



The Leeds  
Teaching Hospitals  
NHS Trust

# Health Equity & Public Health Strategy

2025-2028



# FOREWORD

We are pleased to introduce you to the Trust's Health Equity & Public Health Strategy 2025-2028, building on the principles and replacing our Health Inequalities & Public Health Strategy that was published in 2022.

Our strategy defines how we will embed equity at the heart of everything we do and maximise our contribution to improving health equity in the populations we serve. We are committed to tackling health inequalities through our role as a provider of clinical services, as an anchor institution and as a partner in the wider health and care system. Our NHS constitution says we have a "duty to promote equality through the services we provide and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population".

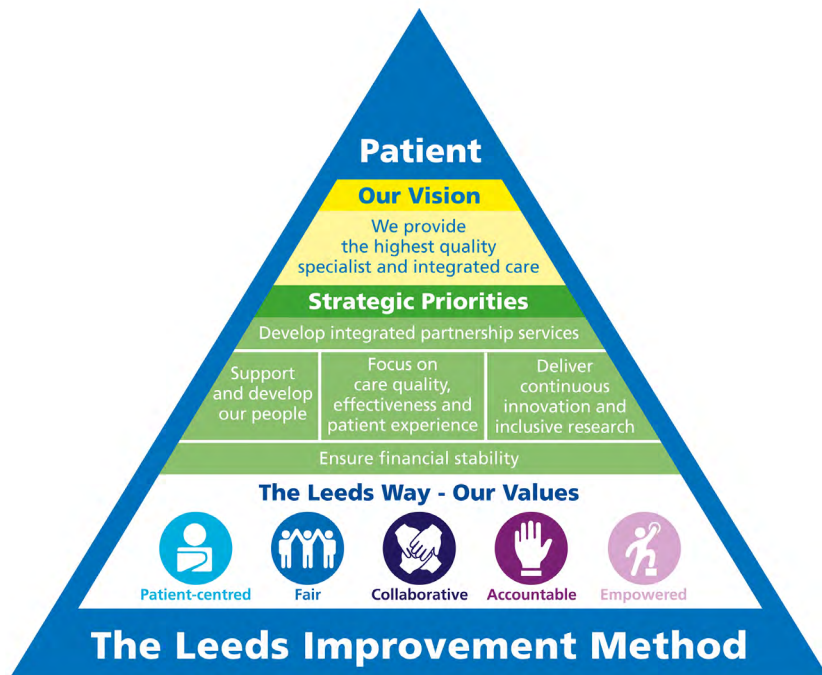
Fairness is a core value of LTHT. Being fair, removing barriers to access, being inclusive and accepting that some people need more help, is fundamental to how we deliver care. I look forward to continuing to work with you all to deliver the highest standards of equitable treatment and care to our patients in line with the Trust's vision and goals, annual commitments and the Leeds Way values.



**Prof. Phil Wood**  
Chief Executive and  
Exec. Lead for Health Inequalities

# OUR STRATEGY

Leeds Teaching Hospitals NHS Trust is an ambitious organisation with a clear vision to provide the highest quality specialist and integrated care. Our vision, values and strategic priorities are summarised in our strategic triangle below, which shows patients at the centre of everything we do.



- One of the **largest teaching hospitals** in the country
- A **regional and national centre for specialist treatment** and the **local hospital for the Leeds community**
- **Seven hospitals** across **five sites** in the city
- Treat around **1.6 million patients** every year
- Spend around **£1.9 billion** each year
- Almost **22,000 staff**
- Established **Centre of Excellence** for Research and Innovation at scale and a top recruiter for clinical trials

Our mission:

to be an internationally renowned academic healthcare institution, working in partnership to deliver the highest quality, safe, effective and innovative care which improves outcomes.

To support delivery of the strategy, we have seven multi-year goals which drive our long term activity and seven annual commitments which are refreshed each year to consolidate our in-year priorities.

Our multi-year goals are:

- Deliver fit for purpose healthcare.
- Deliver top quartile healthcare performance.
- Deliver a sustainable surplus by becoming the most efficient teaching hospital.
- Have an embedded culture of service improvement and innovation.
- To be a leading academic healthcare institution.
- Have a consistent, high performing and sustainable workforce.
- People receive person-centred care in the most appropriate setting.

Our 7 annual commitments are available on our [website](#).



## The Leeds Way

The Leeds Way is what we stand for and what we want to achieve. It is how we do things around here and what makes Leeds Teaching Hospitals different to other organisations. The Leeds Way is described in our strategic triangle; it encompasses our ambition through our vision and strategic priorities and our culture through our values, as created by our staff. It sets out what our stakeholders can expect from us as a Trust.



Patient-centred



Fair



Collaborative



Accountable



Empowered

# The Leeds Improvement Method

The Leeds Improvement Method (LIM) is our philosophy of continuous improvement that underpins all our organisational strategies. It brings the principles of daily management methods, improvement methodology, respectful behaviours and the removal of waste from processes together.

## Our strategy framework

This strategy is part of a wider suite of strategies that work together to support the Trust to meet its overarching vision. At the centre of this is the Trust's corporate strategy, supported by three core strategies and eleven enabling strategies. This strategy framework enables us to ensure our strategies align and are updated appropriately to reflect and support the overall Trust strategy.



# ACHIEVEMENTS 2024

## OUR FOUNDATIONS

- 1. Making the invisible visible:** Equity data embedded within a range of data dashboards including Outpatients, Maternity, ED and Cancer.
- 2. Multiple tailored patient engagement** activities targeting patient groups experiencing or at risk of known healthcare inequalities. e.g. Respiratory patients, maternity patients who smoke, people in recovery, young people accessing A & E to understand their experience of safeguarding, digitally excluded groups.
- 3. Maturing:** Outcome of our Trust Board self-assessment on health inequalities work at LTHT.

## OUR ENABLERS

- 4. Equity embedded** into all Quality Improvement projects within Maternity Services.
- 5. Over 150 people** attended cross provider good practise events focussed on practical action to reduce missed appointments and improve health equity.
- 6. Building our workforce capacity and confidence:** Training developed and delivered throughout the year on health inequalities, inclusive engagement, smoking cessation, drugs and alcohol, and brief advice.
- 7. Equality & Health Inequality Impact Assessment tool** adopted and rolled out.

## OUR DELIVERABLES

- 8. Over 20 improvement initiatives** taking place by teams across LTHT to improve inequalities in access, experience or outcomes e.g. Improving access for black men.
- 9. 100's of patients seen by our social prescriber** in A&E improving health equity through supporting patients with non-clinical needs.
- 10. 90% of inpatients screened for smoking and alcohol** on admission to hospital and linked to specialist services.
- 11. Over 1000 smokers supported to quit** through our fully established Stop Smoking Service.

# INTRODUCTION

Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. Health equity is when everyone has a fair chance to be healthy. It is the absence of the inequalities, which arise due to the conditions in which we are born, grow, live, work and age.

Health inequalities directly impact: our services; people's need for healthcare; how people access healthcare; people's experiences of care; and outcomes from treatment.

The demographics of the population we serve means we need to take health equity seriously. We have a large population living in deprived areas who are dying on average 10 years earlier than those in the least deprived areas. Those in the most deprived areas are also living 18 years longer in poorer health. Not only is this inequity morally abhorrent, but earlier onset of ill health (e.g. before retirement age) also increases costs within the NHS.

**1/3 of children in Leeds**  
live in the  
**10% most deprived areas**  
nationally



**1/4 of adults in Leeds**  
live in the  
**10% most deprived areas**  
nationally



# Inequity in the NHS

Inequality impacts everything we do as a healthcare provider. Examples include:

## Healthcare access

- Due to many barriers, there are disproportionately high rates of missed appointments from patients living in deprived communities
- Length of time on waiting lists: Kings Fund research shows that those in the most deprived communities are twice as likely to wait more than a year for elective treatment compared to those in affluent areas
- There are disproportionately high rates of A&E attendance from patients living in deprived communities in part due to a lack of access to planned care.

## Patient Experience

- Racialised communities report poor experiences of care due to issues such as lack of cultural competence, cultural safety, language barriers
- People with learning disabilities have significantly longer lengths of stay in hospital than other groups.

## Health Outcomes

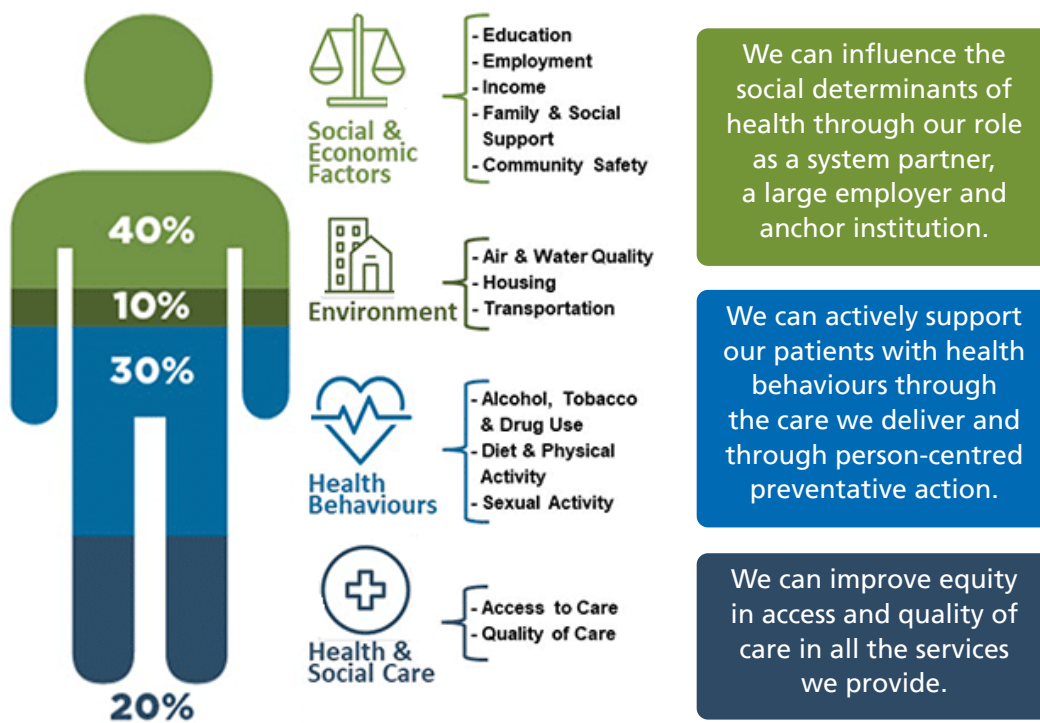
- People living with severe mental illness face one of the greatest health equity gaps in England. Their life expectancy is 15-20 years shorter than the general population.
- Black women are 3.7 times more likely to die during or in the first year after pregnancy than white women
- Compared with the wider population, the average age at death for people with a learning disability is 23 years younger for men, and 27 years younger for women. People with a learning disability from Black and minority ethnic backgrounds can expect to live just 34 years, just over half the life expectancy of their white counterparts.

## Our Staff

- Patterns of inequalities in our communities also impact our workforce of which 21% of live in the 10% most deprived areas in England (IMD 1) and 29% of our workforce are from black and minority ethnic backgrounds.

## What approaches can be taken to improve health equity within an acute NHS trust?

The diagram below shows the modifiable factors that impact on our health. We accept as an organisation that many factors that drive health inequality are beyond our control, but that LHTT still have a vital role to play in improving health equity.



### Modifiable factors that impact our health

*(taken from the Scottish Chief Medical Officer Annual Report 2022-3)*

## Preventing ill health

Prevention plays a vital role in tackling health inequalities. The life expectancy gap between the most and least deprived communities is driven by preventable and manageable disease. The upcoming 10-year health plan from central Government has a strong focus on ill-health prevention. Furthermore, the Government has highlighted that one of the three fundamental shifts for the NHS needs to be a move from “treatment to prevention”. In Leeds, Goal 2 of the [Healthy Leeds Plan \(2023-2028\)](#) is centred on prevention through increasing early identification and intervention (of both risk factors and actual physical and mental illness).

At LTHT we have a significant role to play in prevention through:

- **Identifying risk factors** for disease in patients and offering advice, intervention or treatment to stop disease (primary prevention). Example: Identifying smokers and offering tobacco dependency treatment.
- **Detecting health problems early** to support earlier identification, intervention and treatment (secondary prevention). Example: Breast cancer screening.
- **Minimising the harm from existing conditions** through careful management (tertiary prevention). Example: Optimising medication for those with chronic kidney disease to prevent the need for dialysis.

## CORE20PLUS5 framework

The '[CORE20PLUS5](#)' framework is designed to drive targeted action within the NHS on healthcare inequalities for adults and children and young people. This framework informs our strategic approach to tackling inequalities (see Appendix 1).

CORE20PLUS5 supports a focus within the NHS on the 20% most deprived communities in England. In Leeds, due to our demography, the focus is primarily on the 10% most deprived communities which forms 26% of our population. The framework also promotes a focus on 'Plus Groups', people that we know experience poorer health outcomes such as ethnic minorities, people with learning disabilities, and people experiencing homelessness.

The '5' within the framework speaks to five specific clinical areas where we know inequalities exist and where taking action will drive improvement.

## The NHS Workforce

LTHT is an employer of over 22,000 people. There are significant opportunities to improve workforce health and reduce inequities through: our recruitment processes; by ensuring staff have high quality employment; understanding and responding to health inequalities within our workforce; and by supporting staff health and wellbeing. Not only will this improve the health of our staff but will also have a direct impact on the quality of care that patients receive.

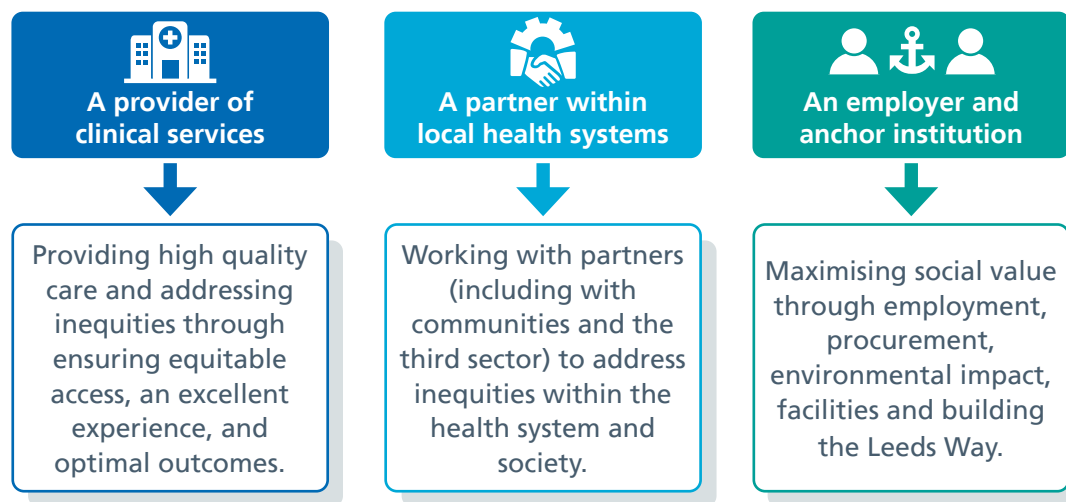
This approach directly aligns with the [2023 NHSE equality, diversity and inclusion improvement plan](#). One of the high impact actions within the plan specifically encourages trusts to develop and implement an improvement plan to address health inequalities within the workforce.

# OUR STRATEGY

## What will LTHT do to improve health equity?

Our vision is to embed equity at the heart of everything we do and maximise the Trust's contribution to improving health equity in the populations we serve.

The Trust has three main roles in addressing health inequalities:



## Who will we focus on?

The LTHT Health Equity strategy supports the CORE20PLUS5 approach by ensuring there is a clear focus on:



### People living in areas of deprivation

(namely those who live in index of multiple deprivation (IMD1<sup>1</sup> areas). Through the [Leeds Health and Wellbeing Strategy](#) we have committed to ensuring “people who are the poorest improve their health the fastest”.



**People who experience poorer health outcomes** that would benefit from a targeted approach. Specifically, we will consider those with the worst health outcomes:

- **People with learning disabilities and autism**
- **People with serious mental illness**
- **Ethnic minority communities**
- **Inclusion health groups<sup>2</sup>**



### Our staff who experience poorer health outcomes.

This include staff that are at higher risk of discrimination, have long term conditions, disabilities or experience deprivation.

1. Index of multiple deprivation (IMD) is a way of measuring how deprived a neighbourhood is through looking at a range of factors including income, employment, education, health, crime, housing and living environment. IMD 1 is the 10% most deprived small areas nationally. IMD 10 is the 10% least deprived.
2. Inclusion Health groups are defined as people who are socially excluded and experience a greater number of risk factors for poor health – such as stigma, discrimination, poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

## Which areas do we need to focus on to embed equity into everything we do?

Our building blocks:



\* Business processes is a broad term which refers to how we manage our business and services at the trust. For example, it refers to how we embed equity into processes such as resource allocation, contracting, risk assessment and business proposals.

# How will prevention help tackle inequity?

Prevention of ill health is one of the biggest things we can do to tackle inequity. However, we must make sure that actions to prevent ill health are targeted according to need (for example to the needs of deprived communities) to make sure we do not inadvertently worsen inequity.

## Existing preventative programmes

We commit to ensuring all existing preventative programmes are actively seeking to address inequality, from smoking cessation services to cancer screening. We will focus on ensuring our existing programmes are accessible to those with the most need, using the 'Five A's of Access' as a guide (see chart below). By designing our programmes for those often excluded from healthcare, we will better accommodate the needs of all.

<b>Approachability</b>	<p><b>Is the service friendly and accessible for all?</b></p> <ul style="list-style-type: none"> <li>• Is it easy for all to understand how to access the service?</li> <li>• Is the service easy to reach? What does patient feedback say?</li> <li>• Are the Accessible Information Standards met?</li> <li>• Are staff adequately trained regarding accessibility and communication?</li> </ul>
<b>Acceptability</b>	<p><b>Are all services accessible regardless of patient characteristics?</b></p> <ul style="list-style-type: none"> <li>• Are different communities' health, cultural and social beliefs considered? And the impacts of this recognised?</li> <li>• Is the service equitable for all? What processes are in place to know this?</li> <li>• How are changes to services are communicated with people?</li> </ul>
<b>Availability</b>	<p><b>Do people have different options to access depending on need?</b></p> <ul style="list-style-type: none"> <li>• How are people's identified needs responded to?</li> <li>• Is the physical environment accessible?</li> <li>• What solutions are available to address digital and language barriers?</li> <li>• Is the service timely?</li> </ul>
<b>Affordability</b>	<p><b>Have considerations about costs been made?</b></p> <ul style="list-style-type: none"> <li>• For example, cost of taking time off work, cost of transport, cost of caring</li> </ul>
<b>Appropriateness</b>	<p><b>Is the service shaped by population need?</b></p> <ul style="list-style-type: none"> <li>• Are services suitable for different communities? What do patients feedback?</li> <li>• Have they been shaped by patient feedback and need?</li> </ul>

Ref: Public Health,  
Leeds City Council

## Developing new or improving preventative programmes

In LTHT's role in identifying risk factors (primary prevention), we will focus on working with patients to reduce the modifiable risk factors that result in the most ill health: smoking, alcohol, physical inactivity and obesity.

In LTHT's role in detecting health problems early and minimising harm from existing conditions (secondary and tertiary prevention), we will focus on the manageable conditions that cause the greatest burden of disease: cancer, heart, lung and kidney disease.

We will use the significant existing evidence base to implement, or improve our implementation of, high impact preventative interventions designed to be delivered within the NHS. For example: identify people with alcohol dependency in acute hospitals, provide specialist interventions and referral into community services for ongoing support and treatment.

## How will we work with our partners to improve health equity?

### Patients, carers and communities

Our most important partners are our patients, carers and the communities we serve. At the heart of tackling health inequity needs to be an understanding of the realities of those most affected by poor health outcomes and finding solutions that work for our patients and communities. We commit to listening, involving and developing solutions alongside patients, carers and communities. As well as new engagement opportunities, we will seek to maximise the use of existing insights from patients, carers and communities throughout strategy delivery.

### System partnerships

We seek to be advocates for addressing health inequity throughout all our partnership work. Our executive lead for Health Inequalities will provide leadership on tackling inequity across West Yorkshire and the Leeds Health and Care Partnership.

We commit to making Leeds a Fairer, Healthier City (Marmot City) and will support our city-wide partners to join up, scale up and be bold in our action to tackle inequity.

We will actively contribute to place based and system partnership groups and collaboratives whose aim is to coordinate and strengthen the system response to tackling health inequalities. We will represent the needs of our patients in these forums and support solutions to inequity that sit beyond the boundaries of our Trust. We will bring back learning and implement relevant solutions within LTHT.

We will continue to work closely with other NHS providers in the city to align how we tackle health inequities, share learning and amplify impact. We seek to work more closely with provider colleagues as one team, being smart about how we share resource, develop solutions, build capacity to make more rapid progress on tackling inequity.

The third sector are a vital partner in tackling inequity. Firstly, we commit to applying the insight that third sector organisations can contribute through their close connections to communities. Secondly, we will explore strengthening our collaborations with third sector organisations in delivering models of care better adapted to the needs of those who have the worst health outcomes.

## How will we improve equity through our role as an anchor institution?

We will continue to be active members of the Leeds Inclusive Anchor Network, recognising our vital role as a large institution and major employer within our city. We commit to ensuring all the work we do as an anchor institution actively addresses health inequity within our staff and within our communities.

We recognise the vital role we have as an employer. We seek for our workforce, across all levels of the organisation, to reflect the communities that we serve. We commit to using employment as a tool for tackling poverty and providing opportunities for our local communities. We prioritise the health and wellbeing of our workforce, seeking to do what is in our gift to reduce health inequities experienced by our staff members.

We will seek to address system recommendations from the Marmot City Report and embed health equity within all policies, looking beyond clinical services to areas such as estates, facilities, procurement, sustainability and waste. This will include opportunities to strengthen the social value delivered through contracts and procurement. We will embed our Equality and Health Inequalities Impact Assessments across all relevant parts of the organisation.

## How will we deliver the strategy?

The LTHT Health Equity & Public Health Strategy will be supported by an organisational wide annual action plan. This plan will clearly set out agreed activity against the priority areas of focus (our building blocks).

Each year the action plan will state areas of focus relating to each of LTHTs core roles in tackling inequity. These areas of focus will be determined by trust wide priorities, NHS planning guidance, emerging opportunities and insight from staff and communities.

## The focal areas for Year 1 are highlighted below as examples

These will be reviewed on an annual basis:

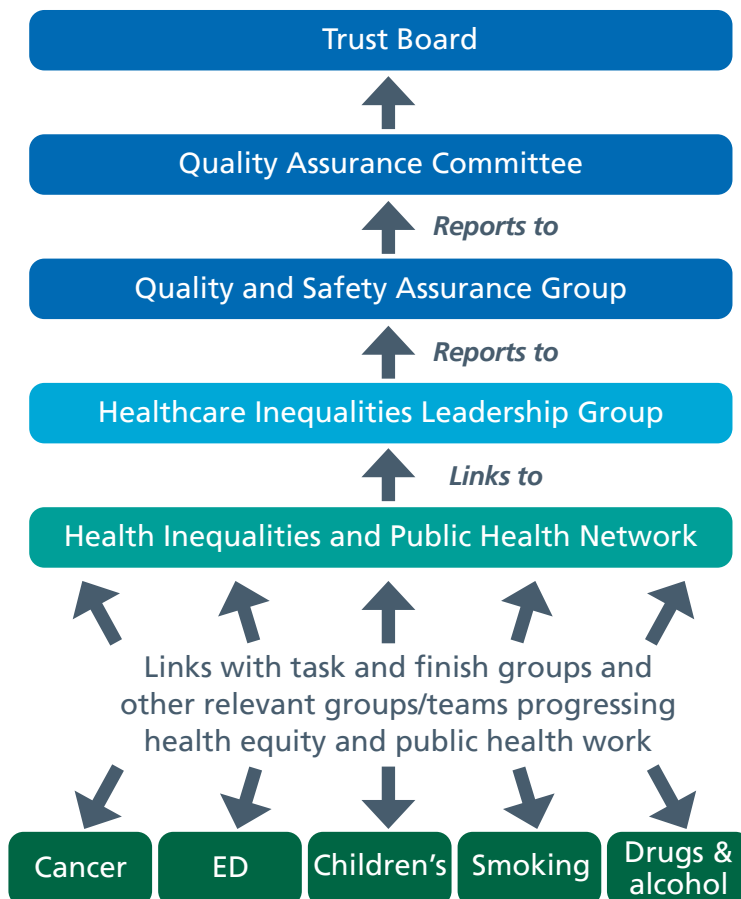
1. As a provider of clinical services:  
**Focus on Improving Equity in our Waiting Lists**
2. A partner within local health systems:  
**Focus on Improving Renal Health**
3. As an employer and anchor institution:  
**Focus on Health Equity within our Workforce**

These areas of focus help us as a large organisation to better coordinate our efforts, concentrate our capacity and build momentum around specific topic areas. The aim is to make improvements more visible, measurable and impactful.

Equity is everyone's business and therefore we need to work in agile teams to embed equity in all that we do. There are already multiple teams, groups and individuals whose work actively supports the delivery of this strategy. The Health Inequalities and Public Health Network is a vital forum to link individuals and teams and to coordinate and align our work.

Throughout delivery of the strategy, it may be necessary to establish (and step down) task and finish groups to make progress on specific actions detailed within the annual action plan.

### Schematic of Internal Governance Arrangements



**Purpose:** Provide leadership and decision making on tackling health inequalities across the trust. Progress key trust wide tasks, unblocking sticky issues. Monitor impact.

**Purpose:** Sharing learning, building technical expertise across LTHT, peer support, supporting health equity and public health strategy implementation.

**Purpose:** Progress focussed work on tackling health inequalities within the context of specific departments/CSUs/topics.

# How will we measure progress?

As a Trust, we have a duty to report on the following Health Inequalities indicators within our Trust annual report<sup>1</sup>

- Elective activity vs pre-pandemic levels for under 18's and over 18's
- Emergency admissions for under 18's
- Proportion of adult acute inpatient settings offering smoking cessation services
- Proportion of maternity inpatient settings offering smoking cessation services
- Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under

We also commit to disaggregating the performance measures listed below by:

1. IMD
2. Ethnicity
3. Learning disability
4. Age

Whilst working towards further disaggregation of key measures such as Interpreter requirement, autism, sexual orientation and inclusion health group status.

**Performance measures:**

- Data quality of key equity variables (such as ethnicity recording)
- Outpatient missed appointment and was not brought rate
- Average Length of Wait
- Patients waiting more than 18 weeks RTT
- Emergency care standard
- 7-day reattendance at A&E
- Proportion of complaints related to the 3 C's (communication, compassion and coordination)
- Patient safety incidents
- Average length of stay (average and long stays)
- Composition of workforce (across all grades)

The measures we monitor may change over time to respond to emerging priorities. There will be additional measures to monitor progress against our annual action plan.

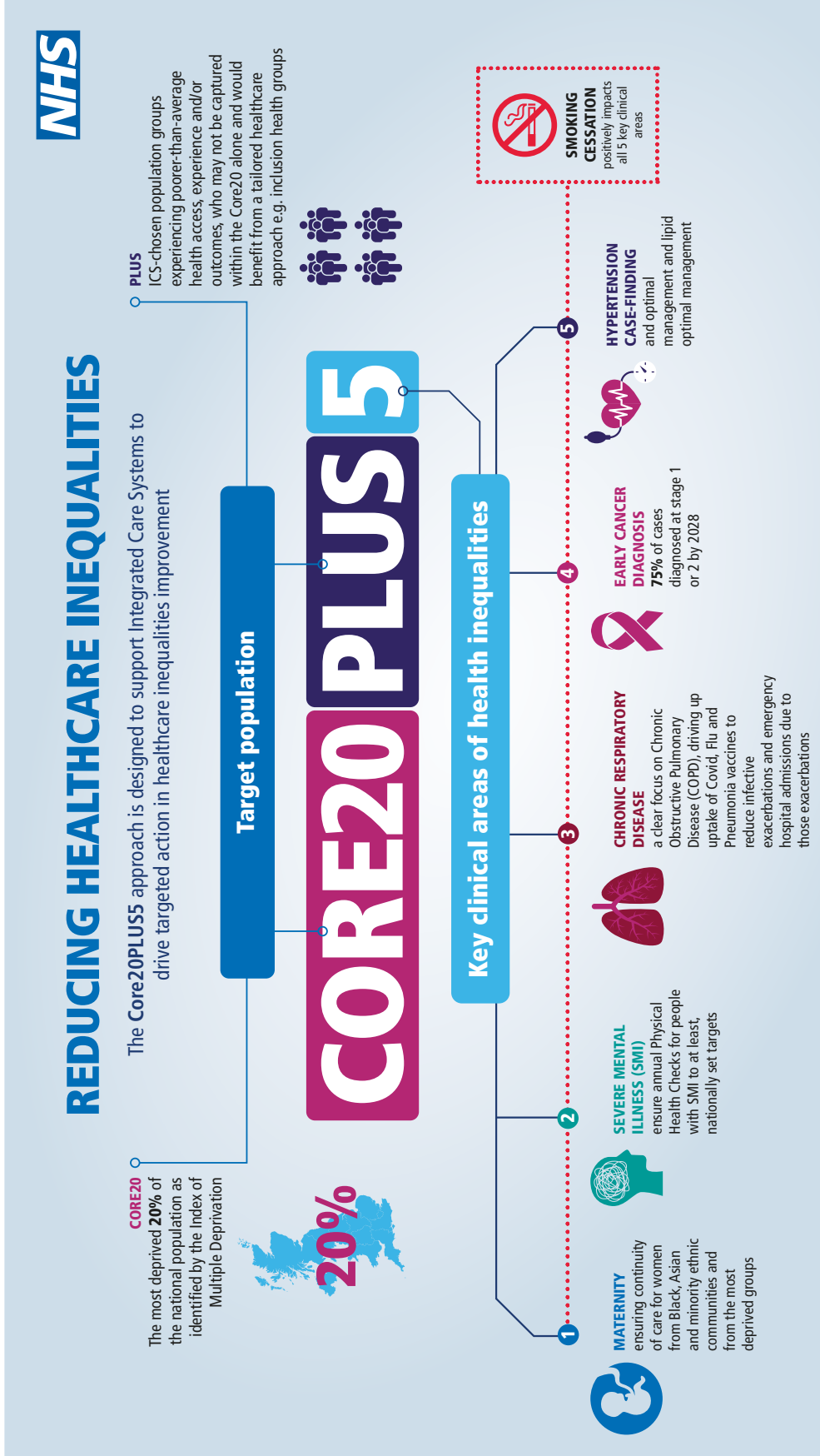
We also commit to being part of City-Wide measuring and reporting of health inequalities, such as the Marmot City Indicators and any indicator sets developed through the Leeds Healthcare Inequalities Group.

---

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

# Appendix 1:

## CORE20PLUS5 frameworks - Adults



CORE20PLUS5 frameworks - Children & Young People

