NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside ICB

Annual Report 2024/25 Appendix

Health Inequalities Report

1. Health Inequalities Report

1.1. It is a core purpose of the ICB to tackle inequalities in outcomes, experience and access. ICB's are required to "have regard to the need to – a) reduce inequalities between persons with respect to their ability to access health services, and b) to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

1.2. Information should be used to develop an understanding of general healthcare needs, understand healthcare access; experience and outcomes; be published within or alongside annual reports; and inform service improvements and reductions in healthcare inequalities.

1.3. At a minimum, ICBs should publish information at ICB level but may also wish to publish at Trust level subject to discussion with Trusts[1].

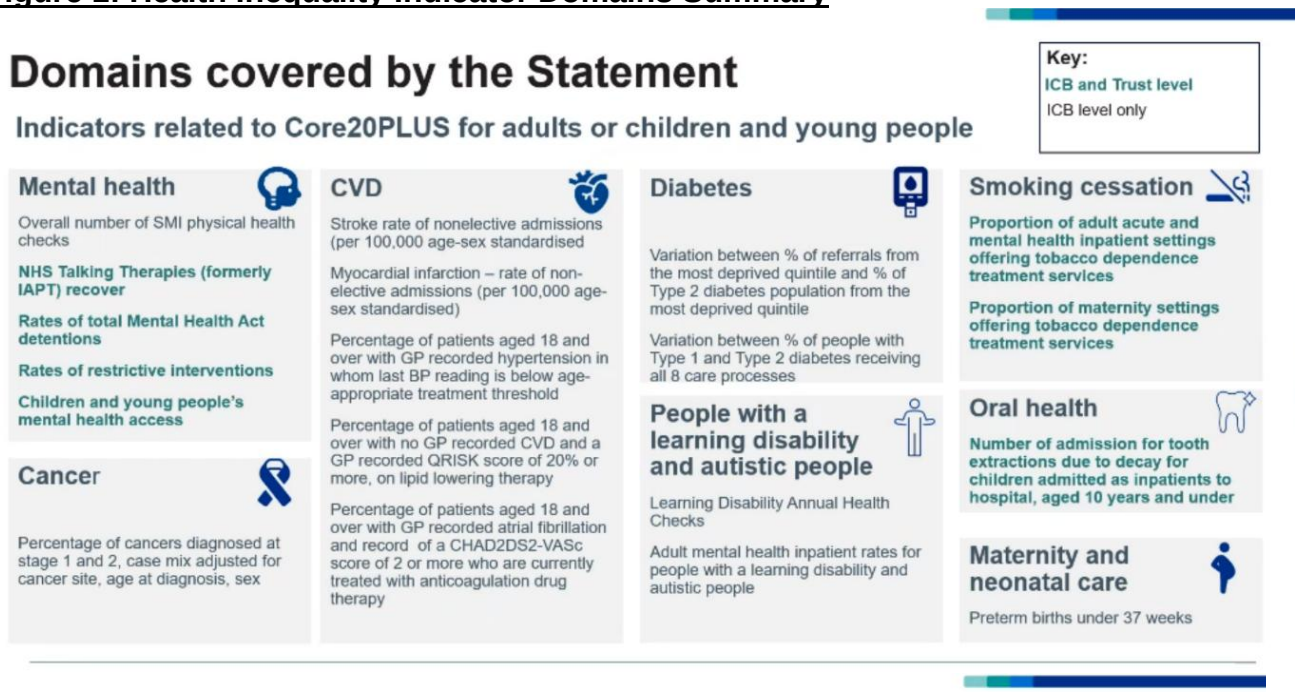
1.4. Our main ICB Annual Report for 2024/25 provides the narrative detail around the work undertaken across the ICB during 2024/25 and provides an overview of our system led approach to tackling inequalities with our Health and Care Partnership and groundbreaking All Together Fairer Strategy.

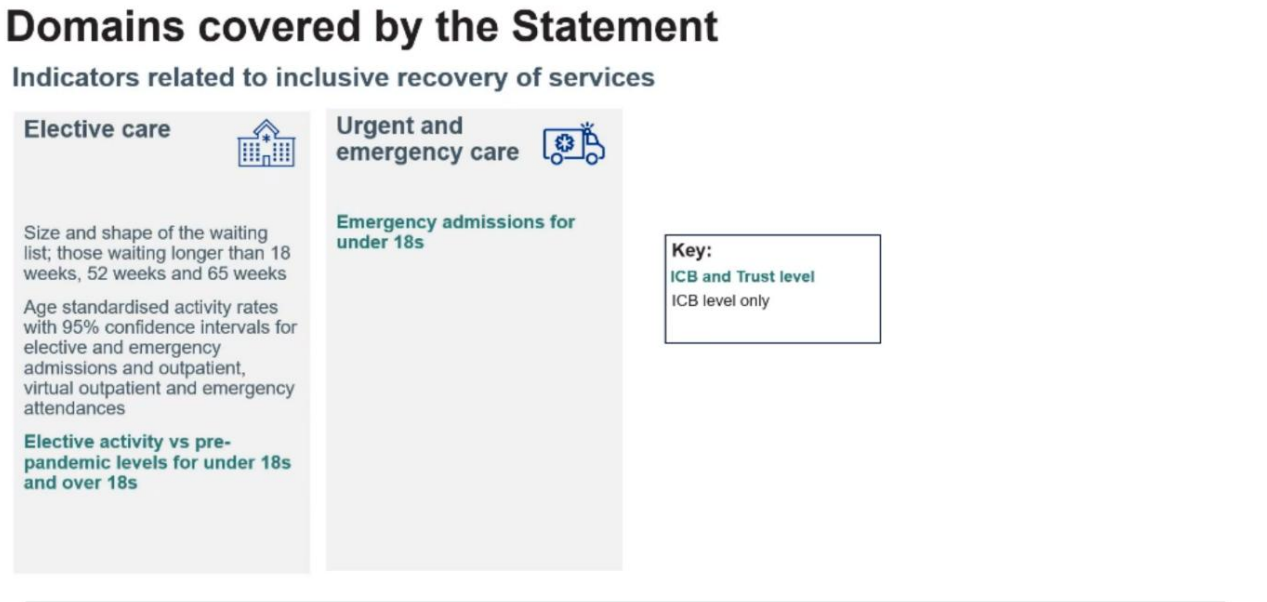
1.5. This document provides an overview summary of the published data and metrics that are used to monitor and inform action on health inequalities across our Cheshire and Merseyside population as well as providing a summary of the actions undertaken as a consequence of this.

1.6. This appended report provides an overview of the key domains related to inequalities and published data we use against those domains and health care inequalities. The domains that are required to be published in line with the Health Inequalities Statement are described in Figure 1.

[1] NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

Figure 1: Health Inequality Indicator Domains Summary





2. Tackling Inequalities in Cheshire and Merseyside

2.1. In Cheshire and Merseyside, there are 2.7 million people living across areas of both significant wealth and substantial deprivation. The mental and physical health and care challenges are faced by some of the most deprived neighbourhoods with the greatest health inequalities in England. We know that 33% of our population live in the most deprived neighbourhoods in the country and 26% of our children (0-15 years) live in poverty. We also know that those in more deprived areas suffer reduced quality of life, increased mental health problems, and die earlier than those from more affluent backgrounds.

2.2. Through our Joint Forward Plan (JFP) we aim to prevent ill health and tackle inequalities and improve the lives of the poorest fastest and believe we can do this best by working in partnership across our system. This will allow everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

2.3. In 2022, the ICB commissioned Sir Michael Marmot and the Institute of Health Equity to publish the All Together Fairer report[2]. All Together Fairer is Cheshire and Merseyside's collaborative approach to reducing health inequalities in the subregion, it brings together public, private and third sector organisations with one shared aim: build a fairer, healthier Cheshire and Merseyside.

2.4. The report was built upon local health inequalities data packs across all nine of our local authority places, and also led to the development of a number of Beacon Indicators to help baseline and monitor the complex inequalities that exists in an ICB of our geographical size, detailed analysis of the indicators can be viewed in Section 12 of this report.

2.5. The Health and Care Partnership receive an annual stocktake of progress against these Beacon indicators, with detailed interventions and levels of progress across our nine places and against the eight key All Together Themes for Action.

2.6. Our Data into Action programme also supports action on Health Inequalities, it uses evidence to understand our expenditure and activity across different settings to determine where we optimally invest/disinvest our existing resources for improved outcomes and efficiency. Where we have developed increasingly sophisticated ways of understanding the health and care needs of our population, we are committed to turning 'intelligence into action'. This is our ability to bring focussed, and therefore meaningful, interventions to those who most need it. Finding and intervening for those in greatest need 'turns the dials' on improvement in the health and care outcomes of our population in an equitable way. This is underpinned by our Digital and Data Strategy which describes some of the key challenges to our population, and our plans to use data and digital tools to help address these challenges.

2.7. Information is used to inform service improvement and reductions in healthcare inequalities. This includes using the information to inform:

- strategy development
- policy options review
- resource allocation
- service design
- commissioning and delivery decisions
- service evaluations.

2.8. Our clinical priorities are clearly documented in the JFP. They are evidenced based to not only improve health outcomes of our population, but also to make best use of resources to avoid ill health. These cover the following disease groups, cancer, cardiovascular disease, respiratory disease and mental health. We also recognise

[2] Cheshire-and-Merseyside-report_interactive-v6.pdf (champspublichealth.com)

segments – complex lives (physical health, mental health, drug/alcohol misuse and children in the care system) and frailty and dementia. These areas are known to have differential outcomes for different groups within our population, so it is vital that we can view the data about these patients and conditions through a lens of inequality in order to target improvement activities.

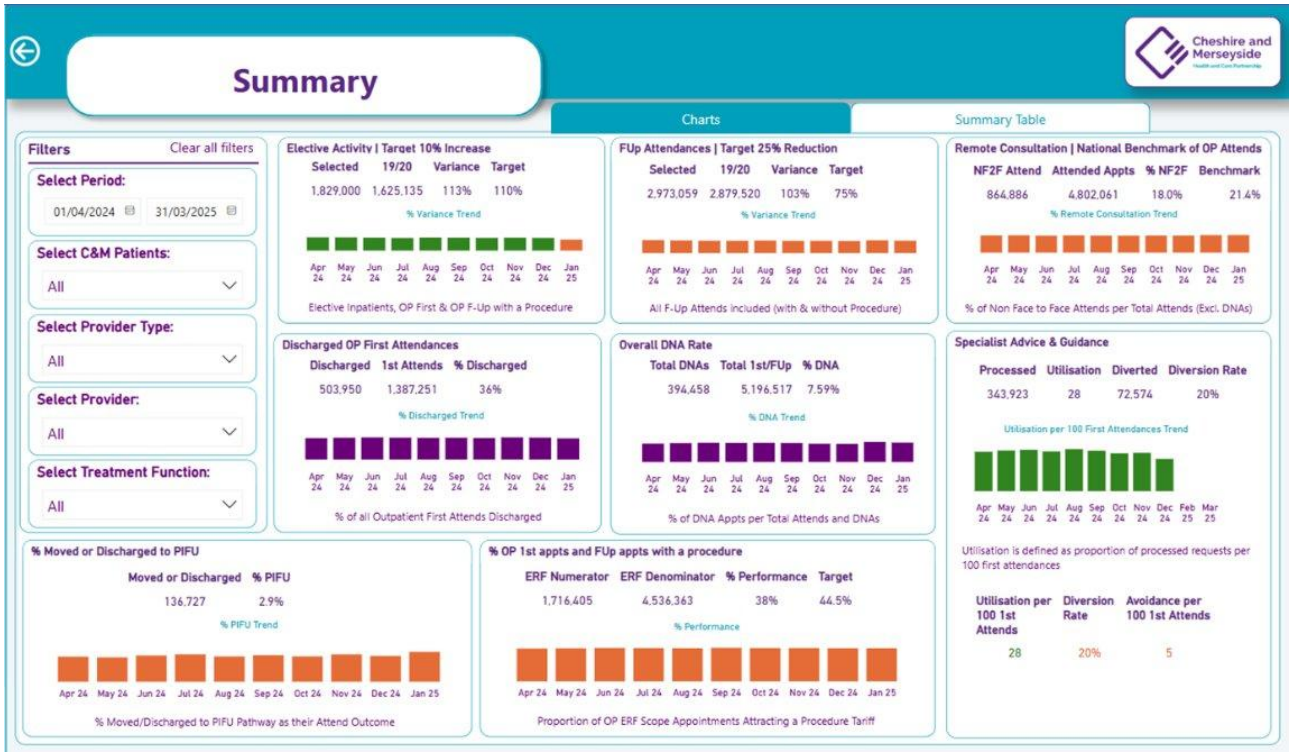
2.9. The following sections provide a summary of the types of information and reports used in Cheshire and Merseyside to guide improvement actions, with examples of the actions completed for each area during 2024/25.

3. Elective and Urgent Care

3.1. Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances:

Source: Secondary Uses Service (SUS)

3.2. Elective activity vs pre-pandemic levels for under 18s and over 18s:

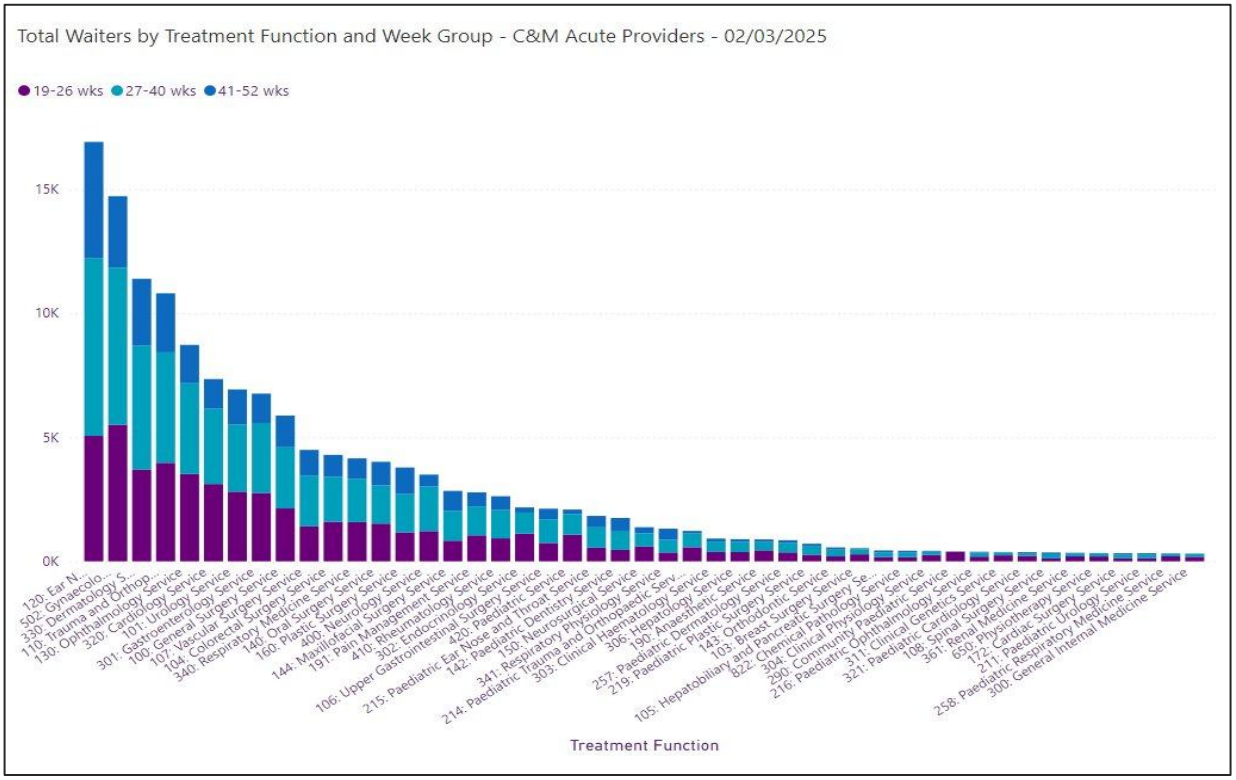


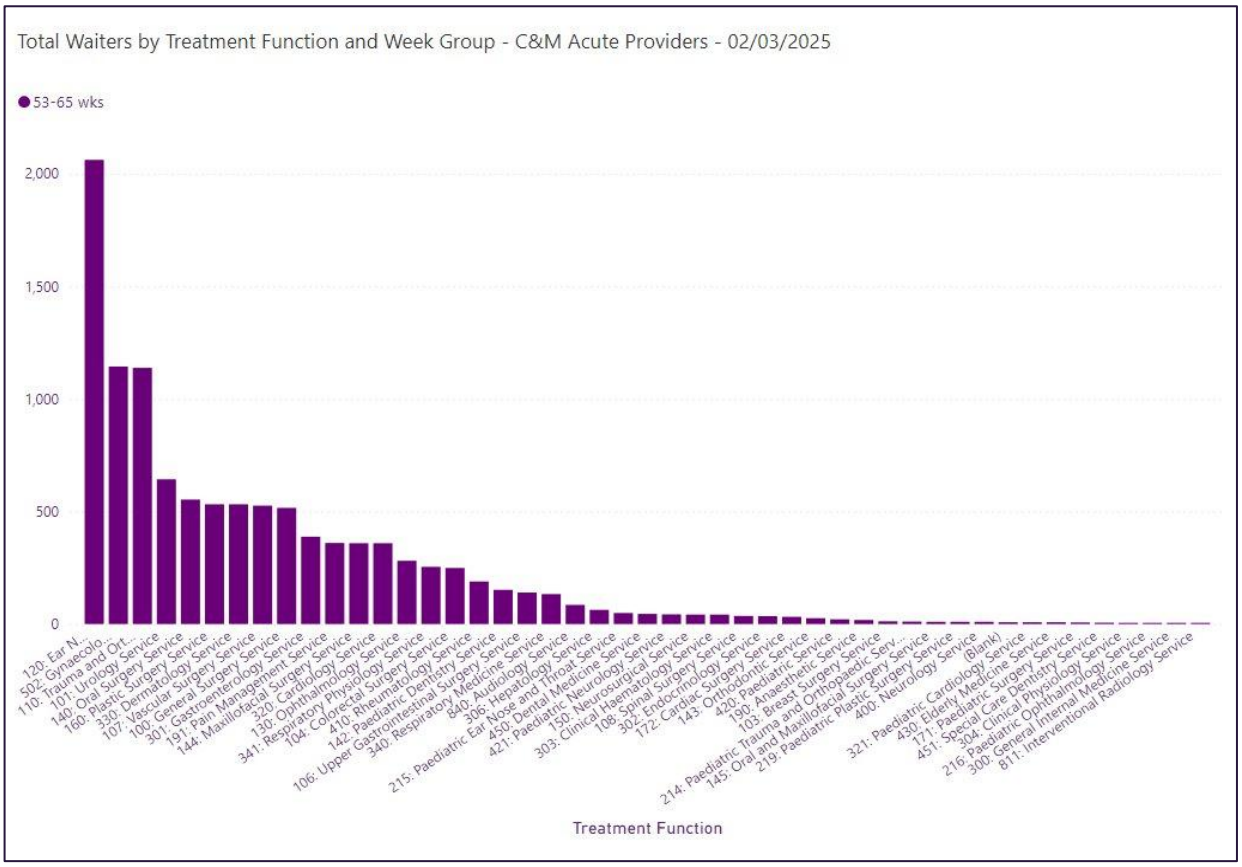
Source: Secondary Uses Service (SUS), Elective Recovery Outpatient Collection (EROC)

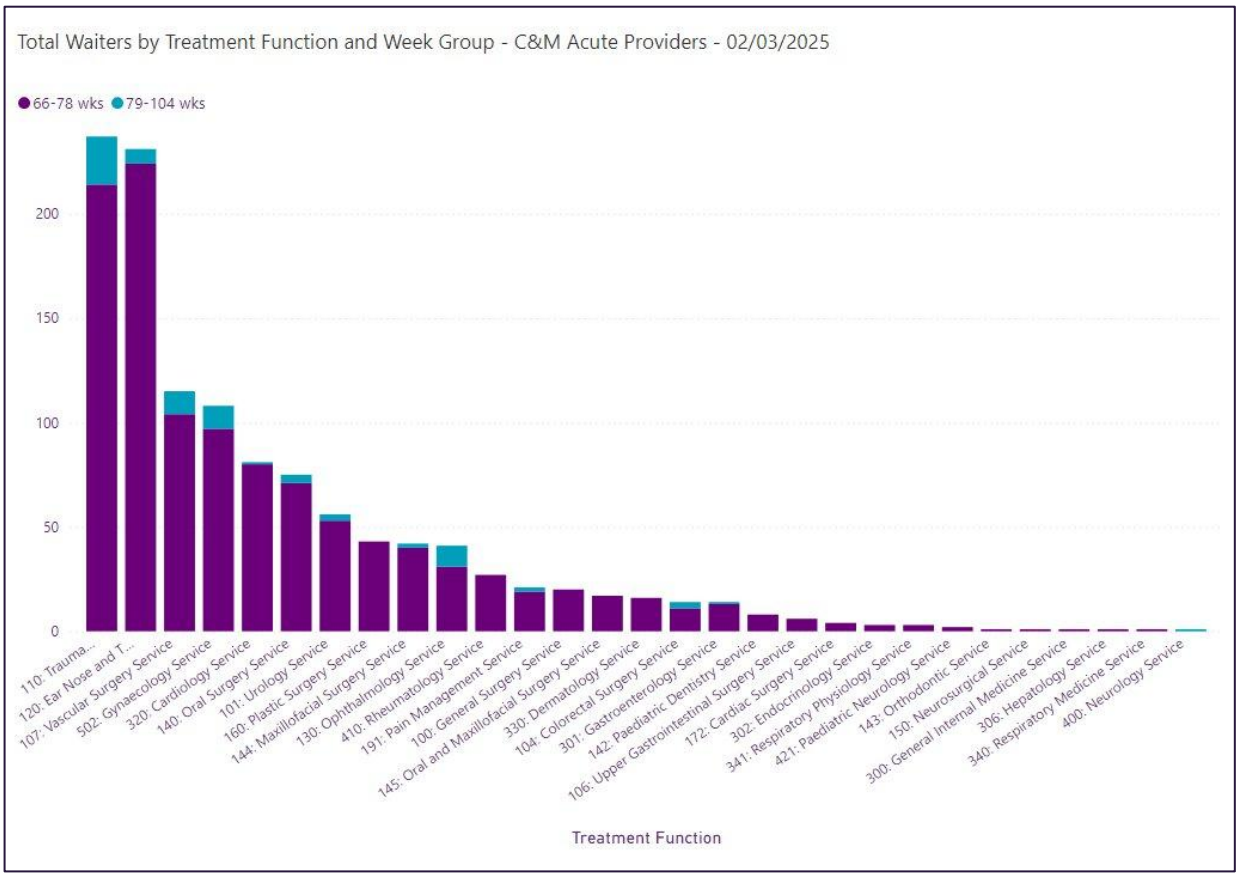
3.3. Community Services waiting times for children and young people:

Source: Community Services Data Set (CSDS)

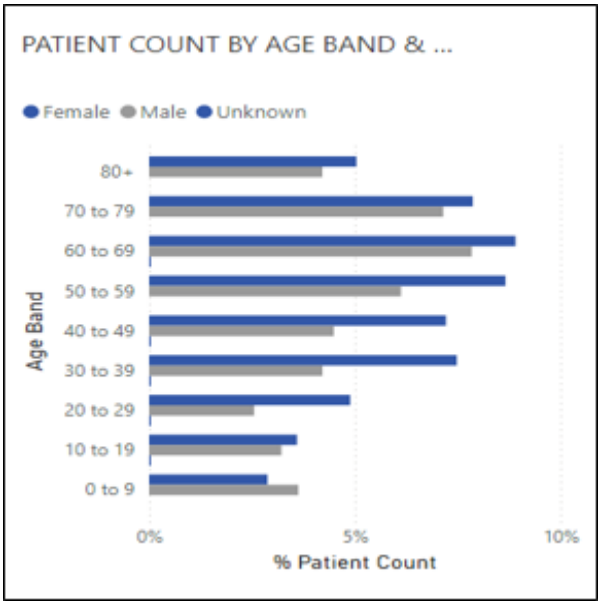
3.4. Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks:

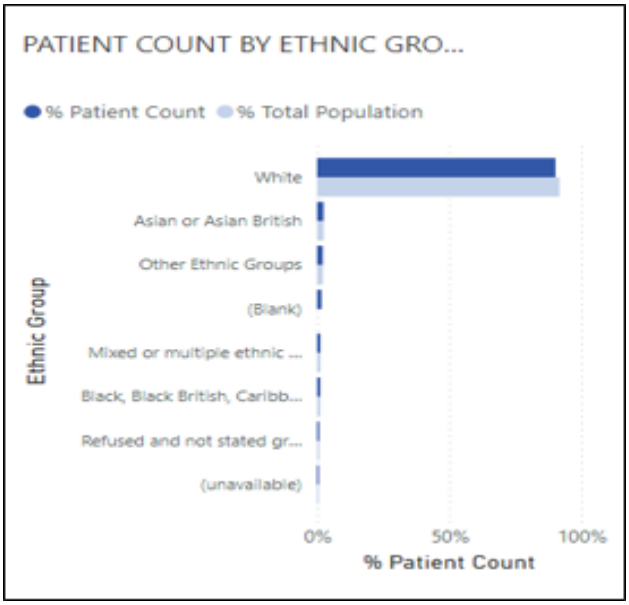


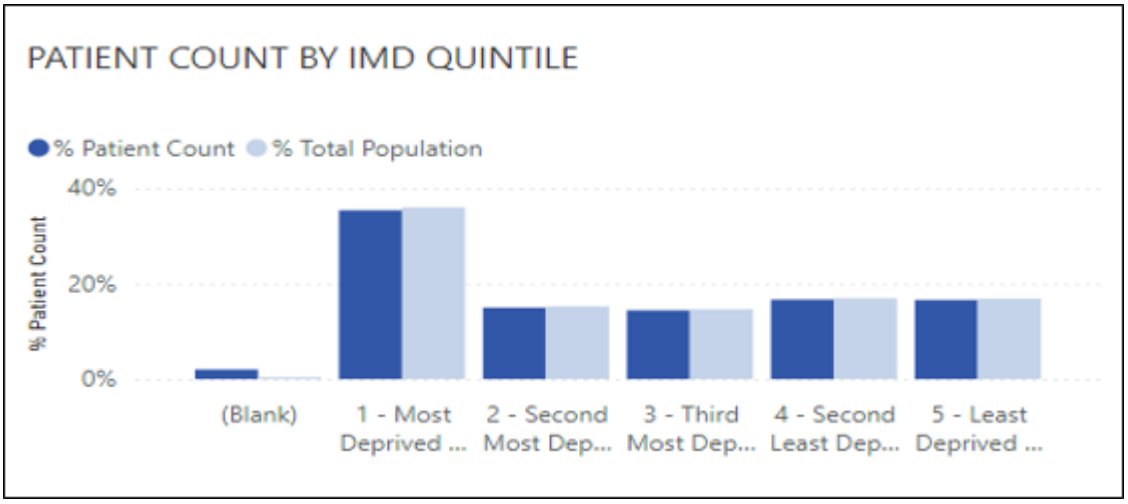




Source: NHS Referral to Treatment (RTT) collection

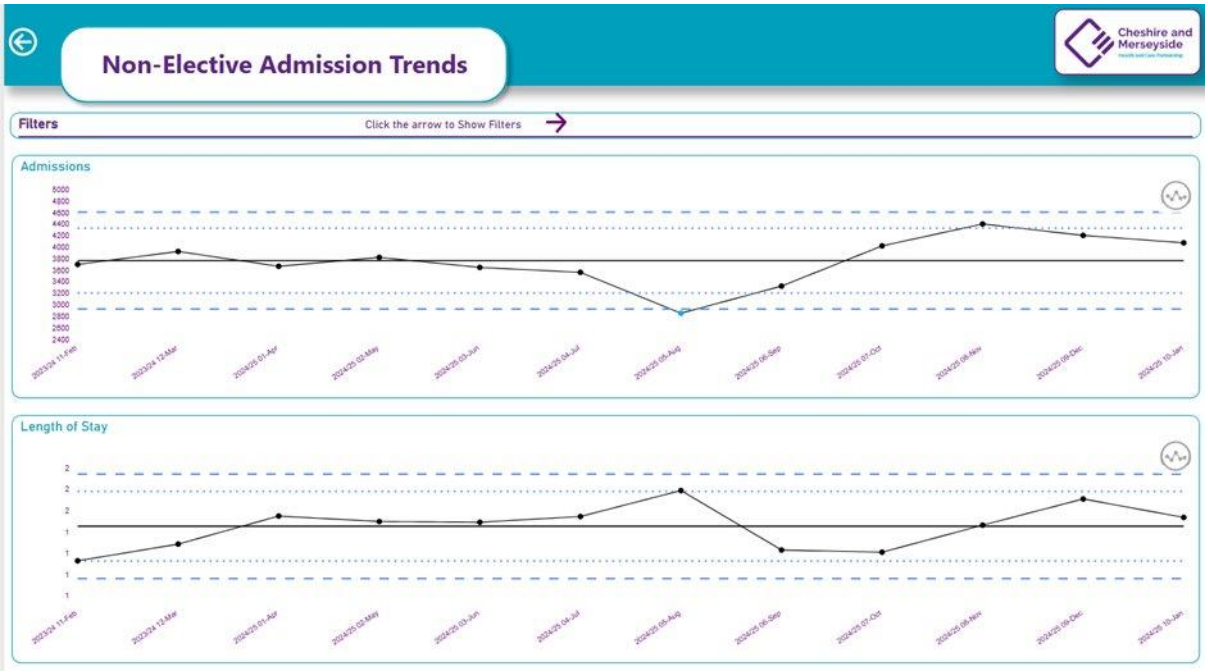






Source: Secondary Uses Service (SUS), Primary Care records, Johns Hopkins ACG system.

3.5. Emergency admissions for under 18s



Source: Secondary Uses Service (SUS)

3.6. **Summary of Actions**

3.6.1. The Cheshire and Merseyside Acute and Specialist Trust (CMAST) has been leading a programme of work to reduce the risk of causing and widening health inequalities as part of the elective recovery work.

3.6.2. The programme has five key areas of priority these are:

- Waiting well and impacts of waits
- Mutual aid and patient movement
- Access and patient choice

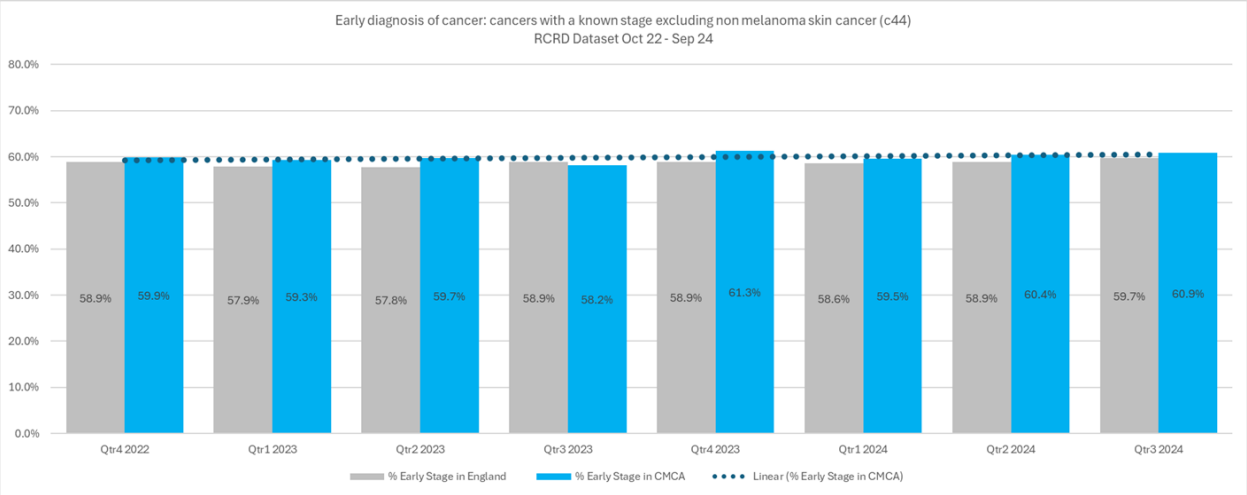
- Independent sector inequalities
- Data and information that informs decisions we make

3.6.3 Potential future areas of work across these priority areas include, proactively offering onward referral to lifestyle services for those who smoke, drink to unsafe levels, have a high BMI or are physically inactive with priority being given to referring those from our most deprived communities.

3.6.4 A programme of work has been undertaken to develop a prehab model for Cheshire and Merseyside. This model is focused on ensuring that patients are supported to adopt lifestyle changes across smoking, alcohol, weight and physical activity. Crucial to this model is ensuring that the services are accessible, delivering them within the communities that patients live in and that any barriers to access are removed.

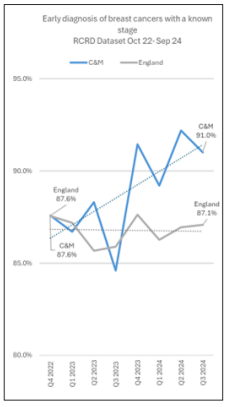
4. Cancer

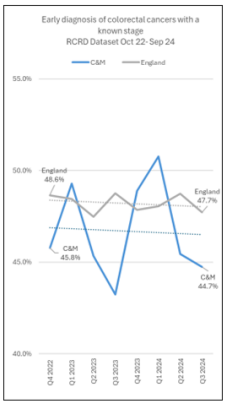
4.1. Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex

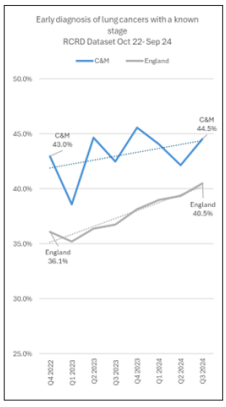


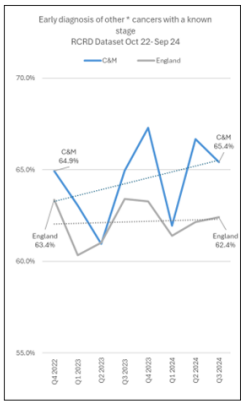
Average percentage early diagnosis: Oct 22 – Sep 24

Area	Breast	Colorectal	Lung	Prostate	Other
Cheshire and Merseyside	88.6%	46.7%	43.3%	55.4%	64.1%
England	86.6%	48.2%	37.8%	55.9%	62.0%









*Other excluding non-melanoma skin cancer

Source: Rapid Cancer Data Registration Dataset

4.2. Cancer Summary Actions

4.2.1. NHS Cheshire and Merseyside have achieved significant progress in cancer outcomes and as an Integrated Care System we were the first in England to achieve the target of 90% of patients receiving a diagnostic test within six weeks of referral after the COVID-19 pandemic.

4.2.2. A screening and immunisation oversight group has been established as a sub-group of the NHS Cheshire and Merseyside Population Health Partnership. This group takes a key leadership role in increasing uptake and reducing inequalities in uptake of the national cancer screening programmes and HPV vaccination.

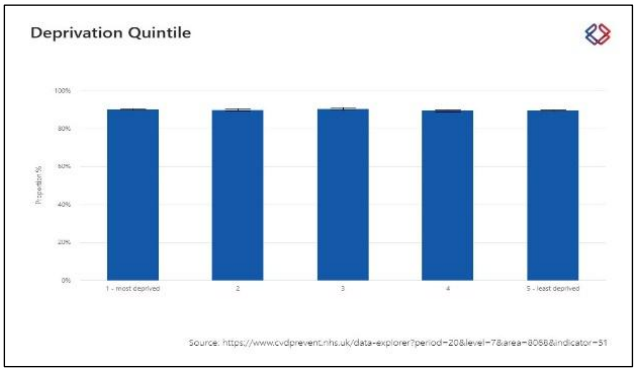
4.2.3. Targeted Lung Health Checks are now fully live in Wirral and Warrington with the ambition of implementing them across the whole of Cheshire and Merseyside by 2028. The implementation has taken a health inequalities lens with work being targeted at those most in need.

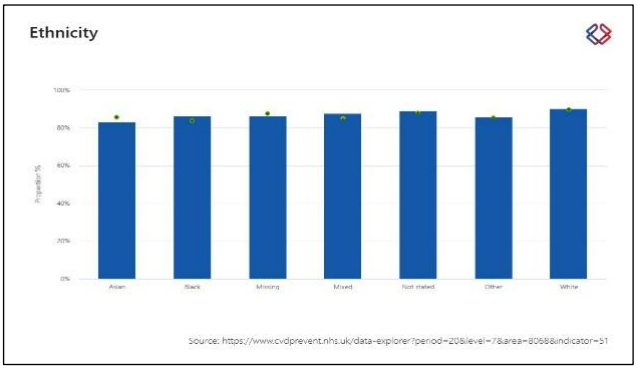
4.2.4. To address some of the inequalities in outcomes for cancer patients, the Cheshire and Merseyside Cancer Alliance developed the 123 training. Delivered to health professionals both face-to-face and online it provides them with the knowledge and skills to take action to reduce health inequalities. Whether it's creating easy read documents, delivering appointments in a more flexible way or supporting patients on low income to access benefits, the training outlines the small changes that can be made to improve outcomes for cancer patients. Launched in October 2024, so far 800 professionals have completed the training and committed to changing something within their control to tackle health inequalities.

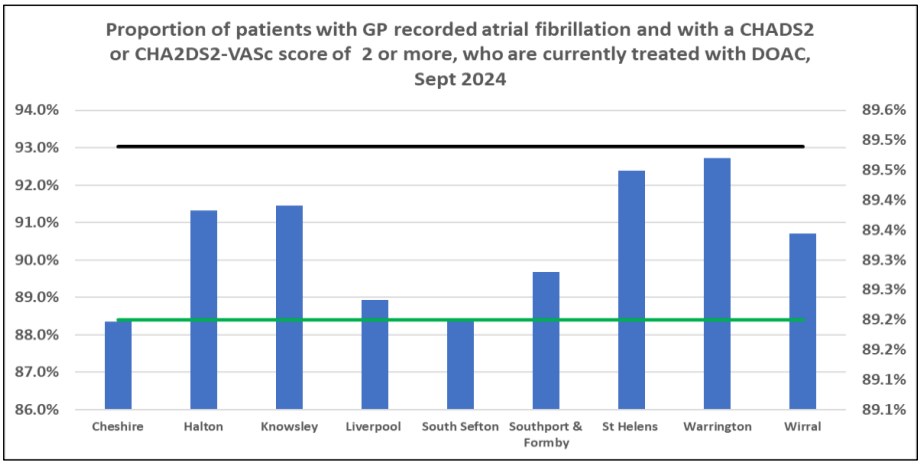
4.2.5. In partnership with the Liverpool Head & Neck Centre, part of the Liverpool University Hospitals NHS Foundation Trust (LUHFT), Cheshire & Merseyside Cancer Alliance (CMCA) have funded a two-phase pilot providing a direct access phone line for head and neck cancer services. Designed to improve early diagnosis of head and neck cancers the project used targeted marketing and communication campaigns in two of the most deprived areas of Kirkby. Promoting symptoms of head and neck cancers alongside messaging about how to prevent these cancers a direct access line was offered to those with symptoms of a hoarse voice and/or lump in their neck for three weeks or more. A total of 164 patients contacted the number and due to triage challenges 162 patients were seen in clinic with two benign cases being found. The findings from this pilot are now being used to inform phase two of the work.

5. Cardiovascular Disease

5.1. CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy:

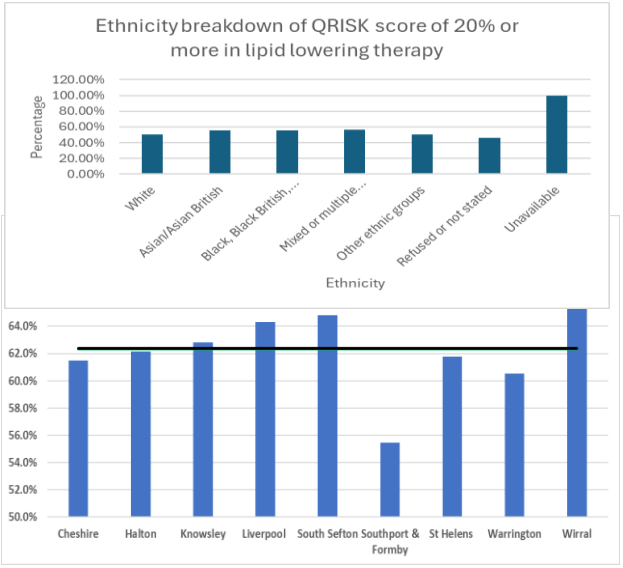


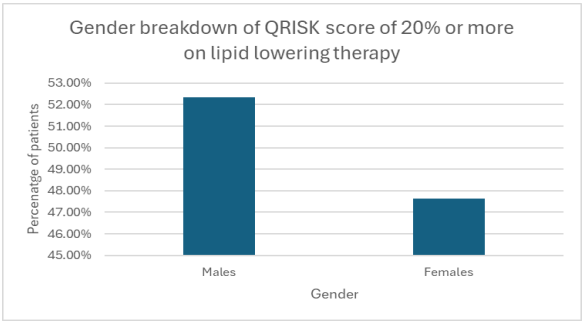


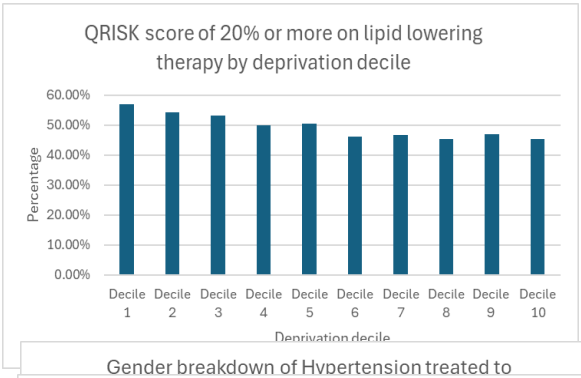


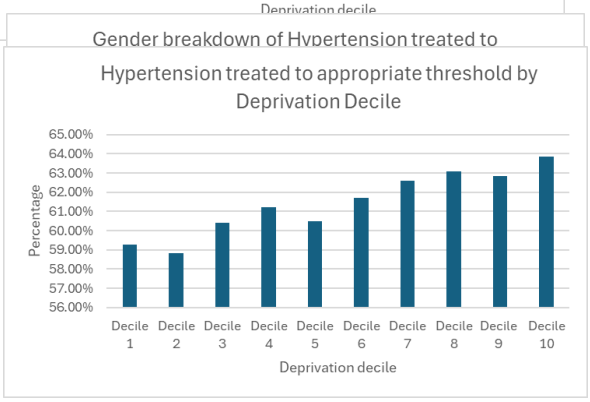
Source: Primary Care records

5.2. CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy:



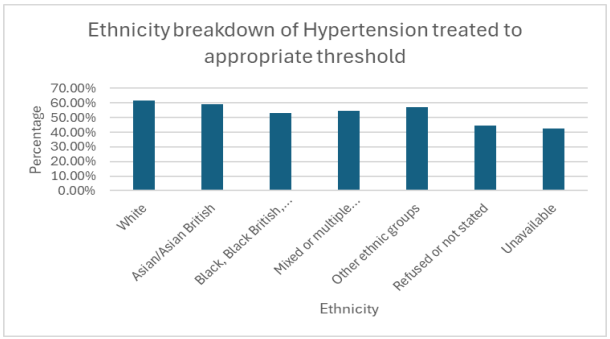






Source: Primary Care records

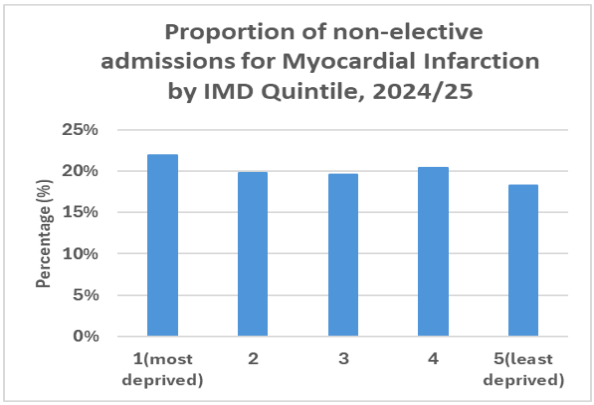
5.3. CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last

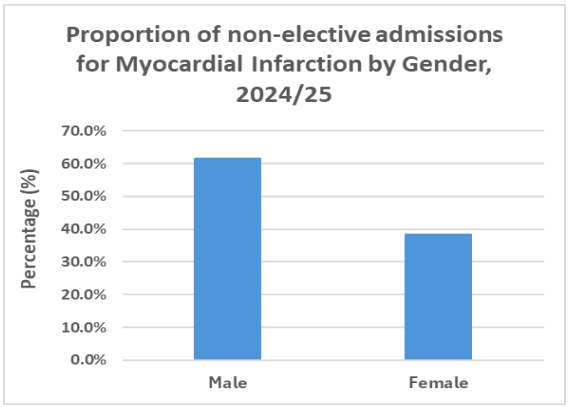


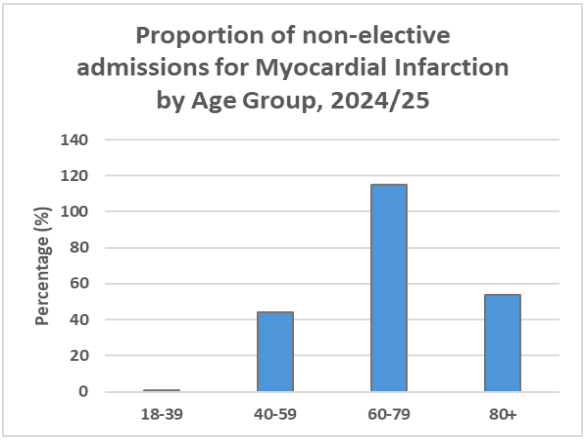
blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold, by data

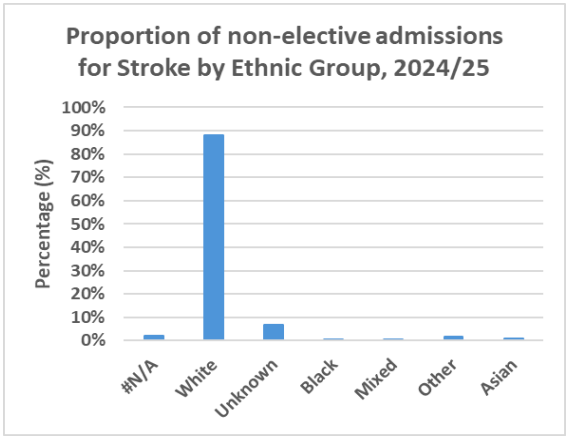
Source: Primary Care records

5.4. Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)

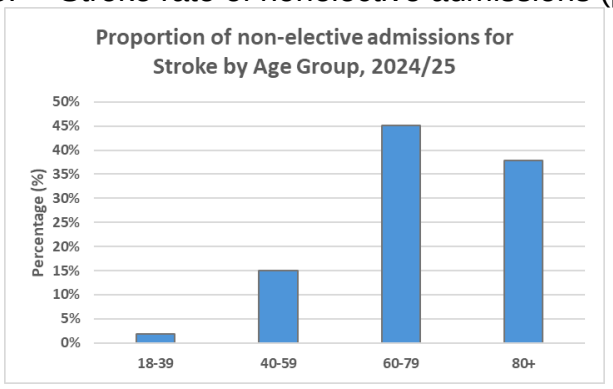


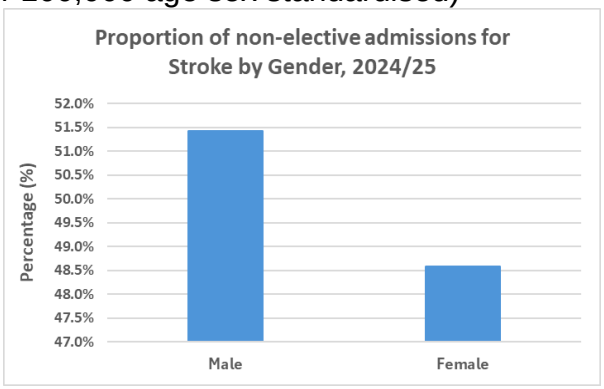


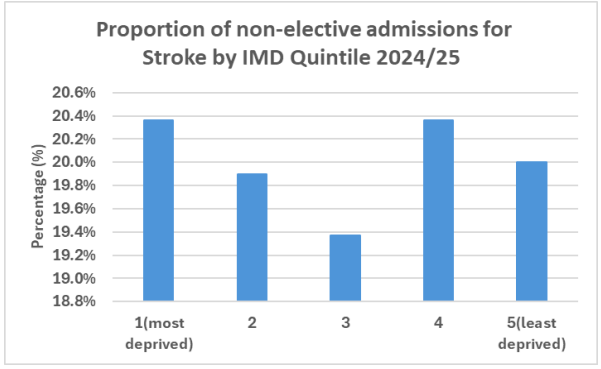


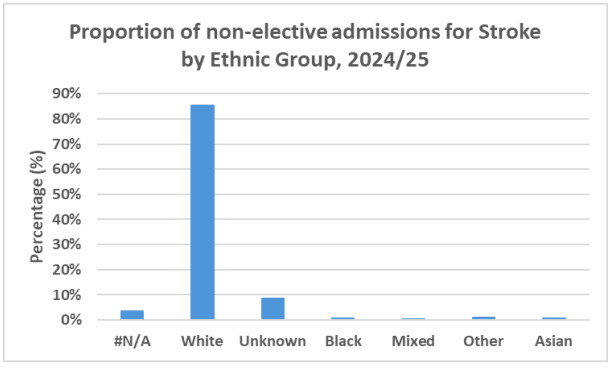


5.5. Stroke rate of nonelective admissions (per 100,000 age sex standardised)









5.6. CVD Summary Actions

5.6.1. NHS Cheshire and Merseyside now have a Senior Responsible Officer (SRO) and prevention programme manager for cardiovascular disease (CVD) who commenced in post during 2024/25.

5.6.2. The Cheshire and Merseyside CVD Prevention Board has been re-established and met in quarter three of 2024/25 and is chaired by the new SRO. Development work with the board has been initiated to agree key priorities and establish priority sub-groups.

5.6.3. A new Community of Practice for NHS Health Checks has been established to identify how health checks can be optimised across Cheshire and Merseyside. Other priority working groups that have been establish are those focusing on Lipid Management and Hypertension.

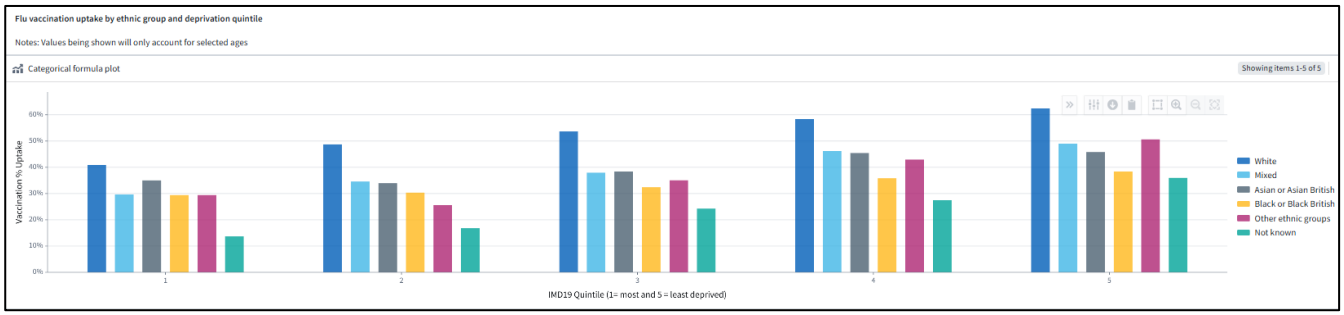
5.6.4. NHS Cheshire and Merseyside has committed to recurrently funding the Familial Hypercholesterolemia service and the CVD Prevention Service as a commitment to the importance of these services and the outcomes they deliver for patients.

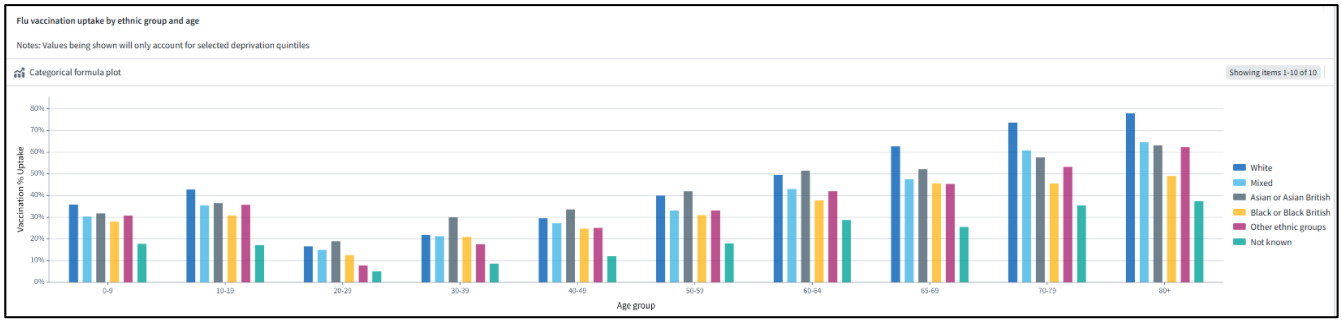
5.6.5. A package of support funded through NHS Cheshire and Merseyside Health Inequalities funding has been designed to work in partnership with some of the lowest performing practices in areas of high deprivation to optimized blood pressure.

5.6.6. NHS Cheshire and Merseyside were successful in securing funding to become part of the CLEAR CVD prevention programme a national programme designed to transform CVD prevention care in the community. The funding will support 16 Primary care Networks to participate in an evidence-based model which offers sustainable and improved care.

6. Respiratory

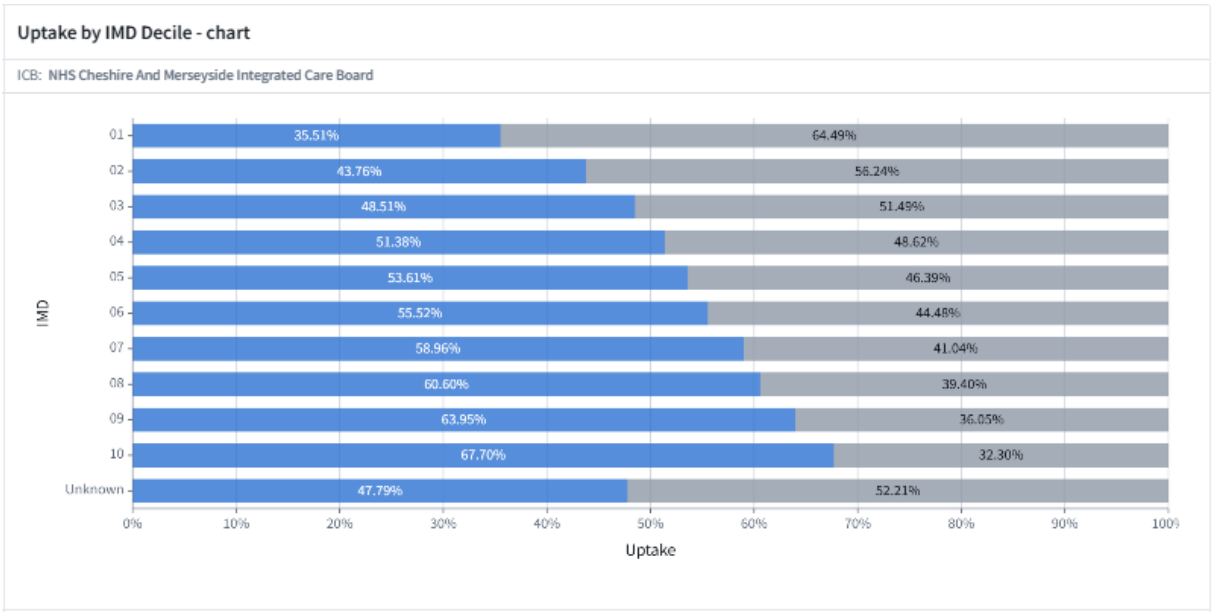
6.1. Uptake flu vaccination by socio-demographic group





Source: Federated Data Platform

6.2. Uptake of COVID vaccination by socio-demographic group



Source: Federated Data Platform

6.3. **Respiratory Summary Actions**

6.3.1. Primary prevention of respiratory conditions remains the priority for NHS Cheshire and Merseyside. Commitment to this has been demonstrated through a three-year financial commitment to the All Together Smoke Free programme using Health Inequalities funding. This programme will work collaboratively across the system to achieve the ambition of ending smoking everywhere, for everyone by 2030. The programme is delivering across a range of priority areas including advocacy, education, partnerships, tackling illicit tobacco and vapes, smokefree environments, regulation, data and intelligence and support to quit.

6.3.2. Delivery of the Treating Tobacco Dependency Services across Acute and Maternity services continues to prioritise providing tobacco treatment to inpatients and pregnant women. This programme of work has resulted in smoking at time of delivery reducing significantly as well as increases in the

number of inpatients making quit attempts and accessing community smoking cessation services to continue their quit attempt after discharge.

6.3.3. Piloting of a children and young people's vaping treatment service has been funded in Alder Hey Children's Hospital, recognising the risk long-term use of vapes poses to children and young people who have never used tobacco products.

6.3.4. A screening and immunisation oversight group has been established as a sub-group of the NHS Cheshire and Merseyside Population Health Partnership. This group takes a key leadership role in increasing uptake and reducing inequalities in uptake of the Influenza, COVID-19, RSV and Pneumococcal vaccines.

6.3.5. Targeted work to reduce health inequalities in uptake of the COVID-19 vaccination and Influenza vaccination has been undertaken through the delivery of a targeted mobile outreach service. The Living Well bus works delivers an accessible service across migrant and Gypsy, Roma and Traveller communities as well as targeting the most deprived communities across Cheshire and Merseyside.

6.3.6. Working in partnership with Health Innovation North West Coast a workshop will be delivered with system wide stakeholders to identify opportunities for primary and secondary prevention of respiratory conditions. Reducing health inequalities will be a key focus of the discussion and targeted actions.

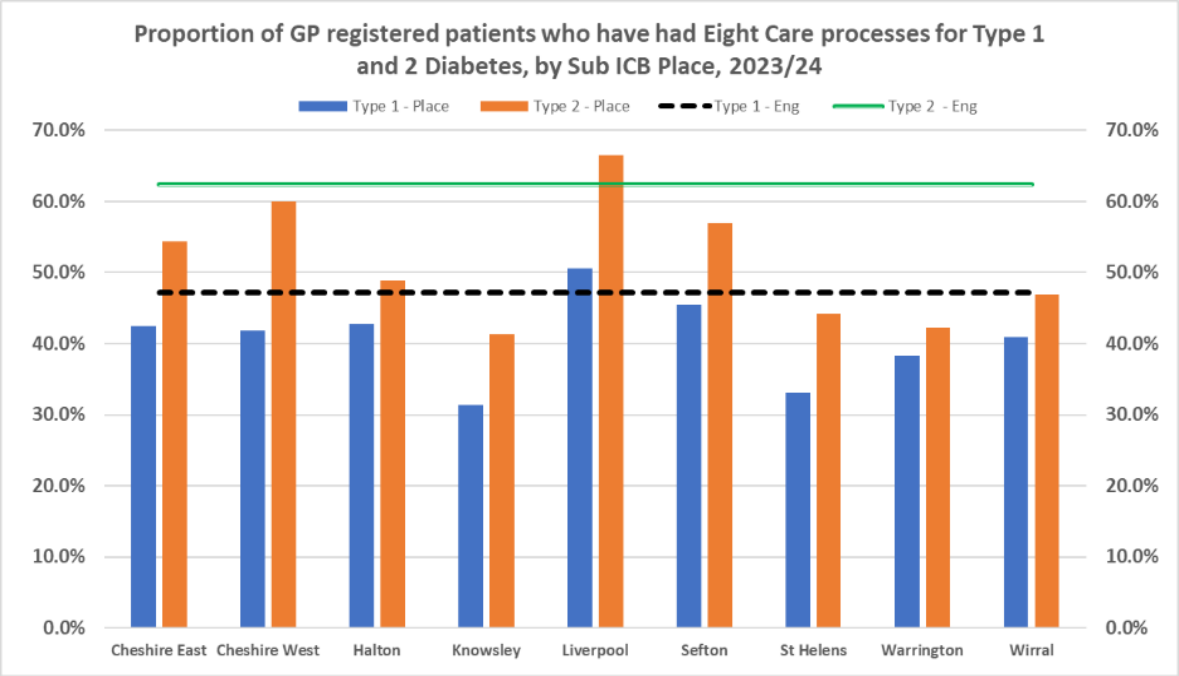
6.3.7. Cheshire and Merseyside continues to focus on delivery of the asthma bundle, and interventions are being delivered to address key areas that exacerbate asthma – this has an emphasis on the addressing the wider determinants of health inequalities.

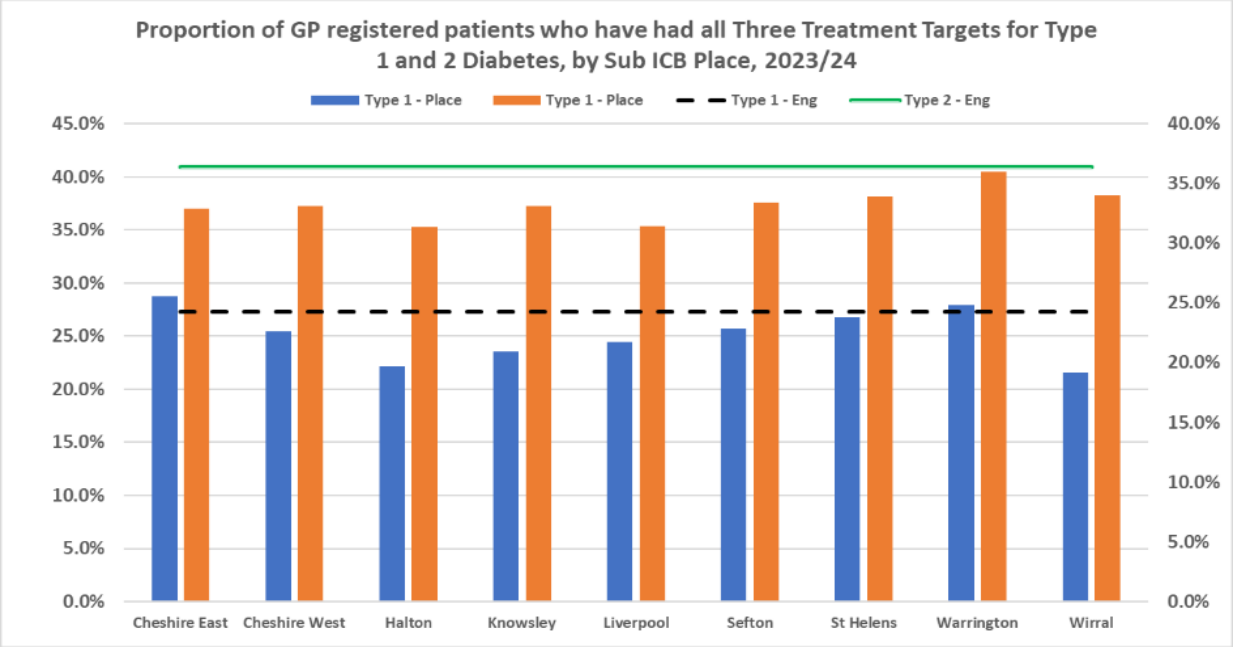
6.3.8. Delivery of the fuel poverty programme continues to be expanded across the community respiratory teams. Using the fuel poverty dashboard Respiratory teams are able to undertake a targeted approach to delivering support to those patients with respiratory conditions who are experiencing fuel poverty or poor-quality housing that could be contributing to worsening their respiratory conditions.

7. Diabetes

7.1. Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile.

7.2. Variation in the proportion of patients with Type 1 and Type 2 diabetes receiving all 8 care processes





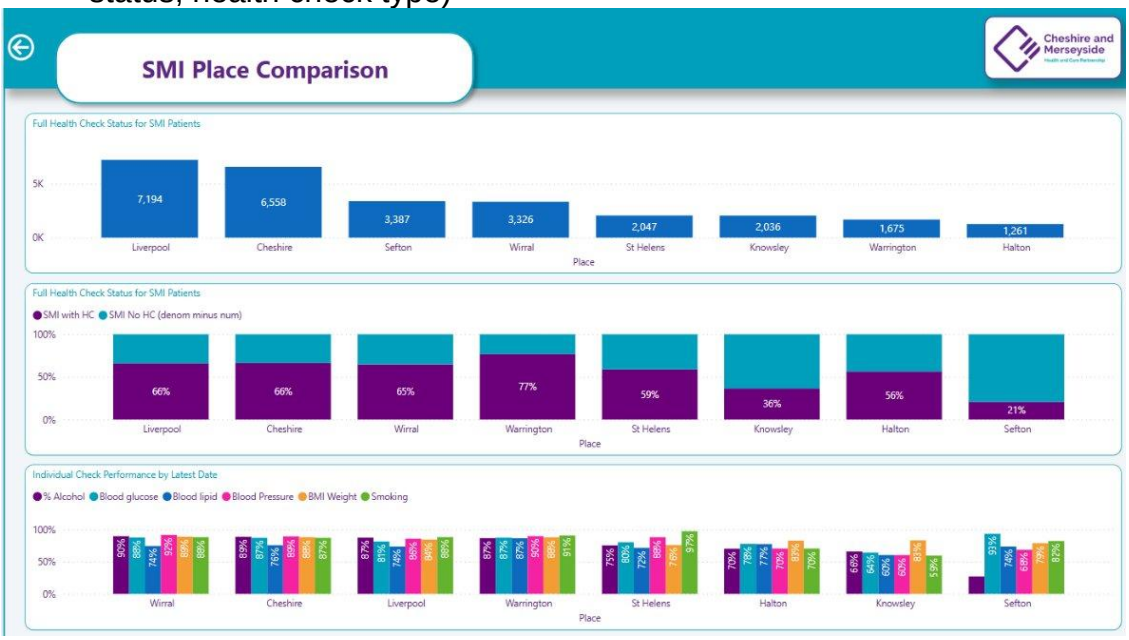
Source: Primary Care record

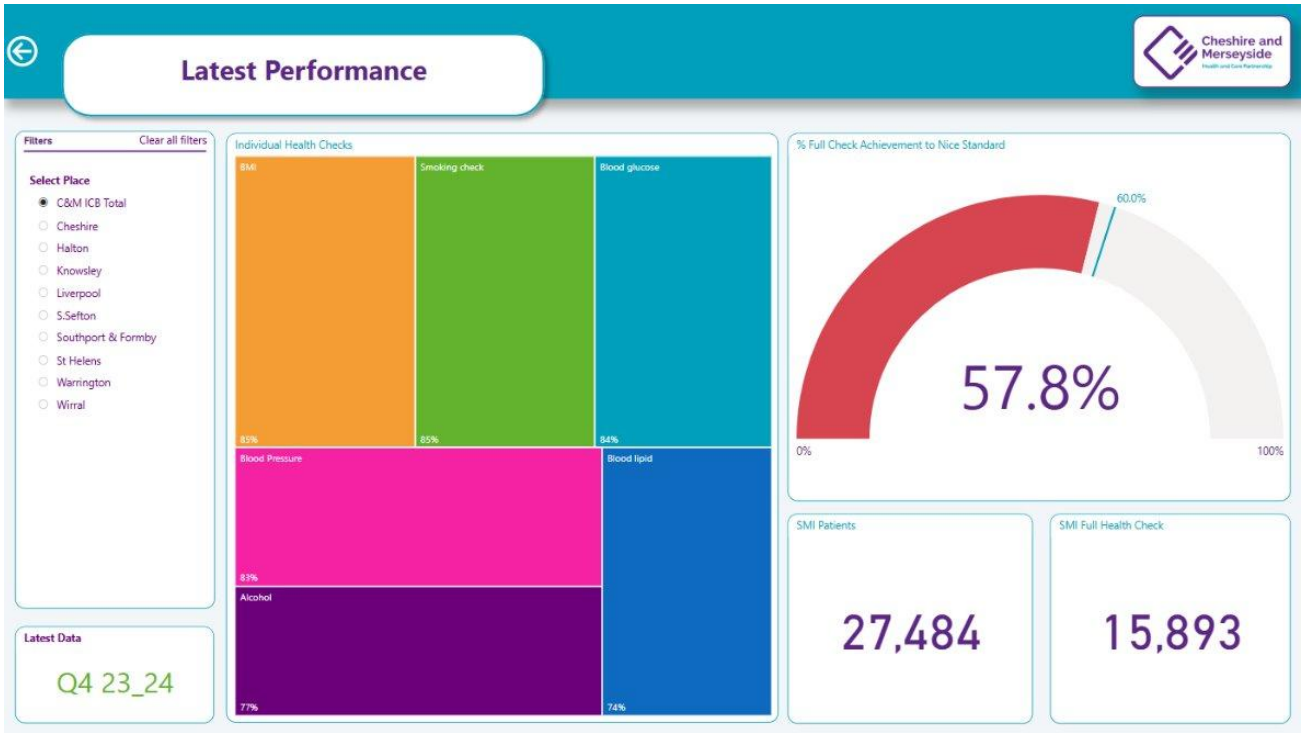
7.3. Diabetes Summary Actions

7.3.1. A Whiston technology pilot has targeted children living in the most deprived deprivation deciles and those from BAME communities to access better diabetes care technology with 85 children in total now in receipt of improved technology.

8. Mental Health

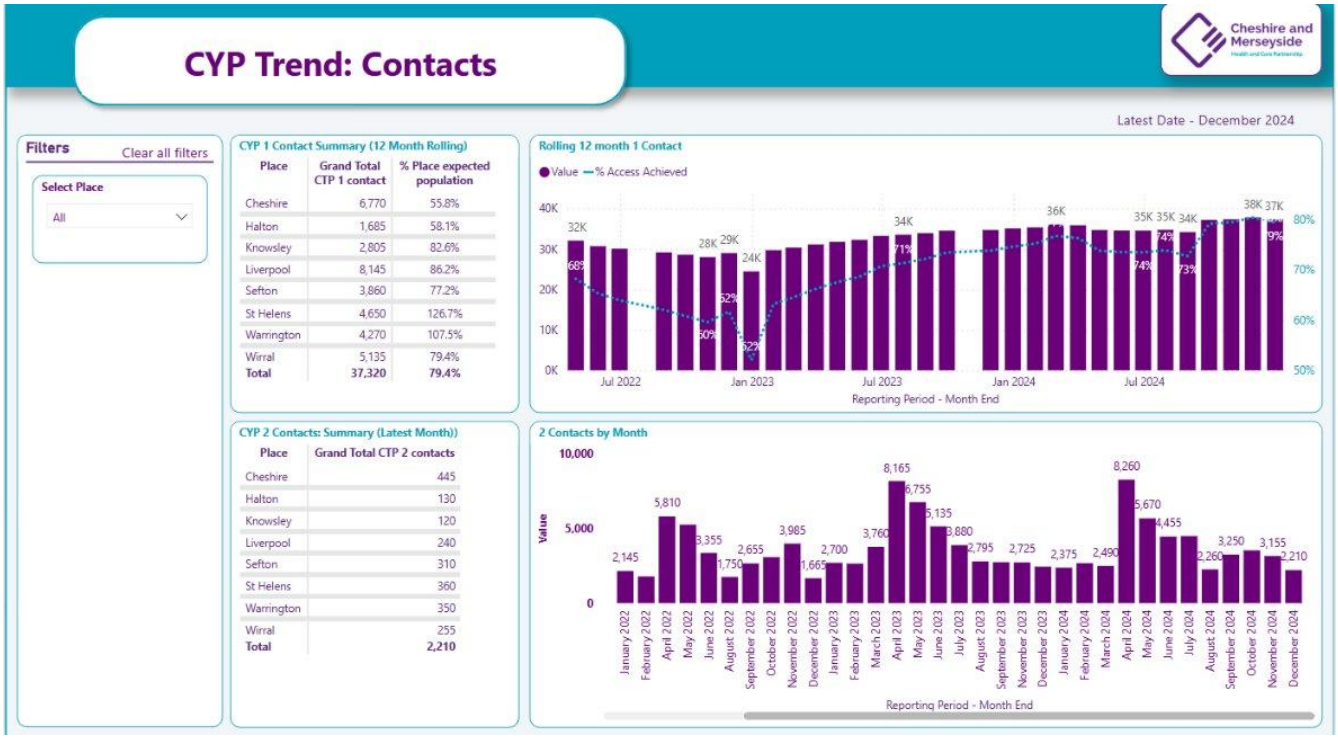
8.1. Physical Health Checks for people with Severe Mental Illness
Patient level tool to filter and select patients key risk factors (age, vaccination status, health check type)





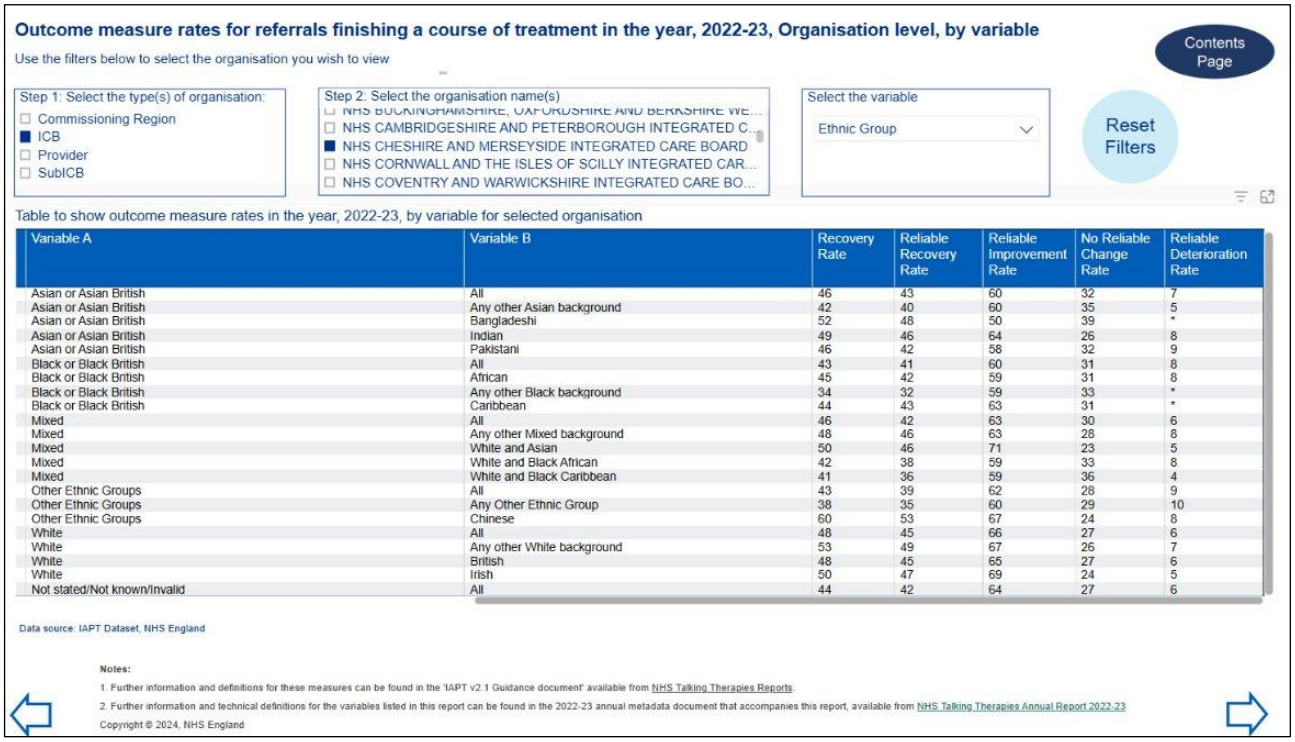
Source: Primary care records

8.2. Children and young people's mental health access



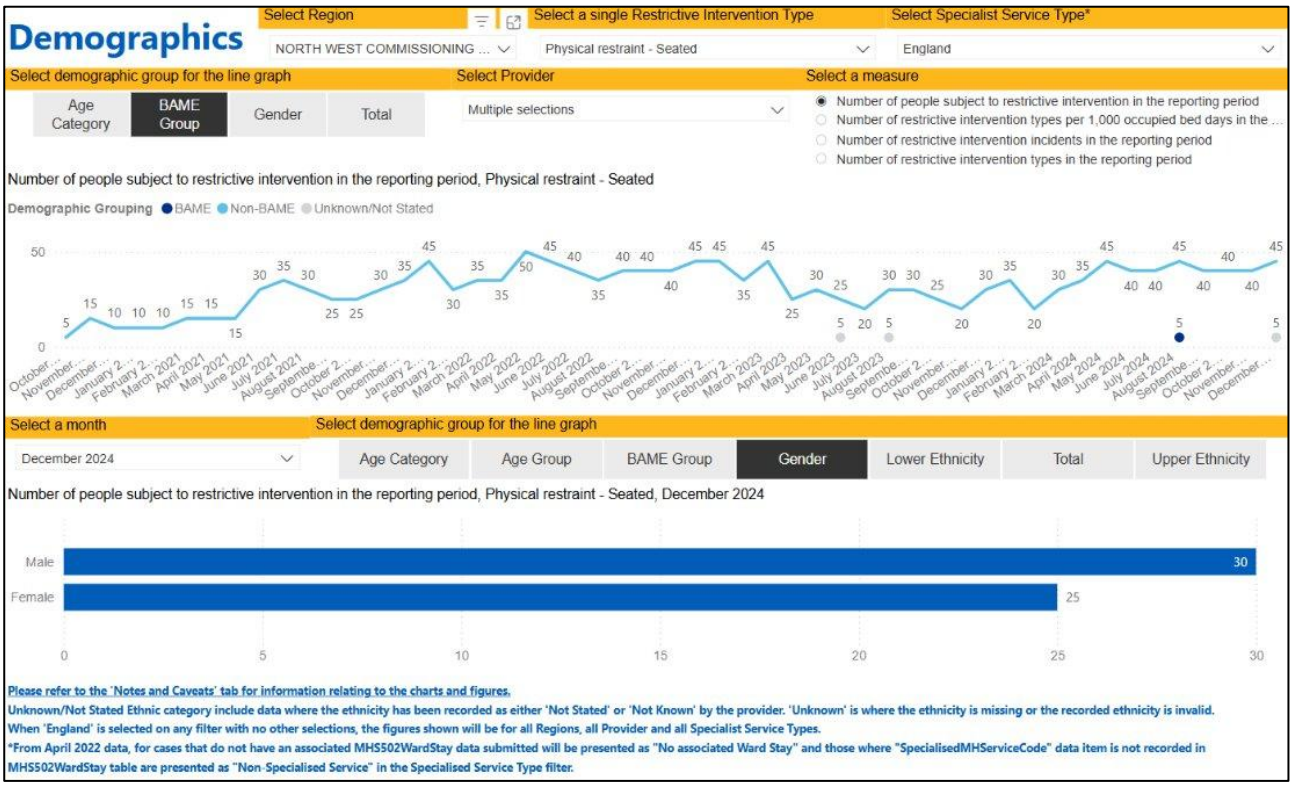
Source: NHS Digital

8.3. NHS Talking Therapies (formerly IAPT) recovery



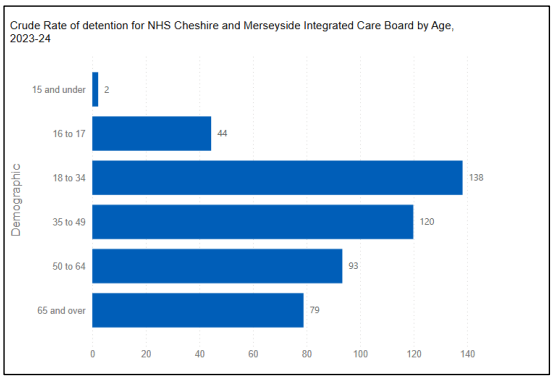
Source: NHS Digital Microsoft Power BI

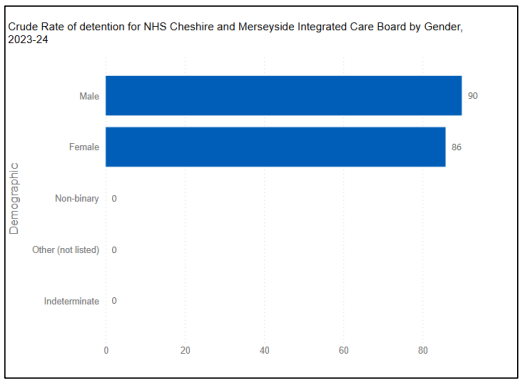
8.4. Rates of restrictive interventions

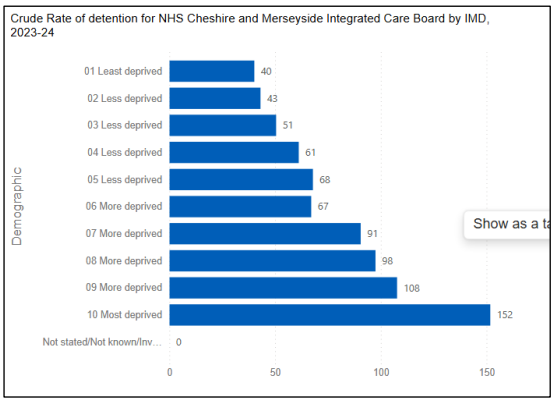


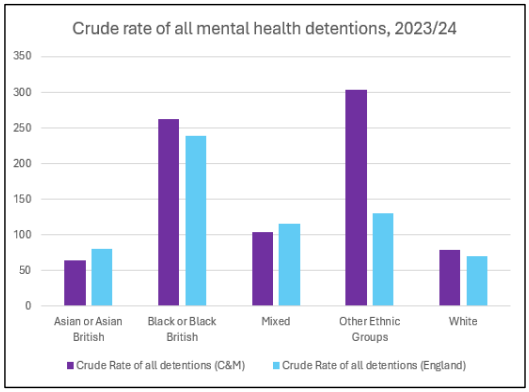
Source: NHS Digital: Microsoft Power BI

8.5. Rates of total Mental Health Act detentions









Source: MHSDS collection, NHS Digital Microsoft Power BI

8.6. **Mental Health Summary Actions**

8.6.1. Significant inequalities in life expectancy for mental health patients are well known, with people in contact with mental health services nearly five times more likely to die prematurely than those not in contact with mental health services. The metric on delivery of health checks reflects a key intervention the NHS can provide to identify where support for a patient's physical health needs is required. National data is used alongside local demographic data through the CIPHA platform to allow clinicians to assess the need for targeted outreach to support people to access the health checks and follow-up interventions. Securely held data can be accessed by clinicians and using easy to use filters, cohorts of patients can be identified and called in to practice to conduct checks.

8.6.2. More people received an SMI health check in quarter three of 2024/25 than any equivalent quarter in previous years. This demonstrates a sustained improvement in performance from previous years with 12,823 SMI health checks conducted during the year. Data is now being utilised at system level, to inform a strategic approach to offering the full six aspects of the SMI check. In particular, Cheshire have contracted with VCSFE provider to provide a consistent model and approach across all of Cheshire and Wirral for improving health outcomes for people with SMI. It is anticipated that this approach will lead to improvements in the delivery of health checks for people with SMI.

8.6.3. Development and launch of the Cheshire and Merseyside business intelligence dashboard for SMI health checks has enable places to review their performance and target support and resources.

8.6.4. The NHS Cheshire and Merseyside Board received a dedicated session on SMI Health Checks in quarter three of 2024/25 to update on progress and agree actions for further improvement.

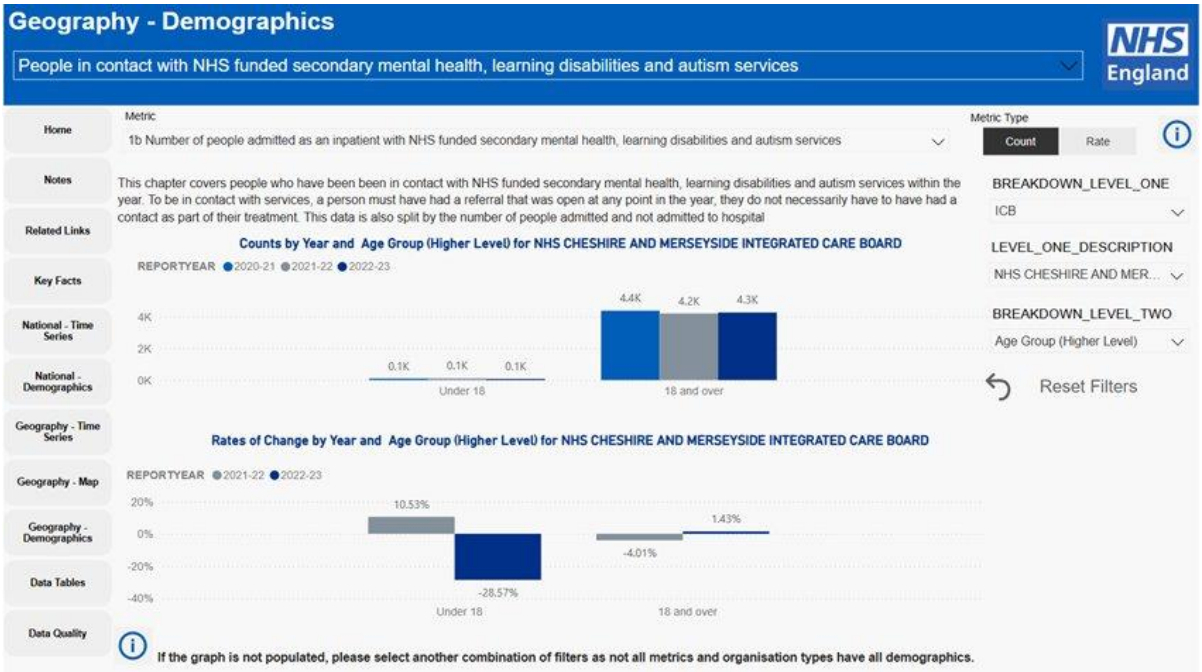
8.6.5. Offering home visits as a reasonable adjustment for the patient has resulted increased access to NHS Health Checks for those with SMI.

8.6.6. Engagement with children and young people, parents and carers, along with professionals and stakeholders to better understand where improvements can be made to support children and young people's mental health has been undertaken. This engagement has supported the refresh of the children and young people's Mental Health Plan for Cheshire and Merseyside.

8.6.7. Wirral Place launched 'Branch' in November 2024, the digital platform with matching function and team working alongside Wirral CAMHS and the Alliance to deliver. The platform received over 116 referrals in its first five weeks of operation and increases access for local children and young people.

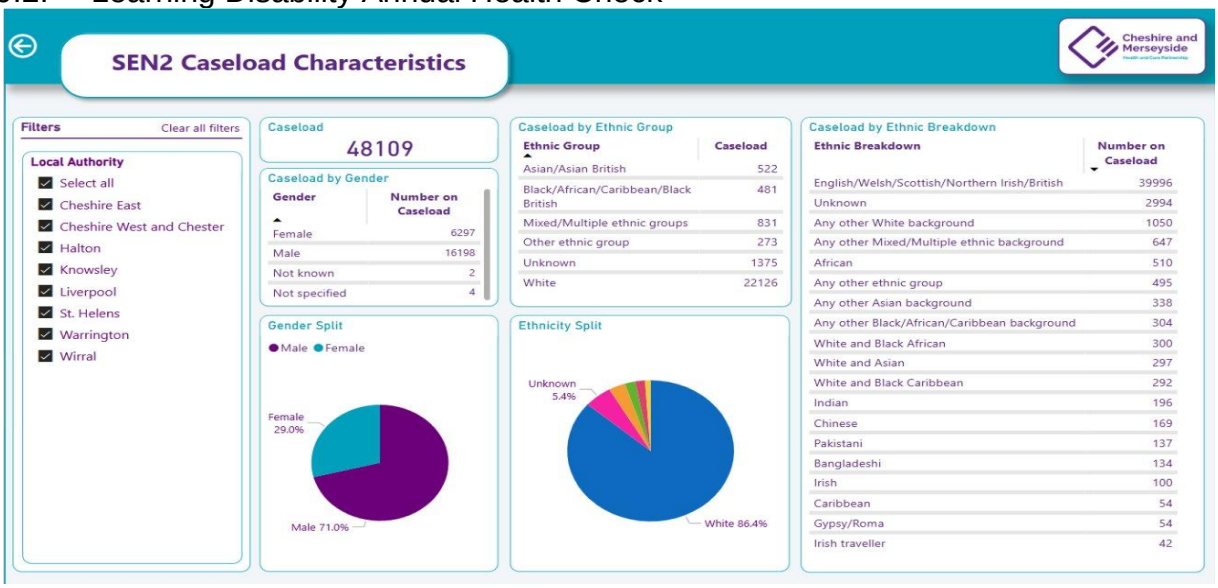
9. Learning Disability and Autistic People

9.1. Adult mental health inpatient rates for people with a learning disability and autistic people



Source: NHS Digital Microsoft Power BI

9.2. Learning Disability Annual Health Check



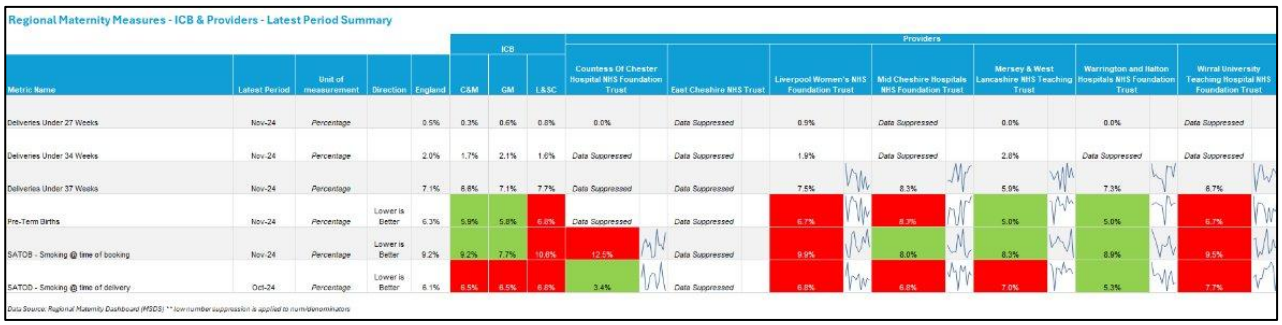
Source: Local Authority data supplied locally to ICB

9.3. **Learning Disability and Autism actions**

9.3.1 People with learning disabilities and autistic people remain a priority for increasing uptake of NHS Health Checks. Data from the LeDeR reviews is being reviewed to identify opportunities for improving uptake of preventative services across the priority areas of obesity, long-term health conditions management and screening uptake.

10 Maternity and Neonatal

10.1 Preterm births under 37 weeks



Source: Local provider data flows to ICB

10.2 **Preterm Birth Summary Actions**

10.2.1 Work has continued throughout 2024/25 to implement the continuity of care model with a particular focus on developing teams in areas of high deprivation and families from marginalised communities across maternity services.

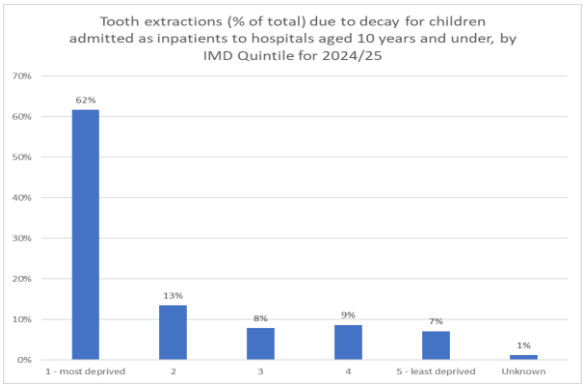
10.2.2 Progress in reducing the smoking at time of delivery rate has continued throughout 24/25. All midwives continue to implement the maternity smoking cessation pathway which includes carbon monoxide monitoring, very brief advice

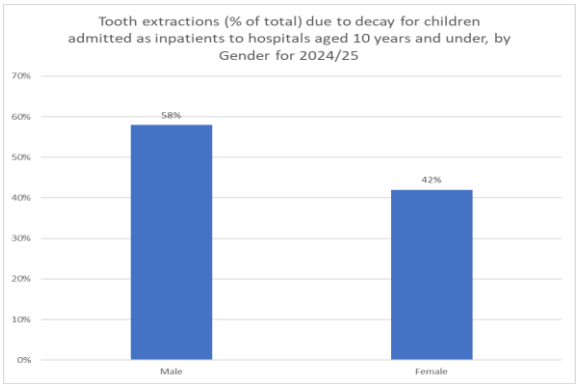
and onward referral into the maternity based treating tobacco dependency service. A number of maternity services have also implemented opportunities for women to be offered smoking cessation advice before their booking appointment to ensure women are supported to quit as early as possible in their pregnancy.

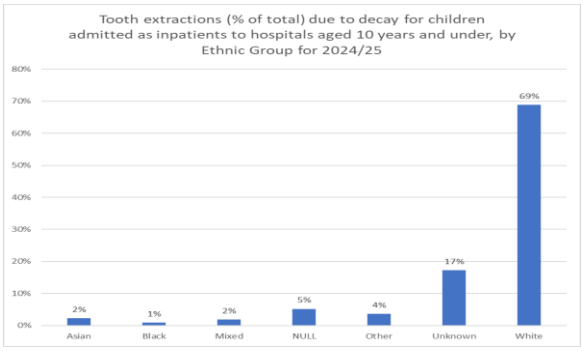
10.2.3 Three maternity sites have now gone live with a national incentive scheme which offers pregnant women a financial incentive to quit smoking during pregnancy.

11 Oral Health

11.1 Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted).







11.2 **Oral Health Summary Actions**

11.2.1 In response to the results of the Cheshire and Merseyside oral health survey which identified dental decay being highest in our poorest communities, NHS Cheshire and Merseyside have invested in a supervised tooth brushing programme led by the Beyond Children and Young Peoples Transformation Team. The three-year supervised toothbrushing programme started in April 2024. The programme delivers supervised toothbrushing alongside free toothbrush and toothpaste packs for children aged 2-7 years old living in our poorest communities. So far 229,908 toothbrush and toothpaste packs have been given out to families across Cheshire and Merseyside.

11.2.2 Supervised toothbrushing training is being targeted at early years settings in Liverpool due to the Local Authority having them highest levels of dental decay in children in Cheshire and Merseyside. Thirty-three settings have received training to date.

11.2.3 Tiny teeth an oral health and peer support programme in Liverpool uses peer support volunteers to deliver positive oral health messages, support to access dental services top parents of 0-5 year olds living in Liverpool.

12. Treating Tobacco Dependence

12.1 Proportion of adult acute inpatient settings offering smoking cessation services

- 100% of our acute inpatient settings in Cheshire and Merseyside are offering smoking cessation services.
- All 11 acute inpatient services are providing smoking cessation services across Cheshire and Merseyside

12.2 Proportion of maternity inpatient settings offering smoking cessation services:

- 100% of our maternity settings in Cheshire and Merseyside are offering smoking cessation services.
- All seven maternity services are providing smoking cessation services across Cheshire and Merseyside

12.3 Treating Tobacco Dependency Summary Actions

12.3.1 A baseline assessment has been undertaken of all NHS Trusts across Cheshire and Merseyside to understand how well they have embedded the Smokefree policy and associated Treating Tobacco Dependency approach. Opportunities will be identified across NHS Trusts in 2025/26 to embed improvements in implementation of Smokefree policies and associated Treating Tobacco Dependency services.

12.3.2 System engagement meetings are undertaken with all acute providers quarterly to understand current delivery arrangements and identify any challenges to delivery.

12.3.3 The Cheshire and Merseyside Treating Tobacco Dependency Forum continues to be delivered to enable providers of Treating Tobacco Dependency services to share best practice and resolve shared challenges.

12.3.4 Additional top slice funding was secured during 2024/25 from NHS England to provide additional training to newly recruited Treating Tobacco Dependency service staff.

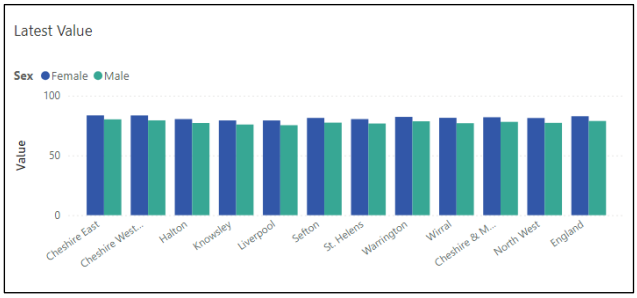
13 All Together Fairer Beacon Indicators

13.1 All Together Fairer Marmot Dashboard of Beacon Indicators: The All Together Fairer Programme exists to support development and delivery of a strategic approach to improve population health and address inequalities in health and the social determinants of health across Cheshire and Merseyside. It facilitates collaborative engagement and action to support whole system implementation of appropriate policies and initiatives in line with our All Together Fairer strategy.

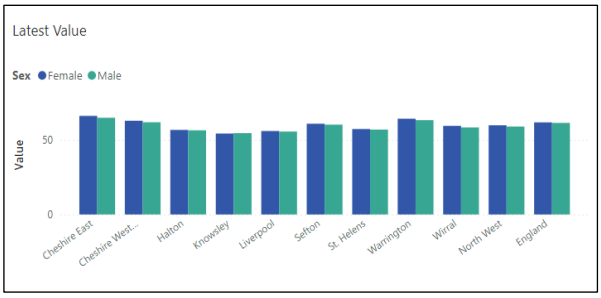
13.2 Nine Marmot Place Leads & C&M Marmot Community Leads have been established to lead priority programmes locally. These are accountable to the C&M Marmot Community Advisory Board which reports to C&M Population Health Board.

13.3 The Beacon Indicator Set was developed during the preparation of the All Together Fairer report launched in May 2022. A total of 22 indicators were chosen to measure progress in action on the social determinants of health and this is key to programme implementation and is accessible to leads within each place. These have now been reduced to 20 indicators.

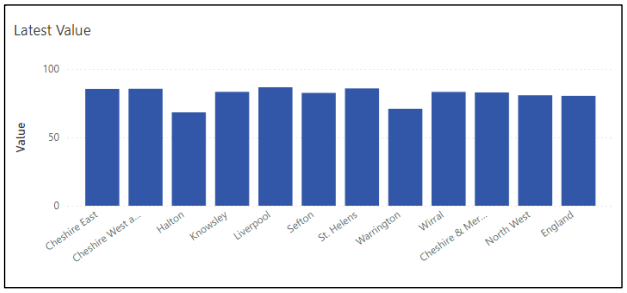
Life Expectancy



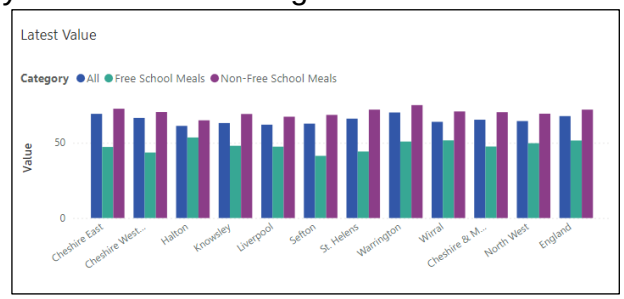
Healthy Life Expectancy



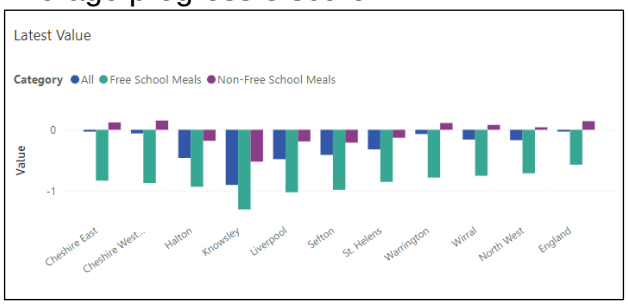
Percentage of children achieving a good level of development at 2-2.5 years



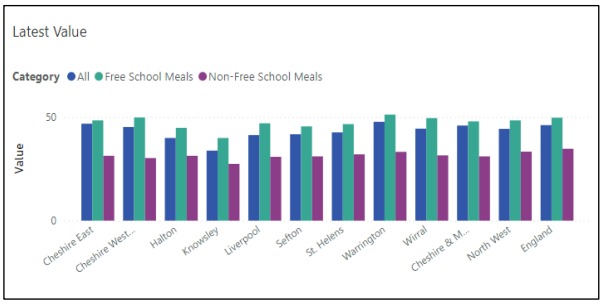
Percentage of children achieving a good level of development at the end of early years foundation stage



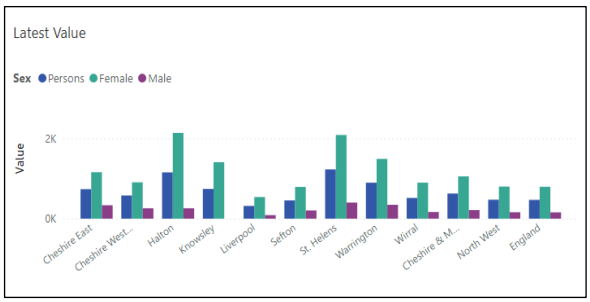
Average progress 8 score



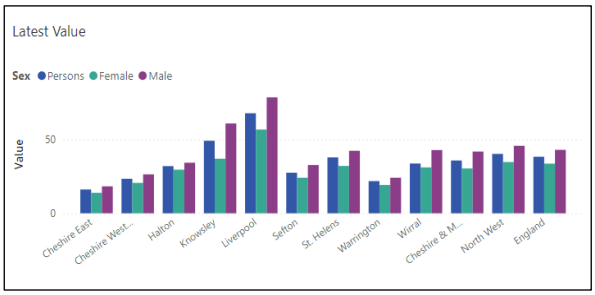
Average attainment 8 score



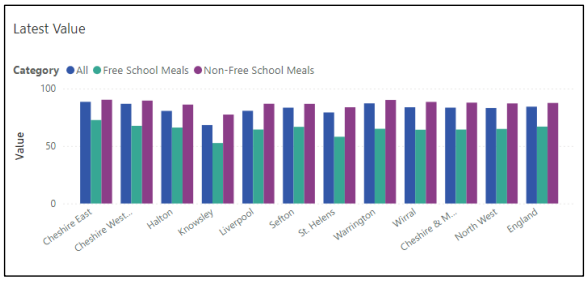
Hospital admissions as a result of self-harm 15-19 year olds



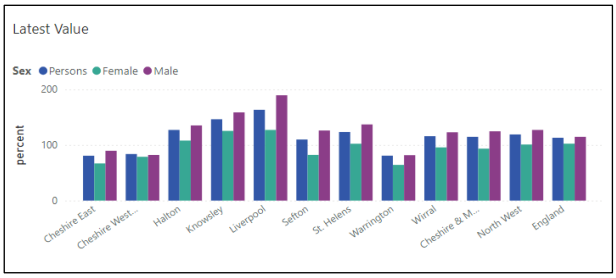
Percentage of 16-17 year olds not in education, employment or training



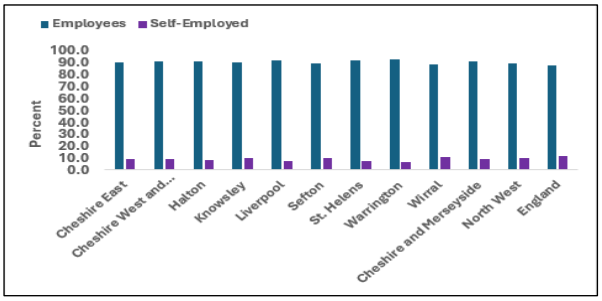
The percentage of pupils that go on to achieve a level 2 qualification at 19



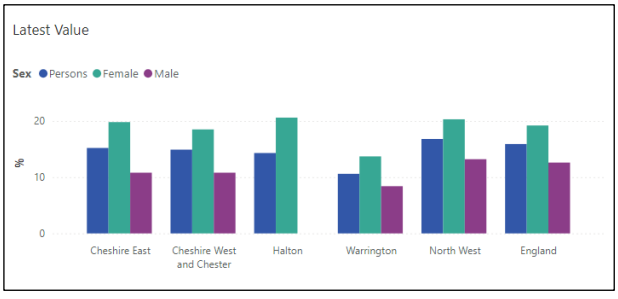
Percentage of persons who are unemployed aged 16+



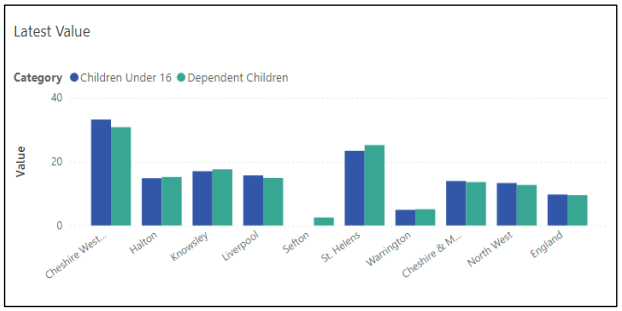
Employment status by employment type



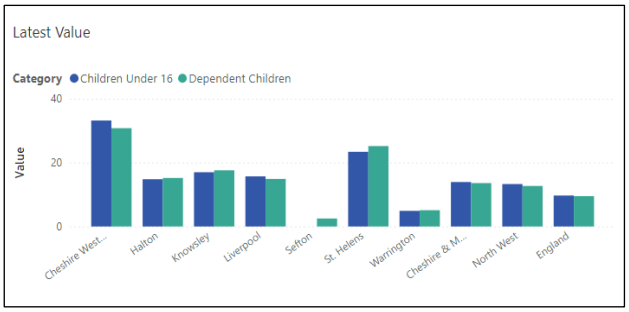
Percentage of employees earning below real living wage



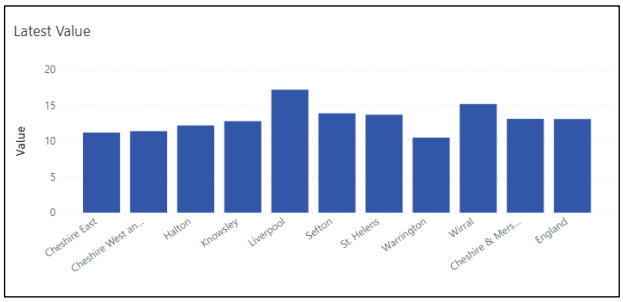
Proportion of children living in long-term workless households



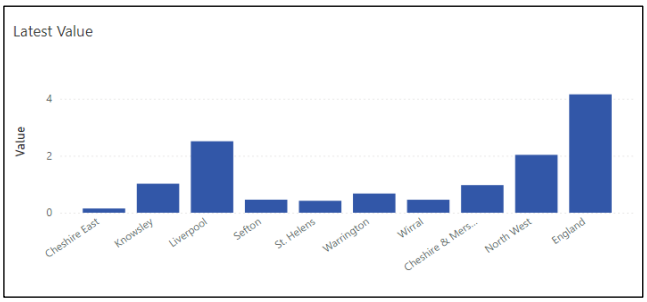
Percentage of children in relative and absolute poverty



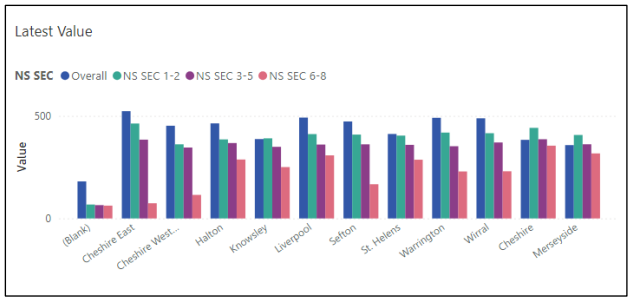
Percentage of households in fuel poverty



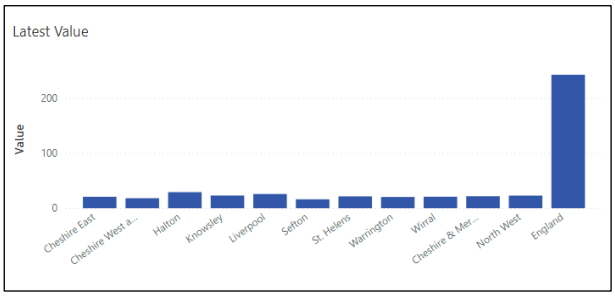
Households in temporary accommodation



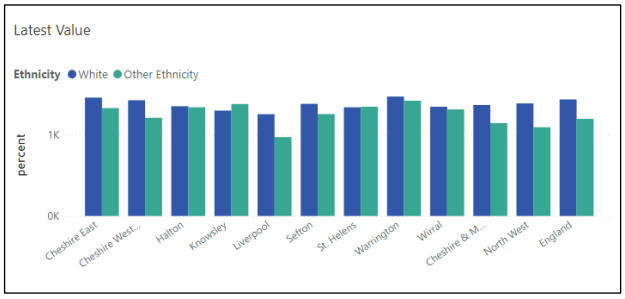
Activity levels: Active, Fairly Active or Inactive



Percentage of adults who feel lonely often/always or some of the time



Employment by ethnicity



Percentage of adults walking/cycling for travel at least three days per week