

## Meeting of the Board of Directors

### Item 3.1

**Subject:** Health inequalities update  
**Date of Meeting:** 25<sup>th</sup> March 2025  
**Prepared by:** Tom Pharaoh, Director of Strategy  
**Presented by:** Tom Pharaoh, Director of Strategy  
**Purpose of report:** To provide an update on health inequalities at LHCH

BAF Ref	Impact on BAF
BAF7 – Anchor institution	Provides clarity on position with regard to health inequalities at LHCH, an update on progress in developing controls. The paper will also inform the refinement of the BAF risk for 2025/26.

<b>Level of Assurance (please tick)</b> To be used to provide the Board / Committee with a guide on the extent of assurance and evidence of assurance provided within the report		<input checked="" type="checkbox"/>
Level of Assurance	Description	
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.	<input type="checkbox"/>
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.	<input checked="" type="checkbox"/>
Moderate	There is an adequate system of internal control, however, in some areas weakness in design and/or inconsistent application of controls puts the achievement and some aspects of the system objectives at risk.	<input type="checkbox"/>
Limited	There is a compromised system of internal control as weaknesses in the design and / or inconsistent application of controls puts the achievement of the system objectives at risk.	<input type="checkbox"/>
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.	<input type="checkbox"/>

# Health inequalities at LHCH: update paper

March 2025

## 1 Introduction

Health inequalities are unjust and avoidable differences in people's health across the population and between specific groups. The health inequalities agenda is linked to, but separate from, the more general agenda of equality, diversity, and inclusion. The concept of health inequalities is also distinct from the concept of population health management, although the two are often conflated and confused.

The Board of Directors received a position paper on health inequalities at LHCH at its meeting in September 2024. The purpose of that paper was to:

- Summarise the background to the health inequalities agenda,
- Clarify the role of NHS provider trusts in tackling health inequalities,
- Set out LHCH's work to-date in response to this agenda, and
- Outline the proposal for a ongoing programme of work to continue to tackle health inequalities by focusing on factors that are within the Trust's control.

The purpose of this paper is to refer back to some of the context set out in the September 2024 paper and provide an update on the programme of work outlined at the time.

## 2 The role of NHS trusts in reducing health inequalities

Recent guidance from NHS Providers, *Reducing health inequalities: A guide for NHS trust board members*, seeks to clarify the role of NHS provider trusts:

*The causes of health inequalities are complex, but research has shown that the main drivers of health inequalities are social determinants; the environments people live in, access to employment, the kind of start they had in life.*

*Inequalities are also driven by the ways in which health services are designed, delivered, funded, and by the quality of clinical care received.*

*The NHS plays a role in both mitigating against the impact of the wider determinants and in reducing healthcare-based inequalities.*

The NHS Providers guidance helpfully sets out the two clear ways in which NHS services can address health inequalities:

1. By ensuring **fair access, experience, and outcomes** across different groups in the population.
2. By acting as an **anchor institution** to support work on the wider determinants of health

The LHCH health inequalities programme has therefore adopted this helpful model. It is structured to reflect this distinction between the two separate work streams, with the addition of a further supportive cross-cutting workstream that looks to develop within LHCH the **leadership and culture** to tackle health inequalities.



This paper provides an update on the progress and ongoing work in each of these three workstreams.

### 3 Developing leadership and culture

LHCH has Board level leadership for health inequalities in place through the Director of Strategy. This arrangement began in advance of the change in Director of Strategy in April 2024.

The LHCH Board of Directors has undertaken work to enhance and assess its awareness and understanding of the health inequalities agenda and its policy drivers. The presentation of the health inequalities position paper in September 2024 was a continuation of this.

The position paper set out that the establishment of a new working group was the first next step in developing our leadership and culture on this issue. The *Health Inequalities and Anchor Institution Group* has now been established. The first meeting of this new group was in October 2024. The group was established to act as a focus for Health Inequalities and Anchor Institution work within the Trust. The Group reports to Operational Board via a chair's report following each meeting.

Following its first meeting the group noted a risk that the scope of the health inequalities and anchor institution agenda may be too broad to consider in a single forum as it was initially constituted. The format and constitution of the group was therefore reviewed in advance of the next scheduled meeting. There is now a smaller core membership group that

will be supplemented at each meeting on a topic-specific basis and a rolling programme is in development to support this.

## 4 Ensuring fair access, experience, and outcomes

Seeking to better understand the equitability of LHCH services has been the focus of the Health Inequalities and Anchor Institution Group since its formation in October 2024. This work has been led by the Trust's data and analytics team. The analysis undertaken has focused on fair access to services in two main areas:

- Patients who do not attend their scheduled outpatient appointments, and
- Patients on the referral to treatment waiting list.

### 4.1 Outpatient 'did not attends'

Data on the proportion of patients that did not attend (DNA) their scheduled outpatient appointments during the whole of 2024 have been analysed through a series of different health inequalities lenses. The initial findings of this analysis were that:

- Patients aged below 50 are more likely to DNA, especially those aged 16-29 (the DNA rate was more than 18% in this group)
- Older patients are less likely to DNA, but the DNA rate increases slightly for patients aged 90 and above (the DNA rate was more than 11% in this group)
- Gender did not seem to have an overall impact on DNAs, although rates were marginally higher in younger males
- The figures indicate that non-white ethnic groups had higher DNA rates, but the data were unreliable as a high number of patients did not have their ethnicity recorded
- There appeared to be a clear correlation between deprivation, as measured by the Index of Multiple Deprivation (IMD), and DNA rates.

The apparent link between deprivation and DNA rates led to a more detailed analysis being undertaken. Three separate sets of data were analysed:

- Data on hospital-based outpatient appointments from the Trust's patient administration system (PAS)
- Data on outpatient appointments with the Knowsley community service, and
- Data on outpatient appointments for radiology services (from the CRIS system)

The results of the analysis are set out in the tables below along with the data from all three systems combined.

### PAS Data

Deprivation	New	OP A&D	DNA
1	12.3%	28925	3568
2	9.9%	12907	1273
3	9.2%	8563	791
4	8.4%	7338	616
5	7.4%	8753	648
6	6.6%	7442	489
7	6.4%	7864	504
8	5.6%	9300	525
9	5.4%	7485	401
10	5.2%	5312	278
Unknown	7.7%	9601	738
Grand Total	8.7%	113490	9831

### Community Data

Deprivation	New	OP A&D	DNA
1	3.6%	21679	782
2	3.1%	6654	203
3	2.9%	2615	77
4	2.6%	2972	76
5	2.3%	3922	92
6	2.2%	1429	31
7	1.8%	1261	23
8	2.0%	1249	25
9	3.1%	551	17
10	5.7%	87	5
NULL	15.0%	20	3
Grand Total	3.1%	42439	1334

### CRIS Data

Deprivation	New	OP A&D	DNA
1	8.4%	5979	503
2	7.2%	2594	186
3	6.0%	1710	103
4	5.5%	1429	79
5	3.6%	1802	65
6	4.5%	1605	72
7	3.6%	1615	58
8	4.0%	1836	73
9	3.6%	1555	56
10	2.1%	1031	22
Unknown	4.5%	2362	107
Grand Total	5.6%	23518	1324

### All Combined Data

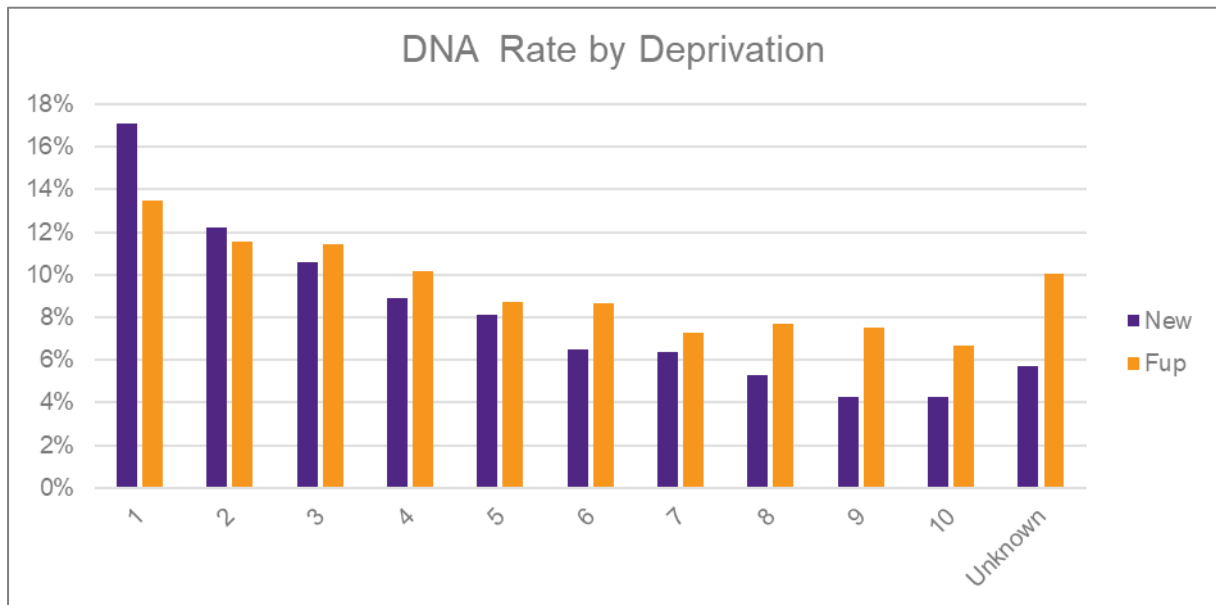
Deprivation	New	All	DNA
1	8.6%	56583	4853
2	7.5%	22155	1662
3	7.5%	12888	971
4	6.6%	11739	771
5	5.6%	14477	805
6	5.7%	10476	592
7	5.4%	10740	585
8	5.0%	12385	623
9	4.9%	9591	474
10	4.7%	6430	305
Unknown	7.1%	11983	848
Grand Total	7.0%	179447	12489

The key findings from the above data were that:

- In all three data sets, DNA rates were substantially higher in patients from the most deprived areas
- For all data combined, the DNA rate in patients from the least deprived areas was under 5% whereas the rate for patients from the most deprived areas was 7.5% or above
- 51% of all combined outpatient appointments were for patients in the most deprived three deciles; this figure rises to 73% of community outpatient appointments

- The lowest recorded DNA rates were in the Trust's community services, but there was still a correlation with deprivation.

An analysis was also undertaken of the hospital PAS data through the lens of the type of outpatient appointment (new or follow-up appointment).



The data clearly show that:

- Patients from the least deprived areas had a higher DNA rate for follow-up appointments than new appointments, and lower DNA rates overall
- Patients from the more deprived areas had a higher DNA rate overall and had a similar DNA rate for new and follow-up appointments
- Patients in the most deprived decile had a significantly higher DNA rate for new appointments, which has the potential to deepen health inequalities.

In conclusion, The data indicate a clear association between DNA rates and deprivation. Additional analysis is required, but there is a clear need for the Trust to consider further action to seek to reduce DNA rates in more deprived groups and thereby seek to lessen the potential for health inequalities to emerge.

## 4.2 Patients on the referral to treatment waiting list

Data on the composition of the Trust's referral to treatment (RTT) waiting list in December 2024 has also been analysed through the same health inequalities lenses. The key findings were that:

- Waiting times did not appear to be affected by age, with no more than 2% of patients in any age band classed as long waiters (52+ weeks)
- Waiting times did not appear to be affected by gender, with no more than 2% of male or female patients classed as long waiters (52+ weeks)
- Waiting times did not appear to be affected by levels of deprivation, with no more than 1% of patients from any deprivation decile classed as long waiters (52+ weeks) – see table below

Deprivation	Waiting Times							Grand Total
	00-06	07-17	18-25	26-35	36-51	52-72	73-103	
1	39%	38%	12%	8%	3%	0%	0%	100%
2	38%	33%	16%	8%	4%	1%	0%	100%
3	33%	40%	14%	8%	4%	1%	0%	100%
4	36%	34%	16%	8%	5%	1%	0%	100%
5	34%	37%	16%	9%	4%	0%	0%	100%
6	37%	33%	15%	10%	4%	1%	0%	100%
7	34%	35%	19%	6%	5%	1%	0%	100%
8	24%	41%	21%	9%	4%	1%	0%	100%
9	30%	36%	17%	11%	6%	1%	0%	100%
10	31%	39%	15%	9%	5%	1%	0%	100%
Unknown	26%	36%	14%	14%	7%	4%	0%	100%
Grand Total	35%	37%	15%	9%	4%	1%	0%	100%

The RTT waiting list analysis therefore provides assurance that waiting times for treatment do not appear to be affected by age, gender or deprivation. This lack of correlation between deprivation and waiting times is a positive position, but the situation should be continually monitored to ensure that the position is maintained.

A similar analysis of the waiting list was carried out by ethnicity. This analysis highlighted no immediate concerns but was limited due to the quality of the Trust's records on patient ethnicity. Just 51% of patients on the RTT waiting list had a recorded ethnic group. The Trust must work to improve its data quality before assurance can be provided on the fairness of the RTT waiting list by ethnicity.

### 4.3 Recommendations

It is recommended that three new health inequalities metrics are added to the Trust's strategic oversight framework (SOF) for 2025/26:

- Outpatient 'did not attend' (DNA) rate in patients from the most deprived areas\* – Drive metric

- Percentage of referral to treatment (RTT) long waiters from most deprived areas\* – Watch metric
- Percentage of patients on RTT open pathways without a recorded ethnicity status – Drive metric

\*For the purpose of these metric most deprived areas will be defined as Index of Multiple Deprivation (IMD) deciles 1-3

## 5 Acting as an anchor institution

### 5.1 Background

The Health Foundation describes anchor institutions as large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. These organisations are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community. By strategically and intentionally managing their resources and operations, anchor institutions can help address local social, economic, and environmental priorities in order to reduce health inequalities.

While the main function of NHS trusts is to provide health services, they can also play an active role in supporting partner organisations and communities to address the wider determinants of health. Many hospitals are developing their role as an anchor, making a positive impact on communities. Encouraging and requiring provider trusts to act as anchor institutions is a key part of NHS Cheshire and Merseyside's approach to health inequalities. NHS Cheshire and Merseyside has set out clear expectation that provider trusts commit to this agenda through adopting and achieving a range of pledges, charters, and awards.

### 5.2 Updates

LHCH was an early adopter of the overarching Cheshire & Merseyside Anchor Institution Charter in 2022 and action trackers are in place to monitor the multiple actions and projects that contribute to our anchor institution status. The trackers are managed by a project manager in the Strategy and Transformation Division working closely with colleagues across the Trust. The Trust has started to use a system called the Social Value Portal to allow the measurement of the social value created by our anchor initiatives.

Our anchor institution work takes place across a number of areas:

- Preventing ill health and supporting wellbeing
- Reducing our environmental impact
- Purchasing for social benefit
- Widening access to quality work
- Working closely with communities and local partners

There is clear potential for the five Liverpool Adult Acute and Specialist Provider (LAASP) Trusts to work together ever more closely on the anchor institution and health inequalities



agendas as they come together in the University Hospitals of Liverpool Group (UHLG). Collaborative working has already started in several anchor institution areas, and LUHFT's programme manager attended the most recent Health Inequalities and Anchor Institution Group meeting to update the group on LUHFT's current anchor programme.

### **Preventing ill health and supporting wellbeing**

The Cheshire and Merseyside Prevention Pledge provides a framework for trusts in the region to demonstrate their commitment to preventing ill health and supporting wellbeing in patients and staff. LHCH adopted the Prevention Pledge in 2022 and our work in prevention and wellbeing (and therefore in support of the Pledge) continues to take place in a number of areas.

The main recent development in this area has been our successful case to NHS Cheshire & Merseyside for the sustained funding of two cardiovascular disease prevention services previously piloted by LHCH with non-recurrent transformation funding.

- The familial hypercholesterolemia (FH) service: FH is an inherited condition that predisposes affected individuals to extremely high cholesterol levels and premature cardiovascular disease. There is significant underdiagnosis of the condition and the service seeks to identify those affected early and prevent their future deterioration.
- The CVD prevention clinic: a service operating as an extension of the Targeted Lung Health Check programme for patients whose low dose health check CT scan shows an incidental finding of coronary artery calcification.

These two services were operating with considerable uncertainty as they approached the end of their non-recurrent funding. The successful case to the ICB for sustained funding is therefore a real achievement.

### **Reducing our environmental impact**

We are committed to taking action to reduce our carbon emissions and consumption, reduce waste and protect and enhance the natural environment. LHCH has developed a Green Plan to set out how we will reduce our environmental impact and the team continue to link with colleagues across Cheshire and Merseyside to support its delivery.

The Health Inequalities and Anchor Institution Group will work to deliver the Green Plan and support the staff-led activities that continue to lessen the Trust's environmental impact. An example of this is the recent work of the Critical Care team in reducing the volume of single-use glove use in the unit. Following the success on Critical Care, there are plans in place to roll out the 'Gloves Aware' campaign across the rest of the Trust, starting on 1<sup>st</sup> April 2025 with a Green Day.

Environmental sustainability will be a clear anchor focus in the coming months. LHCH will refresh its Green Plan in 2025, in line with the expectations and guidance of NHS England. The new Green Plan is in development and will be presented to the Board of Directors by July 2025. Prior to that a full report on our progress against our current Green Plan will be presented to the Board of Directors in April 2025.

## 6 Conclusion

A new governance forum, the Health Inequalities and Anchor Institution Group, has been formed to drive forward all parts of the health inequalities agenda.

The focus of this group since its formation in October 2024 has been on seeking to better understand the equitability of access to LHCH services. The initial data analysis has provided assurance of the fairness of the Trust's referral to treatment (RTT) waiting list but has also indicated that outpatient DNAs are an area that require future attention to try to lessen potential health inequalities.

The Trust also continues act as an anchor institution, with significant progress in the last six months in sustaining our pilot CVD prevention services. The anchor focus for the coming months will be environmental sustainability, with a report on the delivery of our Green Plan to be presented in April 2025 and a refreshed Green Plan to be published in the summer.

The risks to the programme remain those highlighted in the September 2024 position paper:

- The reliance on the capacity of colleagues from across the Trust to engage in this work alongside their core activities, and
- The reliance for coordination on a single project manager in the strategy team whose responsibilities are broader than health inequalities and anchor institution work

Proposals are being developed to reconfigure the strategy team and identify clear resources to support the health inequalities and anchor institution agenda in future. These proposals will be presented for agreement in March 2025 and will take into account the opportunity to collaborate with our partners in LAASP and the UHL Group.

The Board of Directors is asked to:

- Note the creation of the Health Inequalities and Anchor Institution Group
- Note the positive development of health inequalities data and insights
- Approve the recommendation for the addition of the three initial health inequalities metrics to the strategic oversight framework (SOF)
- Note the continued progress to establish the Trust as an anchor institution
- Note the intention to provide the Board with a Green Plan delivery report in April 2025 and a refreshed Green Plan by July 2025