Mersey and West Lancashire Teaching Hospitals NHS Trust

Mersey and West Lancashire Hospitals NHS Trust

Health Inequalities

3 Year Strategy

2025/26 – 2028/29






March 2025

Contents

1. Introduction

After a little over a year of integrating our two legacy trusts with a combined patient base of around 600,000 and significantly serving 6 local authority places. The time is right to have a greater focus on Health Inequalities and Health Equity for our diverse populations.

We know that chronic, persistent, and unacceptable health inequalities result in poorer health, reduced quality of life, higher costs of care and early death for many people. Marginalised and deprived populations experience health outcomes far worse than the general population. They experience exclusion from services, and economic and social marginalisation.

This strategy has been developed in a context of Covid recovery and cost of living poverty crisis as well as an NHS challenged to address the imbalance of supply and demand for care. We recognise that this journey for the trust to ensure that our approach is rooted in the needs of the diverse communities and their geographies, that we work with local partners and collaboratively with Cheshire and Merseyside colleagues to deliver the very best outcomes for our populations.

The Trust has organised its approach in four priority areas: as a healthcare provider; as a partner; as an employer and as an anchor institution. As a provider of services, we need to shift focus to ensure inclusion, preventative interventions and make every contact count. We will continue to work with partners on the wider determinants of health and develop greater insights on needs. We employ 10,000 and it is important that the welfare and the development of staff is a priority to maximise the quality of care and productivity of services. Finally, as an anchor institution within our communities, we will use our capabilities and economies of scale to positively influence people's lives through employment opportunities and our procurement policies as well as the way we deliver care. This strategy has the following vision and objectives:

Health Inequalities Vision:

Reducing health inequalities by ensuring equitable access to our services and promoting preventable support in the community.

Health Inequalities Objectives:

The Trust will use its role to reduce health inequalities in the communities it serves by:

- Being a **provider** of quality health care
- Being an active **partner**
- Being an **employer** of choice
- Being an **anchor institution**

2. Background and Policy Context

NHS England (NHSE) published a statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) on 27 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.

The National Health Service Act (2006) states that "NHSE must publish a statement setting out a description of the powers available to relevant NHS bodies [trusts, foundation trusts and ICBs] to collect, analyse and publish information relating to inequalities" (section 13SA). This includes inequalities in accessing healthcare services and within health outcomes.

The statement provides NHSE's view on how NHS bodies should use information on health inequalities. NHS bodies are expected to work collaboratively on information collection and analysis to better understand the health and wellbeing needs of their local communities. This involves increasing shared understanding of the demographic profile and geographic distribution of disadvantaged groups, the health and care needs of those in more deprived places, and the wider social, environmental, and economic factors underpinning health inequalities.

The Kings Fund recently cited the statistics below as a case for change:

Infant mortality is twice as high for Black infants and nearly twice as high for Asian infants compared with White infants.
Deaths per 1,000 infants in England and Wales in 2022 = 6.6 Black infants; 5.7 Asian infants; 3.1 White infants.
Source: Office for National Statistics 2024.

People in the most deprived areas are twice as likely to die prematurely from cardiovascular disease than people in the least deprived areas.
111 deaths per 100,000 in the most deprived areas of England compared with 55 in the least deprived areas as of 2022.
Source: Office for Health Improvement and Disparities 2024.

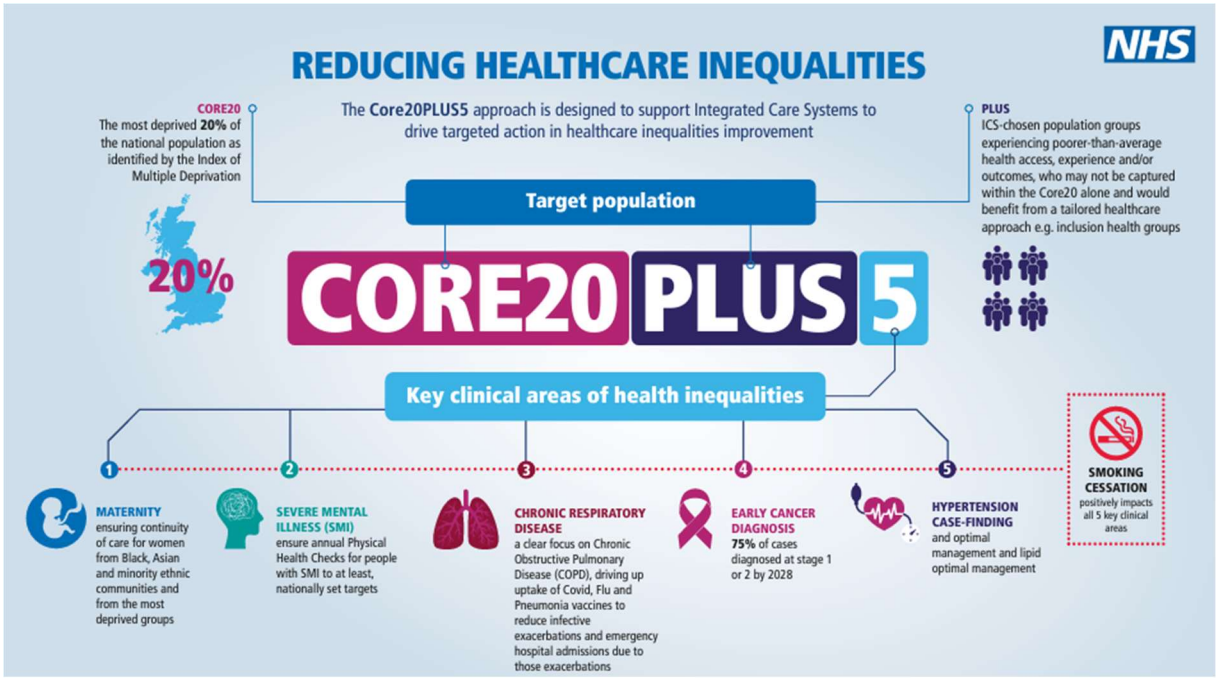
Lesbian, gay and bisexual adults are more than twice as likely to report having a longstanding mental, behavioural or neurodevelopmental condition than heterosexual adults.
16% compared with 6% of heterosexual adults in England 2011–18.
Source: NHS England 2021.

People living in the most deprived parts of England are more than twice as likely to wait over a year for elective care than people living in the most affluent areas in 2022.
Source: Robertson *et al* 2023.

Women experiencing homelessness are less likely to attend breast screening appointments than the general population.
37% had attended a screening compared with 62% in the general population (of those eligible) in England as of 2018–21. Source: Office for Health Improvement and Disparities 2024.

The difference in life expectancy for people living in the most deprived areas of England compared with the least deprived areas is 9.7 years for males and 7.9 years for women.
2018- 2020
Source: Office for National Statistics 2022.

NHS England have also developed the CORE20PLUS5 approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The Infographic below demonstrate this approach:



As part of our plan, the Trust is exploring with partners how we can use the CORE20PLUS framework to have an impact on the services we deliver.

NHSE will publish it's 10-year plan in the Spring 2025, it is likely to place a greater emphasis on preventative services with the aim of reducing health inequalities.

The Cheshire and Merseyside Health and Care Partnership feature health inequalities as the focal point of their strategic plan for 2024-2029. The plan adopts the Professor Sir Michael Marmot's eight themes and converted them in to a set of headline ambitions set out below.

This strategy broadly aligns with the ambitions of Cheshire and Merseyside partners and will be developed as we learn, adapt and tackle the challenges presented by the health inequalities faced by the populations we serve.

3. Definitions

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". This means that some population groups have significantly worse health experiences and outcomes than others.

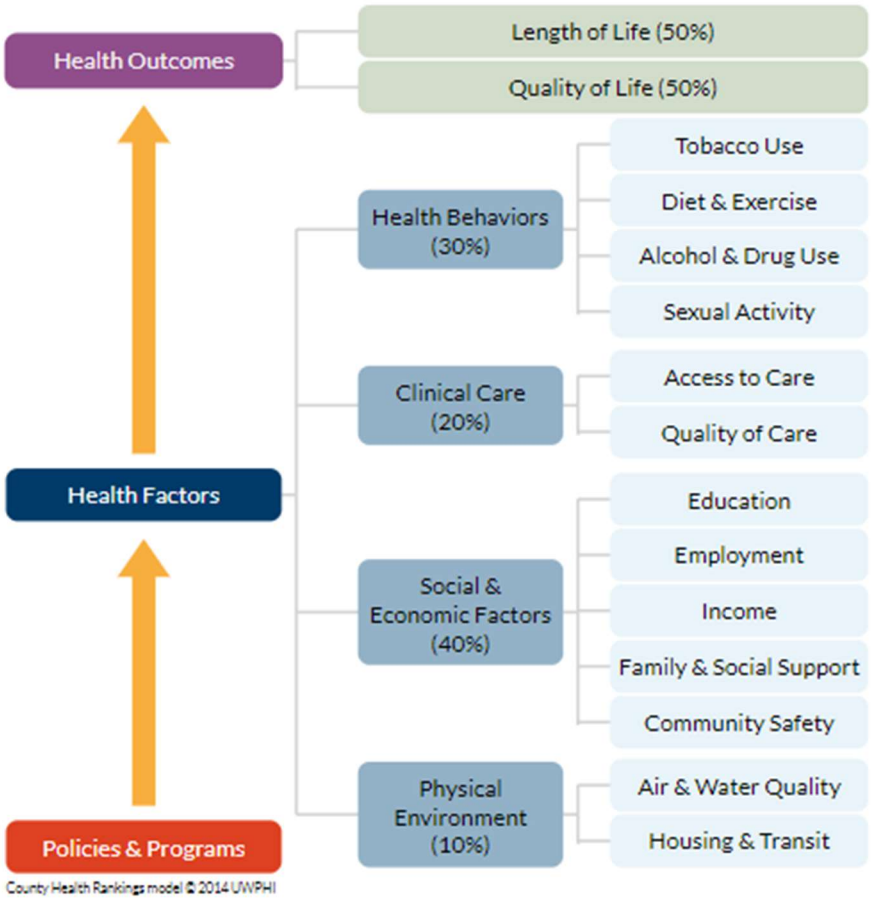
These differences can be due to a range of factors including a person's social, economic, and environmental circumstances – and we know that greater deprivation in any of these factors is associated with an increased risk of becoming ill earlier and dying younger. People with certain characteristics, such as certain ethnicities, sexual orientation, age, and disabilities, also have a lower chance of living a long and healthy life compared to others. This is often due to the exclusion from society that people with these characteristics face.

EQUALITY	EQUITY	BARRIER FREE

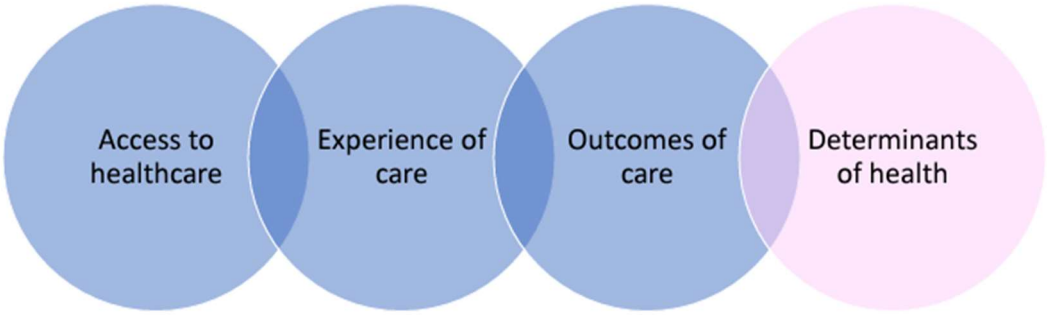
Equality means treating everyone the same or providing everyone with the same resource, whereas **equity** means providing services relative to need. The third image shows the systemic barriers are removed meaning everyone has access without any supports or accommodations because the cause of the inequity was addressed.

Wider determinants are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

The health and wellbeing of our population are influenced by a thriving economy, a healthy environment, having good quality housing in a safe place to live, education and skills, job opportunities and positive social networks and leisure opportunities. These are the 'social determinates' of health and wellbeing and they are thought to determine around 50% of health outcomes, see figure overleaf. The second greater is factor is health behaviours which is considered to determine 30% of health outcomes (diet, exercise, habits).



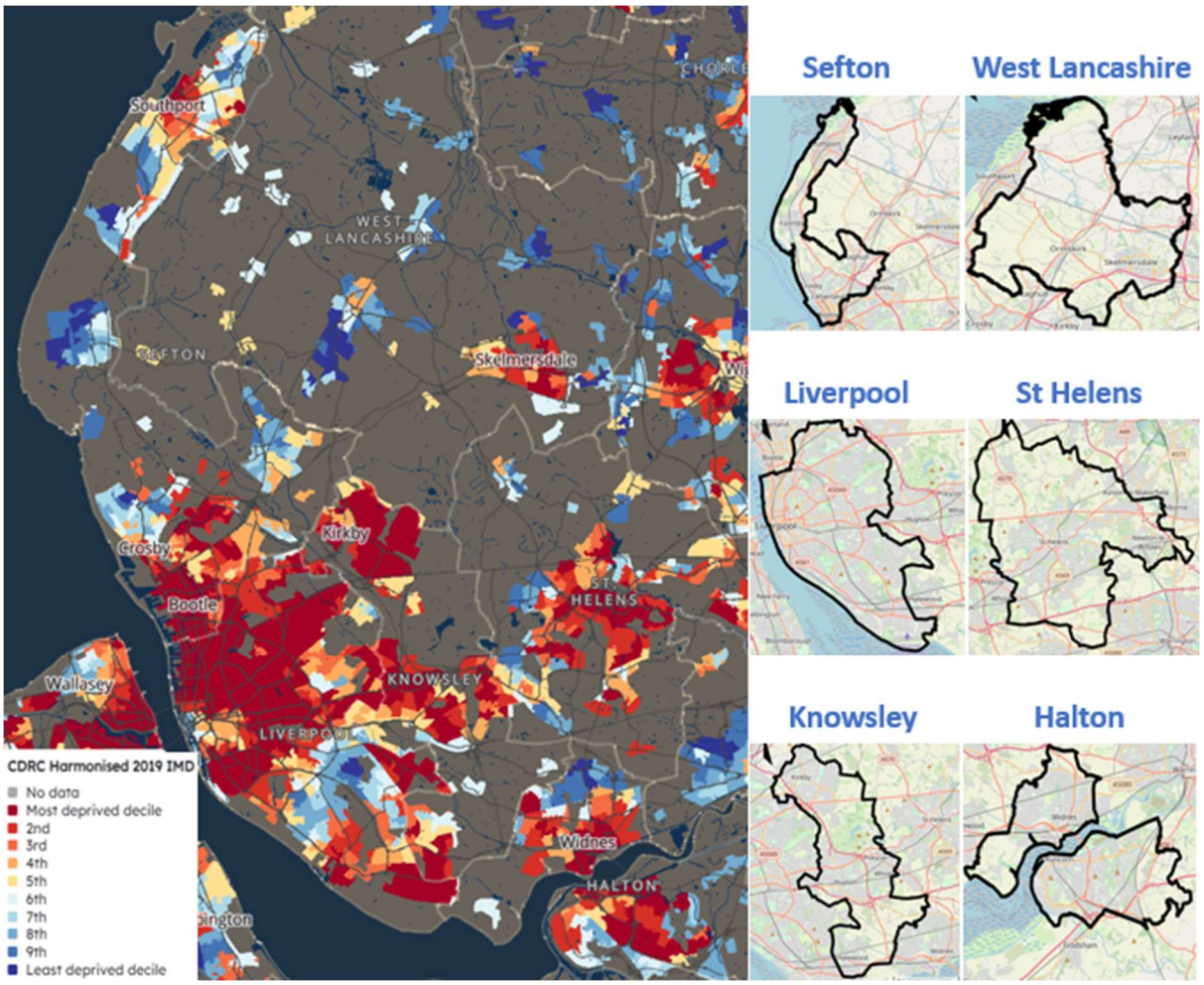
And finally **clinical care** contributes just **20%** to health outcomes, and therefore as a provider of care we also need to consider how we can influence the other factors as a partner, as an employer and as an anchor institution.



The determinants of health can be greatly affected by nationally government policy, the economy and society and locally City Regions, local authorities and ICBs, all commission services and have resources to invest albeit scarce. This strategy explores how we could collectively influence that fourth circle.

4. Our Population

We are a significant provider of services in six local authority areas and our reach stretches into the Lancashire and South Cumbria ICB. Working with such a diverse range of partners has its challenges, but also has benefits in terms of learning and best practice. The figure below reminds us of the geographies we serve and also the levels of deprivation.



Our patient populations come from areas of high deprivation and within the geographies we serve there are communities that endure significant health inequalities, see overleaf.

The table overleaf highlights the extent of the challenges and also within boroughs further inequalities exist:

- in the majority of cases there is a decade between the life expectancy of people living in the worst and least deprived areas in the boroughs
- The Merseyside boroughs have higher mortality rates.
- Behavioural risk factors are much more prevalent.
- Children do not have the best start in life.

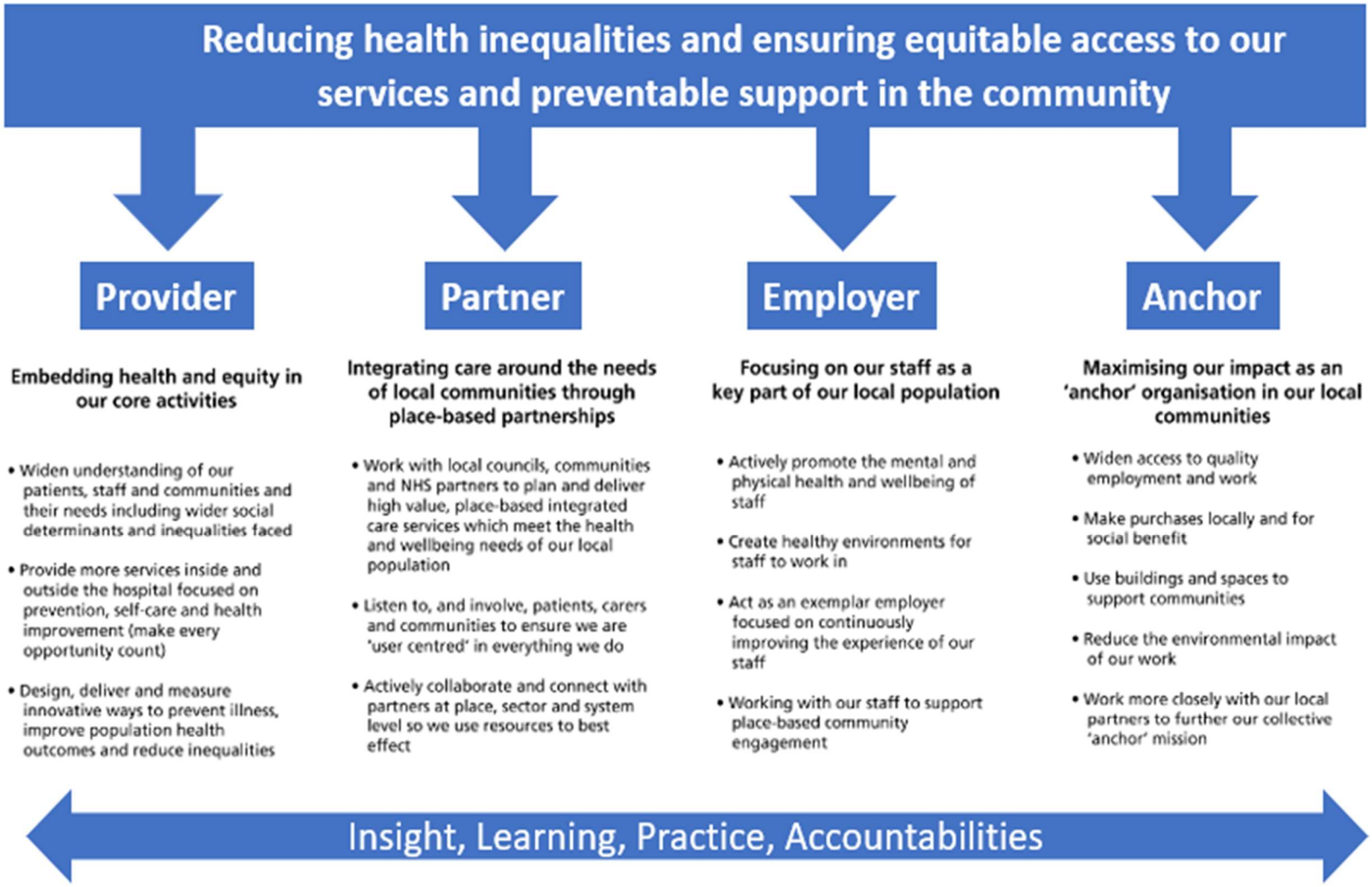
The challenges are quite stark and require a fundamental rethink in how we as a provider, partner, employer, and anchor in the community can play a more influential role in turning the inequalities tide.

A Comparison of Places: Deprivation, Mortality, Risk Factors and Child Health

Place		England	North West	St Helens	Halton	Knowsley	Liverpool	Sefton	West Lancs
Deprivation									
IMD (2019) Rank out of 317		-	-	26	22	2	3	89	155
% of people in lowest quintile		-	-	43.4%	48.6%	62.8%	62.0%		
Health Inequalities									
Life Expectancy: Most	Male	9.7 years	-	12.4 years	10.8 years	11.4 years	11.1 years	11.8 years	8.6 years
v Least deprived areas	Female	7.9 years	-	8.6 years	8.8 years	12.6 years	8.9 years	11.5 years	7.9 years
Causes of Death									
Under 75 mortality rate (all causes)		330.5	388.4	411.9	428.1	476.2	497.6	369.2	332.7
Mortality rate from CVD		71.7	86.6	85.8	88.4	98.9	106.1	76.9	74.3
Mortality rate from cancer		132.3	145.6	143.1	170.9	185.3	179.4	141.6	129.3
Suicide Rates		9.64	10.4	16.1	11.4	11.5	9.54	11.5	13.3
Behaviour risk factors									
Hospital Admission for alcohol specific conditions (under 18 yrs)		31.6	45.9	100.2	58.6	45.4	51.7	52.9	37.8
Hospital Admission for alcohol related conditions (under 18 yrs)		663.7	741.5	882.7	862.7	939.7	997	912.3	648.4
Smoking prevance in adults		14.4	14.7	15.8	17.9	18.1	14.7	11.1	14.1
% of physically active adults		66.3	64.7	61.7	62.8	63.3	66.4	63.7	70.6
% of adults overweight or obese		62	64.3	72.6	74.4	71.2	62.4	71.2	69.5
Child Health									
Teenage conception rate		17.8	21.9	37.1	34.9	27.6	28.1	17.4	19.5
% of smoking during pregnancy		10.6	12.7	16.2	17.3	14.6	13.0	12.9	12.6
% of breastfeeding initiation		74.5	64.5	55.3	54.6	48.4	55.0	57.9	62.4
Infant mortality rate		3.93	4.62	3.50	3.40	3.36	6.12	4.20	4.95
Year 6: Prevalence of obesity		20.2	21.5	23.0	25.0	26.9	24.9	21.3	19.4
% of children in low income families		17.0	18.0	19.5	19.6	25.0	26.3	17.1	13.7

5. Our Approach

Our approach to health inequalities is articulated in the framework below:



The framework will help us draw together the initiatives already underway and, importantly, to spot and address key gaps. Getting the balance right balance between actions to improve equity of access, experience and outcomes in our own, core activities (clinical care, research and education) and those that contribute to wider efforts to improve health and to reduce inequalities due to social determinants of health (such as employment, housing, literacy levels and structural racism).

6. Our Journey?

The Trust is involved in a number of initiatives that have and will reduce health inequalities, below are a few examples of the activities that we do or partner with:

HEALTH EQUALITIES GROUP

Prevention Pledge

14 core commitments, covering key themes including:

- Promoting workforce development, workplace health & wellbeing
- Promoting healthier lifestyles for patients/visitors & making every contact count
- Using Marmot principles to address health inequalities & working with partners at Place
- Signing up to C&M Concordat for Better Mental Health
- Embedding prevention in governance structures

social value BUSINESS

Social Value Award

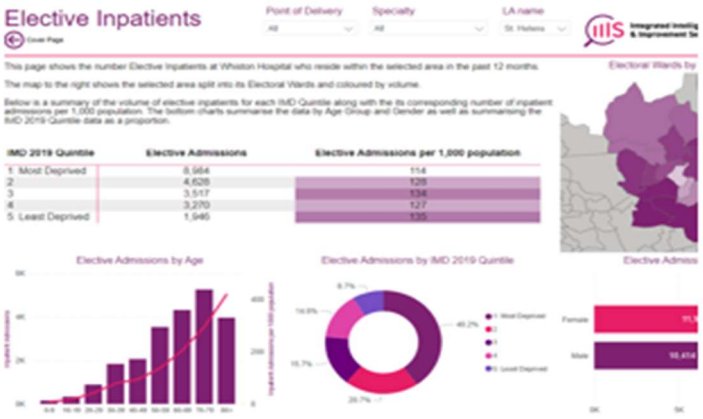
A quality mark which is centred on providing evidence against and making a pledge for one or all of the 4 themes - Innovation, Economic, Social and Environment - the Social Value Award aims to help organisations to recognise the impact that they are making in their community through their social value, deliver social value, and recognises the organisation as an 'Anchor Institution'.

Workforce

- Work Experience Opportunities
- Registered Nurse Degree Parentships Conversion Course
- School Engagement
- Healthcare Science Careers Event

St Helens Skills Academy

Health Inequalities Dashboard



Self-Harm: Prevention & Resolution Service

Smoke Free Service

- Since April we have visited over 1,400 Inpatients
- Of those 52% inpatients wanted to stop smoking
- 73% of those inpatients who wanted to stop smoking, wanted a referral to their community stop smoking service
- We are currently reporting a 40% quit rate of those inpatients who have manged to stay quit 28-days after leaving hospital.

Type 2 Diabetes

Sanofi data interrogation performed, and task and finish group reviewed data

- Diabetic consultant included
- Outcomes from project were fed back to Clinical Directors for St Helens place and associated action plan agreed to review and support changes in service delivery
- Aim to change focus to delivering service in primary care / community reducing pressure on secondary care services
- Organising 'group consultations' for diabetic patients to attend and receive both clinical and educational support

7. Our Plan

The Trust will use its role to reduce health inequalities in the communities it serves by:

- Being a **provider** of quality health care
- Being an active **partner**
- Being an **employer** of choice
- Being an **anchor institution**

This section illustrates how the Trust will convert its strategic intent into a series of deliverables for each objective. This is summarised in the plan on a page overleaf.

The Trust has already been awarded the Cheshire and Merseyside Social Value Award, signed up to the Prevention Pledge and the 14 aspects of the programme, and is in the process of committing to the Anchor Institutional Charter.

The current base year will focus on building the evidence base. MWL has the capability through its data analytics and highly skilled, multi-professional clinical teams who are in contact with 100,000s of patients to risk stratify and understand the needs of its patient population. There is a robust evidence base behind 'make every contact count' to indicate the positive influence clinicians have on the healthy wellbeing behaviours of patients.

Whilst it is recognised that asking about lifestyle issues such as alcohol intake and smoking takes time and adds more of a data collection burden for clinicians, the utility of the data and the impact of the conversation on the patient can be profound.

Likewise, setting up systems to account for how we engage with partnership and the impact we have will have it challenges, but the differences we make can be significant and lasting. We do have a duty to be an exemplar employer and to play a leading role as an Anchor Institution as the biggest employer in the area.

A draft plan on a page has been developed, see overleaf, but we need to do more work with colleagues across the trust and with our partners to help shape a more granular plan that target the agreed priorities.

Plan on a Page to Reduce Health Inequalities

Vision	*Reducing health inequalities by ensuring equitable access to our services and promoting preventative support in the community*					
Objectives To reduce health inequalities	**Development work Year 1 – 2025/26**					**Outcomes**
Being a provider of quality health care	**Embedding Health Equity into Service Delivery**	**Service Transformations with Equity Embedded**	**Making Every Contact Count**	**Data Driven Improvements in Health Inequalities**	**Digitally Enable Services (avoiding exclusion)**	**Patients will have more years in better health. Gain equitable access to services, avoiding crisis interventions through proactive and preventative care**
Being an active partner	**Population Health approach to collaboration and prevention**		**Care Closer to Home**	**Digitally and Data Enable Services**		**Services have adapted to peoples' needs, improved health outcomes and a reduction in the cost of delivery**
Being an employer of choice	**Growing our Future Workforce**		**Equality, Diversity and Inclusion**	**Workforce Health and Wellbeing**		**Staff across the Trust are reflective of the local population with high recruitment and retentions rates and positive satisfaction rates**
Being an anchor institution	**Skills, Employment in Health and Social Care**		**Exploring Development Opportunities with Local Authorities & Partners**	**Leadership within the Places we serve**		**MWL having a net positive impact on the socioeconomic health and wealth of our geography**

1. Provider

Moving from our base year and using the data collected, MWL can then begin to mitigate some of this inequity we may find. Having achieved a dataset, the population groups can be segmented and targeted for a differential approach to care provision that meets their needs. With improved data and some targeted investment, we could begin to explore the priority areas of Core20+5, elective recovery, and urgent and emergency care.

2. Partner

The ICB has been established for over two years and the Trust is an active partner within Cheshire and Merseyside and place-based partnerships are still at varying levels of maturity and capacity. There are opportunities to accelerate efforts to tackle heath inequalities given the mandate set out in the legislation and in NHSE guidance. Places such as St Helens have an Inequalities Commission which researches best practice to be implemented locally.

3. Employer

The third pillar of our health and equity framework is focused on promoting the mental and physical health and wellbeing of our own staff. Over half of our 10,000 staff live locally and many have active roles within their communities - thinking about them as a key part of our local population is essential.

There has been quite a disparity between the quality of the working environment between the legacy STHK buildings and that of legacy S&O. We do have a capital programme of improvements to go some way to levelling up our estate for staff as well as high quality facilities for patients. We also want to act as an exemplar employer focused on continuously improving the experience of our staff.

4. Anchor

Employing a 10,000 strong professionally diverse workforce; caring for 600,000+ residents; and a financial expenditure of around £850m on the provision of healthcare makes the MWL an anchor institution within the communities we serve. The MWL will use this status to positively impact the local economy, society, and economy through:

- purchasing more locally wherever possible, using social value measures in commissioning and procurement
- ensuring access to work, and making sure that job roles are high quality
- supporting families to live healthy, sustainable lives
- supporting the wider transition to a net zero economy, helping to reduce emissions and improve air quality

8. Our Governance

The ongoing development of this strategy and its delivery will need structure and resourcing. The governance structure is shown below:

The Board should approve the development of this strategy and receive assurance for its delivery.

The Executive Committee will monitor progress of the delivery of the strategy and the action plan and improvement metrics and benefits.

A Health Equalities Group should be formed to oversee the shaping of the strategy, engaging with staff and partners as part of its development including a delivery plan. Developing metrics, tracking progress, communicating progress across the organisation and producing an annual report will also be part of their duties.

It is also important to share our ambitions with Partners at the appropriate fora. The table below provides an outline of our approach.

Forum	Role
MWL Board	Approves and monitors delivery of health inequalities of this strategy Receive bi-annual report charting progress and delivering four objectives Reports will align to the requirements of NHS England Health Inequalities Statement
Executive Committee	Will monitor progress and delivery of the strategy including the benefits accruing from the activity
Health Equalities Group	Responsible for the development and co-ordinating the delivery of the strategy and its workplan
Place Partnership Boards/HWB Boards	Engagement with partners, sharing plans and co-ordinating local initiatives

9. Conclusions

It is deeply unjust that some groups of people have significantly worse health and worse experiences of the NHS than others – it is also preventable. The MWL footprint sees some of the country's highest levels of deprivation. The Trust cannot tackle this alone, and it needs to work with partners, particularly with the Local Authority's Directors of Public Health, the ICB and the Voluntary, Faith and Social Enterprise Sector.

Some of the barriers the Kings Fund cited the following barriers to accessing services:

- discrimination and racism

- not being treated with empathy or genuinely listened to
- lack of communication from services
- feeling of powerlessness
- practical barriers, eg, travel costs
- shame and stigma
- services not being flexible, holistic or inclusive enough.
- lack of trust and engagement due to negative experiences in the past.

The new 10 Year NHS Plan is likely to place a greater emphasis on radically transforming the way the NHS works with communities and staff, while reorientating services to focus on prevention.