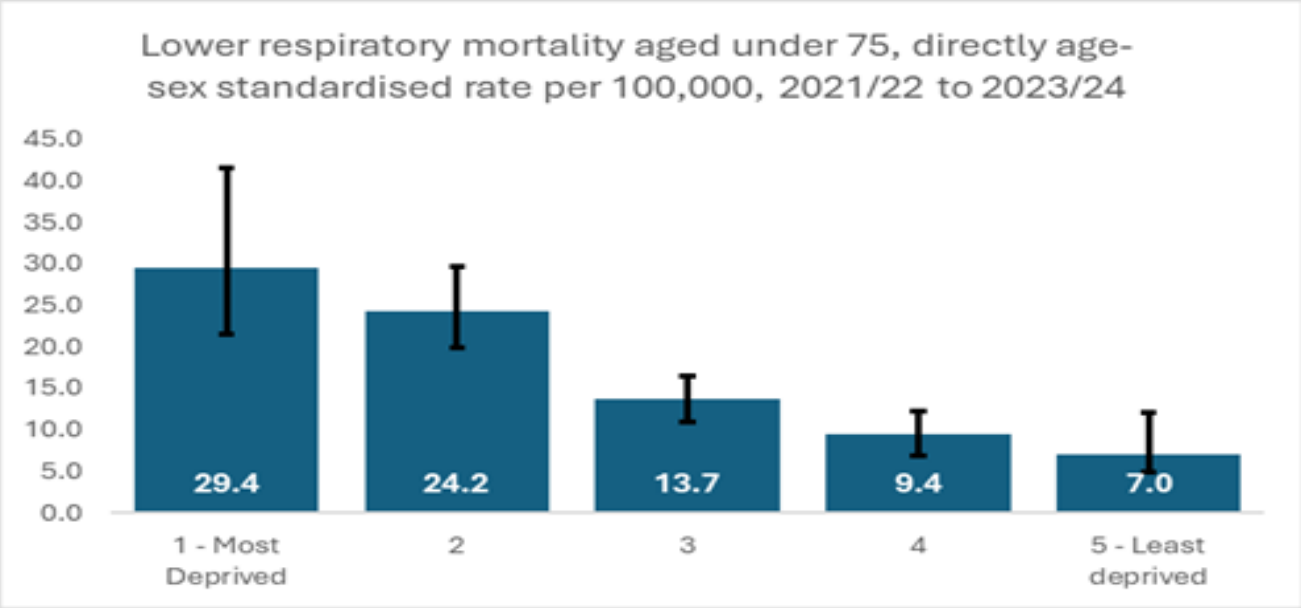


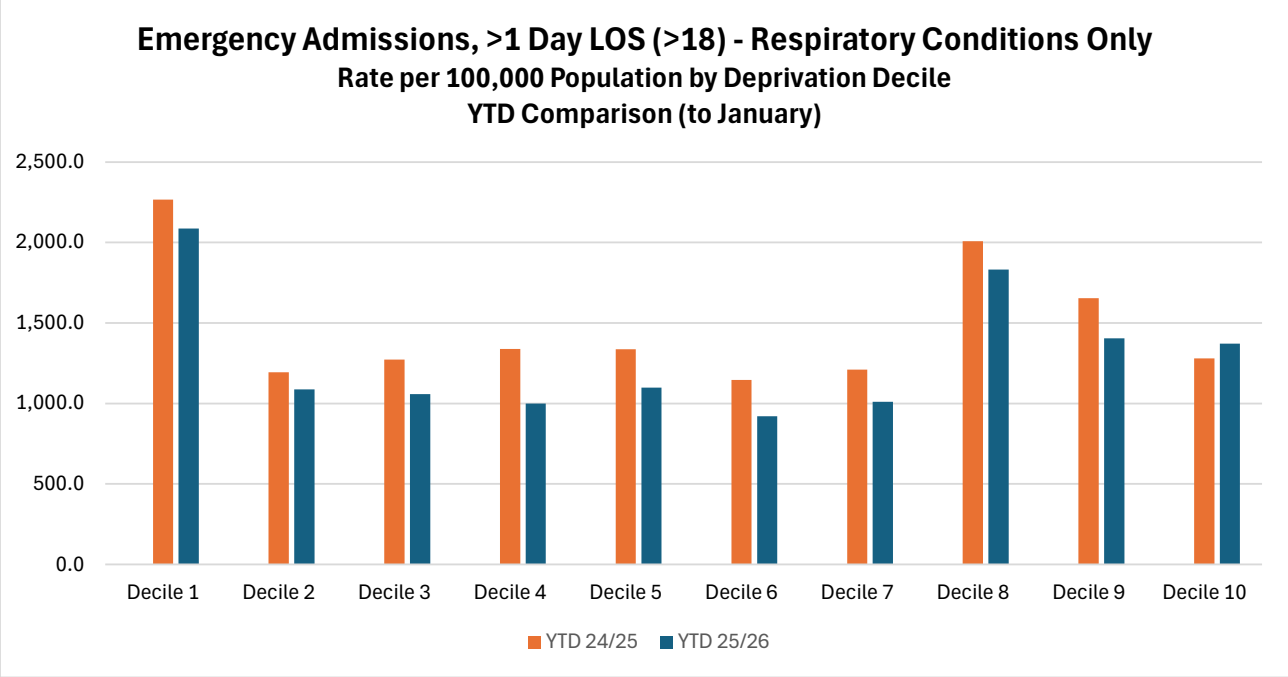
- During 25/26, there isn't any variation when comparing the most and least deprived deciles when looking at the average length of stay for patients admitted due to respiratory conditions. The longest average length of stay in 25/26 is in decile 5 (mid-decile cohorts)
- When looking at the total emergency admissions for patients aged >18 years for respiratory conditions (or a rate per 100,000), patients from the most deprived decile (Decile 1) consume the greatest number of bed days (and have the highest rate of emergency admission)
- Across the least deprived deciles (Deciles 8-10) we see cumulatively the highest rate of consumed beds and rate of admissions, when compared to the Deciles 1-3 (most deprived) and Deciles 4-7 (mid-deciles)





Lower Respiratory Disease - <75 Years Mortality

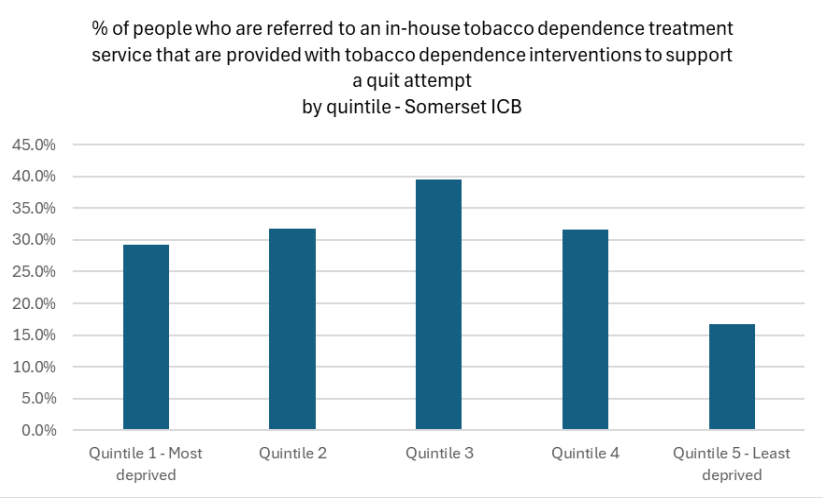


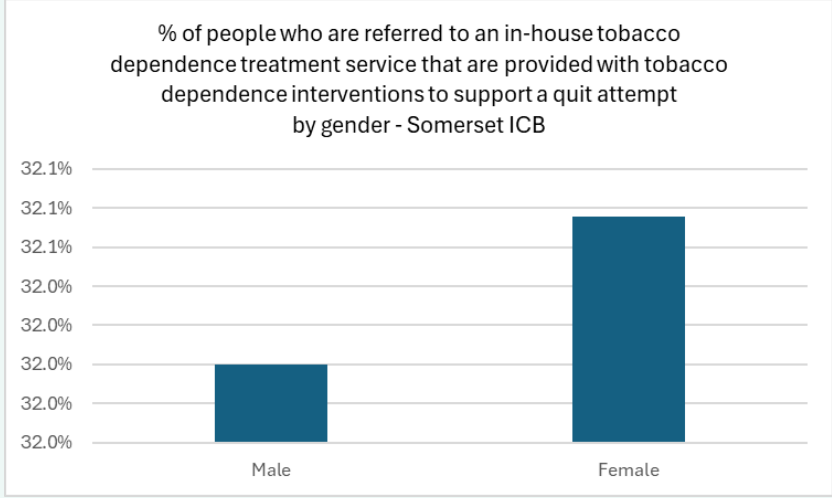


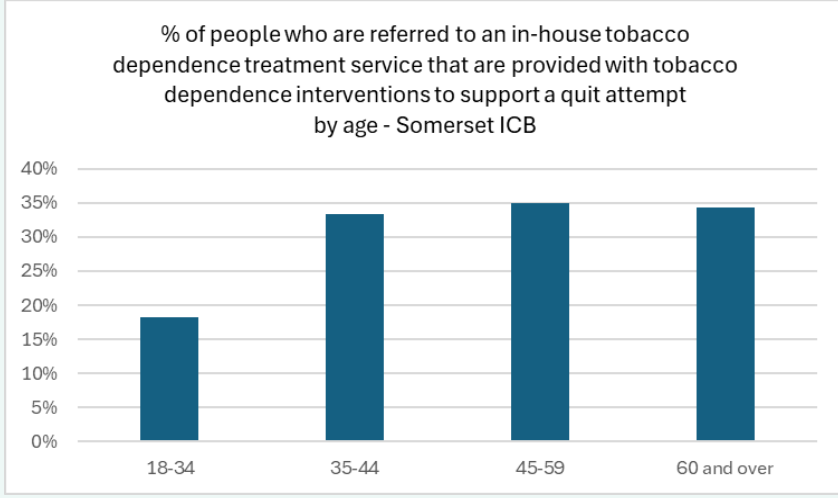
- During the cumulative period 2021/22 to 2023/24 the mortality rate in Somerset (age-sex standardised) for people aged <75 years is significantly higher in the most deprived (Deciles 1-2) population (rate 29.4 per 100,000) compared to 7.0 for people from the least deprived population (Deciles 9-10)
- Whilst the rate of emergency admissions (for all respiratory conditions) for all patients aged >18 years is highest in Decile 1 we do not observe the same pattern as mortality
    - However, please note, this comparison is not on a like for like basis (mortality assessment is <75 years and just lower respiratory, whereas the emergency admissions assessment is all adults and covers all respiratory conditions

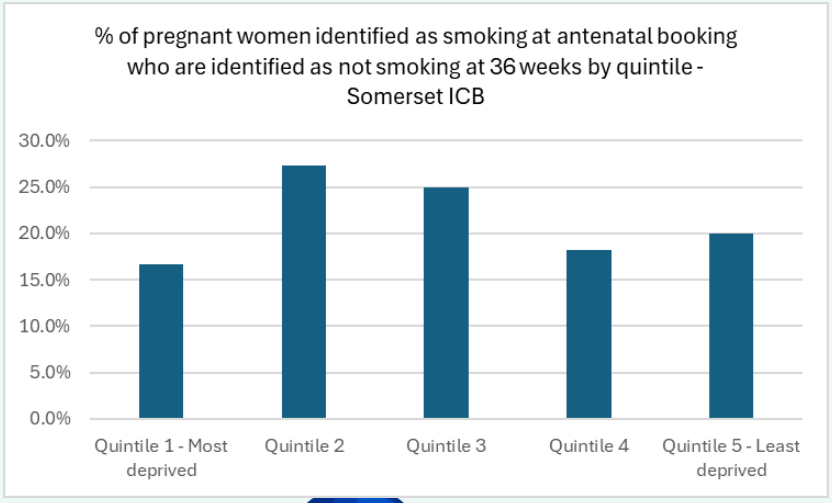
Smoking Cessation - Tobacco Somerset

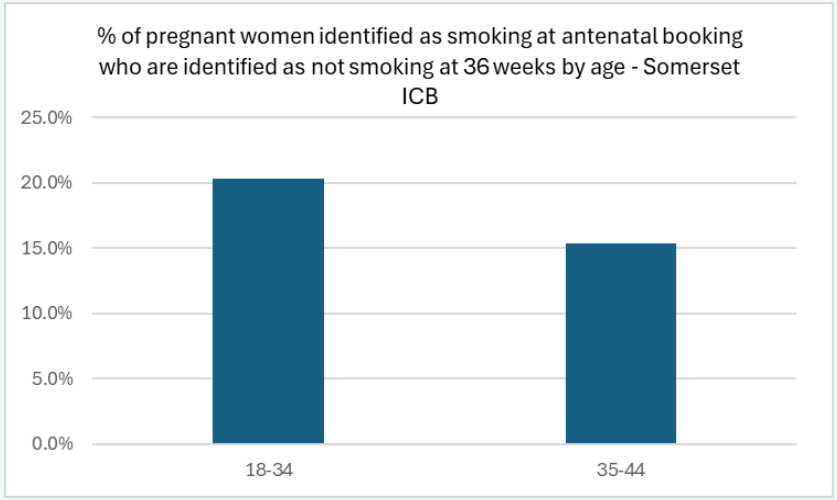
NHS Somerset

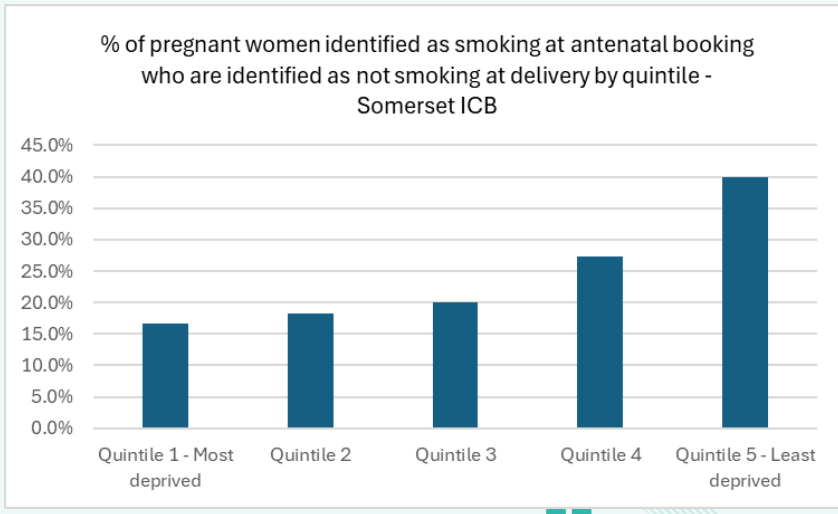












Note: data is taken from Tobacco dependency dashboard from Dec 2024- Nov 2025

Smoking Cessation - Tobacco Somerset

- Tobacco is still the leading cause of preventable premature death and health inequality in Somerset. Two thirds of long-term smokers die an average of 10 years earlier than non-smokers. As well as causing early death, smoking also causes significant disease and disability. Smoking prevalence in Somerset is 10.6% with approximately 50,000 people still smoking across Somerset.

- Somerset smokefree services has seen one of their busiest years yet with nearly 5000 referrals into service and have supported over 1200 smokers in Somerset to quit smoking over 2025/26, with 35% of people quitting from routine and manual workforce. Smokefree service Somerset has the highest quit rate in the region, with 70% of people who set a quit date going onto to quit smoking.

- The hospital smokefree service 'Treating Tobacco Dependency' has assessed nearly 2000 patients by the end of 2025/26. Referring 487 into community smokefree services.

- Somerset's smoking at time of pregnancy (SATOD) is anticipated to be 5% for 2025/26, showing an onward downward trend despite still being above the England average. To date 474 pregnant people have been referred into smoking cessation support, and 44% quit smoking.

- Ongoing service developments to reduce health inequalities form smoking in Somerset include
  - Tobacco health inequalities dashboard for Somerset
  - Targeted pathways for high prevalence groups including substance misuse, routine and manual workforce, mental health and people with long term conditions
  - Improving screening of smoking status across healthcare pathways in primary and secondary care
  - Launch in 2025 of the smokefree app for people to chose digital or local place based smokefree support based on their preference
  - Targeted smokefree campaigns for health inequality groups including pregnant people, families, and working age people.

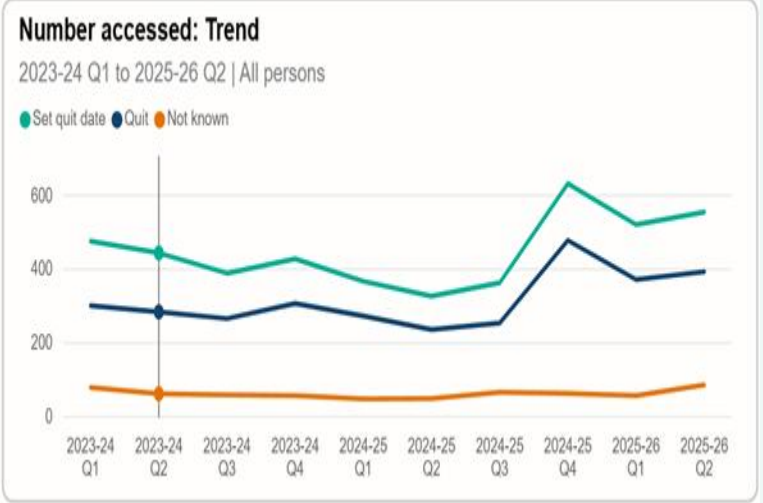


Chart shows the ongoing increase in smokefree service activity since 24-25

Referenced statistics can be found here:

Microsoft Power BI

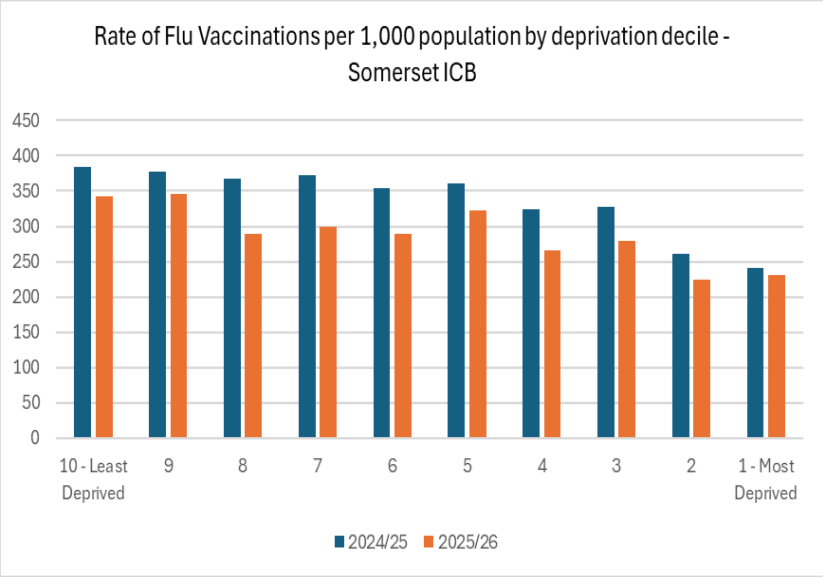
Statistics on Local Stop Smoking Services in England - NHS England Digital

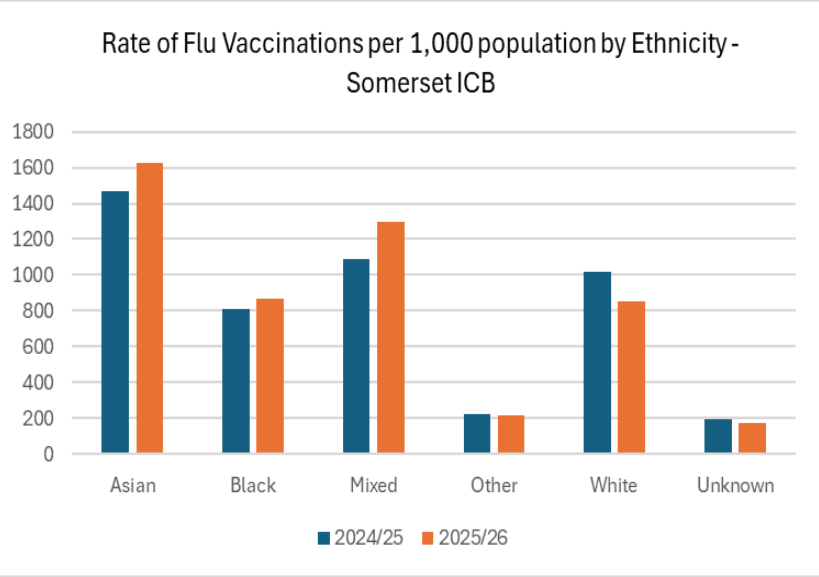
Director of Public Health Annual Report Tobacco 2024

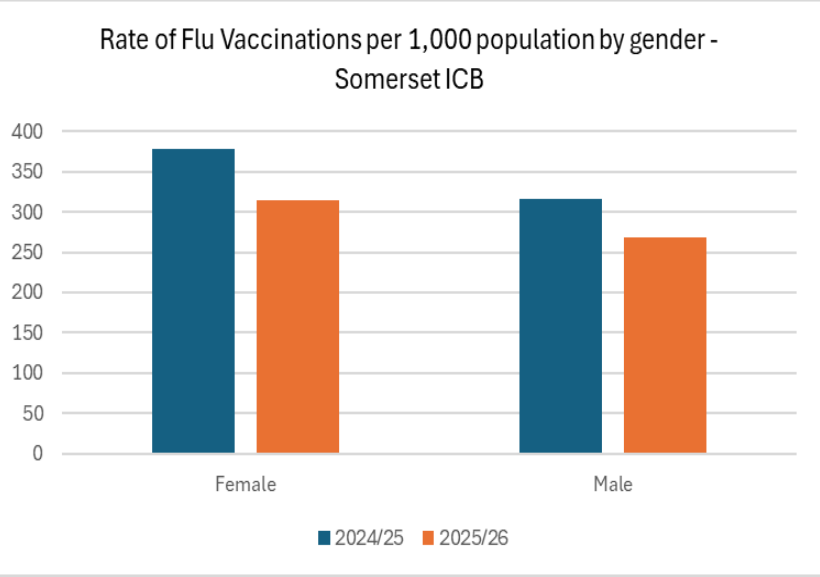
Smokefree Somerset

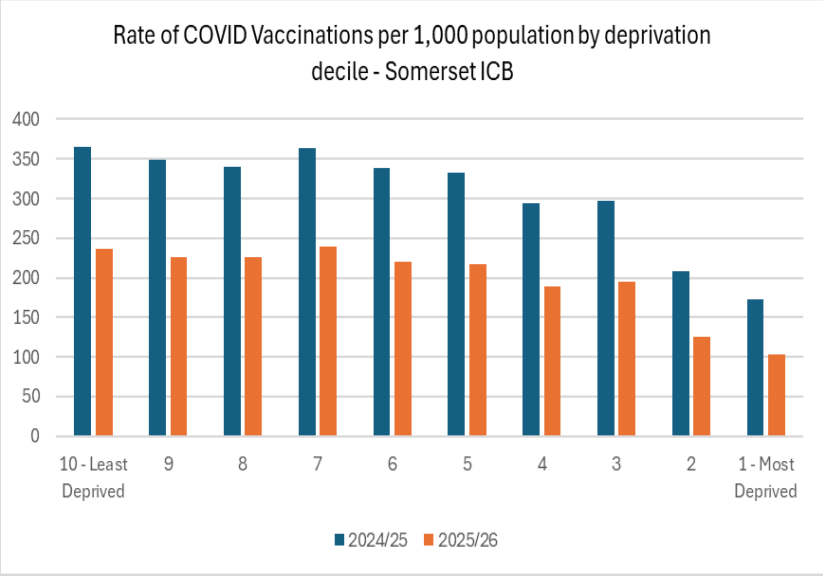
Vaccinations
Flu and COVID only

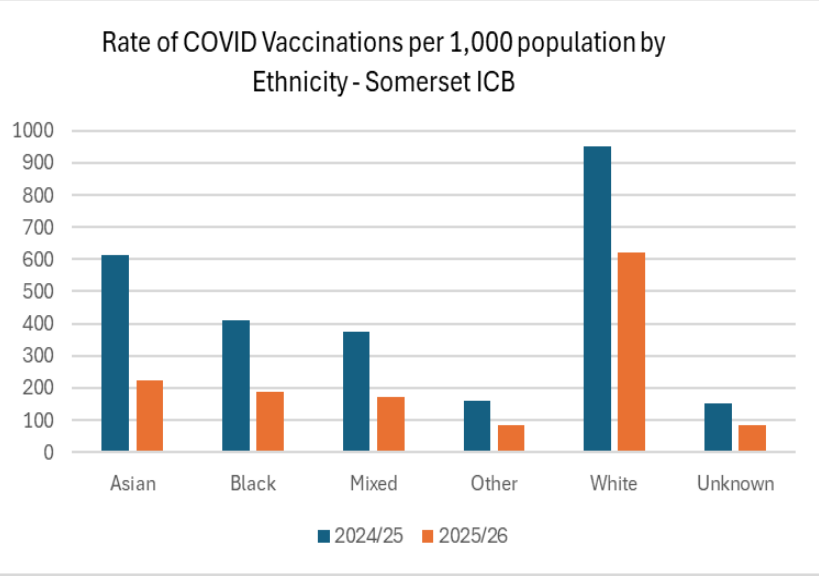
NHS Somerset

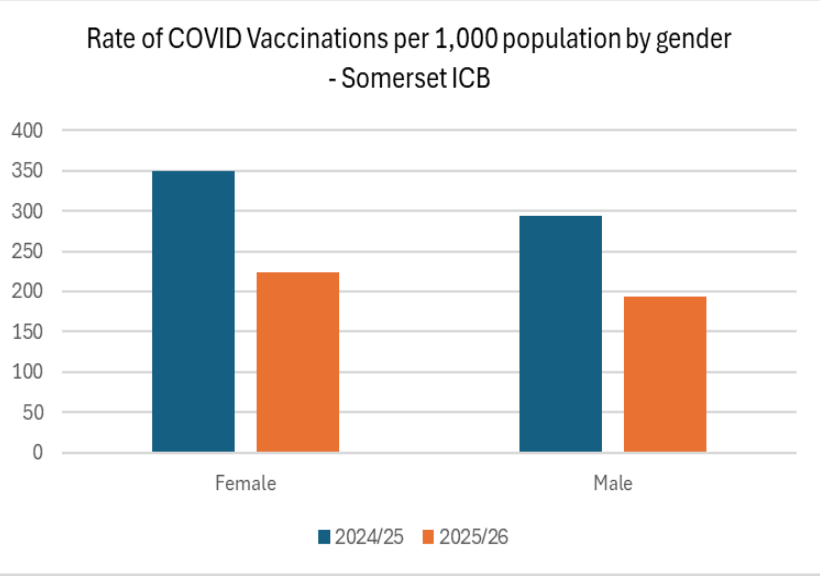












Vaccinations

Flu and COVID only

NHS Somerset

Seasonal Vaccination Programmes and Partnership Working

- Work with Public Health continues to focus on targeting areas of high deprivation and/or low vaccination uptake by delivering local pop-up clinics within communities and working with local pharmacies to expand the vaccination offer. For the 2025/26 seasonal influenza campaign, the system delivered a focused communications campaign. The latest data indicates a further year-on-year improvement in uptake across our most deprived cohorts. Through improved understanding of our ethnic communities, supported by engagement activity delivered by the outreach team, we have also seen year-on-year improvement in influenza uptake across all ethnic groups. Learning from this work will inform planning for the 2026/27 seasonal campaigns. The outreach team also delivered an additional 10,000 influenza vaccination events, alongside educational opportunities to support the flu campaign.

- The COVID seasonal campaigns focused on 'stopping the decline' in vaccine uptake across all cohorts, in line with the NHS vaccination strategy. The latest COVID data for 2025/26 indicates an increasing proportion of people taking up the COVID-19 vaccine across all IMD groups, and this pattern is consistent with the previous year. During 2025/26, the COVID-19 outreach team delivered an additional 37,946 COVID vaccinations across the system, with a particular focus on the most deprived and harder-to-reach communities.

- The winter seasonal campaign also focused on delivering RSV vaccinations for the 75–79-year-old cohort. Early indications from the 2025/26 data show improving levels of uptake. RSV vaccination uptake varies across deprivation deciles, with the lowest uptake observed in the most deprived areas (decile 1) and higher uptake across the mid-deprivation deciles, peaking in decile 6. This pattern indicates lower uptake among more deprived populations and reinforces the need for targeted outreach to support equitable access.

- Somerset ICB continues to work with Somerset Foundation Trust (SFT) and School Aged Immunisation Service (SAIS) teams throughout the seasonal campaigns and during 2025/26, the SAIS team improved vaccination uptake in primary schools from 64% to 69% and in secondary schools from 54% to 61%. This improvement was supported through direct contact with parents who had not initially provided a consent form. A similar approach has also been used to improve uptake of the HPV vaccination programme.

- SFT focused on improving uptake through more convenient vaccination clinics for Health and Social Care Workers. Within the acute setting, uptake increased from 42% in 2024/25 to 56% in 2025/26, representing the highest performance increase within the region for 2025/26. In addition, SFT colleagues have also continued to deliver educational and vaccination clinics, including formal presentations at colleges. Tutors have been provided with materials to reinforce vaccination messaging across the life course, including HPV and seasonal vaccinations

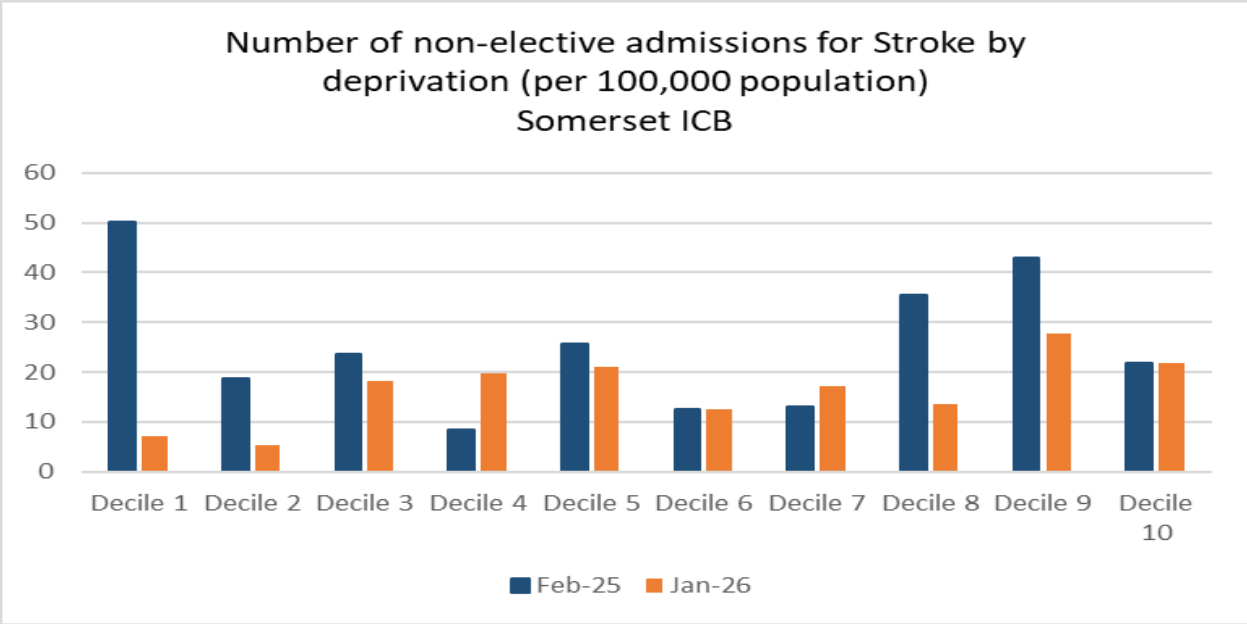
CORE20PLUS5

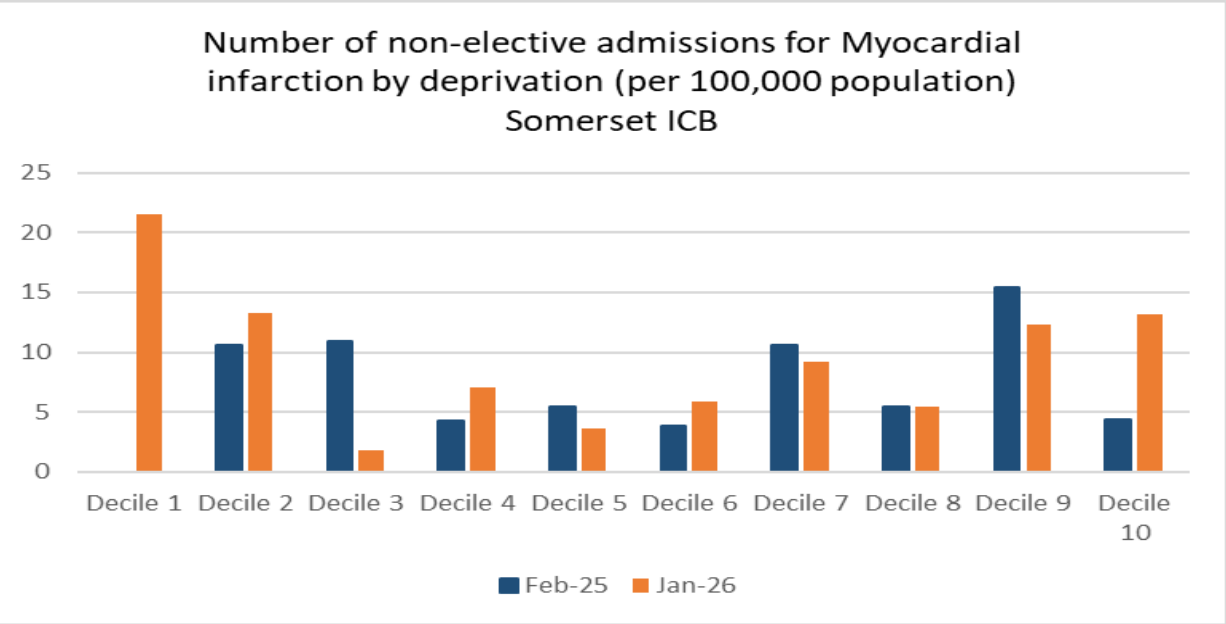
NHS Somerset

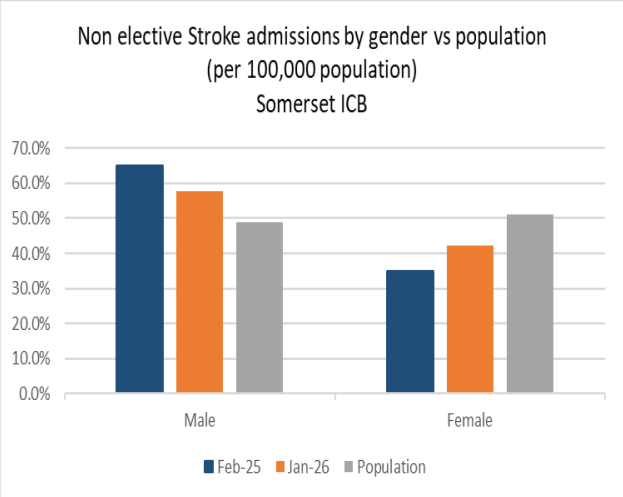
Framework	Domain	Measure	Core or Supporting Metric	Included in Report		Not possible at this time	Not appropriate / applicable	Basis of Reporting
CORE20PLUS5	Cancer	Inequalities in percentage of cancers diagnosed at stage 1 and 2	Core		Page 15-17	☑		Please see Elective Care Cancer Early Diagnosis Section
		Inequalities in rates of 5-year survival following a cancer diagnosis	Supporting			☑		Data unable to be published outside of the NHS so excluded from this report.
		Inequalities in cancer screening coverage – including bowel cancer, breast cancer, cervical screening	Supporting			☑		Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.
	Cardiovascular disease	Inequalities in emergency admissions for stroke	Core	☑	TBC			SUS Data reporting non elective admissions per 100,000 population for Stroke and myocardial infarction, reported by deprivation, age and gender
		Inequalities in emergency admissions for myocardial infarction	Core	☑				
		Inequalities in percentage of hypertension patients treated to target	Core	☑				CVD prevent https://www.cvdprevent.nhs.uk/
		Inequalities in percentage of patients who are manged to target for cholesterol	Core	☑				
		Inequalities in percentage of patients who are manged to target for atrial fibrillation	Core	☑				
		Inequalities in percentage of adults classified as overweight or obese	Supporting			☑		
		Inequalities identified in hypertension case finding	Supporting			☑		
		Inequalities identified in detecting patients with risk of stroke	Supporting			☑		
		Inequalities in proportion of patients discharged from hospital who access stroke rehabilitation	Supporting			☑		Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.
		Inequalities in the proportion of patients discharged from hospital following a heart attack that access rehabilitation	Supporting			☑		Project across the new Cluster underway to provider furhter insights into hypertension case finding across Somerset, Dorset and Bath, Swindon and Wiltshire
		Inequalities in case fatality for stroke	Supporting			☑		
		Inequalities in case fatality for myocardial infarction	Supporting			☑		
		Inequalities in premature mortality from cardiovascular disease	Supporting			☑		
	Learning disability and autism	Number of people in a mental health inpatient setting who have a learning disability or are autistic	Core				☑	Due to low number supression, unable to publish analysis/results
		Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check	Core	☑	TBC			Learning disabilities health checks - NHS England Digital
		percentage of people with suspected autism waiting more than 13 weeks for contact	Core			☑		Work underway to report via the Mental health Services Minimum Dataset in 26/27
		Percentage of people who have had a learning disability annual health check who have an accompanying health action plan	Supporting	☑	TBC			Learning disabilities health checks - NHS England Digital
		Length of stay for people with a learning disability and autistic people in a mental health inpatient setting	Supporting				☑	Due to low number supression, unable to publish analysis/results
		Number of adults with a learning disability or who are autistic in a mental health setting	Supporting				☑	Due to low number supression, unable to publish analysis/results
		Inequalities identified in Learning Disability Improvement Standards	Supporting			☑		Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.
		Inequalities identified in learning from lives and death reviews (LeDeR) faced by people with a learning disability and autistic people	Supporting			☑		Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.

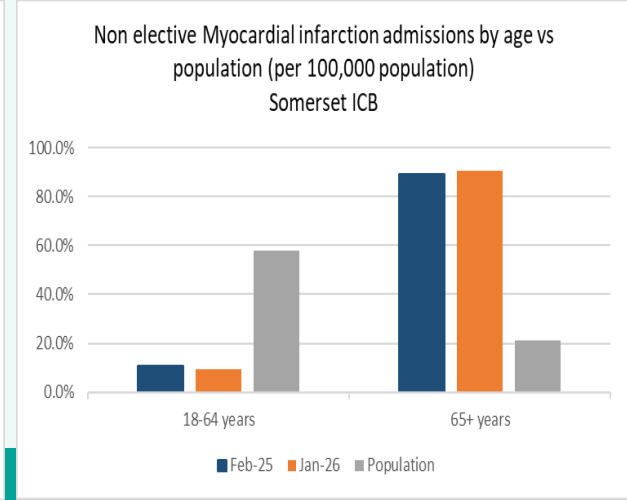
Cardiovascular Disease

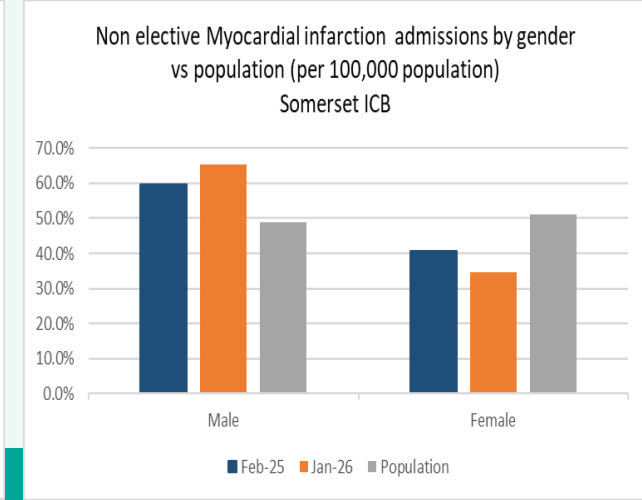
Stroke and Myocardial infarction

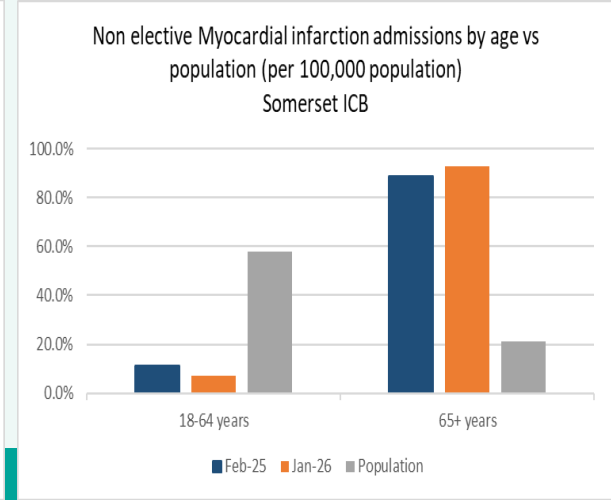








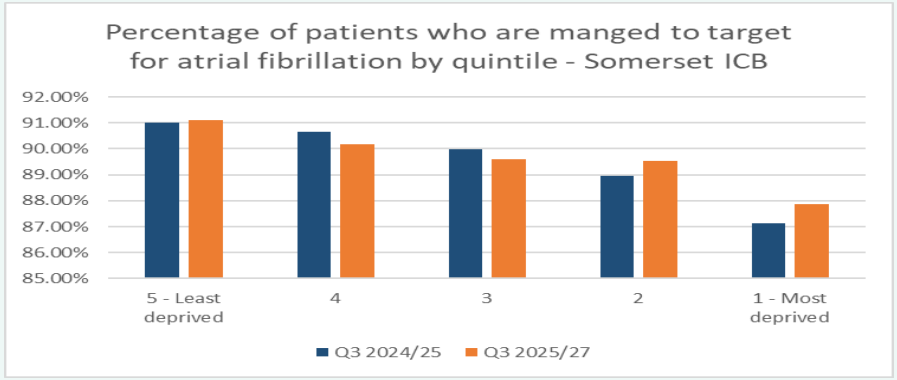


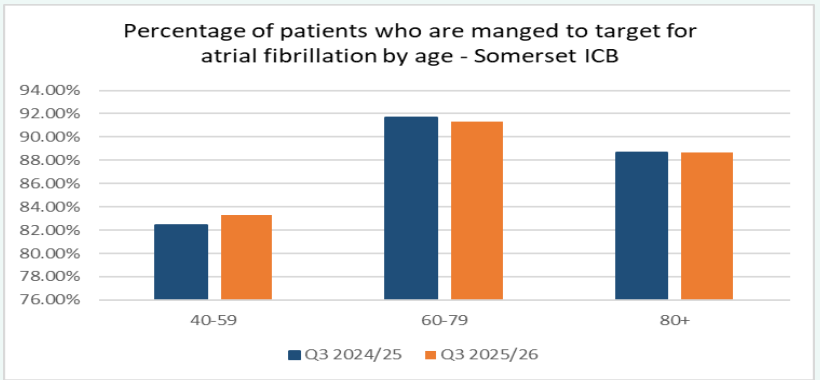


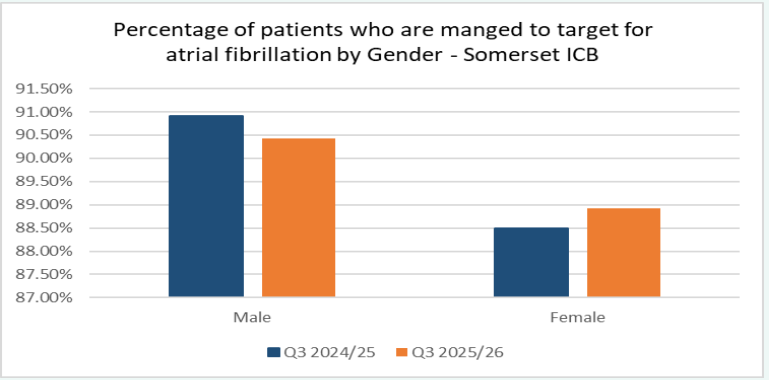
Cardiovascular Disease

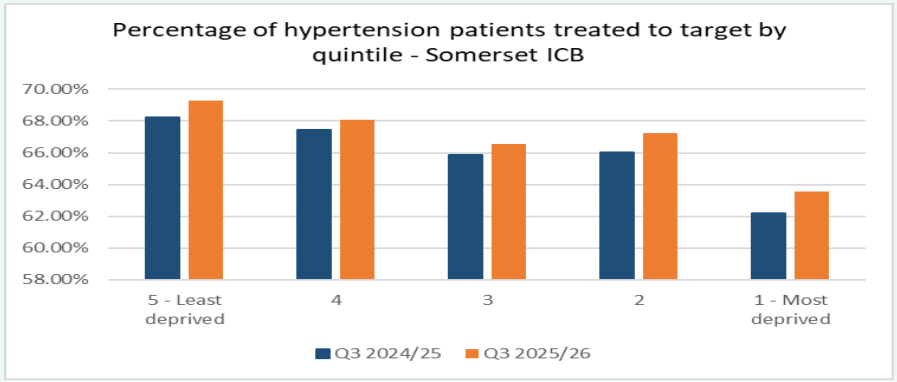
Atrial Fibrillation, Hypertension and Cholesterol

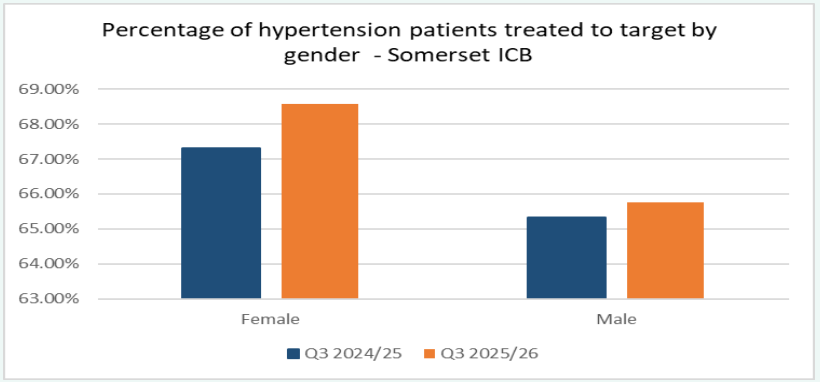
NHS Somerset

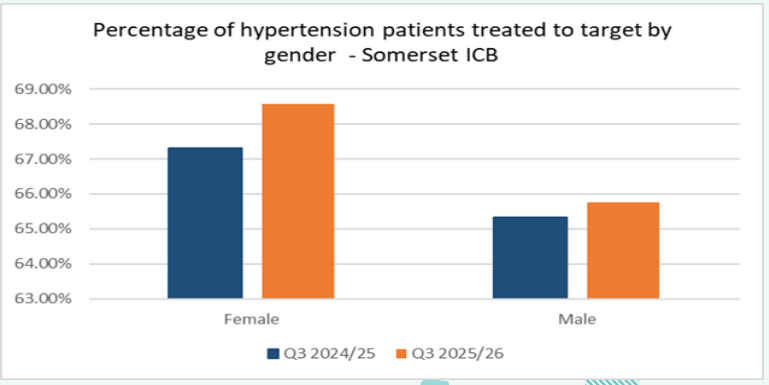


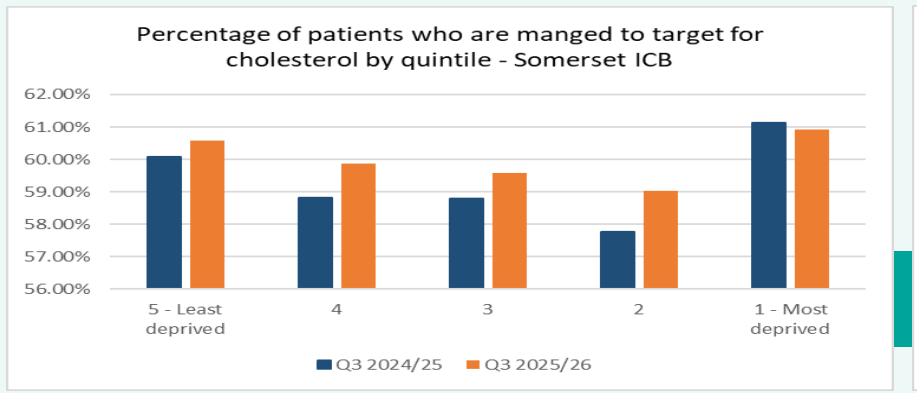


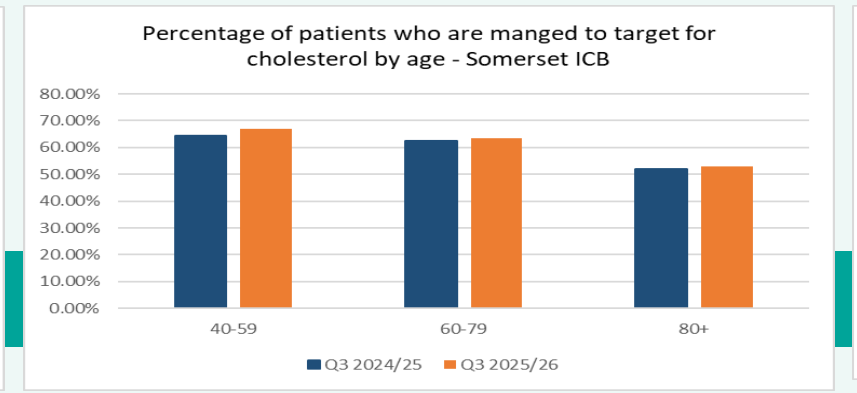


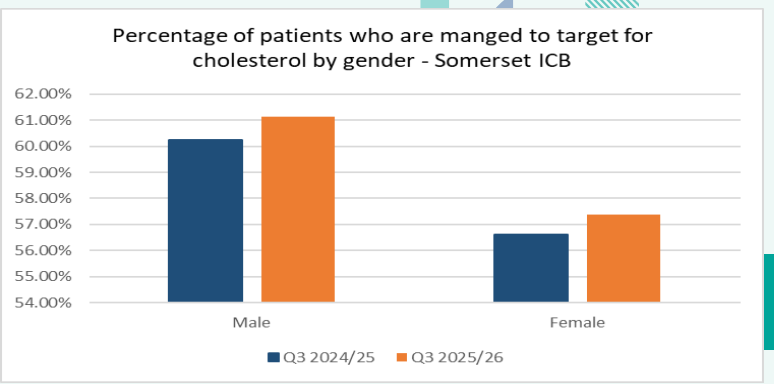












Cardiovascular Disease

Cardiovascular Disease (CVD)

- Prevalence of GP recorded CVD in those adults is higher in Somerset (8.89%) than England ICB median (7.05%). This definition includes coronary heart disease (CHD), stroke, transient ischemic attack (TIA), peripheral arterial disease (PAD), heart failure (HF), and abdominal aortic aneurism (AAA). Inequalities can be seen in diagnosis rates. Males are much more likely to have a diagnosis of a CVD than females. Incidence increases with age being almost double rate in 80+ group compared to 60-79, and in turn this group has about five times the rate in the 40-59 group. Age standardised rates how higher rates of CVD in the more deprived groups with the most deprived group having a rate just over 10% compared to 6.7% in the least deprived group by IMD quintile.

Hypertension

- Somerset has one of the highest rates of diagnosed adult hypertension in England (22.4% compared 18.3%). It also has one of the estimated highest rates of undiagnosed hypertension. Rates of diagnosis increase with age and age standardised rates of diagnosis are higher in males than females.

- On average Somerset has 67.1% of people with hypertension treated to target. However, rates of treatment to target are significantly worse in males, younger people, people living in more deprived parts of Somerset, and people from an ethnic background other than white. Rates are similar but slightly worse in people with a learning disability, and similar but slightly better in people with a severe mental illness.

- Similar inequalities are seen in patters of those with hypertension who have had a recorded blood pressure reading in the previous 12 months. Rates of recent monitoring are lower in males, younger age groups, people in more deprived parts of Somerset and from ethnic backgrounds other than white. However, rates of recent monitoring are higher in those with LD or SMI, likely reflecting the annual health check provision for these groups.

- Somerset has seen some progress to narrow some of these inequalities when looking back across the most recent year of data on CVD Prevent, from September 2024 to the latest CVD Prevent data for September 2025. Overall, we disappointingly saw declines in levels of recent monitoring for those with hypertension, but declines were less for males than females, and slight improvements were seen against the overall trend in the most deprived groups and those with ethnic backgrounds other than white.

Cardiovascular Disease

NHS Somerset

Atrial fibrillation

- Somerset has the highest rate of diagnosis of atrial fibrillation of all ICBs in England at 3.92% compared to the median of 2.92%. This is linked to our overall older age profile within the population as diagnosis rates increase in older age groups.

- Overall Somerset has above average levels of assessment for those with GP recorded AF in the last year using the CHA2DS2-VASc scoring system. In contrast to the inequalities seen in hypertension monitoring, males and younger patients are more likely to be assessed. Rates of assessment do not vary consistently by deprivation and rates in the most deprived cohort are similar to those in the least deprived cohort with lower rates for the intermediate groups. People with SMI are more likely to be assessed.

- Treatment for those at greatest risk, with CHA2DS2-VASc scores above 2, with any anticoagulants or the more potent DOACs is lower than the England average. The following groups are less likely to be on any anticoagulant or a DOAC: people with SMI or LD, females and younger patients (40-59) and especially females are less likely to be treated females are less likely to be treated than males. patients from Asian background or more deprived locations.

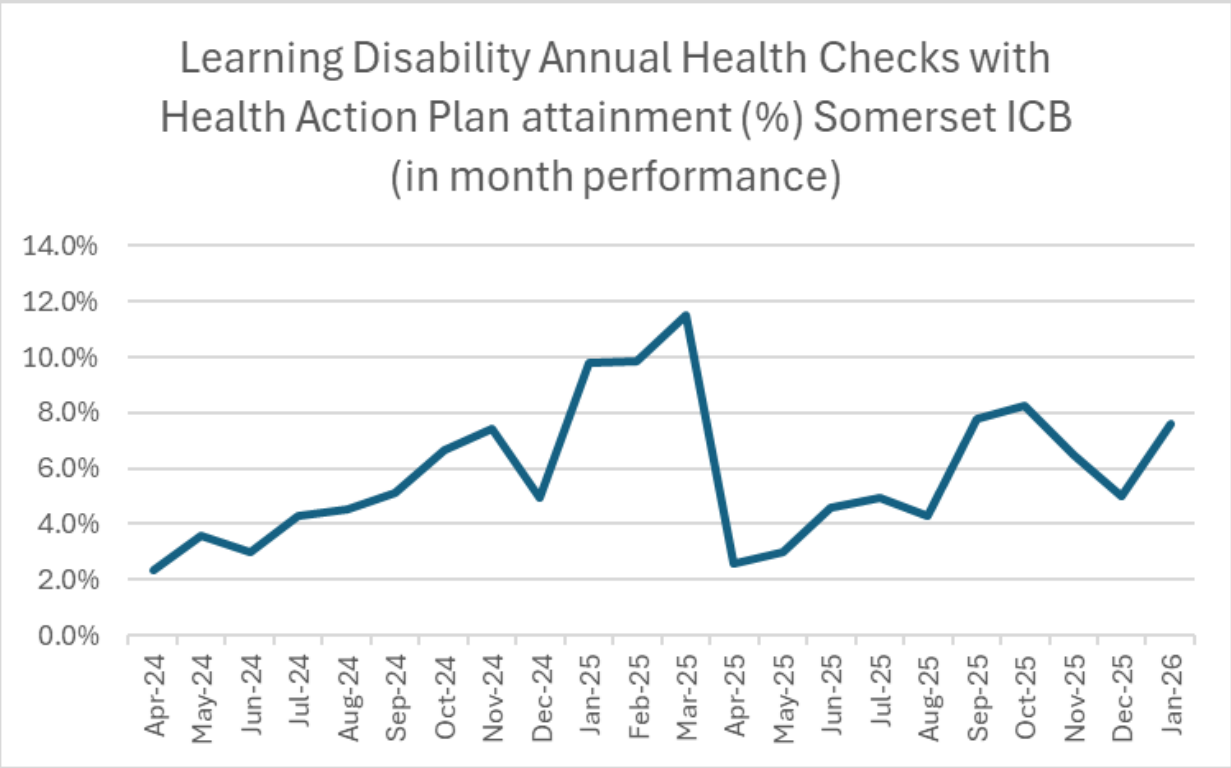
Cardiovascular Disease

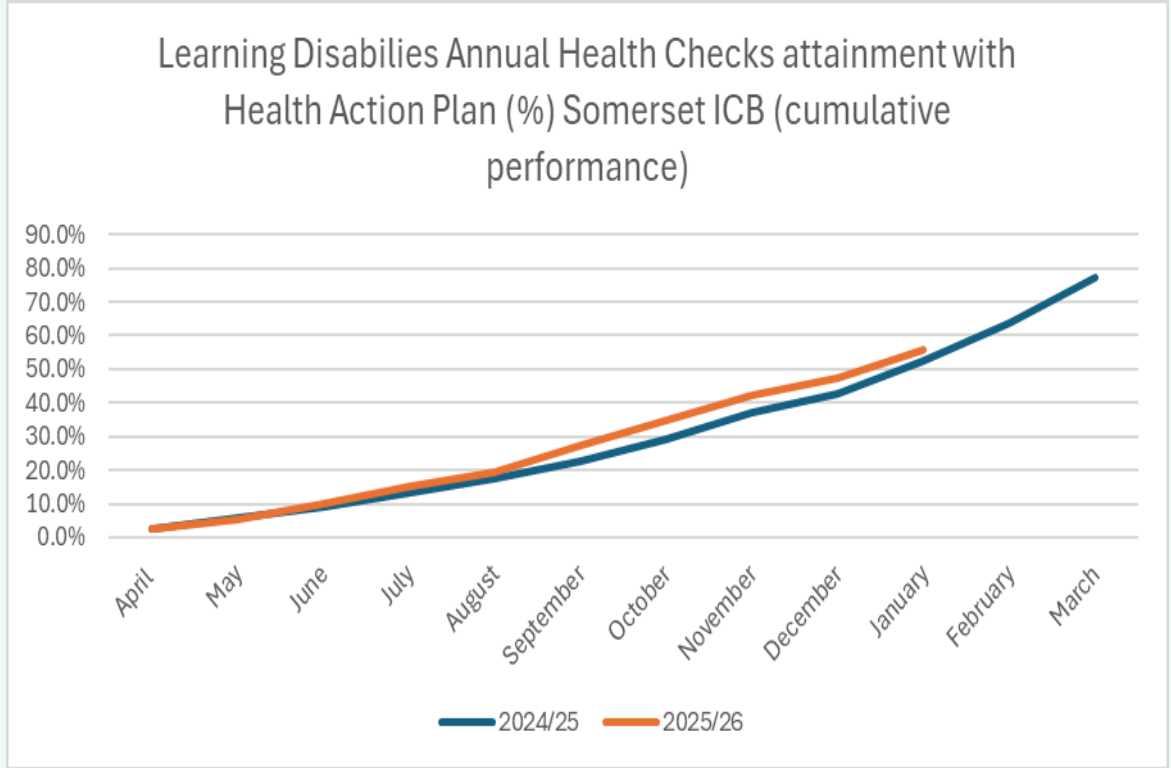
Case Study

- Somerset ICB has again supported a systemwide campaign **‘Take the Pressure Off’.** The campaign aims to raise awareness of the importance of blood pressure checks given geographic inequalities between Somerset and the rest of England but with selection of venues and case studies with an angle towards groups less likely to be monitored, diagnosed and treated to target. Key activities in 2025/6 include:
    - Community blood pressure stands measuring over 1800 people at a range of community events including those specifically aimed at carers and farmers and workplaces particularly targeting those with workforces from more deprived areas and job fairs and job centres to reach those unemployed
    - Roundabout sponsorship in key commuter areas
    - Bannervan (advertising) presence around Somerset featuring male case studies
    - May 2025 Promotion of World Hypertension Day, Borrow a Blood Pressure Testing Kit from your library for World Hypertension Day
    - Sept 2025 Support for Know Your Numbers Day including films featuring male case studies Know Your Numbers - It Could Change Your Story - YouTube and radio coverage on BBC Somerset
    - Nov 2025 Work with Yeovil football club Taking the Pressure Off at Huish Park
    - Jan 2026 Library campaigns to support Stroke Awareness, e.g Next Thursday 29th... - Somerset Libraries Burnham-on-Sea | Facebook
    - Feb 2026 Love Your Heart – Valentine message from Somerset Public Health

Learning Disabilities and Autism

NHS Somerset





Learning Disabilities and Autism

NHS Somerset

- People with a learning disability (LD) face significant health inequalities, including poorer access to healthcare and a markedly reduced life expectancy. The average age of death is 63 years, around 20 years younger than the general population. Annual Health Checks (AHCs) and Health Action Plans (HAPs) are designed to address this gap by identifying health needs early, ensuring appropriate treatment, and promoting preventative health. Evidence shows AHCs reduce unmet health needs, avoidable admissions, and premature mortality.

- Somerset completes a relatively high proportion of AHCs (75–80%), but HAPs remain limited in both quality and uptake. Locally developed Health Needs Questionnaires are under-used, and support for patients and carers to implement HAPs is inconsistent. Despite strong commitment, current systems are fragmented and insufficient.

- In response, and aligned with the NHS Long Term Plan and 10 Year Plan, NHS Somerset ICB began working with Maldaba Ltd and the GP Support Unit in April 2025 to test a digital tool to improve AHC delivery for people with LD. Although framed as a digital project, it is fundamentally a sociotechnical change: success relies on technology, workforce practices, processes, and relationships working together. The Bayswater Institute will independently evaluate the project, with findings due in September 2026.

- The project aims to reduce health inequalities, improve health outcomes for people with LD, reduce administrative burden, and demonstrate value for money. Using recognised quality improvement approaches, including appreciative enquiry, it seeks to strengthen AHC quality; produce meaningful HAPs, and support individuals and carers to use these plans to improve health over time. This work positions Somerset as a national leader in improving LD health outcomes and in adopting innovative digital solutions in primary and community care. All 62 Somerset practices have been approached; 14 expressed interest and 17 have begun implementation. Ten practices have been trained and EMIS-linked. Information Governance and EMIS integration challenges caused delays, but the digital tool is now in use and HAPs are beginning to flow through.

- During these delays, significant progress has been made in building a strong LD Community across Somerset, creating a shared commitment to improving AHC quality and uptake. This network includes the GP Support Unit, LD care providers, the Somerset Registered Car Providers Association, LeDeR, the Somerset FT LD Liaison Team, carers, VCSE partners, and wider stakeholders. We are also working closely with Somerset Council on relaunching the LD Partnership Board and aligning with national AHC campaigns from Mencap and Dimensions.

- We have also developed system-wide resources, including training videos, SOPs, a Mythbuster Tool, Reasonable Adjustment guidance, GP TeamNet materials, and patient/carer-facing HAP information guides.

Homeless Health

NHS Somerset

Overview

- It is recognised that extremely poor health status among inclusion health groups is driven by severe disadvantage and clusters of social risk. For example, someone who is alcohol dependent may also be homeless resulting in vulnerability, limited opportunities, extremely poor health and a reduced life expectancy. Inclusion health groups therefore require an explicit, tangible focus in system efforts to reduce healthcare inequalities.

- The NHS in Somerset working together with Public Health (Somerset) pursued an approach to delivering Homeless and Inclusion Health and in October 2020, in partnership with Somerset County Council, launched the Homelessness Health Care Service – Somerset pilot. The aim was to address the identified unmet need, and our local provision has continued to evolve during 2025/26.

- The Homeless and Rough Sleeper Nursing Service (HRSNS) and the Specialist Outreach Inclusion Health GP roles continue to provide high quality support across Somerset. The HRSNS is now fully staffed following significant changes over the last year and recruitment, retention, and skill mix, including developing Nurse Prescriber roles to enhance the outreach offer have been strengthened throughout the year. Specialist Outreach GP provision is now available countywide, with all services delivered through VCSFE settings and direct outreach.

- In late 2025, Somerset Council piloted two specialist Rough Sleeper Social Worker posts to strengthen the NICE recommended MDT model. These roles support people rough sleeping and those facing multiple disadvantage.

- The programme continues to attract national interest, with presentations at events including the National Homelessness Conference (January 2026).

- A Community Hubs working group, led by Somerset Council Housing Commissioning, is exploring opportunities to expand community and VCSFE outreach for housing, health and wellbeing. There is potential to link this to the work being done by Clive Shore (NHS).

Homeless Health

NHS Somerset

Update on Joint Forward Plan (2024–2029)

- The Plan identified an action for 2024/25: “Evaluation of Homeless Health programme and development into an Inclusive Health Programme.” While the evaluation was delivered, development into a full Inclusive Health Programme has not yet been achieved.

Progress in 2024–2026

- **GP Outreach -** Public Health supported recruitment to the Sedgemoor Inclusion Health GP post, with Dr Chery appointed in July 2024. Funding for this role and the Mendip post remains subject to annual approval, often confirmed only shortly before the start of the financial year. There are now 10 funded outreach GP sessions delivered weekly across Somerset.

- **Evaluation and Reporting -** A Public Health led evaluation of Homeless Health activity (Summary Evaluation Report, January 2025) was presented to the Population Health Transformation Board in February 2025. Key recommendations included securing funding and developing a future service model. Findings informed the Somerset System Priority: Homeless Health document (May 2025), prepared for the Health Inequalities Report and these insights were also included in the ICB Tackling Healthcare Inequalities report (June 2025). In October 2025, ICB submitted an Inclusion Health report to NHSE/OHID South-West, highlighting ongoing risks related to insecure funding and limited programme leadership.

- **Strategy and Commissioning –** the ICB has developed an Options Appraisal for future commissioning, and working with Public Health drafted the Somerset Inclusion Health Strategy 2026–2028 which was presented to the Population Health Transformation Board in February 2026. The Board agreed to:

    - Seek confirmation from the incoming Chief Officer for Population Health Improvement to sponsor the strategy
    - Bring the strategy forward early in 2026/27 for approval, formal endorsement and implementation planning
    - The Board noted current uncertainties in Cluster governance but emphasised the need to maintain momentum.

  The Inclusion Health Strategy is referenced in the ICB MTP support pack (NHSE ICB Board Assurance 2026-27) as evidence of planning for underserved communities.

Homeless Health

NHS Somerset

Commissioning and Future Model

- The Population Health Transformation Board have considered the longstanding issues of fragmented funding, lack of coherent commissioning, and the need for a sustainable, integrated model and in February 2026 agreed: to continue all existing funding for 2026/27 to avoid service disruption during redesign and to recommission the Homeless Health Service into a single integrated Inclusion Health model, targeting go live by April 2027.

Next Steps and Alignment with the Joint Forward Plan

- There is now a clear path to adopt the Somerset Inclusion Health Strategy (2026–2028) and to move toward commissioning and mobilising a single integrated Inclusion Health service by April 2027. Together, these developments contribute to fulfilling the objectives set out in the Somerset Five Year Joint Forward Plan regarding tackling inequalities and developing an Inclusion Health programme.

Coastal Communities

NHS Somerset

- Professor Chris Whitty's 2021 Chief Medical Officer Report highlighted that nationally, coastal communities have deep rooted inequalities with higher raters of disease burden, lower life expectancy, increased preventable mortality and higher rates of disability.

- Some of our communities need extra support to improve their life experiences in health and care. An example of inequalities in our coastal communities include:
    - By 2028, we expect more than half of West Somerset residents will be aged over 65 years.
    - In our Somerset coastal communities 23% of people aged 16+ live with a long-term condition. It is lower at 17% in non-coastal communities.
    - In West Somerset young people are more likely to be overweight. For example: 12.9% of children in reception year are very overweight vs 10.1% for Somerset. In year 6 of school, 24.7% are very overweight vs 17.4% for Somerset.

- Somerset has launched the Work Well Initiative which is a national government programme to support people with health conditions and disabilities back into work which strongly fits with Somerset's coastal challenges around health and economic inactivity. The aim is to provide free, tailored support to help people start, stay and progress in work, focusing on the overcoming health-related barriers to employment.

NHS Somerset

Health Inequalities Programme Review (Children)

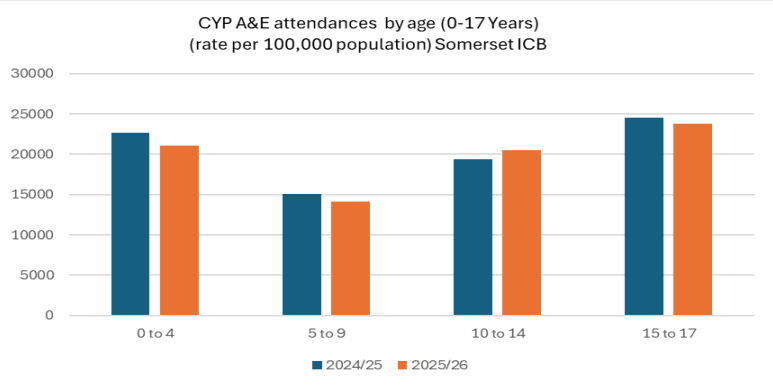
CORE20PLUS5

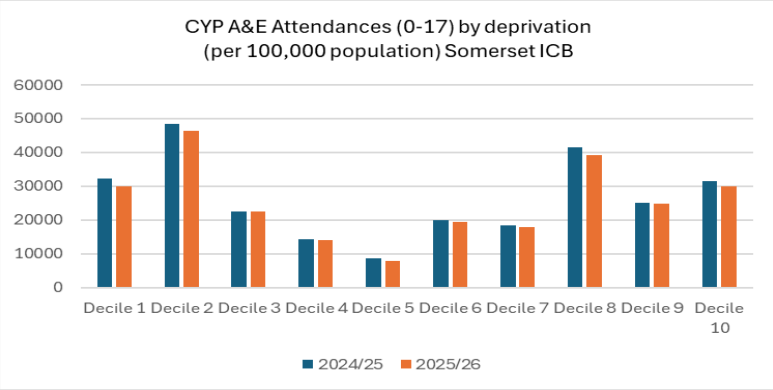
NHS Somerset

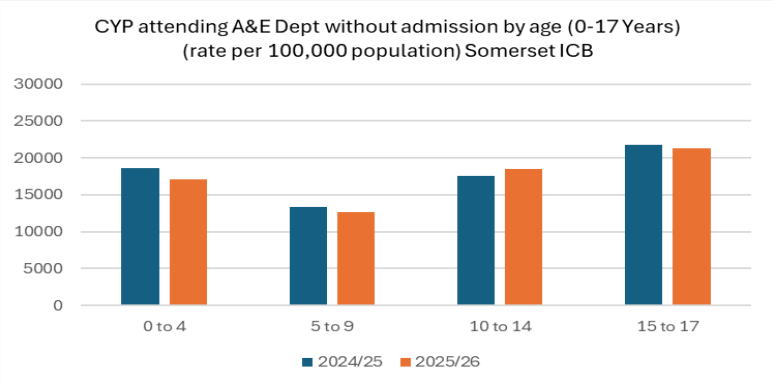
Framework	Domain	Measure	Core or Supporting Metric	Included in Report		Not possible at this time	Not appropriate / applicable	Basis of Reporting
CORE20PLUS5 (CYP)	Urgent, emergency and community care	Inequalities in children and young people (CYP) emergency department attendances	Core	☑	TBC			Emergency Care dataset, reporting A&E type 1&3 attendances by deprivation, age and gender
		Inequalities in accessing specialist paediatric and multidisciplinary support for CYP in community settings	Core			☑		Data source to be identified to report upon this indicator
		Inequalities in percentages of CYP attending ED departments without admissions	Supporting	☑				Emergency Care dataset, reporting A&E type 1&3 attendances without admission by deprivation, age and gender
		Inequalities in percentages of attendances broken down by acuity reported at triage	Supporting	☑				Emergency Care dataset, reporting A&E type 1&3 attendances broken down by acuity by deprivation, age and gender
	Asthma	Inequalities in CYP asthma, including emergency department admissions and dispensing of reliever only inhalers	Core	☑				Emergency Care dataset, reporting A&E type 1&3 attendances for Asthma or respiratory illness where recorded reported by deprivation, age and gender
		Inequalities in prevalence of childhood asthma (under 18)	Supporting			☑		Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.
	Diabetes	Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes	Core	☑				Check data source with Rose
		Inequalities in percentage of CYP using diabetes technology, including continuous glucose monitoring, insulin pump, and hybrid closed loop	Supporting	☑				
	Oral health	Inequalities in elective admissions of hospital-based tooth extractions due to dental caries	Core	☑				SUS reporting planned admissions to hopsital for tooth extractions for children under 18 (Check WLMDS data source)
		Inequalities in percentage of children and young people with visibly obvious dental decay	Supporting			☑		Data source to be identified to report upon this indicator

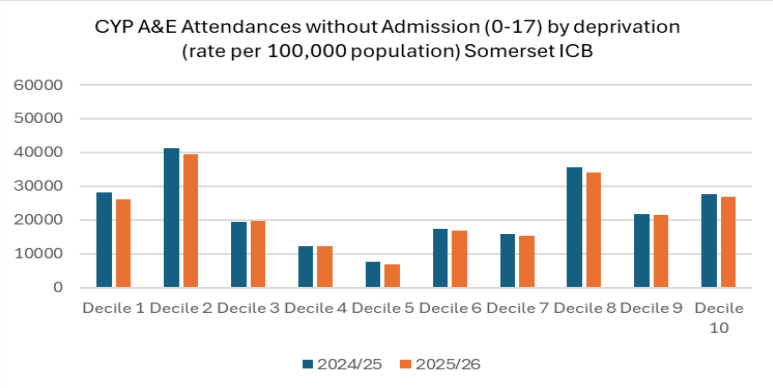
Urgent and Emergency Care

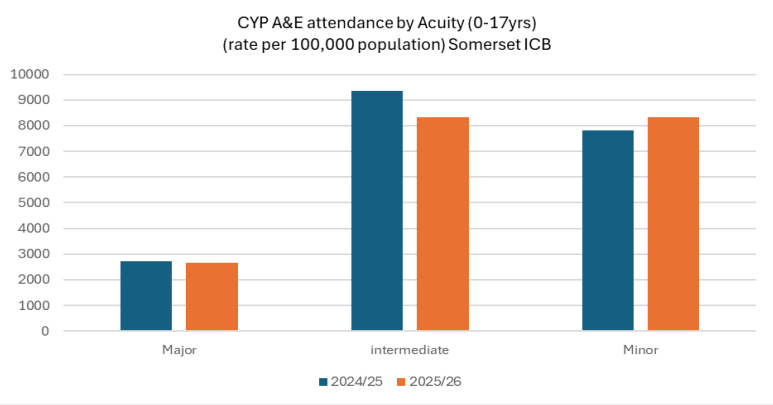
CYP A&E attendances

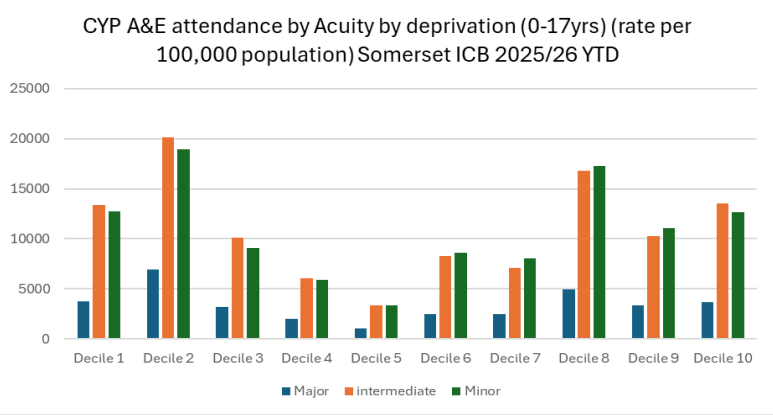












- There is variation across the CYP age bands with ages 0-4 and 15-17 years seeing a higher rate of A&E attendances.
- There is also variation when looking at A&E attendances by deprivation decile with deciles 2 and 8 seeing a higher rate of attendance however, 1 and 10 show little difference.
- The pattern in variation by age and deprivation of those attendances without admission is similar to the overall picture of attendances. On average the data shows overall around 87-88% of attendances are without admission which is consistent across the age cohorts and deprivation deciles.
- There is variation of acuity type with a higher rate of intermediate and major acuity reported across 2024/25 and 2025/26 which is also evident when reviewing the data by deprivation.

Children & Young People
Long Term Conditions – Asthma

- **Clinical Insight: Reasons for ED Presentation**
  - In asthma, deprivation-related factors (e.g. housing, smoking exposure, financial barriers) contribute to increased risk of emergency presentations
  - Provider feedback highlights that many asthma-related emergency department (ED) attendances are potentially avoidable and linked to gaps in routine care and system-wide prevention. Common drivers include, poor adherence to treatment and inhaler use, lack of education and absence of personalised asthma action plans (PAAPs), limited ability of children and families to self-manage and environmental and social factors, including, poverty and housing conditions (e.g. mould), exposure to smoking and financial barriers to attending appointments.

- National reviews (National Review of Asthma Deaths (NRAD) and National Child Mortality Database (NCMD)) are referenced as highlighting similar themes, particularly around lack of asthma plans contributing to poor outcomes.

- Some variation is observed across age groups with younger children presenting with preschool wheeze / asthma overlap and teenagers presenting with poorer adherence and asthma control. Health inequalities are noted to exacerbate risk, particularly where social and environmental factors impact condition management and access to care.

System Gaps Contributing to Inequalities

- Gap in workforce, service provision across Somerset geography and prevention support in the community and prevention, leading to inequitable service access

- Education and Self-Management
  - Limited structured education for children and families across primary care, hospital settings and ED attendances
  - Missed opportunities to improve, inhaler technique, trigger management and use of asthma action plans

- These gaps contribute to poor long-term asthma control, increased likelihood of repeat ED attendances, variation in care quality across Somerset and increased risk of late or acute presentation

- Targeted actions to close the gap include children and young people asthma training across the system, including study days and spirometry training for primary care and community staff. Spirometry improves diagnosis and ongoing management of asthma, supporting earlier intervention and reducing avoidable ED presentations

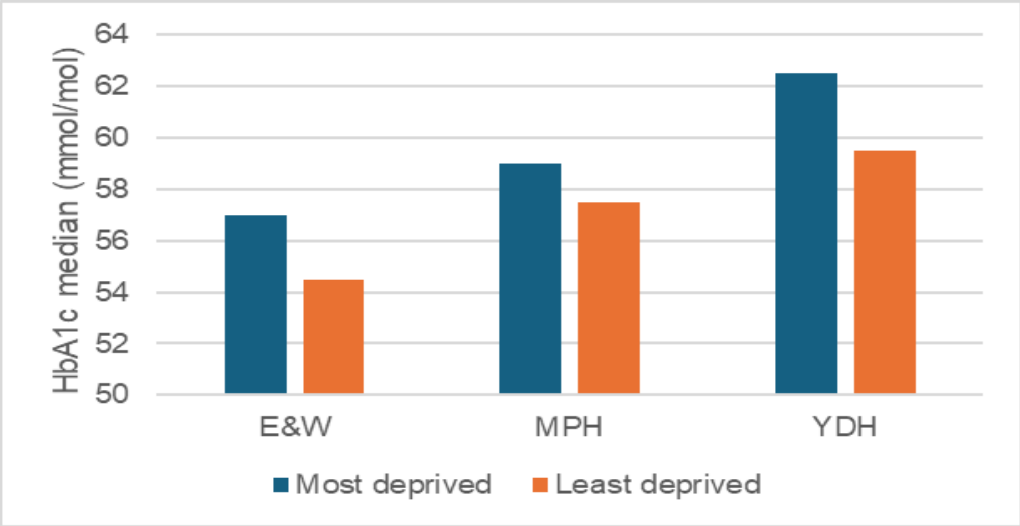
Children & Young People
Long Term Conditions – Epilepsy

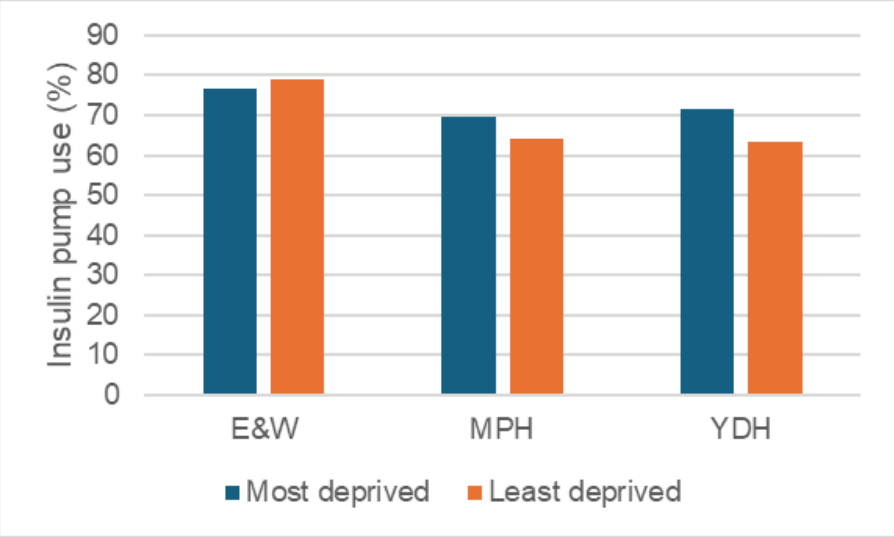
NHS Somerset

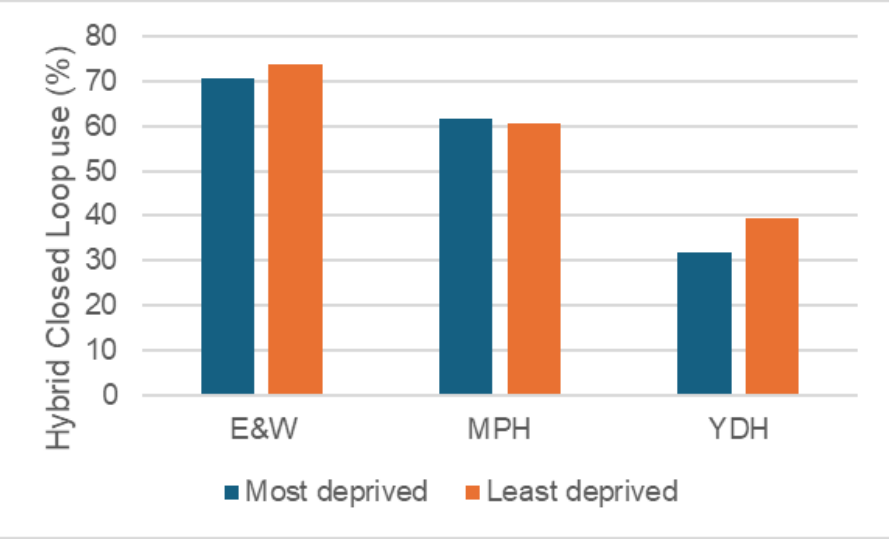
- All children and young people diagnosed with epilepsy in 2024-25 were seen by an Epilepsy Specialist Nurse (ESN) within the first year of diagnosis
- The average waiting time for specialist nurse support is 4-5 weeks which is above the national standard, although this is noted to be a common national challenge
- Detailed breakdowns (learning disability, autism, deprivation, ethnicity) are not currently available locally, however this information is expected through the Epilepsy12 national audit although 2023-24 data is incomplete and not reliable and more robust data is anticipated in the next audit cycle (expected 2027)
- Epilepsy is described as a heterogeneous condition, with some children requiring repeated contact due to complex or difficult-to-control epilepsy
- Heavy reliance on national audit (Epilepsy12) for inequalities data
- Current local data is limited, particularly for demographic breakdowns and inequalities analysis
- Actions:
    - Work is underway to strengthen local data quality and completeness, including backdating and submission to the Epilepsy12 audit, to enable improved understanding of outcomes and inequalities
    - A site visit at YDH in Q1 2026-27 to better understand current challenges, with a particular focus on workforce capacity and access to specialist support

Children & Young People
Long Term Conditions – Diabetes

NHS Somerset







Children & Young People
Long Term Conditions – Diabetes

- **Access to Recommended Care (NICE Processes)**
  - Somerset's Annual Health Check completion rate has improved from 68.7% in Q1 to 82% in Q3 (2025-26)
  - Somerset is performing above the England and Wales average (79.2%)
  - Some variation remains, particularly for older children and young people and ethnic minority groups
  - Focus is required to maintain performance through Q4 2025-26

- **Clinical Outcomes – HbA1c (Glycaemic Control)**
  - Median HbA1c across Somerset is 59 mmol/mol (Q3 2025-26), higher than the England and Wales average (55.5 mmol/mol), against the recommended treatment target of <48 mmol/mol, though this is challenging to achieve across paediatric populations nationally
  - Inequalities are evident, with poorer control in:
    - More deprived populations
    - Ethnic minority groups (noting small cohort sizes)
    - Older children and young people (>12 years)

- **Treatment Targets (<48 mmol/mol)**
  - In Q3 2025-26, 10.9% of children and young people in Somerset achieved the recommended HbA1c target of <48 mmol/mol, which is below the England and Wales average of 19.2%
  - Inequalities are evident:
    - Lower achievement in the most deprived groups (8.9%) compared to least deprived (10.7%)
    - Lower achievement in older children and young people (>12 years: 10%) compared to younger children (13.1%)
    - Variation by ethnicity is observed, though interpretation is limited by small cohort sizes

Children & Young People
Long Term Conditions – Diabetes

NHS Somerset

- **Technology Access (Insulin Pump and Continuous Glucose Monitoring (CGM))**

  - Insulin pump use in Somerset has increased to 67.7% in Q3 2025-26, though remains below the England and Wales average of 77.9%
  - CGM uptake is high at 92.4%, slightly below the England and Wales average (95.3%)
  - Variation in access is observed:

    - Lower uptake in older children and young people (>12 years) across both technologies, more pronounced for insulin pumps (64.4% vs 75.3%) than CGM (90% vs 97.8%)
    - Higher uptake in more deprived groups, particularly for CGM (96.2% vs 89.8%), suggesting broadly equitable access
    - Some variation by ethnicity however, interpretation

- **Advantaged Technology (Hybrid Closed Loop (HCL)**

  - Uptake of HCL systems in Somerset has increased to 55.1% in Q3 2025-26, but remains significantly below the England and Wales average (72.3%)
  - Inequalities in access are evident:

    - Substantially lower uptake in older CYP (≥12 years: 49.8%) compared to younger children (66.7%)
    - No clear variation by deprivation, suggesting broadly equitable access across socioeconomic groups
    - Some variation by ethnicity, though interpretation is limited by small cohort sizes

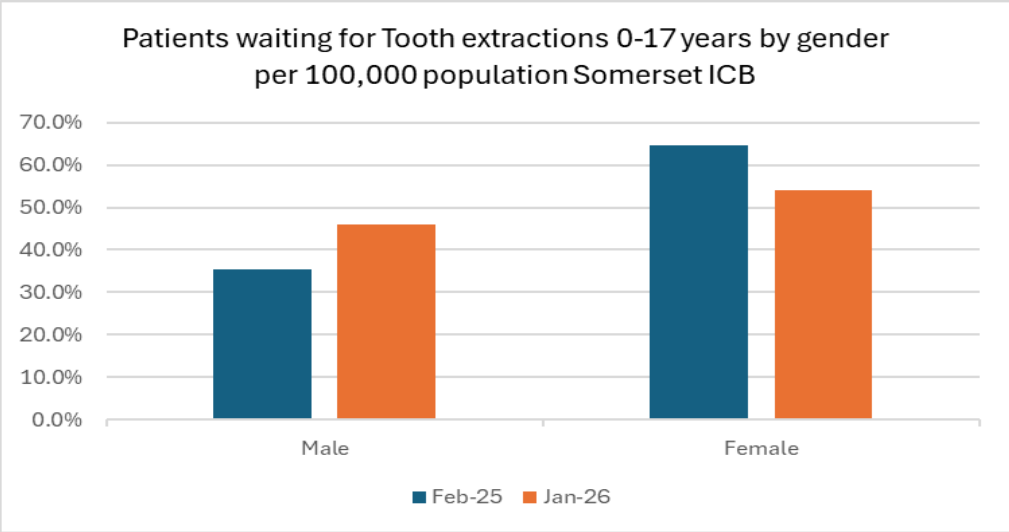
- **Treatment Diabetic Ketoacidosis (DKA)**

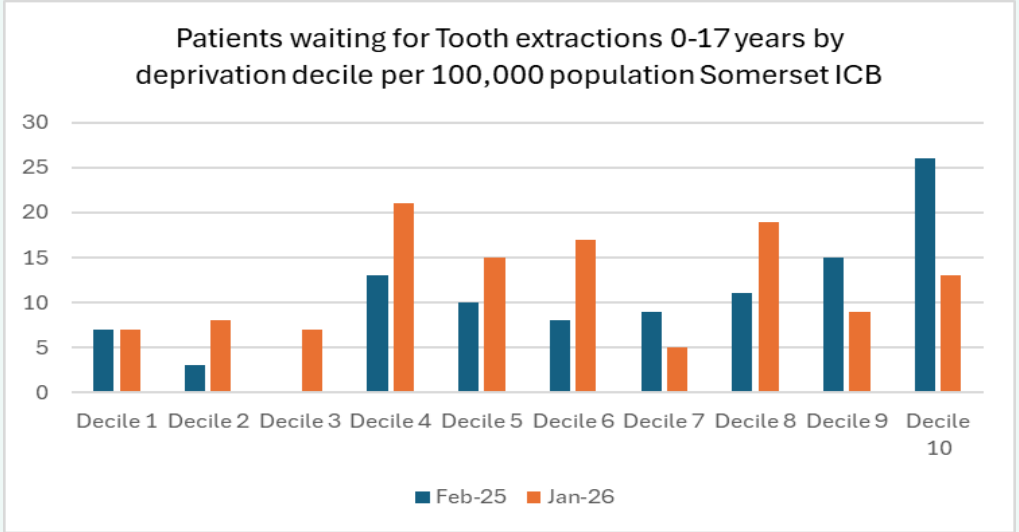
  - DKA is a serious complication of diabetes and a marker of avoidable harm
  - In Somerset, DKA at diagnosis is reported as <4%, compared to 24.1% nationally, though this is based on very small numbers and should be interpreted with caution
  - Post-diagnosis DKA remains low (1.7% / 1.7 per 100 CYP in Q3 2025-26) and has improved significantly from the previous year

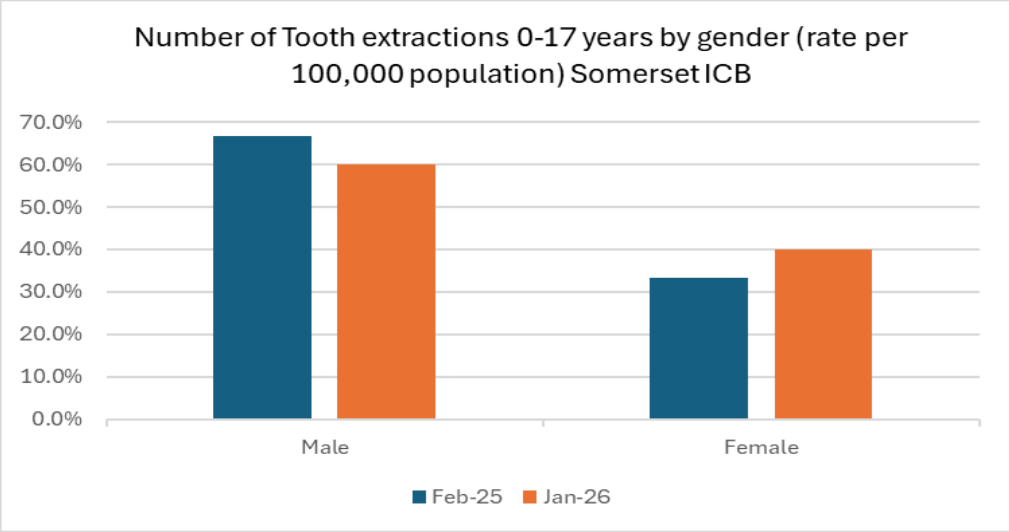
  - Some variation is observed locally:
    - Higher rates in older CYP (>12 years)
    - Higher rates in more deprived groups

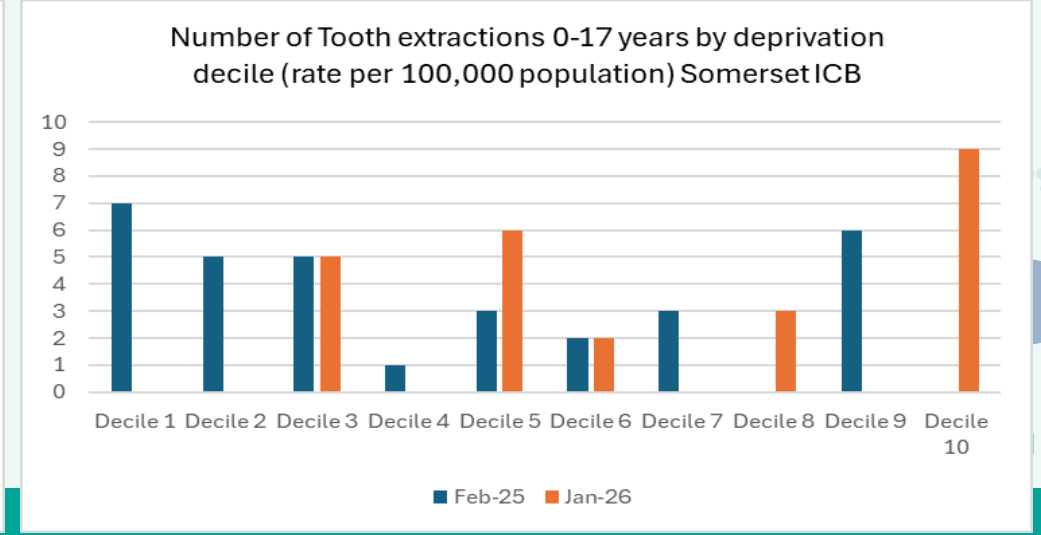
Oral health

NHS Somerset









Oral health

NHS Somerset

- Oral health remains an important area of focus within Somerset's approach to reducing health inequalities. The Supervised Toothbrushing Programme continues to be delivered as an evidence-based intervention aimed at improving oral health outcomes for young children and reducing the prevalence of dental decay. The programme provides children aged 3–5 years attending early years settings with access to daily supervised toothbrushing and has been prioritised for those living in the most deprived communities. Initial implementation focused on settings within Index of Multiple Deprivation (IMD) deciles 1 and 2 before being expanded to include settings across IMD deciles 1–6. Further expansion is planned during 2026/27 to include settings within IMD deciles 7–10; however, delivery and impact within the most deprived communities will continue to be closely monitored to ensure that those with the greatest need remain prioritised and that the programme contributes to narrowing oral health inequalities across Somerset.

- Improving access to NHS dental services remains a key priority, particularly for residents living in CORE20 populations and areas affected by rural deprivation. Between October 2025 and May 2026, three new dental practices have opened in Wellington, Chard and Crewkerne, increasing NHS dental capacity in parts of the county where access has historically been more challenging. These additional services are expected to improve access to routine and preventative dental care, reduce travel requirements for patients, and support earlier intervention, helping to address inequalities in access to oral healthcare.

- To ensure continued access to specialist dental services for vulnerable populations, Somerset ICB has completed the contract award process for Community Dental Services for a further two years. The service plays a vital role in providing paediatric and special care dentistry for individuals whose needs cannot be met within general dental practice settings. This includes children and adults with complex needs, including people with learning disabilities, autism, dementia and other conditions that may require additional support or reasonable adjustments to access care. Securing the continuation of this service supports equitable access to dental care and helps to reduce inequalities experienced by some of Somerset's most vulnerable residents.

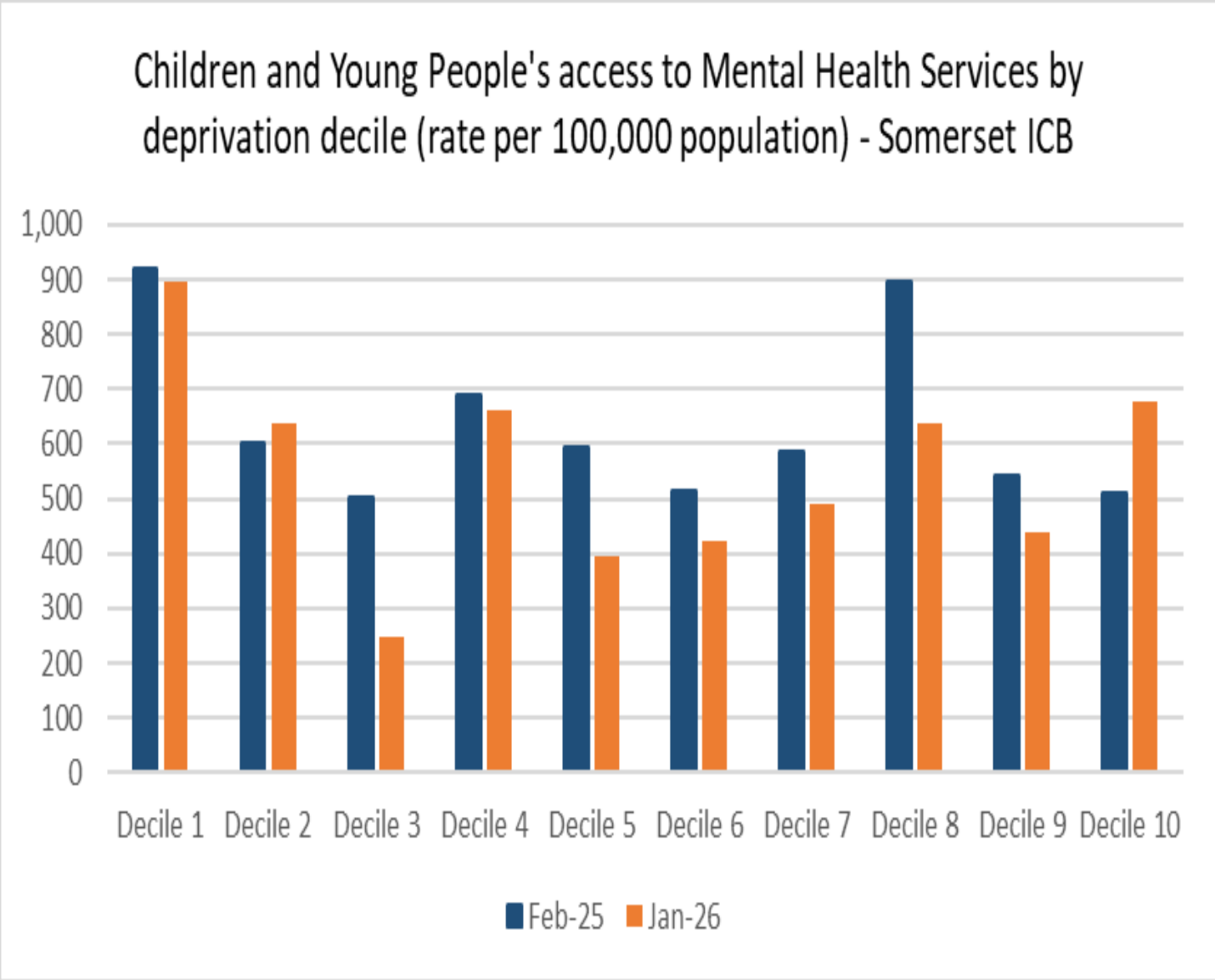
CORE20PLUS5

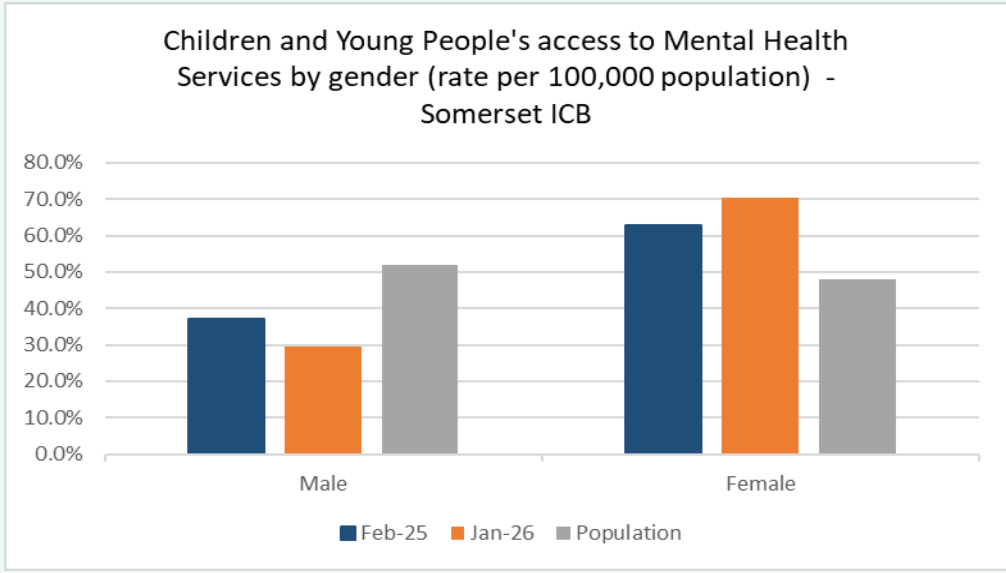
NHS Somerset

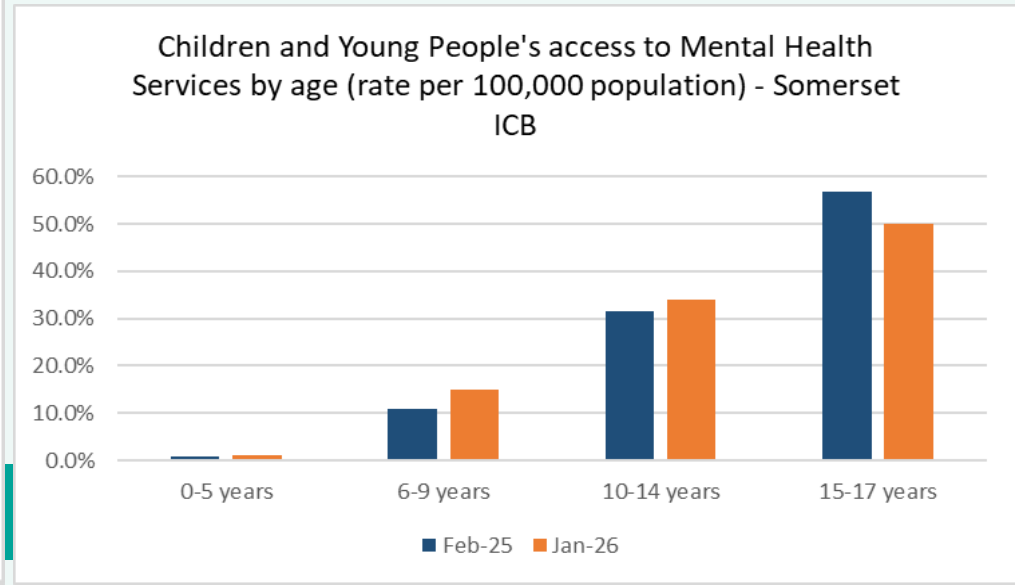
Framework	Domain	Measure	Core or Supporting Metric	Included in Report		Not possible at this time	Not appropriate / applicable	Basis of Reporting
CORE20PLUS5 (CYP)	Mental health	Inequalities in access rates to CYP mental health services for 0–17-year-olds	Core	☑				As per Mental Health Core data pack definition for MHSDS CYP 1+ contact: This is a count of people aged 0 to 17 who have had at least one contact (either direct or indirect) in the previous 12 months.
		Inequalities in rates of diagnosed mental health conditions	Supporting			☑		Work underway to report via the Mental health Services Minimum Dataset in 26/27
		Inequalities in the wider social determinants of health that impact on the prevalence of, acuity and recovery from mental health conditions	Supporting			☑		Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.
		Inequalities identified in patient pathways, such as late entry/presentation to mental health services, differences in routes into services (for example, police vs. primary care) and rates of unattended contacts	Supporting					Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.
		Inequalities in the use of restrictive forms of care (such as the Mental Health Act detentions and restrictive interventions)	Supporting	☑				No children detained during 2025/26 therefore not applicable
		patient reported outcome and experience measures recorded in local and national tools	Supporting			☑		Local reporting to be established during 2026/27 via the linked dataset which will be available later in the year.
DATA QUALITY	Ethnicity recording	percentage of records with blank or null codes for ethnicity	Core	☑				
		percentage of records with residual ethnic codes, including: not stated, not known	Core	☑				
		percentage of patient records with a valid, non-residual ethnicity code in data sets	Core	☑				

CYP Access to Mental Health Services

NHS Somerset







CYP Access, Experience and Outcomes

Service Overview and Demographics

NHS Somerset

- Children and young people's mental health services in Somerset are provided by the following Providers:

  - **2BU** is a targeted early intervention mental health and wellbeing service for LGBTQ+ children and young people
    - 42% of patients are from rural areas with 27% from suburban and 15% urban
    - Gender identity breakdown is 23% non-binary and 19% transgender with the remaining cohort including male, female and self-described identities
    - 73% report a disability or additional need

  - **Young Somerset** includes a Community Wellbeing Service (CWS), Mental Health Support Teams (MHST) and Early Years provision
    - Approximately two-thirds of referrals are female with males are more likely to be identified earlier (e.g. Early Years interventions)
    - There is an increasing over-representation of neurodivergent children and young people, and a significant proportion of referrals include SEND needs
    - Most service users are from white British backgrounds however ethnicity data includes a proportion of unknown or incomplete recording, limiting full analysis

  - **Kooth (Digital Mental Health Support)** provides a free, anonymous digital mental health platform offering self-help, peer support and access to practitioners for children and young people
    - The age profile shows 10–12-year-olds make up 20%, 13-16year olds 46%, 17–18-year-olds 16%-, and 19–25-year-olds (including SEND) 18%
    - 69% are female, 23% male with remaining users identify as other or non-binary
    - Most service users are reported as from white backgrounds (88%) with the remaining 12% from minority ethnic backgrounds

  - **Phoenix (Child Sexual Abuse Support Service)** delivers specialist support for children and young people affected by trauma, including those who have experienced child sexual abuse and those with complex safeguarding needs
    - Most referrals are for female children and young people, with males representing a small proportion of access
    - The service predominantly supports young people aged 13-16, with smaller numbers of younger children and those aged 17-25
    - Most service users are from White British backgrounds, with a small but increasing proportion from minority ethnic groups across the year
    - Referrals are received from across Somerset, with higher volumes in Sedgemoor and South Somerset, and an increase in West Somerset and out of area referrals observed in later quarters

CYP Access, Experience and Outcomes

Variation in Access and Engagement

NHS Somerset

- Overall, there is some variation in engagement across the Children and Younger People Mental Health Services:
  - There is some evidence of both over- and under-representation, with under-represented groups being the young people from minority ethnic backgrounds and over-represented groups in young people with SEND and young people experiencing mental health difficulties. In the case of Kooth, for some marginalised groups, including those from minority ethnic backgrounds and males, there is lower engagement with structured support and higher use of self-help resources
  - Variation in engagement depending on age, parental support and suitability of intervention and engagement also varies across groups often requiring adapted approaches with flexible delivery models essential to maintain engagement
- Inequalities identified - barriers to access services leading to risk of poorer outcomes include
  - Geography - our rural geography, with limited public transport and associated travels costs
  - Family circumstances and ability to attend regularly
  - Digital exclusion due to limited access to appropriate technology
  - Stigma and discrimination fear of judgement or lack of inclusivity
  - Lack of awareness of specialist provision
  - Language and cultural differences
  - Instability in living / personal arrangements
  - Vulnerable groups
- Social determinants impacting mental health
  - Social pressures including family rejection or lack of understanding, bullying, discrimination and exclusion in school, social isolation, poverty and housing instability and trauma and safeguarding concerns

CYP Access, Experience and Outcomes

Actions to Address Inequalities

NHS Somerset

- Actions during 2025/26
  - 2BU has implemented approaches to improve access and equity which include a flexible outreach model (online, community-based, one-to-one), identity-affirming support, tailored to LGBTQ+ young people, adaptations for neurodivergent young people and those with SEND, strong partnership working with schools, early help and community and voluntary sector organisations and targeted outreach to young people not in education, isolated or marginalised groups
  - Young Somerset has taken a range of actions to improve access including strong partnership working with schools, primary care, voluntary sector offering a wide range of flexible delivery models such as virtual support and community-based delivery. The service also makes adaptations for neurodivergent children and young people and those with SEND. In addition, the service has also introduced a self-referral pilot within MHST, improving access and a Participation and Inclusion Lead to better understand barriers alongside Innovative models such as Young Persons Clinics in primary care settings
  - Kooth has implemented a range of approaches to improve access including self-referral access with no waiting lists or thresholds, delivery of support through digital, community and education settings and development of local directories to support signposting. Targeted engagement includes outreach in schools, colleges and community settings, partnerships with health, education and voluntary sector organisations, use of both digital and face-to-face engagement approaches. Kooth has also developed approaches to improve cultural inclusivity and engagement with under-represented groups through co-production and targeted content.
- Future Opportunities
  - Strengthening referral pathways across services
  - Service development exploring different approaches for any identified under served groups
  - Improving access to technology for virtual delivery

NHS Somerset

Data Quality

Ethnicity recording

- The table below shows the ethnicity recording across main datasets

Ethnicity	2021 Census	Inpatient	Outpatient	ECDS	WLMDS	MHSDS	MSDS
Asian	2%	1%	1%	1%	0%	1%	5%
Black	0%	1%	0%	0%	0%	0%	4%
Mixed	1%	0%	0%	1%	0%	1%	2%
Other	0%	0%	0%	1%	0%	0%	1%
White	96%	72%	71%	77%	66%	88%	84%
Not stated	0.0%	17.5%	21.0%	11.4%	22.5%	5.6%	3.4%
Not known	0.0%	8.0%	6.3%	8.8%	10.4%	3.2%	1.2%
Blank	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.1%

- The table below shows a comparison in the proportion coded with ethnicity excluding not Know, not stated and blank

% Coded	Feb-2025	Jan-2026	Change
Inpatient	74%	75%	1%
Outpatient	72%	77%	4%
ECDS	78%	82%	4%
WLMDS	67%	67%	0%
MHSDS	90%	91%	1%
MSDS	94%	97%	3%