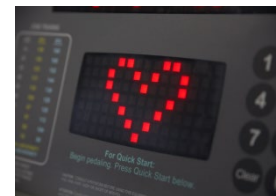
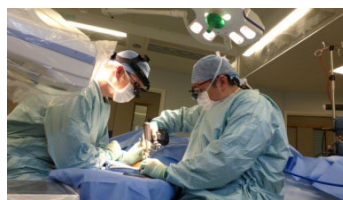


# Health Inequalities and Waiting List Analysis



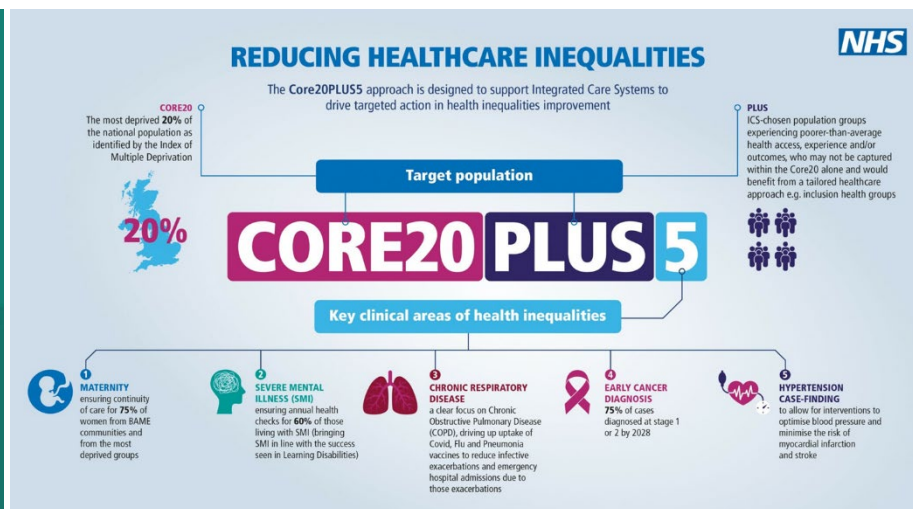
# Part 1 - Context

# Tackling Health Inequalities

- BTHFT work on health inequalities covers Access, Outcomes and Experience
- Current work includes:
  - Engagement with CSUs to understand current activity relating to inequalities
  - Sharing of best practice from external sources and within the Trust
  - Enabling staff to understand and discuss impacts and causes of health inequalities
- Key priorities – prioritisation of HIs, utilising data, anchor organisation role, population based care and collaborative working

# Health Inequalities

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

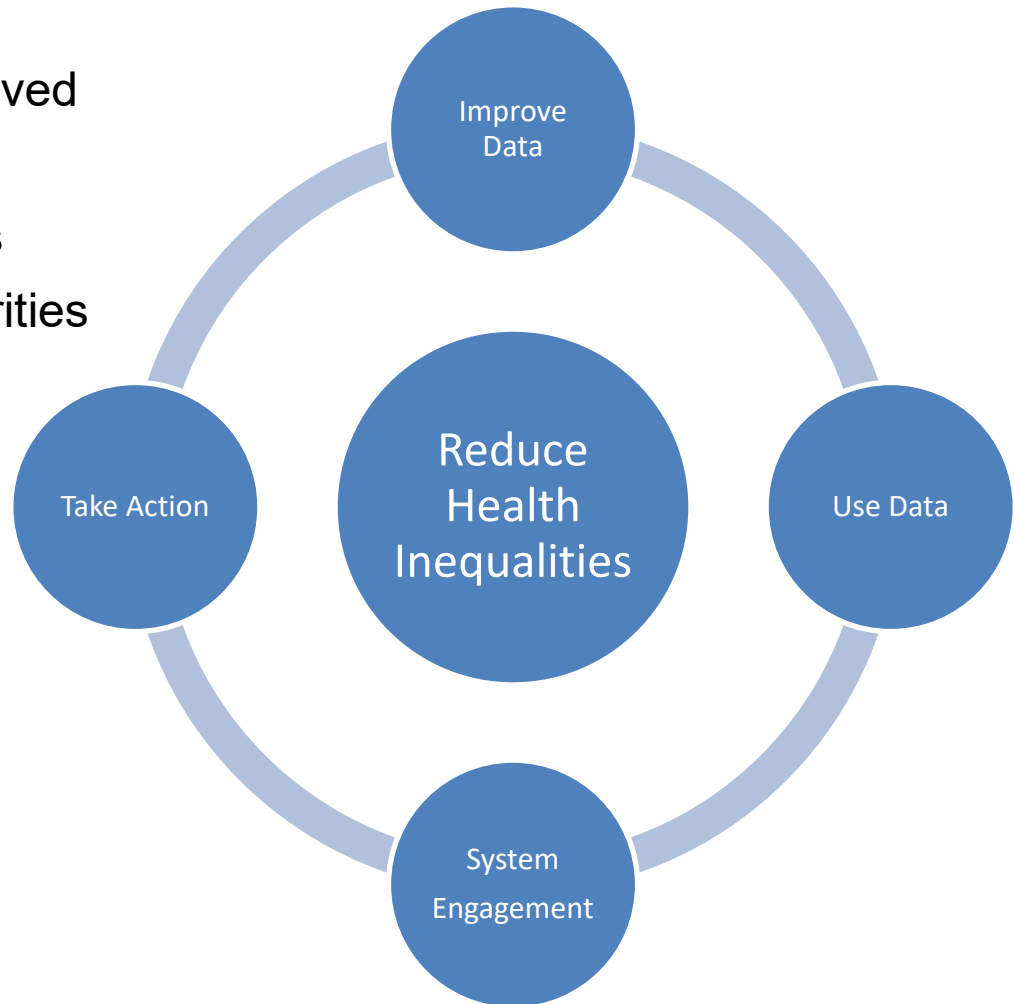
# 2022/23 Objectives

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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 (LD) 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.

# Approach

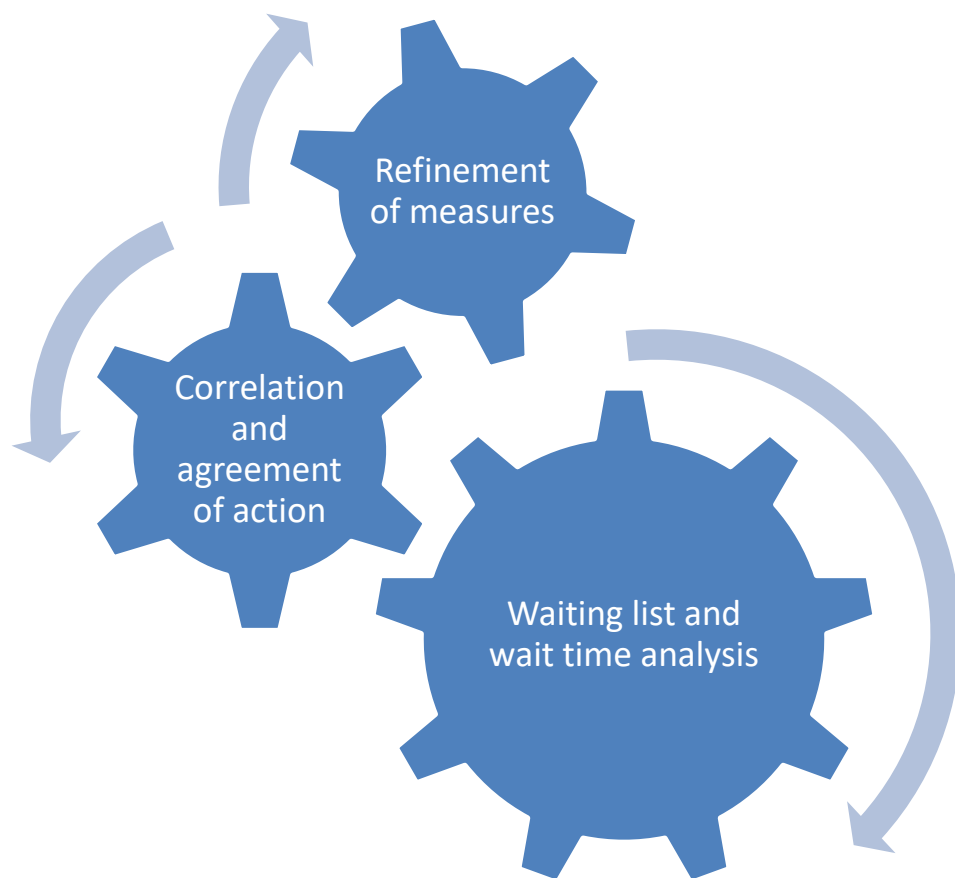
- Multiple departments involved
- Cyclical approach
- Aligned to Trust objectives
- Connected to system priorities



# 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**
- **Indices of Multiple Deprivation (IMD), ethnicity and LD data items** were added to a master patient index and joined to all existing waiting list data
- The CORE20 cohort (**20% most deprived in ICS footprint**) has been identified from national data providing this lens on waiting time analysis
- Outputs from this **analysis** shared with internal groups and also partners across the place footprint
- To ensure analysis can be repeated and CSU's empowered to utilise this data locally all **waiting list related processes** are being 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

- Ongoing review of waiting list profile, time to first outpatient (OPA), time to decision to admit (DTA), time to treatment (non-admitted and admitted clock stops), time from DTA to treatment, and DNA rates
- **Recently added:** review of inpatient waits by priority; review of referral data by practice area; deep dive into DNA rates
- Analysis split by patients from the 20% most deprived areas using the national IMD tables which **aligns to the CORE20 principles**
- Analysis doesn't include the other communities identified by the plus element of CORE20Plus5 – potential development for 2023/24
- Trust level position reviewed and then Treatment Function Code (TFC) level analysis by exception, data compiled to allow further analysis by patient characteristics
- Ethnicity and age explored within deep dive analysis of DNA rates

# What we know

- Overall **half of our waiting list** is 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 6-8 weeks
- On average patients from the CORE20 cohort wait **one week longer for their first outpatient appointment**
- This gap is consistent with the 2019/20 baseline
- CORE20 patients are **nearly twice as likely to not attend (DNA)**
- Gap most prominent in Colorectal, Dermatology, Restorative Dentistry, Rheumatology, Stroke, and Urology
- 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 splitting the data by referral priority starts to explain this

# 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)
- DNA rates are **highest for younger people** in the most deprived areas, consistent for each referral priority
- There are no clear trends by ethnicity when viewing wait time and DNA rates by IMD and referral priority

# DNA Deep Dive

- At an aggregate level there is no correlation between DNA rate and ethnicity within the CORE20 cohort by referral priority
- At a specialty level there was some correlation between DNA rate and ethnicity in a couple of instances which we are exploring further
- There is a **strong correlation between DNA rate and age**
- This is repeated for almost all specialties we looked at
- Focussed action to reduce DNA rates for younger patients in the lower IMD areas would have a positive impact on the variance in wait times between CORE20 and other cohort
- Findings shared with Act-As-One programme

# Treatment analysis

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- Fewer referrals from the CORE20 cohort result in an admitted treatment, although they are **more likely to be admitted on FT pathways and less likely on routine and urgent**
- CORE20 cohort are typically given the same clinical priority within TFC and by referral priority, some exceptions are being explored ...
  - For Skin cancer CORE20 are less likely to be referred, treated and a P2; for Gynaecology and Urology cancer CORE20 are less likely to be referred but more likely to be admitted and a P2
  - Routine referrals are often higher for CORE20, result in fewer admissions and those that are admitted are more likely to be P3 and less likely to be P2; except for within women and children's services
- Analysis by treatment priority shows once given a clinical priority the **time to TCI correlates with TFC and not IMD** – highlighting the importance of allocating capacity to the correct teams

# Key Findings

- CORE20 patients 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
- There is no real difference within referral priority (FT, Urgent, Routine) for CORE20 and other patient wait times
- This extends into wait times for treatment with a strong correlation with the initial referral priority and increased DNA rates impacting on time to treatment
- Referral priority to be explored further but **no evidence of variance in clinical prioritisation** of surgical waiting lists for CORE20 patients and treatment dates given fairly within priority grouping

# Referrals

- Referral priority impacts on the time waited and representation within each priority is not evenly distributed by the population within each IMD.
- Internal data can be broken down by practice and practice area but no obvious trends are visible.
- Next steps would include an audit of clinical notes to enhance internal data and partnership work to utilise data we don't have routine access to.
- The two questions to explore would be:
  - Should Obstetrics, Paediatrics, Diabetes, and Infectious Diseases have such high CORE20 demand for routine referrals?
  - Should ENT, Skin/Plastics, Upper GI and Urology have such low CORE20 demand for cancer referrals?
- This will also enhance the treatment analysis



# Part 3 – Access related actions

# LD Prioritisation

- Learning Disability flag included in all waiting list analysis and part of the **weekly waiting list management** process
- First OPA expedited for LD patients via this process
- Wait time to first OPA shorter for LD patients by TFC's and referral priority
- Treatment prioritised for LD patients within each of the clinical priority groupings – order as follows LD P2, Other P2, LD P3, Other P3, LD P4, Other P4
- Treatment numbers for LD patients are low making analysis difficult but prioritisation evident through weekly meetings
- GP data being added to dashboards to provide insight on overall coverage of the LD flag (and potentially increase numbers for treatment analysis)

# Paediatric DNA's

- Act-As-One led work to **reduce DNA rates within Paediatric first outpatient clinics** across Bradford District and Craven
- High DNA rates for Paediatrics across AHFT and BTHFT
- Proportion of Paediatric waiting list from CORE20 cohort is high, particularly for routine referrals, meaning a reduction in DNA rates and improvement average wait times would benefit the population with the poorer health outcomes
- Insight beyond appointment data was gained via community groups and structured conversations
- Themes included communication, time of appointment, location, other comments/ suggestions for improvement
- Actions being **progressed in response** include changing communication strategy, targeting reminder calls and offering travel support, improving interpreter availability, utilising DrDoctor better

# Next steps

- Continue to refine how we use data in support of understanding equity of access and it's relationship with health inequalities e.g. working with system partners on referral data
- Power BI reporting being incrementally built and used to make this analysis more routine
- Further strengthen the weekly monitoring of LD prioritisation by including in weekly senior operational performance reports
- Continue working with system partners to explore enhancing the data and informing action plans in place – particularly focussing on DNA reduction
- Digital inclusion/ exclusion to be explored; DNA rate analysis links to opportunities around digital solutions for younger cohorts who have higher DNA rates

# Thank you