

UNDERSTANDING AND REDUCING HEALTH INEQUALITIES

Author: Simon Pizzey Sponsor: Mark Wightman

Trust Board paper M

Purpose of report:

| This paper is for: | Description | Select (X) |
|--------------------|--|------------|
| Decision | To formally receive a report and approve its recommendations OR a particular course of action | |
| Discussion | To discuss, in depth, a report noting its implications without formally approving a recommendation or action | X |
| Assurance | To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan | |
| Noting | For noting without the need for discussion | |

Previous consideration:

| Meeting | Date | Please clarify the purpose of the paper to that meeting using the categories above |
|-------------------------------|------|--|
| CMG Board (specify which CMG) | | |
| Executive Board | X | ESB October 2021 |
| Trust Board Committee | | |
| Trust Board | X | |

Executive Summary

Context

The onset of COVID-19 has acted as an eclipse moment for the country and the NHS. Through the differential infection rate & disease outcome experienced by those from BAME and/or lower socio economic communities and/or those with underlying health conditions (such as diabetes) during the pandemic, Health Inequalities has now become a major focus for all providers of public services. This shift in importance is reflected in the central role that Health Inequalities now plays in the release of all national Planning Guidance.

It would be fair to suggest, that prior to the COVID-19 pandemic, focus for action in relation to Health Inequalities centred upon the local determinants of health (pre NHS contact) and primary care. The 2021/22 planning guidance was the first national requirement for acute & community providers of NHS care to take action in relation to understanding and addressing Health Inequalities.

This paper has been produced to provide an update to the Executive leads, on the Trust's approach to:

- Developing an understanding of differences in access, experience and outcomes,
- Developing positive interventions to reduce any differences in access, experience and outcomes,
- Providing structure around the process of understanding & addressing differences of access, experience & outcomes,
- Engaging with research & wider system partners,

Over the next six months, a UHL Health Inequalities Task force has been convened to:

- Launch and complete a full service review & development of positive intervention action plans across four major specialties,
- Provide regular (monthly) updates to the Executive Strategy Board on the progress across the Health Inequalities agenda,
- Continue to contribute to the LLR Health Inequalities Task Force,

It is proposed that a bi-annual progress update is provided to the Trust Board.

Questions

This paper requests the following from Trust Board members:

- To note and receive the paper's contents,
- To support the direction of travel and act as sponsor for the pilot work,
- To support the adoption of evidence based positive interventions to reduce the current differences in service access, experience & outcomes,

For reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

| | |
|------------------------------|--------------------------------------|
| Safe, surgery and procedures | [Yes /No /Not applicable] |
| Safely and timely discharge | [Yes /No /Not applicable] |
| Improved Cancer pathways | [Yes /No /Not applicable] |
| Streamlined emergency care | [Yes /No /Not applicable] |
| Better care pathways | [Yes /No /Not applicable] |
| Ward accreditation | [Yes /No /Not applicable] |

2. Supporting priorities:

| | |
|---------------------------------------|--------------------------------------|
| People strategy implementation | [Yes /No /Not applicable] |
| Estate investment and reconfiguration | [Yes /No /Not applicable] |
| e-Hospital | [Yes /No /Not applicable] |
| More embedded research | [Yes /No /Not applicable] |
| Better corporate services | [Yes /No /Not applicable] |

Quality strategy development

[Yes/~~No~~ /Not applicable]**3. Equality Impact Assessment and Patient and Public Involvement considerations:**

- What was the outcome of your Equality Impact Assessment (EIA)?
Not applicable
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
Not applicable
- How did the outcome of the EIA influence your Patient and Public Involvement?
Not applicable
- If an EIA was not carried out, what was the rationale for this decision?

4. Risk and Assurance**Risk Reference:**

| Does this paper reference a risk event? | Select (X) | Risk Description: |
|---|------------|-------------------|
| Strategic: Does this link to a <i>Principal Risk</i> on the BAF? | | |
| Organisational: Does this link to an <i>Operational/Corporate Risk</i> on Datix Register | | |
| New Risk identified in paper: What <i>type</i> and <i>description</i> ? | | |
| None | x | |

5. Scheduled date for the **next paper** on this topic: [TBC]6. Executive Summaries should not exceed **5 sides**

INTRODUCTION

In 2010, Sir Michael Marmot released a review into Health Inequalities. This review (for the first time), introduced an evidence base to the well-established anecdotal understanding of the impact social determinants have on health. Specifically, this review highlighted that the conditions people are born into and then subsequently live, work and die in, directly impact health outcomes. Key highlights from this review included:-

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods,
- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years,
- The Review highlights the social gradient of health inequalities - put simply, the lower one's social and economic status, the poorer one's health is likely to be,

This review suggested that Health inequalities were largely preventable. It highlighted both the strong social justice case for addressing health inequalities as well as the clear & pressing economic case. It was estimated that the annual cost of health inequalities to be between £36 to £40 billion through lost taxes, welfare payments and costs to the NHS.

Following the Marmot review in 2010, a wide range of public health & Primary Care Trust (PCT)/Clinical Commissioning Groups (CGG), interventions have taken place to attempt to reduce the impact of Health Inequalities. Despite the interventions the 2020 refresh of the Marmot review demonstrated that inequalities had in fact worsened. There are a number of hypotheses regarding the reason for the worsening of the position (including the impact of the 2008 global recession & subsequent fiscal recovery programme). The release of the NHS Long Term Plan (2019) outlined an ambitious 5 year strategy for identifying the root causes of the widening health inequalities and attempted to identify solutions to address these systemic challenges.

The onset of COVID-19 has acted as an eclipse moment for the country and NHS. Through the differential infection rate & disease outcome experienced by those from BAME and/or lower socio economic communities and/or those with underlying health conditions (such as diabetes) during the pandemic, Health Inequalities has now become a major focus for all providers of public services. This shift in importance is reflected in the central role that Health Inequalities now plays in the release of all national Planning Guidance.

It would be fair to suggest, that prior to the COVID-19 pandemic, focus for action in relation to Health Inequalities centred upon the local determinants of health (pre NHS contact) and primary care. The 2021/22 planning guidance was the first national requirement for acute & community providers of NHS care to take action in relation to understanding and addressing Health Inequalities.

In response to this planning guidance, University Hospitals Of Leicester identified Mark Wightman as the executive lead for Health Inequalities. This paper has been produced to:

- Share the work to date that the organisation has undertaken to meet the planning guidance,

- Key lessons to date,
- Programme Governance,
- Next Steps,

BACKGROUND AND CONTEXT (THE STATS)

Towards the end of the first COVID-19 pandemic wave, UHL undertook a data exploration exercise. The objective for this data exploration exercise was to build an understanding as to whether there were any differences in relation to access, experience and/or outcomes for different ethnic, socio-demographic populations served by the Trust. This exercise is building on the established data set concerning Health Inequalities for the Leicester, Leicestershire & Rutland health economy.

In relation to the Leicester, Leicestershire & Rutland population, key statistics include:

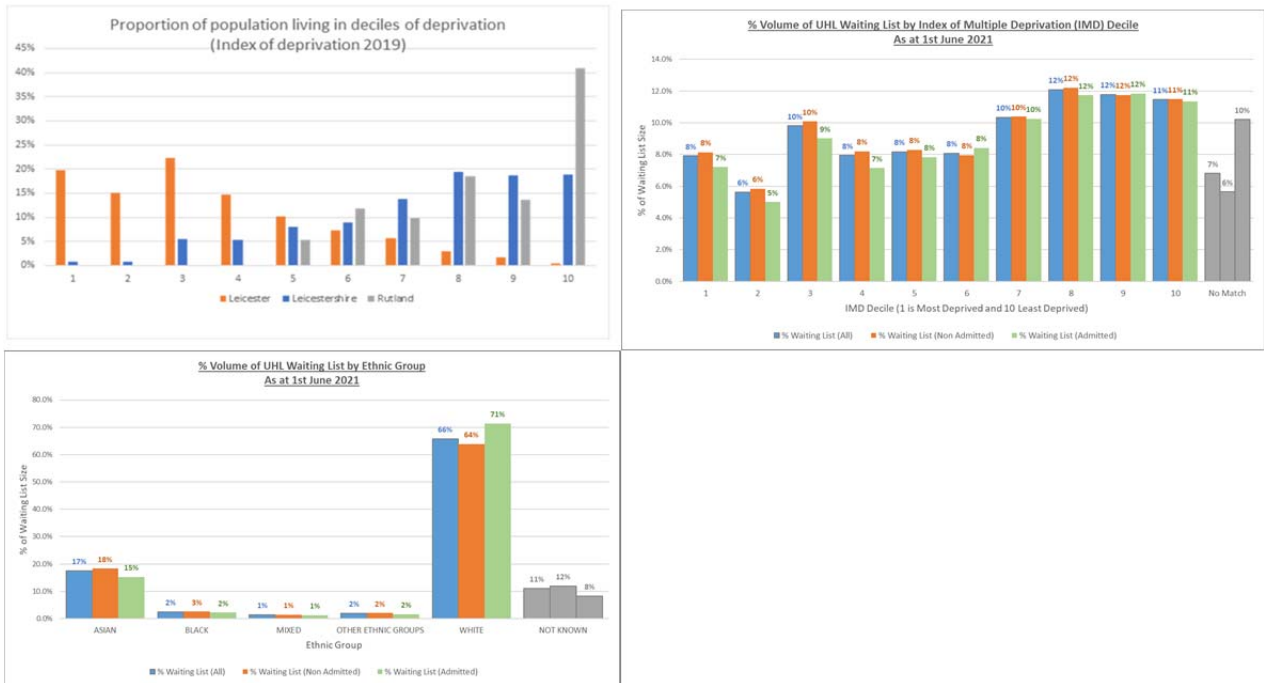
- At present there is a growing life expectancy gap between Leicester and the rest of England. On average a man in Leicester will live 2.4 years less and a woman 2.1 years less than the average for England.
- Life expectancy itself differs across the Leicestershire & Leicester City. The difference between wards in Leicester City with the highest and lowest life expectancy is 7.4 years for men and 7.6 years for women. There is a difference of around 10 years between the ward with the highest life expectancy (Evington, 80.5 years) and the lowest life expectancy for males (Castle, 70.5 years). For females there is a difference of around 5.2 years between the ward with the highest life expectancy (Latimer, 82.6 years) and the lowest life expectancy (Westcotes, 77.4 years).
- Within Leicester City, 24% of adults smoke, with 15% of women smoking throughout pregnancy.
- Around 25% of Leicester adults are obese and a further 36% overweight. Levels of physical activity are low, with only 18% of adults doing 30 minutes of moderate activity on 3 days a week.
- Estimates suggest that around 17% of Leicester's population abuse alcohol, with around 33,000 hazardous drinkers, 11,000 harmful drinkers, and 3,500 dependent on alcohol.
- According to JSNA figures, the health economy of Leicester, Leicestershire and Rutland has significant internal variation with the counties of Leicestershire & Rutland being in the top five counties in relation to general health & wealth. However, Leicester sits within the bottom quartile in relation to general wealth and health.

The above statistics regarding the LLR health economy have been available and well known for many years. However, the findings that have emerged from our exploratory analysis has enabled the development of knowledge previously unknown. Key highlights included:-

- As of June 2021, the elective UHL waiting (admitted & non-admitted) list (from an ethnicity perspective) mirrors the demographic make-up of the total LLR population (as shown by chart 1). This demonstrates (which is representative of the general population) the majority of the current waiting list is from the White British population. However although this is representative of the general population, this does not reflect the known disease burden of the population, or the make-up of the Leicester City population. The Kings Fund released a report in 2021 (The health of people from ethnic minority groups in England) concerning the relationship between ethnicity and disease burdens. This report hypothesis that many of the well-known causes of morbidity & mortality are experienced in greater proportions by those from ethnic minority groups. It would

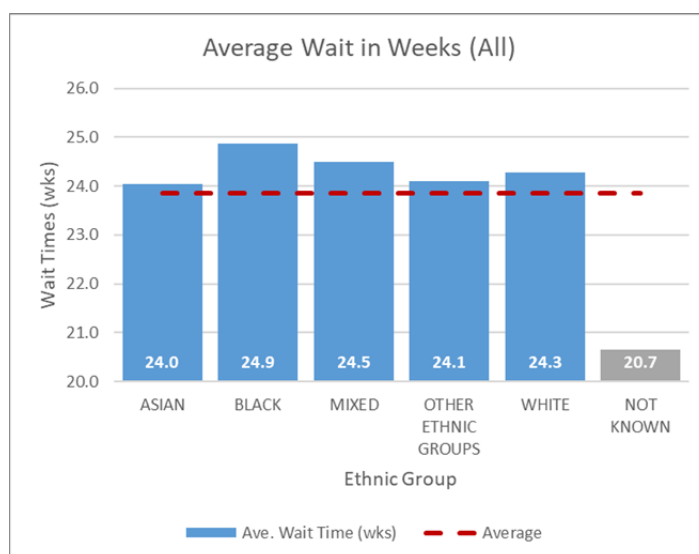
therefore not be unreasonable to expect that if the waiting list were reflective of disease burden/ need, there would be a higher number of BAME patients on the list than simple population numbers would suggest'. For example if the Asian population is 17% of the total but evidence suggests that there is more morbidity in that population, would it be reasonable to expect that the % of the waiting list would be higher than 17%?

Charts 1



- White British patients (as of June 1st 2021) have a shorter average wait on both admitted & non-admitted pathways (as seen in Chart 2).
- There is a difference between longest and shortest waiters of; 0.9 weeks overall, 1.9 weeks Non Admitted and 4.5 weeks Admitted.

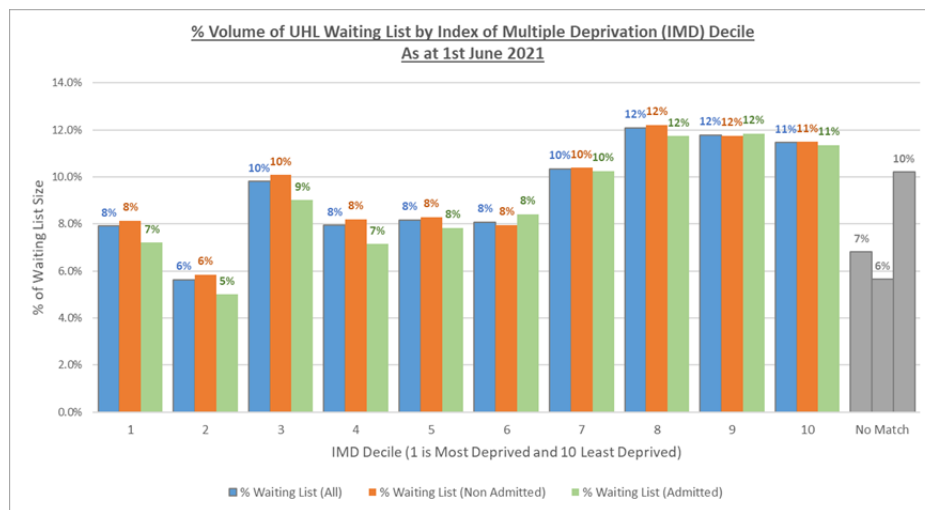
Chart 2



- At the 1st Of June 2021, the wealthiest citizens as measured by the Indices Of Multiple Deprivation (IMD) cohorts, account for 23% of the UHL Admitted & Non-Admitted waiting list,

with the most deprived making up just 13%. This appears counter to what would be expected given the known disease burden associated with the IMD levels and mirrors the Inverse Care Law (that healthcare access is not in-line with need). This is true across admitted & non-admitted pathways. Evidence for this sits within the Joint Strategic Needs assessment which shows that the population of Leicestershire & Rutland, are equal to or better than the national average 88% & 96% out of the 445 national health measures respectively. As a consequence of this, funding to the health economy is reduced as it is anticipated the population would access less healthcare (as it is wealthier & healthier than the general population). However, reality does not reflect this with UHL experiencing (in totality) higher than expected episodes of care and a lower than (as per the Kings Fund research) anticipated rate of demand from those in the most deprived indices.

Chart 3



• Analysis demonstrates the importance of the dynamic between deprivation & ethnicity when understanding and acting on Health Inequalities. Chart 4 & 5 demonstrate that there is limited to no difference in waiting times across all ethnic groups when reviewing the wealthiest deciles of the Indices of Multiple Deprivation. However, differences begin to emerge when reviewing levels 1 & 2 (the poorest levels) of the IMD. This is however, not the case with those from the Black African community on elective Admitted & Non-Admitted waiting lists. 40% of the wealthiest White British population are waiting longer than 52 weeks for a surgical procedure, whilst this is 60% for the Black African population. Within Outpatient waiting lists, 3.8% of the wealthiest White British population are waiting longer than 52 weeks, whilst this rises to 6.4% for the Black population.

Chart 4&5

| Non Admitted Pathway | | | | | | | | No Waiting 52+ weeks |
|----------------------|-------|-------|-------|---------------------|-------|-----------|------------|----------------------|
| IMD Decile | ASIAN | BLACK | MIXED | OTHER ETHNIC GROUPS | WHITE | NOT KNOWN | All Groups | |
| 1 | 4.2% | 4.6% | 6.6% | 4.7% | 5.2% | 2.5% | 4.8% | 275 |
| 2 | 4.8% | 6.3% | 2.1% | 0.7% | 5.1% | 3.8% | 4.7% | 194 |
| 3 | 4.9% | 6.6% | 5.0% | 5.0% | 4.3% | 4.3% | 4.6% | 324 |
| 4 | 4.7% | 4.0% | 7.1% | 8.0% | 4.6% | 4.3% | 4.7% | 272 |
| 5 | 4.6% | 5.2% | 3.6% | 4.8% | 4.1% | 2.0% | 4.0% | 233 |
| 6 | 4.3% | 8.2% | 1.6% | 3.0% | 4.3% | 4.4% | 4.3% | 238 |
| 7 | 4.0% | 4.6% | 2.6% | 5.6% | 3.6% | 4.1% | 3.7% | 272 |
| 8 | 3.9% | 9.3% | 6.4% | 2.9% | 4.1% | 3.2% | 4.0% | 345 |
| 9 | 5.7% | 5.7% | 5.6% | 5.5% | 3.8% | 2.9% | 4.0% | 325 |
| 10 | 3.7% | 6.4% | 1.1% | 5.4% | 3.8% | 3.3% | 3.7% | 300 |
| No Match | 3.9% | 3.6% | 6.5% | 8.2% | 4.8% | 4.9% | 4.8% | 191 |
| All Deciles | 4.6% | 5.5% | 4.5% | 4.8% | 4.2% | 3.8% | 4.2% | |
| No. Waiting 52+ wks | 582 | 98 | 45 | 68 | 1,857 | 319 | 2,969 | |

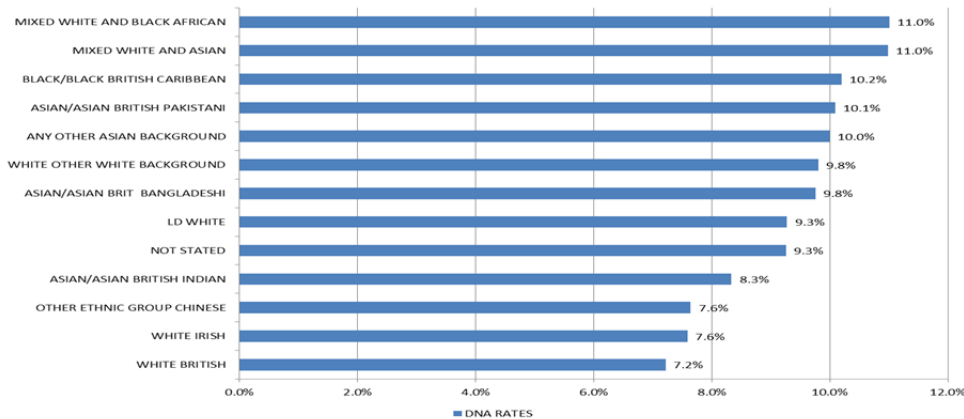
Admitted Pathway

| IMD Decile | ASIAN | BLACK | MIXED | OTHER ETHNIC GROUPS | WHITE | NOT KNOWN | All Groups | No Waiting 52+ weeks |
|---------------------|-------|-------|-------|---------------------|-------|-----------|------------|----------------------|
| 1 | 41.4% | 38.5% | 37.5% | 40.0% | 42.4% | 46.8% | 41.8% | 726 |
| 2 | 42.9% | 39.0% | 50.0% | 43.6% | 39.9% | 24.5% | 40.5% | 488 |
| 3 | 44.8% | 37.1% | 21.1% | 49.1% | 36.3% | 46.0% | 39.3% | 853 |
| 4 | 41.2% | 42.9% | 37.0% | 49.0% | 39.9% | 44.7% | 40.9% | 703 |
| 5 | 43.7% | 60.0% | 57.7% | 50.0% | 36.2% | 33.8% | 38.5% | 727 |
| 6 | 42.5% | 31.4% | 57.1% | 43.2% | 37.6% | 39.4% | 38.7% | 786 |
| 7 | 35.8% | 32.0% | 48.3% | 55.6% | 37.2% | 38.4% | 37.3% | 922 |
| 8 | 38.7% | 47.8% | 37.1% | 39.3% | 37.0% | 33.8% | 37.1% | 1,048 |
| 9 | 40.5% | 37.5% | 48.0% | 26.1% | 37.3% | 29.8% | 37.1% | 1,060 |
| 10 | 35.3% | 62.5% | 40.0% | 41.7% | 35.4% | 35.9% | 35.6% | 975 |
| No Match | 39.1% | 42.5% | 50.0% | 45.7% | 33.9% | 26.6% | 31.7% | 778 |
| All Deciles | 41.3% | 40.9% | 41.9% | 44.6% | 37.2% | 32.0% | 37.6% | |
| No. Waiting 52+ wks | 1,513 | 219 | 129 | 175 | 6,390 | 640 | 9,066 | |

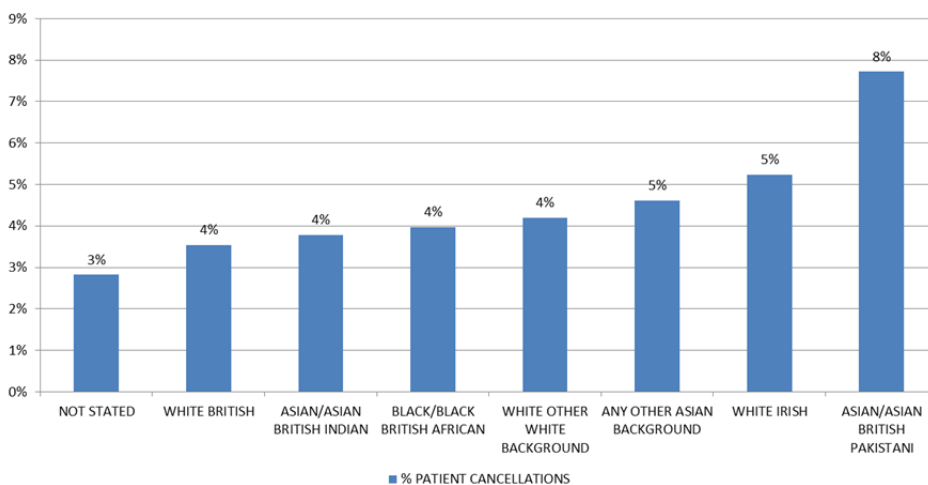
● Throughout 2020/21, the proportion of the White British population that did not attend (DNA) their Outpatient appointment was 7%, this increased to 10% for those from the Asian & Black British population & 11% from those within the dual Black African & British population (as shown by Chart 6). This variation is also identified within those patients who cancelled their operation on the day. The proportion of the Asian/British Asian population that cancelled on the day was double (at 8%) that of those from the White British population (4%).

Chart 6 & 7

2020/2021 OUTPATIENT DNA RATES & ETHNICITY



2020/2021 THEATRES ON THE DAY PATIENT CANCELLATIONS ETHNICITY



PROPOSED APPROACH, SOLUTIONS & RESEARCH

With the data structures developed and with the addition of specialty level reports now produced for CMGs, our focus has shifted to what actions should be taken to address the new understanding that the information reporting has enabled. Across the NHS and similar health systems in Europe, actions are being taken to reduce the differences of access, experience and outcomes for populations. Given the relatively new nature of this work actions/interventions, the majority of interventions are yet to be backed by empirical data (in terms of the success). However, it is clear that other economies/systems/Trusts are broadly working on interventions that can be grouped into three distinct themes, 1) process changes, 2) education & 3) training and research.

In general processes that govern access & experience of those utilising NHS services are designed to apply to the population universally. However, this fails to acknowledge that characteristics such as ethnicity, gender and socio economic status have a direct bearing on an individual ability/sense of entitlement to access health care services. It is apparent therefore that the application of policies universally, may inadvertently reduce the ability of the entire population to access services, for example:-

- *DNA (Did Not Attend) Policy*-Rather than a one size fit all policy for instances of Outpatient non-attendances (1 DNA resulting in a discharge back to GP unless clinically vulnerable), NHS organisations (such as Manchester Health & Care Commissioning Group) are now altering the national policy. This change in approach is taking place in recognition of the differences amongst ethnic & socio-economic groups on rates of attendance. This change whilst providing a short term benefit needs to be supported by service structure change to solve the root causes of this difference. Across 2020/21 those from a Black/Black British African, mixed White & Black Caribbean and any other mixed background communities have DNA rates between 11-15% whilst the white British community were at 7%.
- *Listing For Surgery Policy*-Currently listing for surgical procedures is undertaken on a time basis and in date order. This however, does not accommodate for the known differences in experience and impact of waiting on elective surgical lists. For example a patient waiting for 12 months for hip surgery whilst retired, will not be experiencing the same challenges of an individual unable to work & not receiving pay whilst waiting for their surgery. To address this, Hospitals Trusts (such as Nottingham University Hospitals) have piloted reserving one or two slots on surgical lists for the selection of patients on the basis of socio-economic position. This process is based upon information gathered from the patient during the Outpatient & Preoperative assessment process & could be replicated within UHL. Implementing this approach is not without challenge and the engagement of Medical Ethics departments is essential to understand the positive and negatives of such an approach. To support this, UHL (via Andrew Packham) has produced a pre-habitation business case (for the system), which will shape the level of interaction and support provided to patients during surgical risk factors based on the identified or potential health inequality risk factors.
- *Discharge Policy*-Nationally, the process of identification of suitability for discharge after an inpatient emergency or planned stay within acute hospitals is consistently applied to all individuals and based upon an individual's medical fitness. However, evidence is now emerging of the differential readmission rates (with an NHSE/I 2020 board report highlighting socio-economic & ethnicity being a factor in differential rates of re-admissions) and as a consequence NHS

organisations across the North West of England, are reviewing current discharge policies & processes to implement additional steps in the discharge process to ensure community support for those post discharge are built around the individuals need.

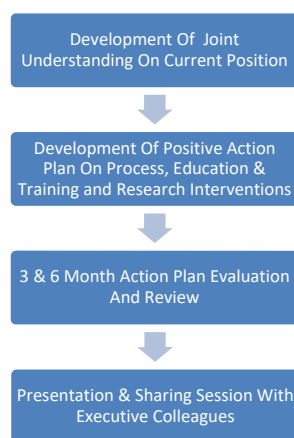
Analysis across NHS England is emerging that highlights the role that organisational culture plays in sustaining differences in terms of access, experience and outcomes of healthcare services. This cultural practice can be both conscious & unconscious. Kent Community Health Foundation Trust implemented unconscious bias training after BME staff reported that they felt 'white' colleagues did not value their skills and this could potentially negatively impact the rate of inequalities within the organisation. Training programmes/forums have been established and Artificial Intelligence technology deployed to identify and reverse these issues. Examples include:-

- *Unconscious bias training*-Examples of decisions to list for surgery, that are based on self-fulfilling stereotypes concerning the risks posed by operating for individuals within certain ethnic groups are emerging across the NHS (The Strategy Unit 2021). UHL is no different to this and anecdotal evidence suggests individuals from certain ethnic groups on occasion have not been listed for surgery due to a perceived risk of negative outcomes. Inevitably, this risk adverse approach to listing has resulted in outcomes that whilst appearing 'better' than other surgeons who do not follow this approach (thus perpetuating this approach). As a direct consequence of this phenomenon, a cohort of patients from an ethnic group may not access the health service necessary to improve their outcomes. A national programme has been developed to work with groups of clinicians to explore their individual decision making processes and acknowledge/address any unconscious bias's that lead to a furthering of Health Inequalities.
- *Active Bystander programme*-In any large complex organisation such as the NHS, there are instances of practices not in-line with the values of healthcare organisations. National research is identifying that due to the complex hierarchical relationship of the NHS, instances of bad practice are not challenged. Examples of these instances include not universally following standard referral pathways for those for whom English is not a first language (Public Health England report in 2010, 2015 & 2021 have highlighted the NHS 'fails' those who do not speak English as a first language). A training support programme has been launched to empower those who witness the behaviour to confront and then escalate if it persists.
- *Artificial Intelligence*-Evidence from across all NHS acute providers (including University Hospitals of Leicester) demonstrates that there is a marked difference between the rate at which White British individuals and those from BAME communities are progressed to further treatment (including surgery, drug therapies & physiotherapy etc). Work by Pierson et al (2021, <https://www.nature.com/articles/s41591-020-01192-7.pdf>) proposed the hypothesis that the structures & practice within health care providers is largely built around the understanding of the social norms of the white majority. As a consequence if a segment of the population does not communicate for example, their symptoms or their relative degree of comfort/pain in the 'received way', the likelihood of progression to further treatment pathways is reduced. Artificial intelligence has been introduced to flag to clinicians that are recommending no further treatment from individuals within BAME communities, to review that decision prior to finalising (NHS digital have released funding to trial a range of solutions of this nature in October 2021). This is a nudge theory approach to change & research which has proved successful in those organisations that have trialled the methodology.

There is now a dynamic and ever growing research field focussed on understanding & reviewing the actions taken to reduce Health Inequalities. This work is currently focussed on reviewing quantitative data to enhance the knowledge on the level of Health Inequalities and qualitative data to explore with focus groups what interventions could be made to addresses the causes of any differences. Leicester University (Through the Centre For Ethnic Health) & University Hospitals of Leicester (through Professor Nigel Brunskill) are working collaboratively to engage with patients who have been discharged at first Outpatients with no ongoing care, in order to understand their experiences and the impact of this outcome. This collaboration between the University and the Trust has also resulted in the submission of bids to undertake research locally on the use of Artificial Intelligence in reducing variation within clinical decision making.

Reflecting on the wide range of interventions and research opportunities, three specialties (Rheumatology, Neonatology/Paediatrics and Respiratory) have been volunteered to undertake full service reviews and the development of action plans focussed on implementing rapid cycle testing of process changes, education & training and research interventions. These specialties have been identified due to the clinical desire & management support to undertake this work. These specialties will use the approach described below across the second half of 2021/22 & into 2022/23. This process will be monitored by the newly developed Health Inequalities Task and Finish Group.

Image 1



GOVERNANCE

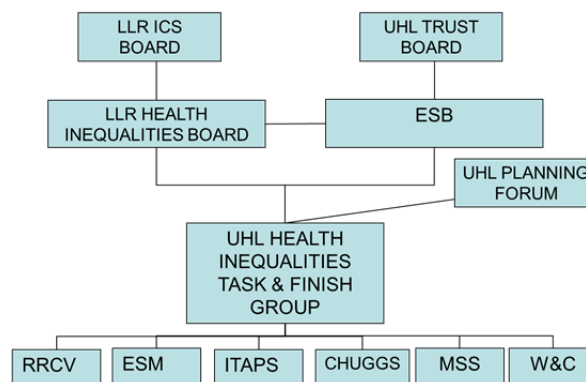
The rapidly increasing importance of the Health Inequalities agenda has led to a number of NHS England & Improvement (NHSE/I) or Clinical Management Group (CMG) initiatives/action plans being initiated locally by individuals within teams.

This in combination with the need to develop a Trust/Specialty understanding of the differences in access, experience & outcomes as well as deliver, at pace positive actions, has highlighted the need for a formal UHL Inequalities governance structure. To respond to this need, the UHL Health Inequalities Taskforce was established. This taskforce will look to achieve a number of key outcomes:-

- To enable a joint understanding of the differential experience of the UHL population.
- To ensure best practice across the organisation is shared.
- To ensure UHL feeds into the wider LLR approach to Health Inequalities and meets the planning guidance.

The image below highlights the new structure and how this new forum will coexist with existing structures. A Terms Of Reference has been produced and each CMG has been asked to identify a managerial/clinical lead to attend the forum (and also take back key actions/messages). This forum will also have a dedicated action plan & project timeline (which will be reviewed by the Trust Executive Strategy Board).

Image 2



This forum includes representation from key internal & system leads for the delivery of elective & non-elective care. This includes:

- A clinical and managerial lead from each CMG,
- A clinical and managerial lead from public health,
- CCG transformation & strategy/planning clinical and managerial leads,
- Public Health & local authority leads,
- Academic partners,
- Business Intelligence,

NEXT STEPS/SUPPORT FROM THE TRUST BOARD

This paper has been produced to provide an update to the Executive leads, on the Trusts approach to:

- Developing an understanding of differences in access, experience and outcomes,
- Developing positive interventions to reduce any differences in access, experience and outcomes,
- Providing structure around the process of understanding & addressing differences of access, experience & outcomes.
- Engaging with research & wider system partners.

Over the next six months, the Health Inequalities task force will:

- Launch and complete a full service review & development of positive intervention action plans across four major specialties,
- Provide regular (monthly) updates to the Executive Strategy Board on the progress across the Health Inequalities agenda,
- Continue to contribute to the LLR Health Inequalities Task Force,

It is proposed that twice yearly progress updates are provided to the Trust Board. This paper requests the following from Trust Board members:

- To note and receive the paper's contents,
- To support the direction of travel,
- To support the adoption of evidence based positive interventions to reduce the current differences in service access, experience & outcomes.