Agenda Item No: 8(b)

Health Inequalities: Report from Cambridge University Hospitals NHS Foundation Trust

To:	Adults and Health Committee
Meeting Date:	Thursday 23 January 2025
From:	Medical Director, Cambridge University Hospitals NHS Foundation Trust
Electoral Division(s)	All

Report author:
Dr Ashley Shaw, Medical Director, Cambridge University Hospitals NHS Foundation Trust

1. Background

1.1 Health inequalities are the difference in the status of people's health. This can be measured in a number of different ways, but is most commonly seen as years of healthy life expectancy or life expectancy.

1.2 Health inequalities are experienced between different groups of people and are often analysed across four main categories: socio-economic (e.g. income); geography (e.g. region); specific characteristics (e.g. ethnicity or sexuality); and socially excluded groups (e.g. people who are seeking asylum or experiencing homelessness).

1.3 As well as a moral and social responsibility, the NHS commissioners and providers have a legal duty to consider health inequalities as part of the planning for, and delivery of, services.

1.4 Cambridge University Hospitals NHS Foundation Trust (CUH), including Addenbrooke's and the Rosie Hospital, provides services as a local hospital for people in Cambridge and the surrounding areas. It is the Major Trauma Centre for the East of England and provides specialist care for the Eastern region (and nationally) in a number of areas, including transplantation, cancer services, neurosciences, rare diseases, and paediatrics.

1.5 CUH also hosts screening services for abdominal aortic aneurysm, breast cancer, cervical cancer, bowel cancer, diabetic retinopathy, and antenatal and new-born screening.

1.6 CUH works with the University of Cambridge, partners in industry, and other NHS Trusts to deliver high quality medical research.

1.7 CUH is a part of the Cambridge and Peterborough Integrated Care System, and is part of the 'South Place' a collaboration with primary care providers in the southern half of the ICS.

2. Main Issues

2.1 The role of CUH in the various aspects of health inequality can be divided in to three broad categories: those where the solutions are entirely within the gift of CUH; those where CUH need to work as part of a system approach; and those where CUH needs to act as an advocate for those with health needs to other organisations.

2.2 These can then be overlaid with the four main categories of challenges listed in 1.2, and applied to the services that we provide.

2.3 Listed below are some examples of the work being undertaken across our various services in the various domains to try and address the health inequalities in our region.

2.4 The CUH website has recently been upgraded and is ranked in the top 3 in the country by the Shaw Trust for accessibility. Information can be accessed in over 30 languages and we are reviewing all patient leaflets. Each policy is subjected to an Equality Impact Assessment screening tool.

2.5 Screening programmes all use invitation letters in the language recorded as the patients preferred, as well as English.

2.5.1 Abdominal aortic screening uses demographic data to identify populations with low uptake of screening, liaising with local GPs and undertaking additional sessions close to patients to boost uptake in areas with reduced uptake.

2.5.2 Breast cancer screening uses mobile vans and extending working days to reach a broad range of communities and tracks uptake by postcode to address inequality. The team work with faith groups to increase uptake in ethnic minority groups and have recently engaged with the Gipsy Roma Traveller community to understand the challenges in providing services in this population.

2.5.3 Antenatal and new-born screening programmes have almost 100% coverage of patients from all communities for the diagnosis of inherited genetic diseases.

2.5 Access to Care: We have recently opened Community Diagnostic Centres in Ely and Wisbech in order that more services can be offered closer to the patient's home.

2.5.1 We have a programme of work in Outpatients to reduce the need for face to face attendance with virtual clinics, patient not present, teledermatology and patient initiated to follow up. In addition we are reviewing the operational hours and availability of clinics, to meet the needs of those on zero hour contracts or other responsibilities.

2.5.2 The Trust uses MyChart for all of our patients; which is fully digital and where patients are able to securely access their health information held within their record in our Epic electronic patient record system.

MyChart is designed to improve communication between patients and their clinical teams at our hospitals, and enable patients to be more involved and informed about their care by having access to their information.

2.5.3 Virtual ward: For some patients, we are able to discharge them to their own home and monitor them remotely. In order to maintain equity, mobile devices are provided to patients to enable them to participate in this and reduce their length of stay in hospital.

2.6 Specific Characteristics: The Trust is working to improve its data collection with regard to protected characteristics. Ethnicity data is best in region at >91%, but other characteristics are less reliably collected and recorded for a combination of reasons.

2.7 Socially excluded groups: CUH has engaged with homeless charities to try and improve services for this population, particularly through the Emergency Department. We have forged links with the Gipsy, Roma and Traveller community, building communication links and attending the Midsummer Fair in Cambridge.

2.8 Medical research is a key aspect of the work at CUH. As part of our strategy we are actively looking to widen participation in clinical research trials and we work with numerous partners to ensure as diverse a group of participants as possible.

2.8.1 The NIHR BioResource national coordinating centre is located in Cambridge (with 18 regional BioResource centres across England) – CUH's Professor John Bradley leads on this nationally. The BioResource Centres provide local interaction, support and recruit new

volunteers. Any one is able to register if they want to be considered/contacted for research purposes. The BioResouce programmes are major initiatives between Centres and partners to tackle specific health conditions.

There is a new research programme from the NIHR BioResource – Improving Black Health Outcomes (IBHO) BioResource, which is focused on improving our knowledge and understanding of health conditions and their unique impacts on UK Black communities. This new research initiative is dedicated to studying health conditions that disproportionately affect people from Black communities. The IBHO invites individuals from Black ethnic backgrounds to participate in research aimed at improving how these conditions might develop and specifically affect those from Black communities.

2.8.2 UPTURN is a new 5-year, £2.8m research programme funded by the National Institute for Health and Care Research and led by Dr Jonathan Fuld**.** The study aims to help people with Chronic Obstructive Pulmonary Disease (COPD) take up, and therefore benefit from, Pulmonary Rehabilitation (PR). The UPTURN programme grant seeks to increase the uptake of pulmonary rehabilitation while lessening known health inequalities. Up to one third of COPD patients do not attend their initial PR assessment or fail to take up the programme, and therefore never get the benefit of the treatment. These are the issues UPTURN aims to address. Some ethnic minority groups have higher rates of COPD than others and low attendance at PR assessment. The UPTURN study will work with patients from the Bangladeshi and Black African & Caribbean communities, their families, and health care professionals to co-design a support package that will work for all but with the ability to be tailored to answer patients' specific questions and concerns about PR.

2.9 Smoking cessation: CUH has introduced a dedicated inpatient smoking cessation service, which is led by our Respiratory Consultant Dr Theresia Mikolasch. This new service provides tailored quit plans, individual counselling, and pharmacotherapy support to help patients achieve their smoke-free goals.

All current smokers must be offered advice, support and treatment to support them to remain temporarily abstinent whilst in hospital. Advice for temporary abstinence creates a teachable moment and often encourages long-term smoking cessation. This is a cost-effective way of improving health outcomes. In practice, this means that all patients must have their smoking status established at the point of admission.

Patients are then referred to a community based service on discharge.

Areas for Development

2.10.1 Data: The collection of, and analysis, of data to understand better the needs and challenges of different communities is a priority for the Trust.

2.10.2 Data Sharing: CUH has committed to the Cambridge & Peterborough Shared Care Record and aims to go live with this in 2025. This will enable clinicians to be able to view the medical records relating to their patient from other providers, for example the CUH records would be available for review by colleagues in Peterborough, should they be needed.

2.10.3 Access to Care: It is a priority of CUH to develop new models of care which will enable

patients to be treated in their own home, for all or part of their care. This will enable us to meet the challenge of a rapidly growing, and ageing population in our area.

2.10.4 Access to Care: The Outpatient Modernisation programme at CUH will aim to be more accessible to patients, reducing the number of journeys to the campus and be available at times to suit individual patients.

2.10.5 Access to Research: We are aiming to increase diversity within the research setting, to enable participation from a wider geographic and demographic distribution.

2.11 In summary, Health Inequalities are a major priority for Cambridge University Hospitals and the wider NHS. We are committed to work to reduce these inequalities alongside our partners across the health and social care system to improve the lives of our population.

3. Source documents

None