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Access to Care - Health Inequalities and Learning Disability Data

Together, putting patients first

Governance

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Health inequalities and what we are doing to address this is a key theme across all areas

- The Equality and Diversity Council (chaired by the CEO) is the committee of the Board that oversees this work, this includes work both locally and across Place
- Academies of the Board all have agenda items that include some aspect of the tackling inequalities agenda
- The Exec to CSU meetings provide further challenges with the clinical triumvirates
- Our operational responses and clinical systems are aligned to help address inequalities in how we record and plan activity
- All new developments have an “inequalities lens”

Context

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- National guidance for 2022/23 focussed on **improving the use of data** to help us better understand health inequalities
- Guidance for 2023/24 has shifted focus to **coordinated action** to improve access, outcomes and experience; building on the work from 22/23

Access Data

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- **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 – this is now a reciprocal process but needs streamlining to improve frequency
- Weekly **access meetings** include the ability to use IMD, ethnicity and LD data items
- A dashboard specific to **reducing DNA rates** is available in support of the work several parties are progressing relating to this objective

Using this data

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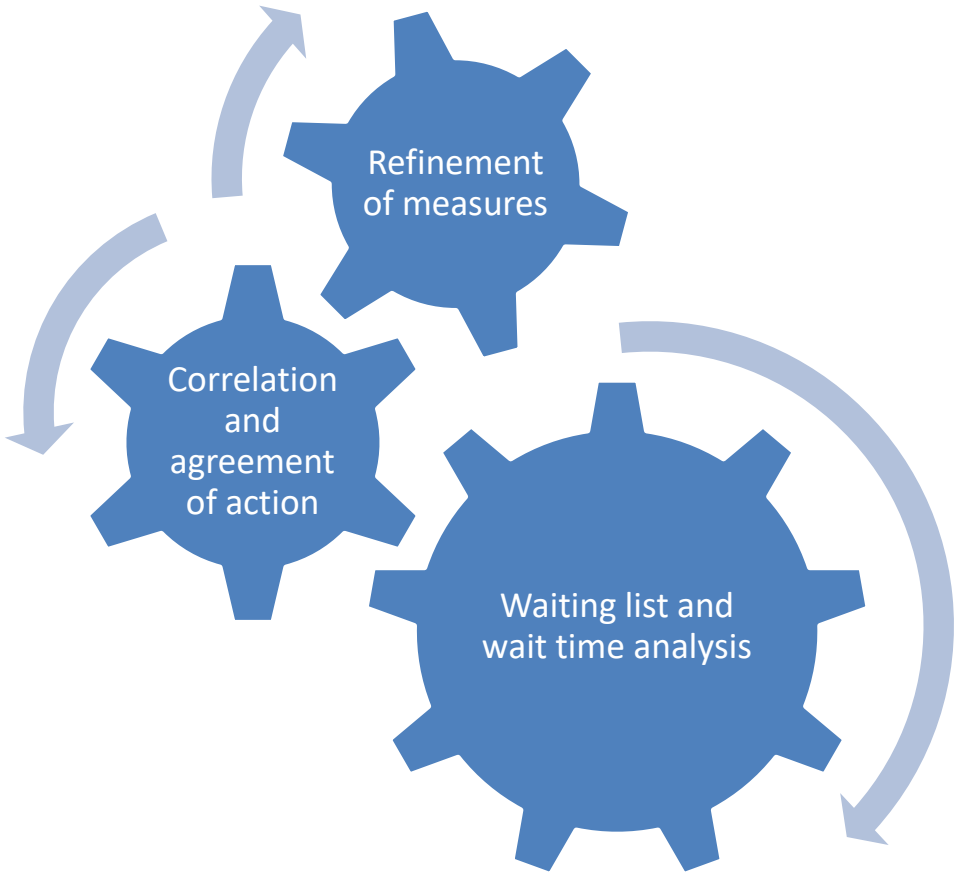

This is an iterative process whereby the analysis of any data will need careful consideration by operational and clinical colleagues.

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.

Key Findings

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- 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 still 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

DNA Deep Dive

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- 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
- 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 and Operational colleagues within BTHFT

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:
  - 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

LD Prioritisation

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- 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 – has **significantly reduced the P2 waiting list** and time to treatment is 3 weeks shorter for LD patients
- Treatment numbers for LD patients are low making analysis difficult but prioritisation evident through weekly meetings
- Waddiloves data being shared again, to support internal processes to check LD flags but also to help us undertake some additional analysis jointly with the care trust on admission reasons

LD Prioritisation

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- Corporate work being led by Assistant Chief Nurse for Adult Safeguarding introduced a number of initiatives to aid in preparation for admission and supporting when admitted, includes:
  - Introduction of the VIP passport and the VIP red rucksack
  - Additional needs support workers to support ward teams
  - LD lead nurse in post who is key point of contact with BDCT (Waddiloves) and customised care planning
  - Introduction of Carers initiatives including open visiting
  - Ongoing work to increase awareness and use of red flags to identify patients with both LD and ND (neuro disability)

Paediatric DNA's

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- 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

Obstetric DNA's

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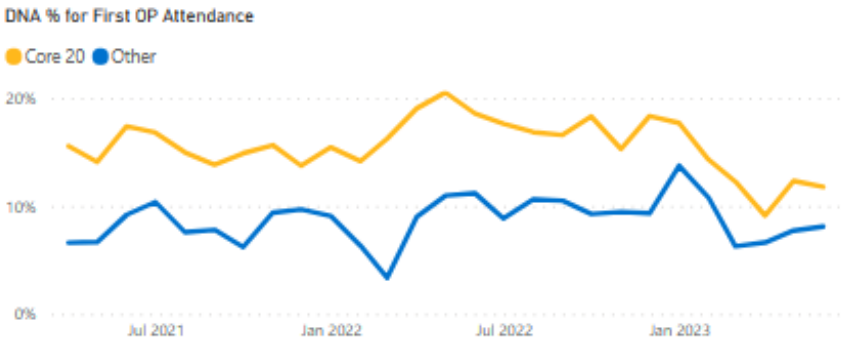
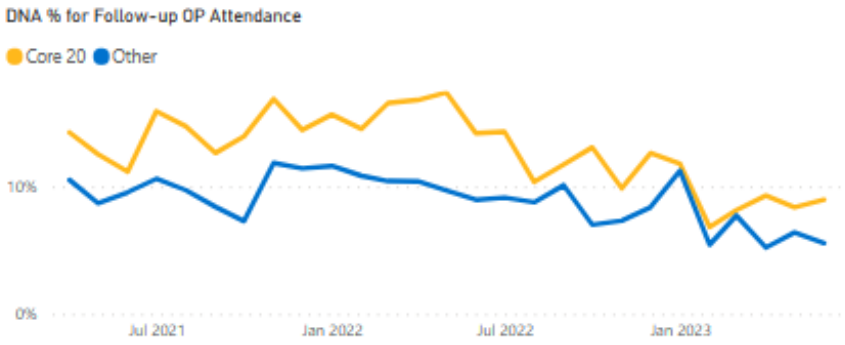
- BTHFT teams have been trialling methods to reduce DNA rates, the use of text reminders being the most prominent approach
- Effective text reminders included:
  - We look forward to seeing you and doctors name
  - Plan your journey and ring if you have difficulty
- Within Obstetrics this work has significantly narrowed the gap between Core20 and other IMD whilst reducing overall DNA rates, particularly for follow up appointments





Obstetric DNA's

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- The involvement of the clinical teams based on clinical review of cases has also flagged health inequalities
- The combined impact of this with the operational initiatives re text message reminders has clearly made a difference.
- Excellent example of the triumvirate working together to address inequalities.
- Initiatives have included:
  - Introduction of a freephone number for the maternity assessment unit, enabling women and families to always be able to make contact
  - Reviewing how we provide transport and helping women who cannot afford to travel to the hospital
  - Introduction of "Ask for Betty"
  - Changes to the way we are using interpreters including wider access to video translation

Nex Steps

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- The use of data and the regular review of data across our system is essential and the Equality and Diversity Council will provide organisational oversight.
- The work of Act as One and the focus this gives enables better working across pathways without the limitations of organisational boundaries.
- The obstetric example has shown that when the triumvirate takes a blended approach to talking problems the results will be greater, greater roll out and understanding across the organisation will ensure spread and reliability in approach.
- Oliver McGowan training is being rolled out over the next 12 months and will provide a greater awareness of all staff to patients and families living with LD/ND.

Thank you