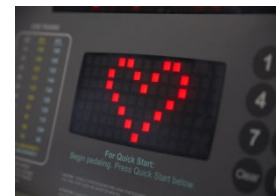
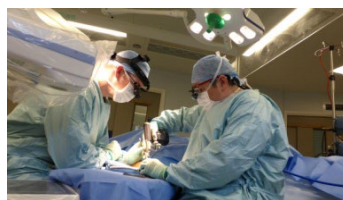


# Health Inequalities and Waiting List Analysis

**Sajid Azeb**  
**Chief Operating Officer**



# Part 1 - Context

# Healthy life expectancy

It's not just about how long people live, it's how well they live too. If we take away the time people are living with poor mental wellbeing and ill health – we get what is known as **healthy life expectancy**.

10 miles  
20 years  
less healthy life

Data source: Office of National Statistics, 2009 - 2013

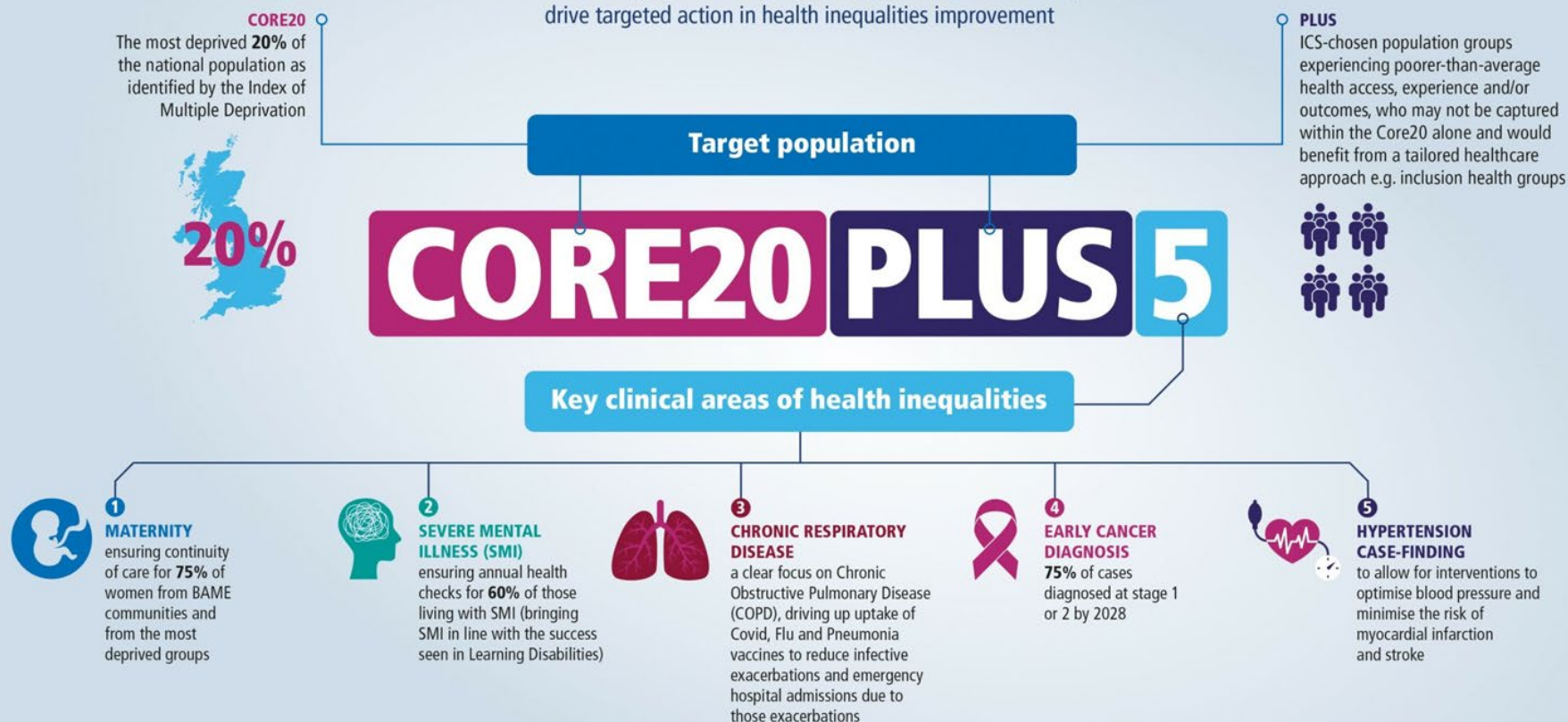


# National Model

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## REDUCING HEALTHCARE INEQUALITIES

The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement



# Place & ICB

- ICS level **CORE20Plus5 Leadership Group** - representation from place Health Inequality leads and relevant partnership programme leads including **clinical and VCSE representation**.
- West Yorkshire was successful in becoming a Wave 1 site for **CORE20Plus5 Community Connectors**. Focus on the “plus” aspect of the approach across the partnership working with two priority population groups – Gypsy and Travellers and Refugees and Asylum seekers to coproduce targeted prevention initiatives that meet the need of local communities.
- West Yorkshire Health and Care Partnership (WYH&CP) has been allocated £10,724,000 as additional resource to **support targeted reductions** in health inequalities for 2022/23.

# 2022/23 Objectives

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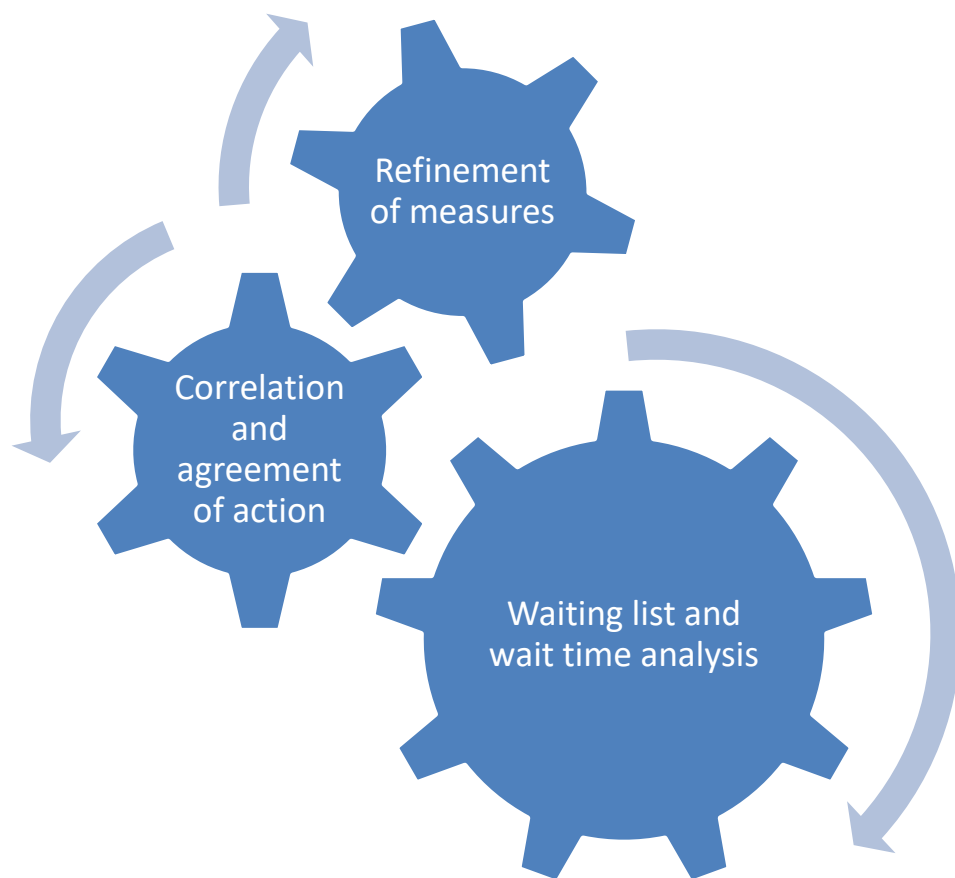
- **The Ask: “Tackling Inequalities in Outcomes, Experience and Access”**
  - **Improved data** collection and reporting will drive a better understanding of local health inequalities in access to, experience of and outcomes from healthcare services, by **informing the development of action plans** to narrow the health inequalities gap.
  - Redoubling our efforts on the **five priority areas** for tackling health inequalities and building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people.
  - Whilst also ensuring that people with a **learning disability and autistic people** are not further disadvantaged in fair access to healthcare.
- Access is only part of the ask but tackling health inequalities is therefore interwoven with the efforts being undertaken to restart, recover and improve service delivery post pandemic.
- Understanding and using data will be key to this.



# Access Data

- Place and ICB work plans will continue to be supported but internal work is required to meet the requirements specific to **equity of access**
- **IMD, ethnicity and LD data items** have now been added to a master patient index which can be joined to all existing waiting list data
- The Core20 cohort (**20% most deprived in ICS footprint**) has been identified from national data – analysis by TFC of time to first OPA, time to DTA and time to treatment included in this report
- From this **analysis**, a decision can be made on what initial action is required and what measures will indicate progress/ success which will then be added to routine monitoring
- To ensure analysis can be repeated and CBU's empowered to utilise this data locally all **waiting list related processes** will be revised to include the ability to use IMD, ethnicity and LD data items
- This will include dashboard reporting in line with the analysis presented later in this report

# Using this data



This will be an iterative process whereby the analysis of any data will need careful consideration by operational and clinical colleagues.

When action is agreed and progress tracked we will then be able to refine the measures and provide further analysis in support of continuous improvement



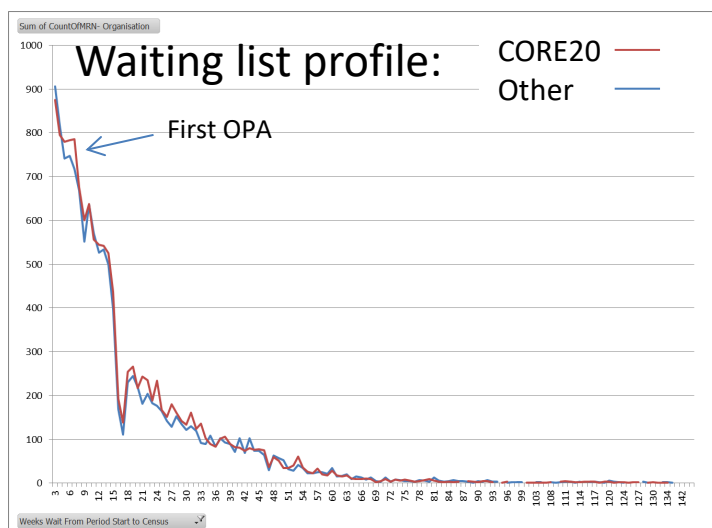
# Part 2 – Our Waiting Lists

# Methodology

- Review of waiting list profile, time to first OPA, time to DTA, time to treatment (non-admitted and admitted clock stops), time from DTA to treatment, and DNA rates
- Analysis split by patients from the 20% most deprived areas using the national IMD tables which aligns to the CORE20 principles
- Assumption that this would be a similar breakdown if done at an ICS level (this isn't currently available)
- Analysis doesn't include the other communities identified by the plus element of CORE20Plus5
- Trust level position reviewed and then TFC level analysis by exception, data compiled to allow further analysis by patient characteristics and/or procedure but not included in this initial report

# Waiting list profile

- Overall about **half of our waiting list** is made up of patients from the 20% most deprived areas (referred to as the CORE20 cohort in this report)
- This is fairly **consistent across time bands** although some gaps are visible at 6 weeks (see first OPA analysis) and between 20 weeks and 30 weeks

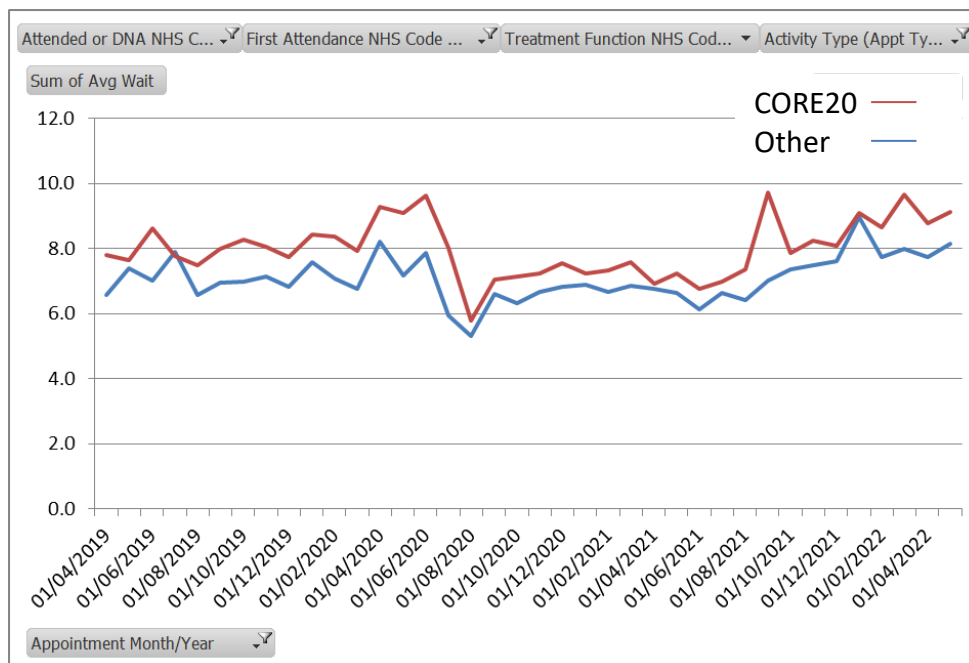


Waiting list breakdown – April 2022

	Not CORE20	CORE20	TOTAL	%CORE20
TOTAL	15865	16583	32448	51%
<18WK	11311	11689	23000	51%
>18WK	4554	4894	9448	52%
>40WK	1362	1327	2689	49%
>52WK	569	567	1136	50%
>104WK	52	55	107	51%

# Time to first OPA

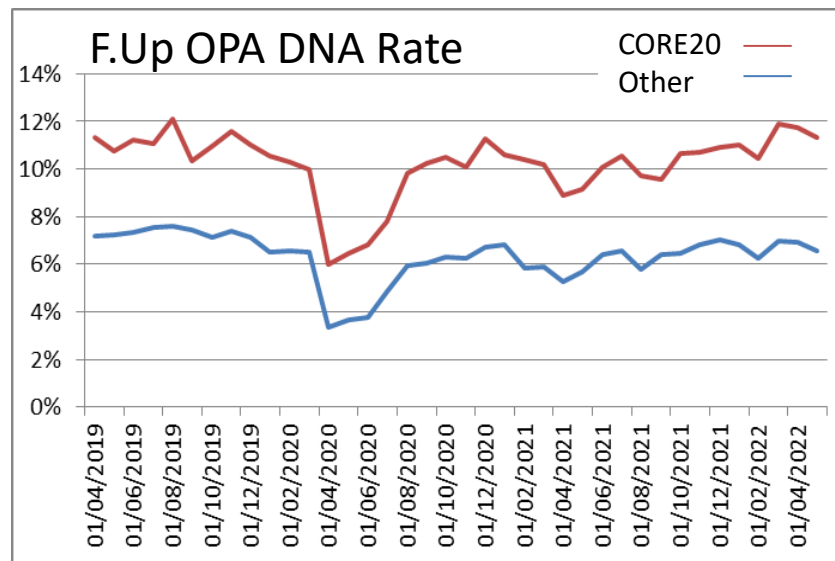
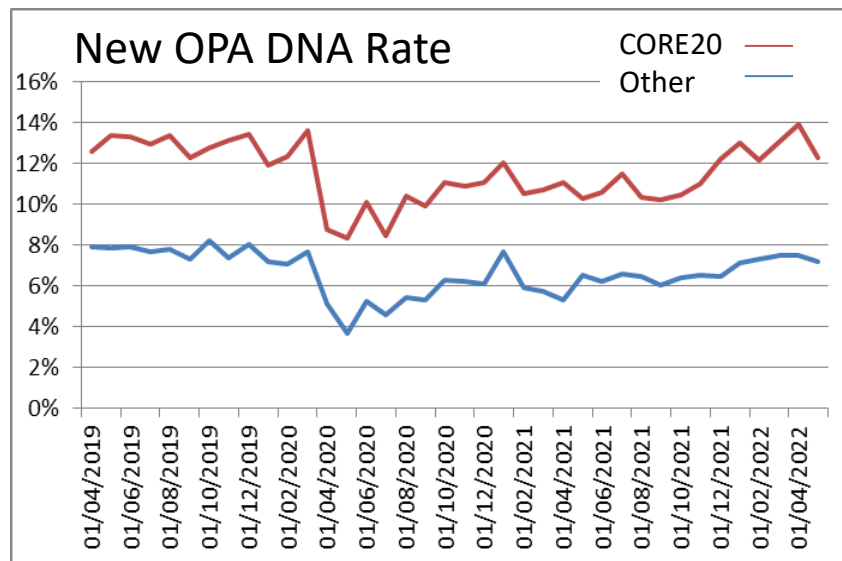
- On average patients from the CORE20 cohort wait **one week longer** for their first outpatient appointment
- This gap has been consistent with the 2019/20 baseline
- DNA rates and TFC trends are explored on the next two slides



Wait time since 2019 (weeks)		
Cohort	Other	All waits
+1.13	+1.03	+1.08
Extra time waited by cohort (weeks)		
2019	2022	Change
+0.89	+0.99	+0.10
New OPA DNA Rate 2022		
Cohort	Other	Difference
7.32%	12.89%	5.57%

# DNA rates

- Difference in DNA rate equates to 0.3 weeks delay (av. wait time) so doesn't account for all of the 1 week variance but ...
- CORE20 patients **nearly twice as likely to not attend**
- Gap most prominent in Colorectal, Dermatology, Restorative Dentistry, Rheumatology, Stroke, and Urology



\*Data doesn't include short notice cancellations which will be at similar levels

# Gaps by TFC

Overall wait time  
has gone up but  
**varies by TFC**

At Trust level the  
gap hasn't really  
changed but for  
some TFC's it has

There are  
examples of TFC's  
where CORE20  
wait less for NPA  
but also examples  
where CORE20  
wait significantly  
longer

	Other v BL	Cohort v BL	All v BL	2019 Gap	2022 Gap	Change
Services where CORE20 patients are waiting less time and this grown since 19/20						
ANAESTHETICS	-2.34	-4.05	-3.11	1.19	-0.52	-1.71
CLINICAL HAEMATOLOGY	3.26	-1.36	0.77	1.78	-2.84	-4.62
PLASTIC SURGERY	3.47	0.69	2.11	-0.69	-3.47	-2.78
Services where CORE20 patients are waiting more time and this grown since 19/20						
CARDIOLOGY	-3.84	-1.07	-2.34	-2.64	0.14	2.78
GENERAL SURGERY	10.62	12.16	11.43	-0.03	1.51	1.54
MIDWIFE EPISODE	7.82	11.41	10.10	-0.30	3.29	3.59
ORAL SURGERY	5.38	6.61	6.01	0.83	2.06	1.23
OPHTHALMOLOGY	0.03	0.65	0.29	0.90	1.52	0.63
PAEDIATRIC CARDIOLOGY	-2.06	0.10	-0.61	-0.70	1.46	2.16
PAEDIATRIC OPHTHALMOLOGY	0.33	2.12	1.49	-0.39	1.41	1.79
PAEDIATRIC SURGERY	-2.26	-0.02	-0.99	0.06	2.31	2.25
UPPER GASTROINTESTINAL SURGERY	3.79	6.63	5.29	0.37	3.21	2.84
VASCULAR SURGERY	6.41	9.52	8.05	0.44	3.55	3.11
Other services where CORE20 patients are waiting longer but where the trend is flatter						
DERMATOLOGY	-0.24	-0.61	-0.38	2.94	2.56	-0.37
ENT	-0.73	-0.47	-0.64	2.15	2.40	0.26
GASTROENTEROLOGY	1.86	1.57	1.66	1.78	1.50	-0.29
NEPHROLOGY	1.31	0.65	1.09	2.33	1.67	-0.66
RESPIRATORY MEDICINE	0.43	-0.11	0.05	1.81	1.26	-0.54
UROLOGY	1.89	1.77	1.84	2.41	2.29	-0.12
Services where CORE20 patients are still waiting more time but this has reduced since 19/20						
NEUROLOGY	6.51	3.65	5.17	5.48	2.63	-2.85
PAEDIATRIC EAR NOSE AND THROAT	1.09	-3.16	-1.63	5.55	1.30	-4.25
Services excluded from this table for visual purposes only, they remain in the overall analysis.						
Grand Total	1.03	1.13	1.08	0.89	0.99	0.10

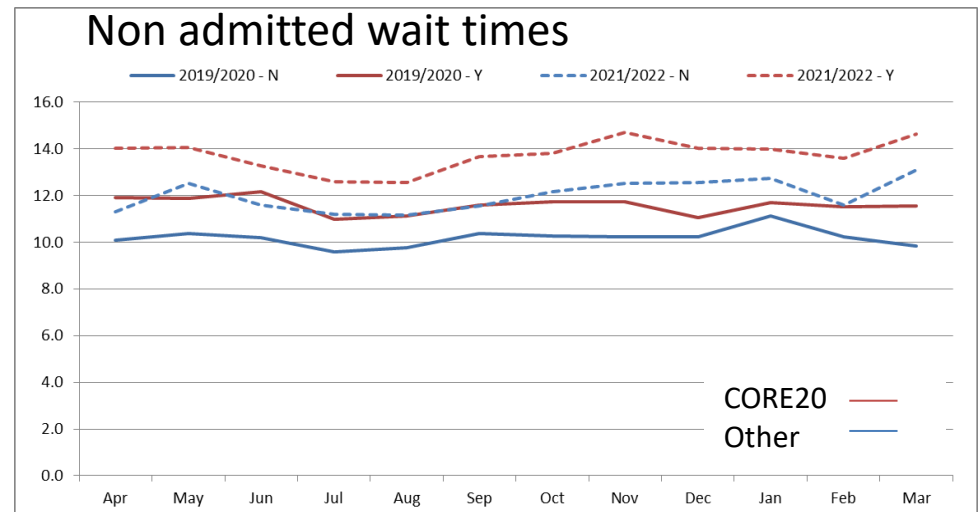
# Impact of referral priority

- Just over 50% of waits and activity are for CORE20 patients
- Activity by referral priority shows that CORE20 account for **55% of Routine**, 51% of Urgent and **41% of Fast Track**
- Within each priority group the **gap in wait time to first OPA is less than 0.2 weeks** suggesting most of the gap to first OPA relates to the variation in Fast Track and Routine demand that is CORE20
- DNA trends are consistent across priority but rates are higher for routine and lower for fast track (which results in the higher DNA rate for CORE20 as they weighted more likely to have routine priority)
- TFC analysis shows that Obstetrics/Midwifery, Paediatrics, Diabetes, and Infectious Diseases have the highest percentage of routine referrals coming from the CORE20 cohort
- Dermatology, ENT, Upper GI and Urology have the lowest percentage of fast track referrals coming from the CORE20 cohort



# Time to non-admitted clock stop

- Gap in 2019/20 was 1.5 weeks and this has grown to 1.7 weeks in 2021/22, overall time to clock stop has increased for both cohorts
- 50% of non-admitted stops were for CORE20 in 2019/20 and this drops to 48% in 2021/22
- Follow up DNA rates (which will contribute to the wait time growing) are lower for Fast Track referrals and the gap between cohorts is much smaller which could account for the CORE20 gap growing (as they are less represented in fast track and more represented in routine)

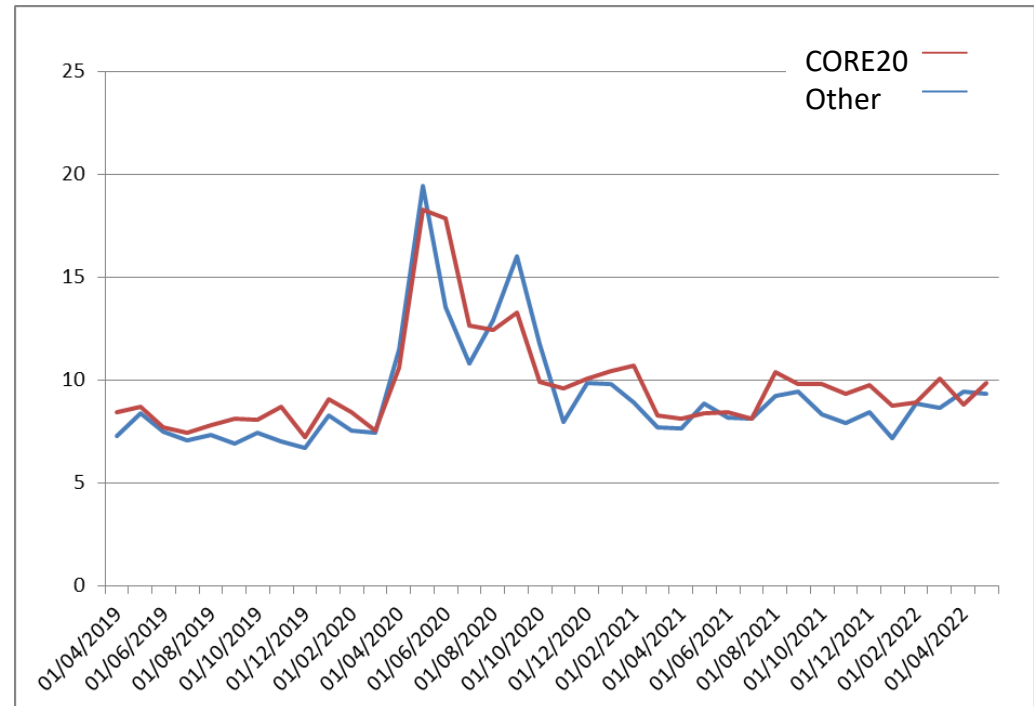


# Gaps by TFC

- Services where CORE are waiting less and this has grown:
  - Audiology, Endocrine, Respiratory
- Services where CORE20 are waiting longer and this has grown:
  - Colorectal, ENT, Ophthalmology, Oral Surgery, Orthoptics, Upper GI
- Services where CORE20 are waiting longer and the trend is flat:
  - Haematology, Dermatology, Renal
- Services where CORE20 are waiting longer and this has reduced:
  - Paed ENT
- Much of this matches the same analysis for time to first OPA
- Additional data is require to extend analysis to include the original referral priority

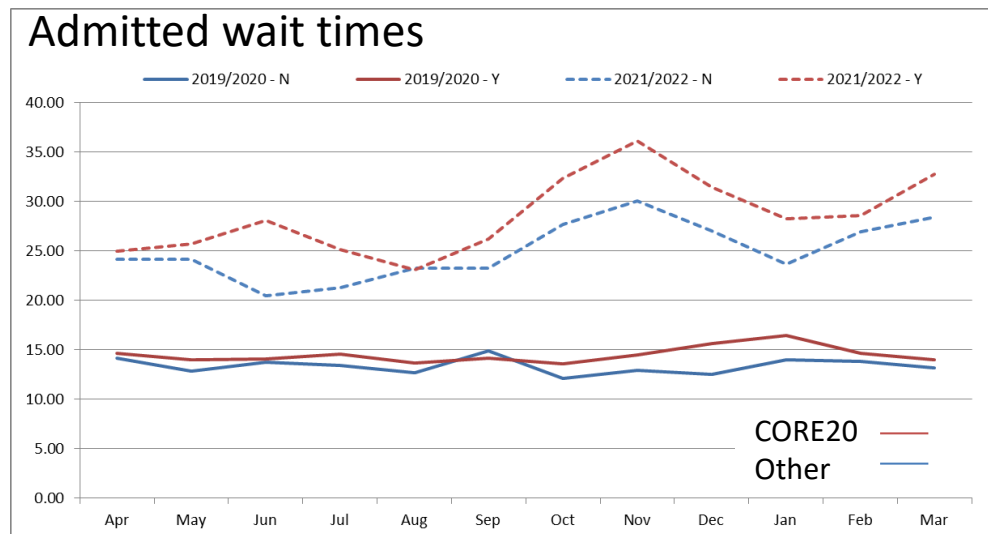
# Time to DTA

- Gap is **less than a week**
- 47% of DTA's are for CORE20 cohort (so less likely to be admitted for treatment)
- Gap for ENT, Neurology, and Vascular at 3 weeks or more



# Time to admitted clock stop

- Gap in 2019/20 was 1.2 weeks and this has grown to 3.7 weeks in 2021/22, overall time to clock stop has increased for both cohorts
- 47% of non-admitted stops were for CORE20 in 2019/20 and this drops to 44% in 2021/22
- During 2021/22 **P2 treatments (more fast track) have been prioritised over P3 and P4 treatments (more routine referrals)**



# Gaps by TFC

- Services where CORE are waiting less and this has grown:
  - Haematology, Endocrine, Pain Management, Upper GI
- Services where CORE20 are waiting longer and this has grown:
  - Breast, Dermatology, General Surgery, Gynaecology, OMFS, Renal, Plastics, Rheumatology, Vascular Surgery
- Services where CORE20 are waiting longer and the trend is flat:
  - Colorectal,
- Services where CORE20 are waiting longer and this has reduced:
  - NIL
- TFC analysis doesn't correlate as strongly to first NPA
- Additional data is require to extend analysis to include the original referral priority
- Additional data is also being requested to support analysis by HRG (and comorbidities)

# Treatment analysis

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- Fewer referrals from the CORE20 cohort result in an admitted treatment, this may relate to the split between Fast Track and Routine (and **possibly supports this prioritisation as correct**)
- At a Trust level the gap in time to treatment expands from the gap already incurred on the outpatient pathway despite it reducing for time to DTA showing the impact during COVID-19 of clinical prioritisation (use of P2, P3, P4)
- **Analysis by procedure, HRG and priority is required** – this is a large piece of work but could be targeted to the TFC's identified in the admitted clock stop analysis to help understand whether complexity is a driver in the wait time gap
- Surgical cancellation and DNA data could also be included in this analysis, as could other barriers to treatment (time of presentation, other intervention prior to elective surgery e.g. acute admission)

# Key Findings

- CORE20 patients seem **more likely to wait longer as they are more likely to be on routine pathways** which have a longer wait time and higher DNA rates
- CORE20 **DNA rates are higher** than other patients across all referral priorities
- CORE20 patients seem **less likely to be referred for cancer** treatment – it isn't easy to identify if this is unmet need but should be explored
- There is no real difference within referral priority (FT, Urgent, Routine) for CORE20 and other patient wait times
- There has been an **increase in time waited by lower priority during COVID-19** which has made some of the wait time gaps for CORE20 patients get bigger



# Preliminary Recommendations

- Work with Obstetrics, Paediatrics, Diabetes, and Infectious Diseases to better understand referral priority by IMD and identify actions to reduce DNA rates
  - internal work related to patient communication and DNA rates
  - partnership work at a practice level to better understand referral patterns and weighting to CORE20 patients
- Also agree actions to reduce DNA rates in Colorectal, Dermatology, Restorative Dentistry, Rheumatology, Stroke, and Urology
- Work with ENT, Skin/Plastics, Upper GI and Urology to review cancer pathways and identify reasons for delays within the CORE20 cohort and representation of in referrals received, this should include analysis of early/late presentation
- Further analysis of Haematology pathways which typically go against the trends observed at a Trust level

# Next Steps

- Further analysis will be undertaken to help refine this report but some recommendations could be progressed and action taken
- Measures should be aligned to these actions to track impact, these can be included across the performance framework as applicable
- Waiting list analysis like that undertaken for this report could be repeated frequently once built into power BI – this should be prioritised with the relevant IMD and patient characteristics included in the filters of the various wait time metrics
- IMD will also be included in all patient level waiting list reports and PTL's to support delivery of any actions agreed in response to these findings

# Thank you