

## Health Inequalities Annual Report

### Executive Summary

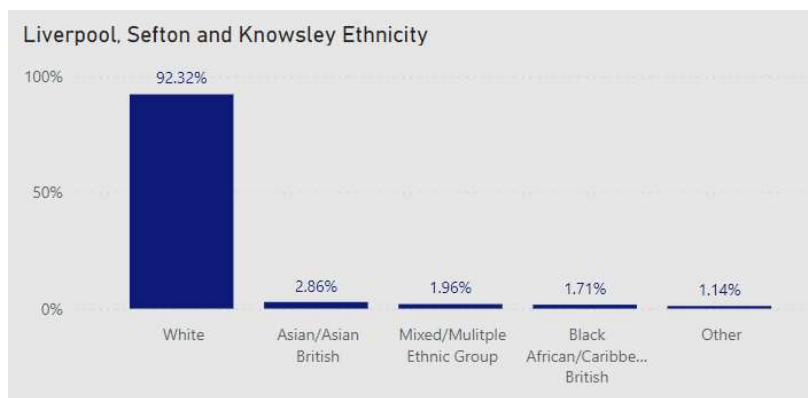
1. NHS England (NHSE) published a statement of information on health inequalities (duty under section 13SA of the National Health Service Act 2006) on 27<sup>th</sup> November 2023. The purpose of the statement is to help trusts and Integrated Care Boards (ICBs) identify key data and information on health inequalities and outline how they have responded to this information within their annual reports.
2. The statement set out a list of data indicators that Trusts are expected to report on and covers the period between 1<sup>st</sup> April 2023 to 31<sup>st</sup> March 2025.
3. This report includes Trust data on health inequalities and as well as action taken by the Trust to reduce inequality and improve health access, experience and outcomes.

### Background

4. Recognising the expanding remit of interlinking work, relating to health inequalities, Equality, Diversity and Inclusion, and social value, a committee restructure was undertaken during 2023/24. Our previous Strategic Black, Asian and Ethnic Minority (BAME) Advisory Committee (SBAC) has since been replaced with our Health Inequalities and Inclusion Committee (HIIC), a Board level committee in June 2023.
5. HIIC receives input and updates from numerous work streams including health inequalities data, prevention pledge, anchor institute, digital exclusion, socio-economic duty and Equality, Diversity and Inclusion.
6. A Health Inequalities Dashboard was developed by the Business Intelligence team to gain a greater insight into health inequalities for patients, show data findings and provide context to drive improvements in these areas. This data is presented regularly to the HIIC.

### Data and Analysis

7. Due to the size of the patient population that the Trust serves, it has been agreed to use local data as a benchmark.
8. When considering indices of multiple deprivation (IMD), Liverpool City Council reported in 2019 that Liverpool is considered the 3<sup>rd</sup> most deprived of 317 local authority areas when looking at the average score and 4<sup>th</sup> most deprived for average rank.
9. As shown below, the ethnic make-up of the area is predominantly white, with only 7.68% of the population identifying as part of an ethnic minority.

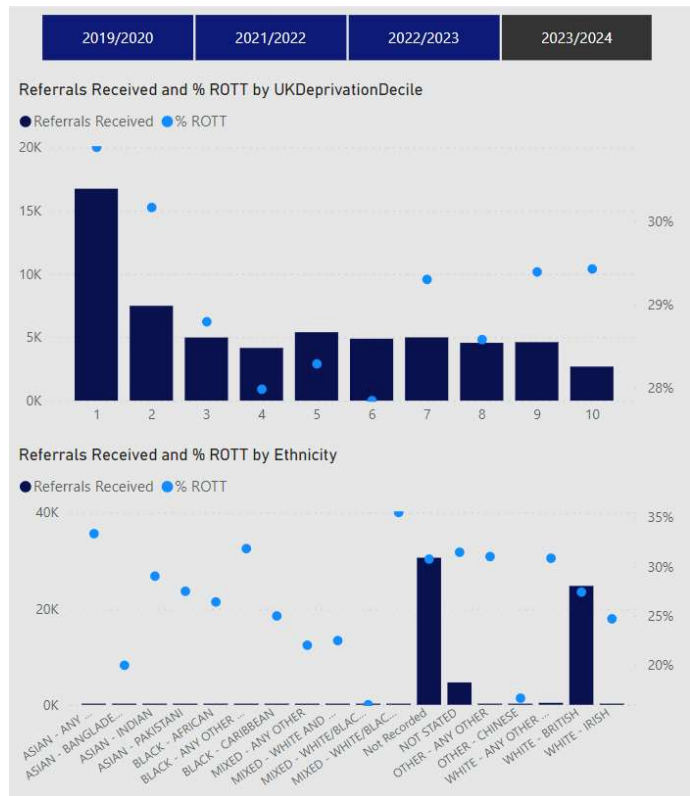


10. This is borne out in the majority of referrals being received for patients who are White British and from more deprived areas.

It is important to note that ethnicity data is not always recorded, which is a problem across Healthcare.

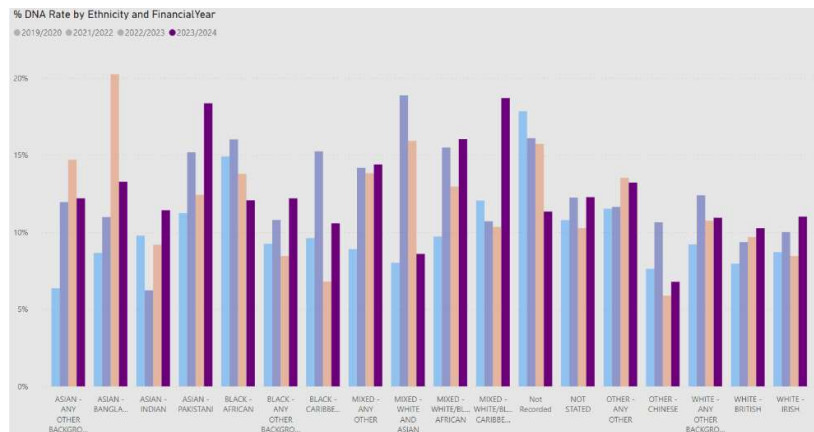
For the Local Area, 2.86% are Asian/Asian British and 1.71% are Black African/Caribbean/Black British. This isn't reflected in our referrals.

ROTT – Removal other than treatment



11. When considering DNA rates, direct correlation between DNA rate and IMD can be seen, which holds true for both face to face and virtual appointments.

12. DNA rates by ethnicity shows that the highest percentage rates sit within Mixed White/Black Caribbean, Pakistani and Mixed White/Black African.



13. The data above highlights the below key points

- The ethnic make-up of the local community is not reflected in referral figures
- Patients in areas of higher deprivation are more likely to DNA their appointments
- Patients from ethnic minority backgrounds are more likely to DNA their appointments

**Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)**

14. Elective recovery

14.1 Elective activity vs pre-pandemic levels for under 18s and over 18s

Available data relating to pre and post-pandemic Waiting List Minimum Data Set (WLMDS), inpatient/outpatient/day case activity (including elective and non-elective) by IMD, ethnicity and age can be found within appendix 1.

This data shows increased waiting times due to elective recovery and an increase in the waiting list size as we attempt to recover post pandemic. It also shows an increase in patients where ethnicity had not been stated and patients under age 20.

14.2 Emergency admissions for under 18s

Emergency admission data for under 18s has been included and reported by both IMD and ethnicity is included within appendix 1.

This data shows an increase in emergency admissions to the Trust compared to pre-pandemic levels and greater admission rates for patients under 18 in the most deprived areas.

15. Mental health

15.1 Rates of total Mental Health Act Detentions

There were 9 occasions in which patients at the Trust were detained under the mental health act in 2023/24.

Q1 – 3

Q2 – 1

Q3 – 3

Q4 – 2

The number of occurrences are low and therefore it would be difficult to gain any meaningful insight into themes and trends within this data, however, the Trust plan to review patient level data by IMD, ethnicity and age in future.

16. Cancer

Data relating to cancer treated (for all targets) pre and post-pandemic by IMD, ethnicity and age is included in appendix 1.

This data shows higher rates in patients from areas of higher deprivation and those between the ages of 50-70. It is difficult to draw any conclusions in relation to rates by ethnicity due to a large (and increasing) number of patients whose ethnicity is not known.

17. Smoking cessation

The Trust are working in collaboration with the Cure Stop Smoking team based at Liverpool University Hospitals Foundation Trust. Any patient that is referred is reviewed by the team and is offered brief intervention and Nicotine replacement products. These products should continue upon discharge (patient choice) and the Cure Team will follow up and see if they wish to be referred to the community stop smoking team.

During 2023/24 99 patients were referred to the service with 58 patients having nicotine replacement therapy prescribed.

## Progress

18. The Trust have undertaken numerous actions to better understand the data provided and reduce health inequalities.
19. Health Inequalities and Prevention has been recognised as one of the twelve strategic risks aligned to the Trust Strategy 2022-25. This has a designated Executive Lead and is assigned to HIIC for monitoring.
20. A review was undertaken of the Trusts waiting lists (including inpatient, outpatient, follow up, elective and day case admissions) to understand if there were any areas of concern in relation to IMD. The data provided the Trust with positive assurance that, although waiting list management continues to be a challenge for all Trusts across the UK, focus has appropriately been on clinical need and longest waiters with minimal patient variation in relation to IMD scales.
21. A similar piece of work was undertaken in relation to DNAs to understand the reasons for higher rates in patients from more deprived areas. The Trust are currently undertaking a number of initiatives to support this patient group as outlined below.
  - Clinical validation of follow up waiting lists
  - Introduction of Patient Initiated Follow Up (PIFU)
  - The purchase of Dr Doctor, a digital patient engagement platform to improve communication with patients
  - Wider system working and collaboration
    - Participation in an initiative to recycle laptops for patients who are classed as digitally excluded, allowing them to attend appointments virtually
    - Satellite clinics in local community centre/libraries in areas of deprivation to reduce transport and childcare costs
    - Working with Everton in the Community health zone hub to explore future opportunities for clinic capacity
22. The Trust have been involved in collaboration working across Liverpool City Region with multiple sectors including police, fire, housing, councils and healthcare providers in relation to the Socio-economic Duty, to develop a shared understanding of socio-economic disadvantage and share best practise in relation to ensuring this is considered in organisational decision making. Plans are in place to review the Trusts Equality Impact Assessment process to include socio-economic status.
23. Due to the location of the Trust, many of our staff also reside in areas of high deprivation. The Trust have been awarded Investors in People Gold standard for our Health & Wellbeing programme for staff which includes Health MOTs.

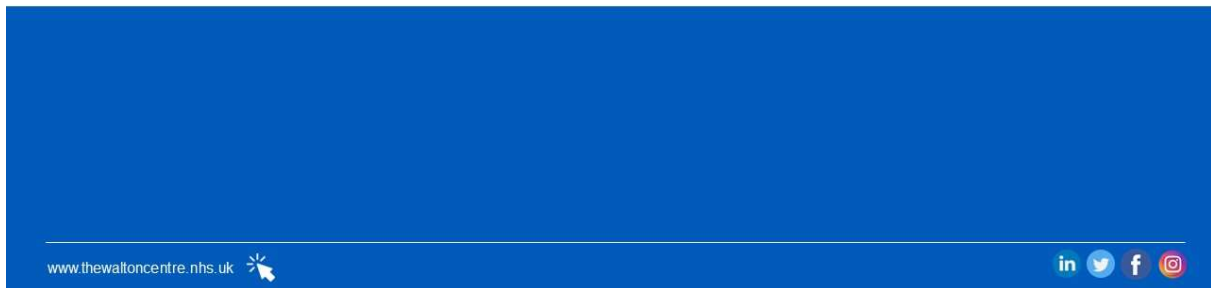
24. Wider system working is key to ensuring equality of access and early diagnosis rates, which tend to be significantly lower in the most deprived areas. In order to ensure quality of care at the first point of contact and to reduce inequalities by area of residency the Trust have a number of services and pathways including the below to ensure appropriate treatment for patients at the earliest opportunity.

- Rapid Access Neurology Assessment (RANA) service - provides rapid and direct access for patients with acute neurological issues to specialist neurology service in consultant led clinics and reduce unnecessary hospitalisations and facilitate speedy diagnosis and management plans.
- Brain Tumour Optimisation Pathway – working with other providers across Cheshire and Mersey, a new pathway has been introduced in 2023 to ensure optimal and immediate diagnosis of a brain tumour.
- Headache Pathway – with advice for both District General Hospital (DGHs) and General Practitioners (GPs) in managing primary headache disorders and recognising red flags and take appropriate and timely action.
- Suspected Papilledema/Increase Intracranial Hypertension (IIH) Pathway – ensuring appropriate investigation and treatment is undertaken in a timely manner within local hospitals with advice provided as necessary from our on call teams.
- Parkinson's Disease (PD) Management Pathway – advice to Acute hospital Trusts in appropriately assessing and managing patients with PD in a local setting
- Seizure/Epilepsy Pathway – to support front-line clinicians to recognise and manage seizures and facilitate rapid referral of seizure patients to an outpatient appointment at The Walton Centre.
- 24/7 Thrombectomy service – ensuring rapid transfer, treatment and repatriation of appropriate acute stroke patients.
- Enhanced Triaging Process – providing full and appropriate advice and management plans in response to referrals from primary care, reducing the need for appointments in specialist clinics and the likelihood of a rereferral in future.

## Appendix 1



# Health Inequalities



## Contents



- To gain a greater insight into health inequalities for patients pre and post pandemic
  - National WLMDs
  - Emergency patients under 18
  - Trust Activity by Point of Delivery
  - Cancer patients treated

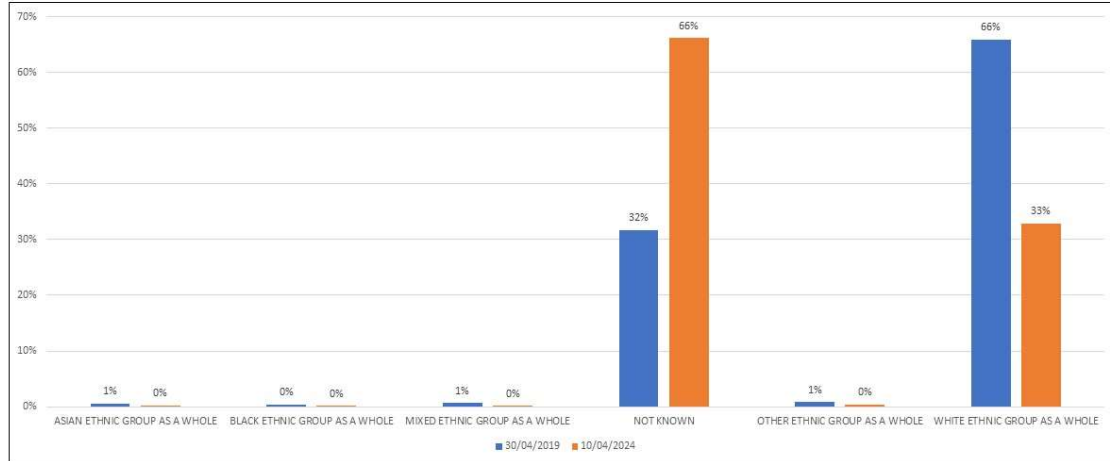


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## National WLMDS by Ethnicity

It is important to note that the Ethnicity isn't always recorded, which is a problem across Healthcare, hence the large proportion of patients where the Ethnicity is 'NOT KNOWN'. This also includes where the Ethnicity has NOT BEEN STATED.

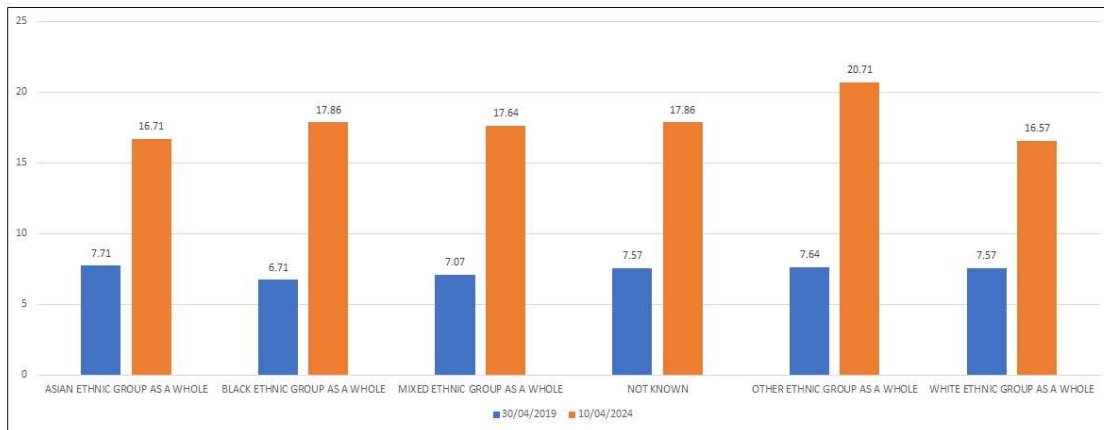


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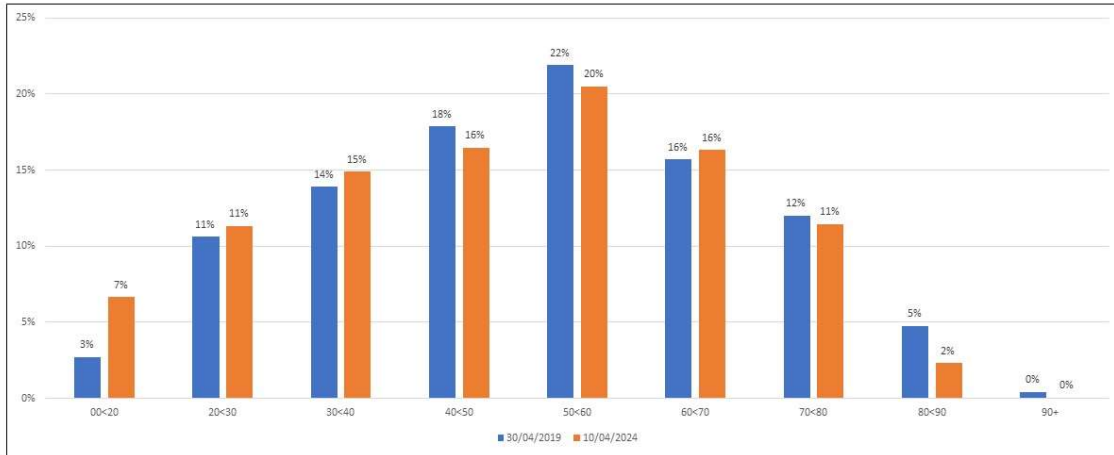
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## National WLMDS by Ethnicity

The chart below shows the median waiting time by Ethnicity. Please note, the increase in waiting times as at the 10/04/2024 is due to elective recovery and an increase in the waiting list size as we attempt to recover post pandemic.

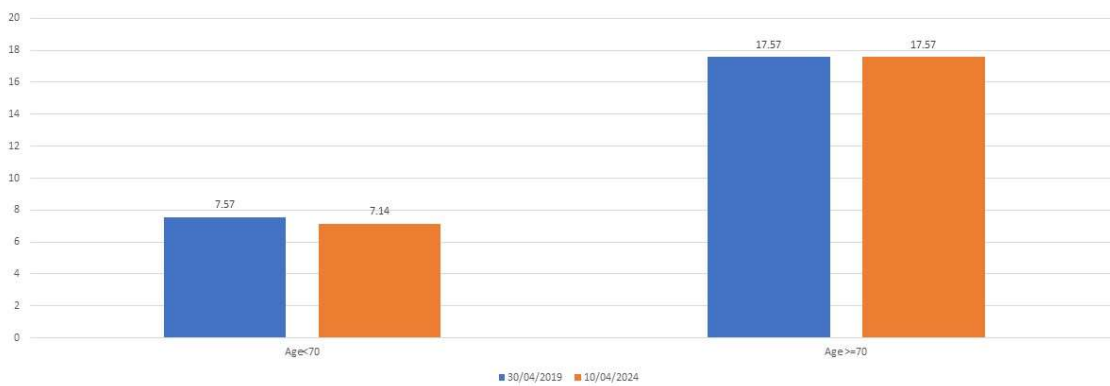


## National WLMDS by Age



## National WLMDS by Age

The chart below shows the median waiting time by Age. Please note, the median wait for patients aged  $\geq 70$  years is the same and this value has been quality checked.



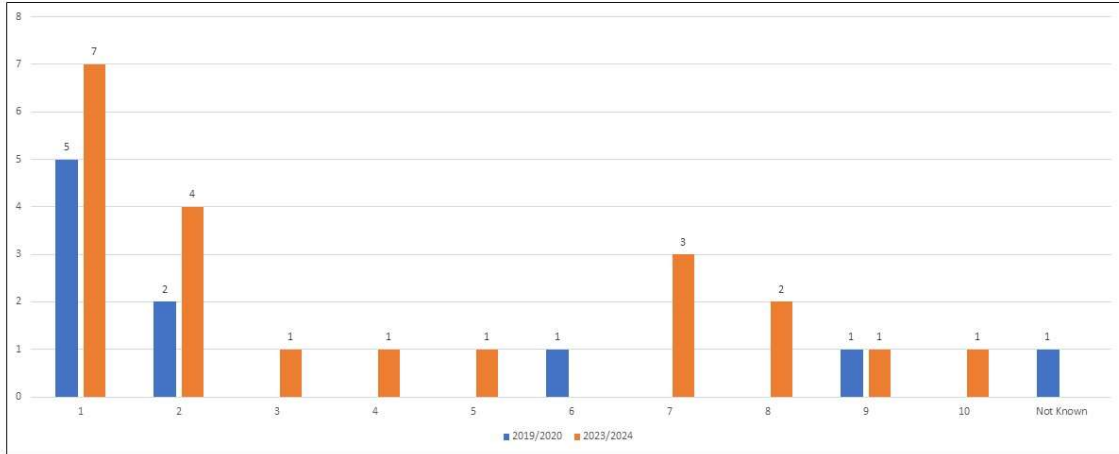


# Emergency admissions under 18



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The number of emergency admissions where the patient is aged under 18 has increased in 2023/24. Below shows emergency admissions for under 18 by Indices of Multiple Deprivation (IMD).

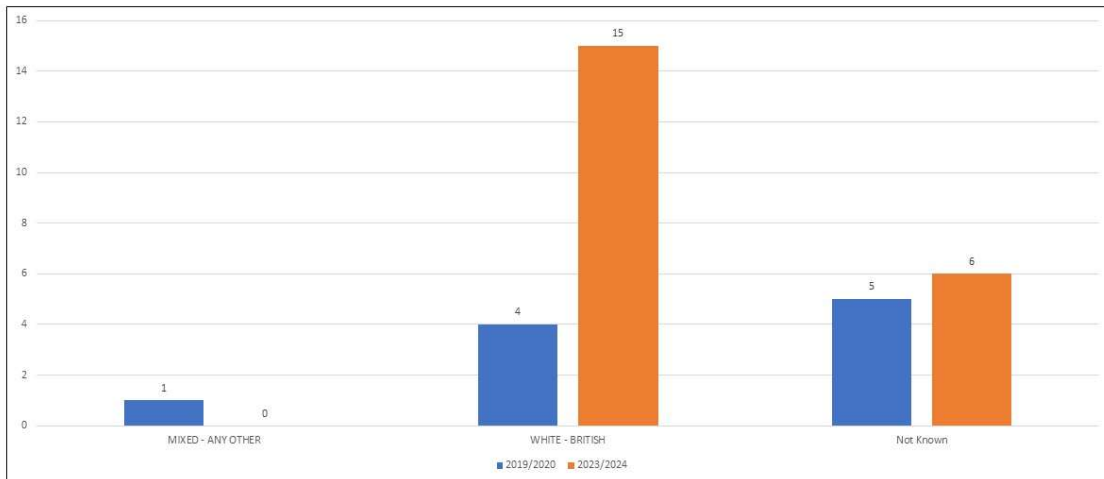


# Emergency admissions under 18

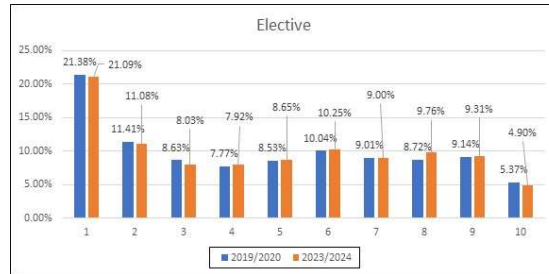
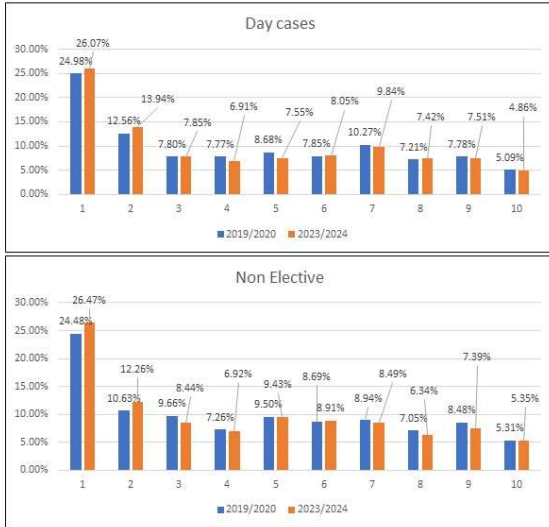


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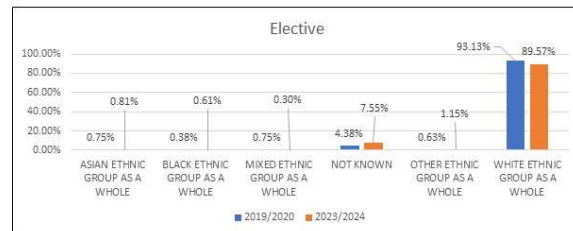
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## Discharges by IMD



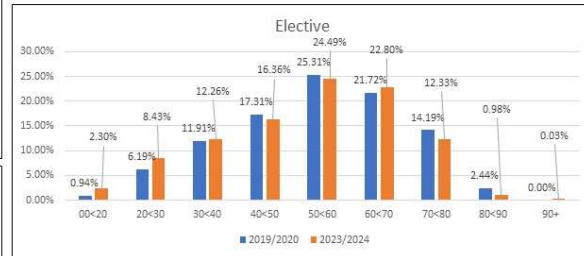
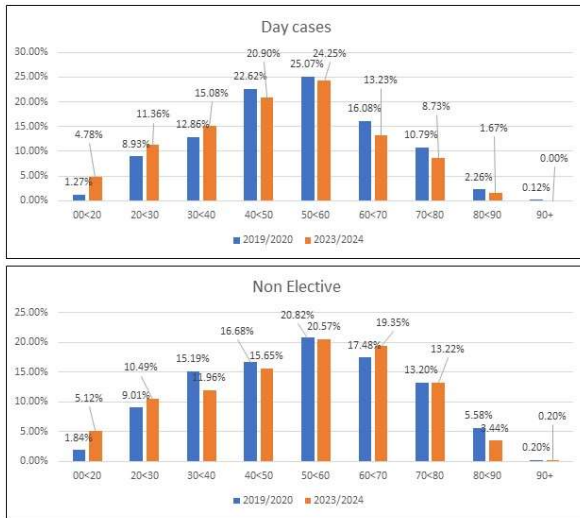
## Discharges by Ethnicity





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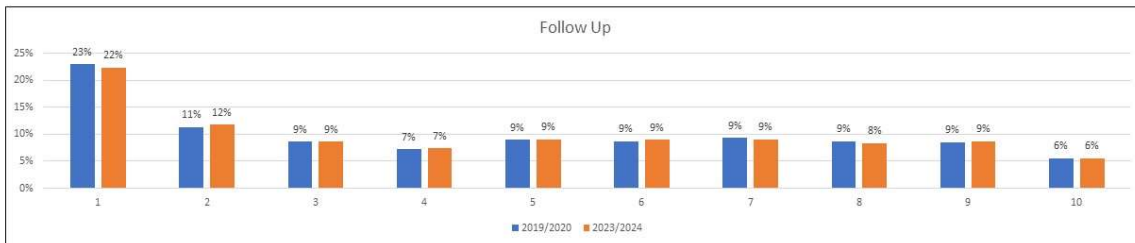
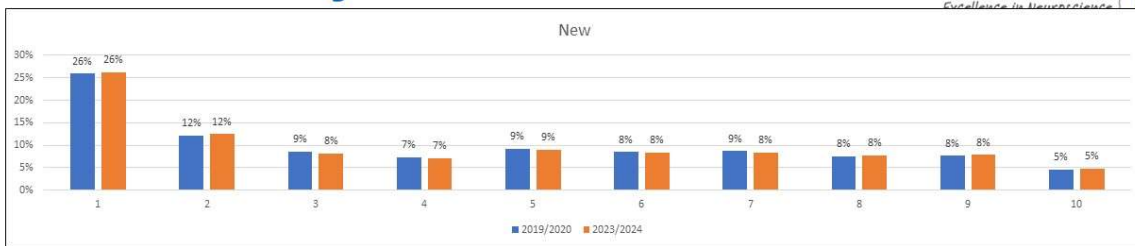
# Discharges by Age (on admission)



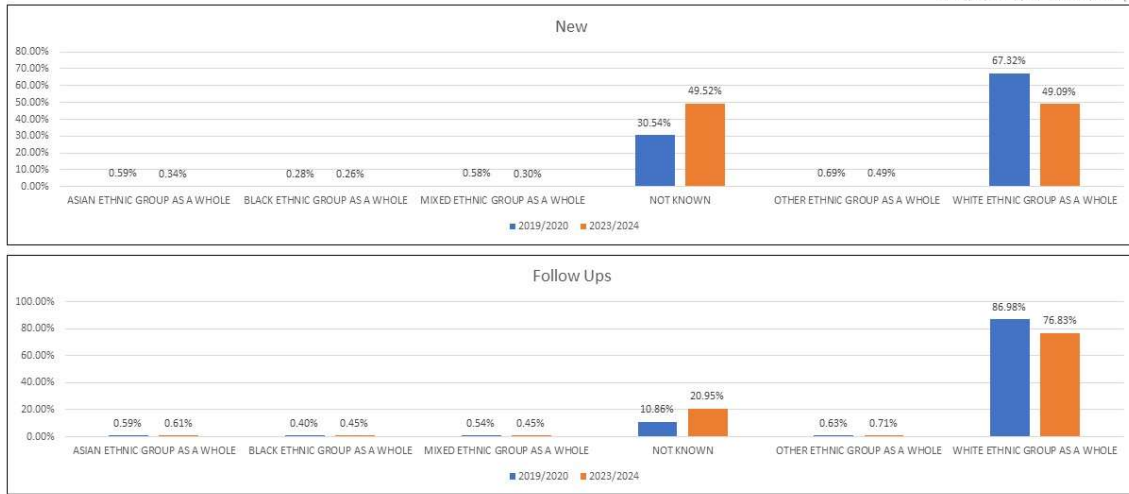
# Outpatient Attendances and Ward Attenders by IMD



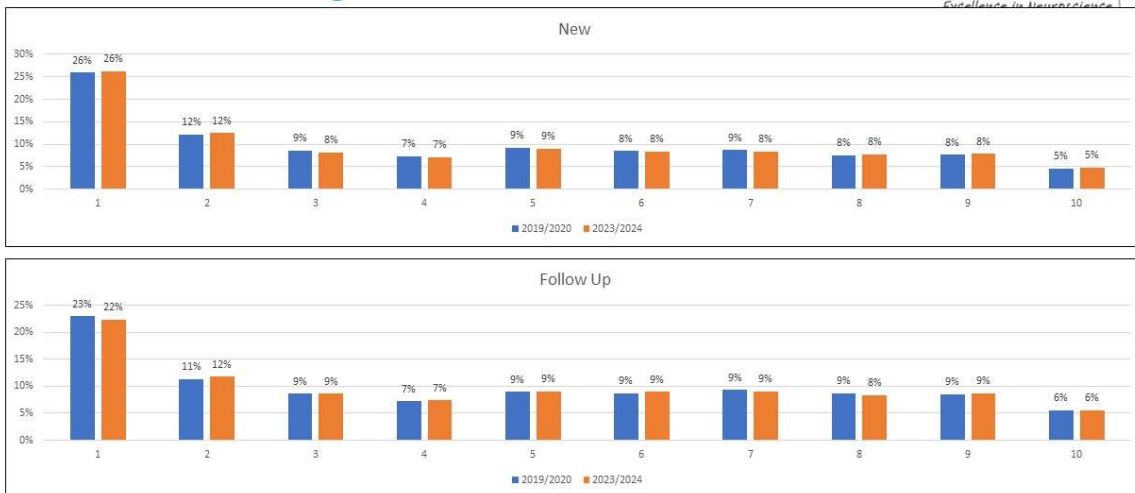
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# Outpatient Attendances and Ward Attenders by Ethnicity



# Outpatient Attendances and Ward Attenders by IMD



# Outpatient Attendances and Ward Attenders by Ethnicity



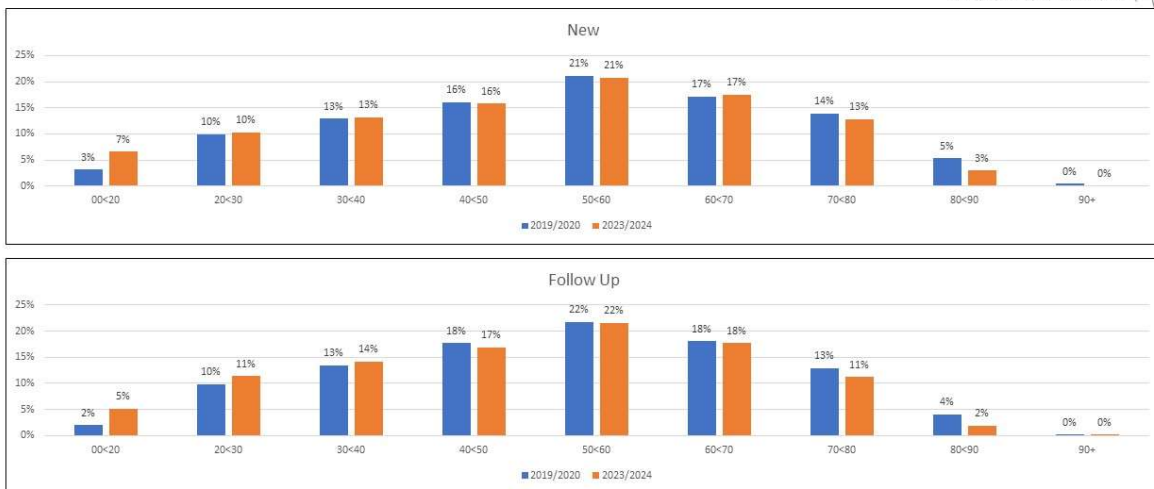
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# Outpatient Attendances and Ward Attenders by Age



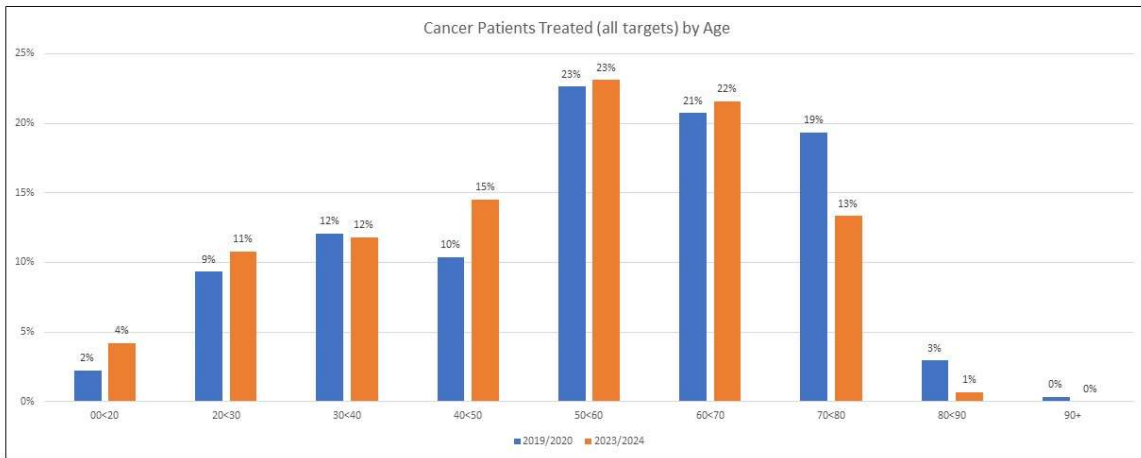
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# Cancer Treated (all targets) Patients by Age



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## Appendix

The Index of Multiple Deprivation 2019 measures relative deprivation across small areas called Lower-layer Super Output Areas (LSOAs) – there are 32,844 of these areas across England, including 298 in Liverpool. An overall IMD score is based on seven different domains of deprivation:

**Income**

Employment – measures the proportion of the working age population in an area involuntarily excluded from the labour market

Education – measures the lack of attainment and skills in the local population

Health – measures risk of premature death and the impairment of quality of life through poor physical or mental health

Crime

Barriers to housing and services

Living Environment – measures the quality of both ‘indoor’ and ‘outdoor’ local environments