Health Inequalities Statement

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HEALTH INEQUALITIES STATEMENT

Health inequalities are unfair, unjust and avoidable differences in health between groups. They arise from unequal access to healthy living conditions, healthcare and the support people receive. In December 2025, the Trust launched its Health Inequalities and Prevention Plan, which aims to create lasting change where preventing illness and health inequalities becomes part of our everyday practice, to improve the health of our population. A key part of this approach is using high-quality data and insight to inform action on health inequalities through both operational and strategic decision-making.

This report sets out our organisational response to NHS England's updated *Statement on Information on Health Inequalities*. The national guidance outlines the statutory requirements for NHS bodies to collect, analyse and publish robust, disaggregated data to understand and address inequalities in access, experience and outcomes. In line with the Core20PLUS5 approach and the wider ambitions of the 10-Year Health Plan, this report describes how we will embed these requirements into our local systems, strengthen data quality, and ensure that insights on health inequalities meaningfully shape our planning, commissioning and service delivery.

The report includes:

- An overview of Wigan borough's health needs
- Understanding healthcare access, experience and outcomes
- Improving data quality, collection and analysis
- Using information on health inequalities — areas of progress and next steps

Understanding Wigan's health needs

Approximately 77% of the Trust's catchment population live in the Wigan Borough[1], which is home to 330,000 people. The population is growing and ageing: between 2011 and 2021 the number of residents increased by 11,472, and the 70–79 age groups grew by over 40%, making this the fastest-growing older population in Greater Manchester. The borough remains predominantly White British (95%), though ethnic diversity is increasing, with notable growth in Asian, Black and mixed ethnic groups over the past decade.

Health inequalities remain one of the most significant challenges. Wigan is the 78th most deprived local authority in England, and 28.5% of residents live in neighbourhoods among the 20% most deprived nationally. These inequalities translate into stark differences in health outcomes: life expectancy varies by 8.1 years for men and 9.1 years for women between the most and least deprived areas, driven largely by higher rates of circulatory disease, cancers and respiratory conditions in more deprived communities.

Overall health outcomes in the borough are worse than the England average. Residents live shorter lives and spend more years in poor health, with healthy life expectancy around 58 years for both men and women. The leading causes of death mirror national trends - dementia, lung cancer, pneumonia and heart disease - but premature mortality is strongly patterned by deprivation. Key preventable risks such as smoking, alcohol-related harm, physical inactivity and obesity continue to

[1] *Microsoft Power BI*

contribute significantly to poor health, with 74.6% of adults living with overweight or obesity and high rates of falls among older adults.

Children and young people also experience poorer outcomes than national averages, including higher levels of dental decay and elevated rates of overweight and obesity in early years, alongside persistent inequalities in child poverty and early development[2].

Understanding healthcare access, experience and outcomes

To help us identify unwarranted variation in access, experience and outcomes across different population groups, this section focuses on inequalities within core performance measures that align with our operational priorities. The analysis concentrates on:

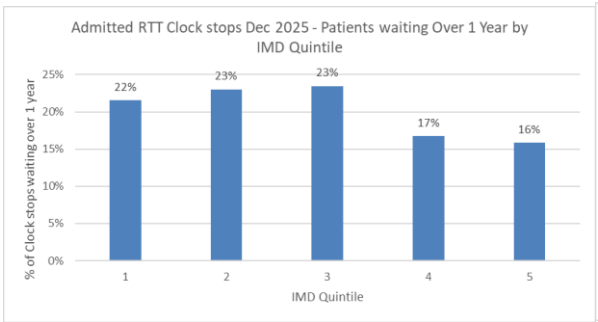
- **Elective care:** waiting lists and outpatient DNAs
- **Urgent and emergency care:** A&E frequent attenders, average length of stay and readmissions
- **In hospital mortality**
- **Index of Disparity**

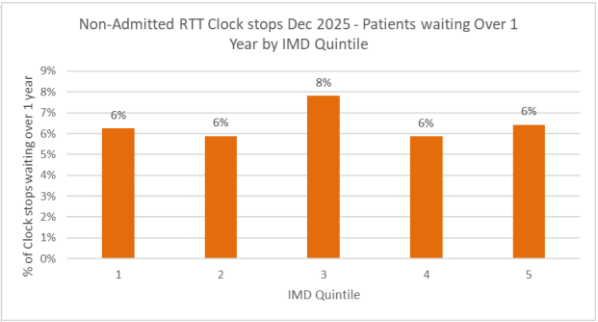
In 2023, three health inequalities insight reports were produced for the Trust, highlighting variation in waiting lists, occurrences of patients failing to attend appointments (DNAs), A&E attendances and emergency admissions. By using the same metrics, we have been able track trends annually. This paper therefore compares performance for April - December 2025 with 2024/25, 2023/24 and 2022/23.

All data has been disaggregated by age, sex, and Index of Multiple Deprivation (IMD), and where possible ethnicity, to identify unwarranted variation linked to protected characteristics and deprivation. These characteristics are now embedded within on-demand reporting, enabling more consistent and systematic monitoring of inequalities.

Waiting Lists

- As of December 2025, the proportion of patients in the more deprived, and median deprived areas who wait over 1 year for admitted care remains higher than the percentage in the least deprived areas.
- Patients waiting over 1 year for outpatient treatment across all of the quintiles ranges from 5.9%-6.4%, except for quintile 3, with 7.8% of patients.

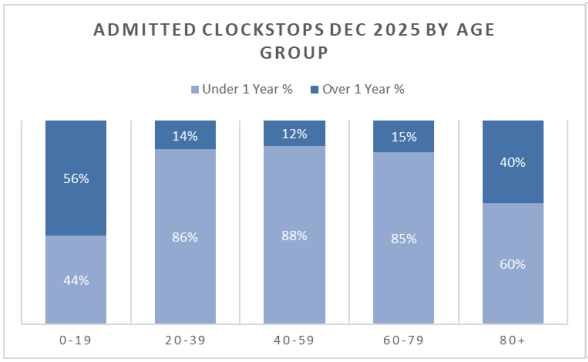


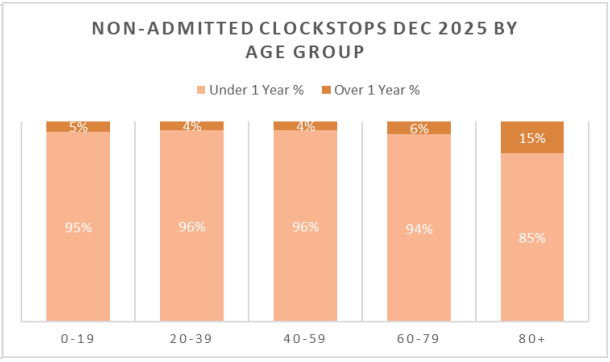


- Children remain more likely to wait over 1 year for admitted treatment, 56%, with 40% of patients aged over 80 years waiting over 1 year, compared with 12-15% for remaining

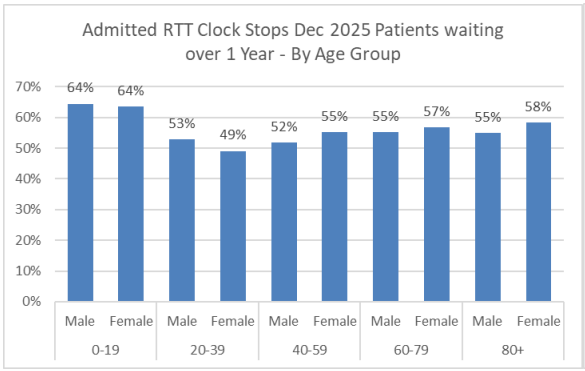
[2] Wigan Borough Joint Strategic Needs Assessment Population Health Summary

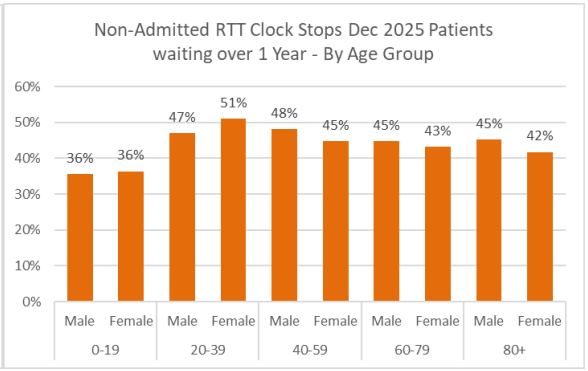
patients. 15% of patients aged over 80 wait over 1 year for outpatient treatment compared to 4-6% for other patients.





- The latest waiting list position, as at December 2025, shows a higher proportion of patients aged 0-19 who waited over 1 year for admitted care.

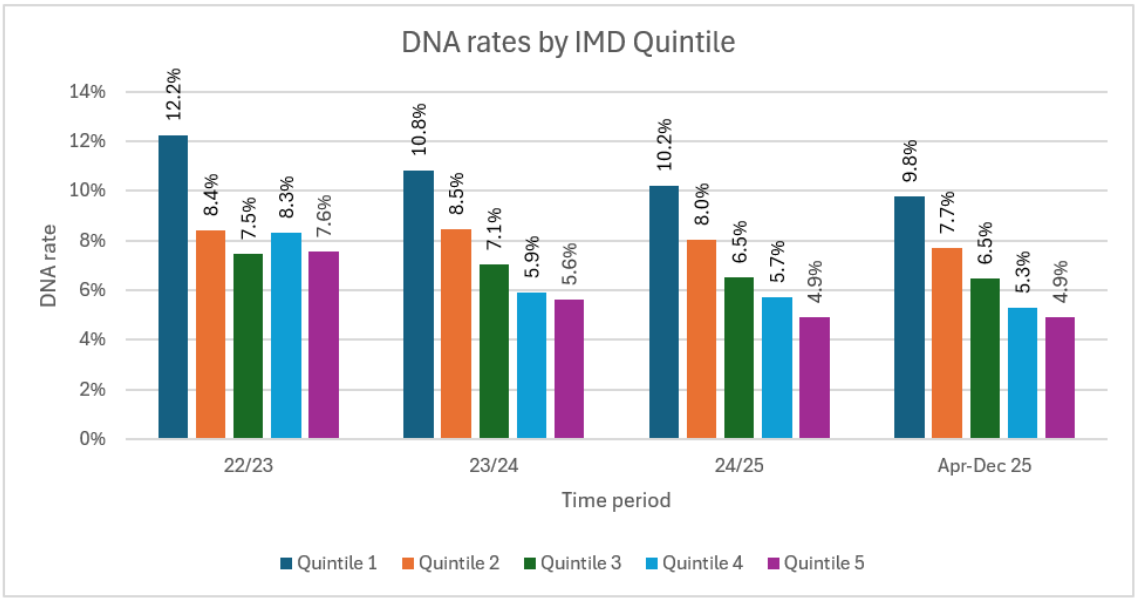




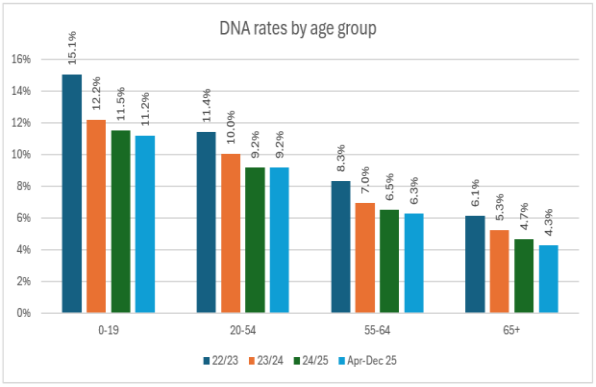
- Disaggregation of patients waiting over 1 year by ethnic group was conducted, but due to small numbers it was not possible to draw any conclusions.

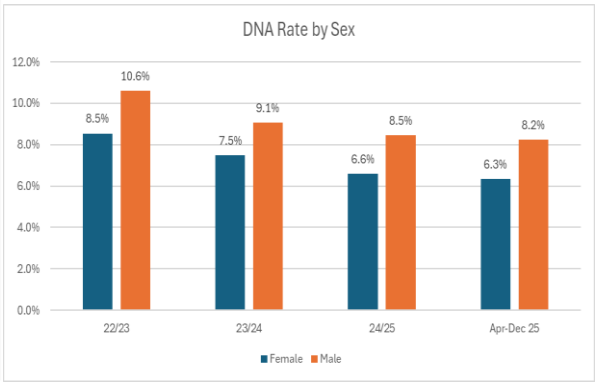
Outpatient DNAs

- The overall DNA rate for the Wigan residents at WWL was 7.4% in April - December 2025, this is showing a downward trend (9.4% in 2022/23 to 8.2% in 2023/24, 7.6% in 2024/25).
- Outpatient DNA rates continue to be highest for those living in the most deprived areas, as deprivation reduces so does the DNA rate.
- Between April - December 2025, the DNA rate for patient's resident in quintile 1 (20% most deprived areas) was twice as high as for those residents in quintile 5 (20% least deprived areas).
- This is consistent with previous years showing a persistent inequality.

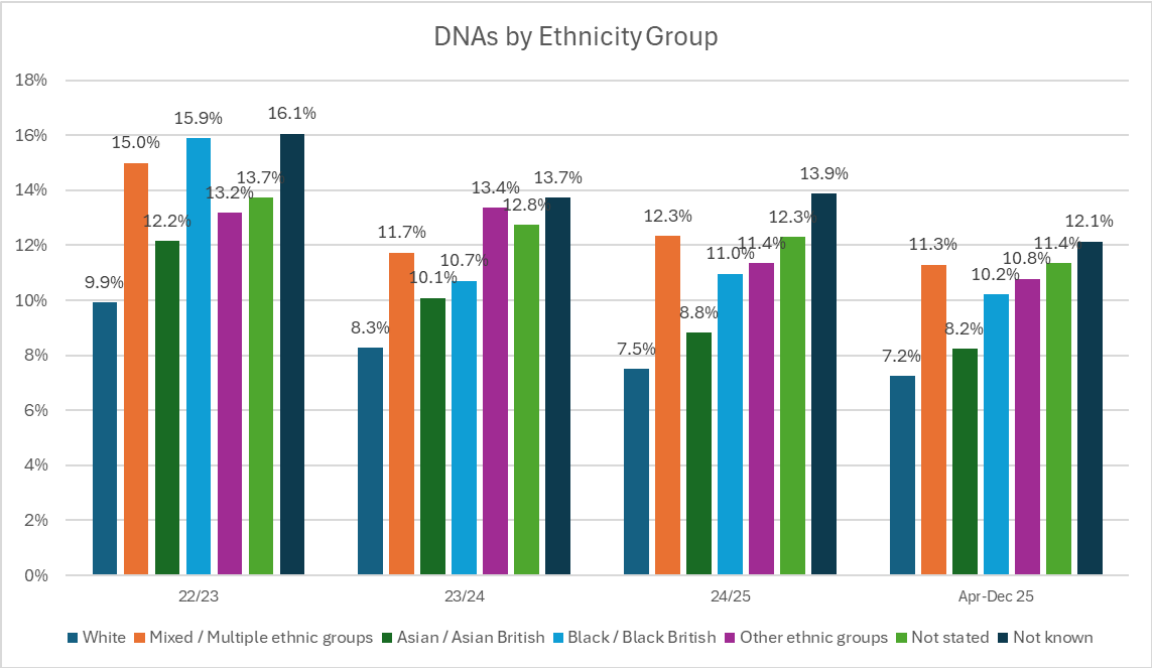


- There has been a year-on-year reduction in DNA rates across all age groups, and by sex. The highest levels remaining amongst the younger age groups, specifically those aged 0 to 19 and males aged 20 to 54 years. As age increases, the rate of DNA continues to reduce across all time periods analysed.
- DNA rates remain consistently higher in males, particularly those aged 20-54 years, with the latest DNA rate being 15.28%.



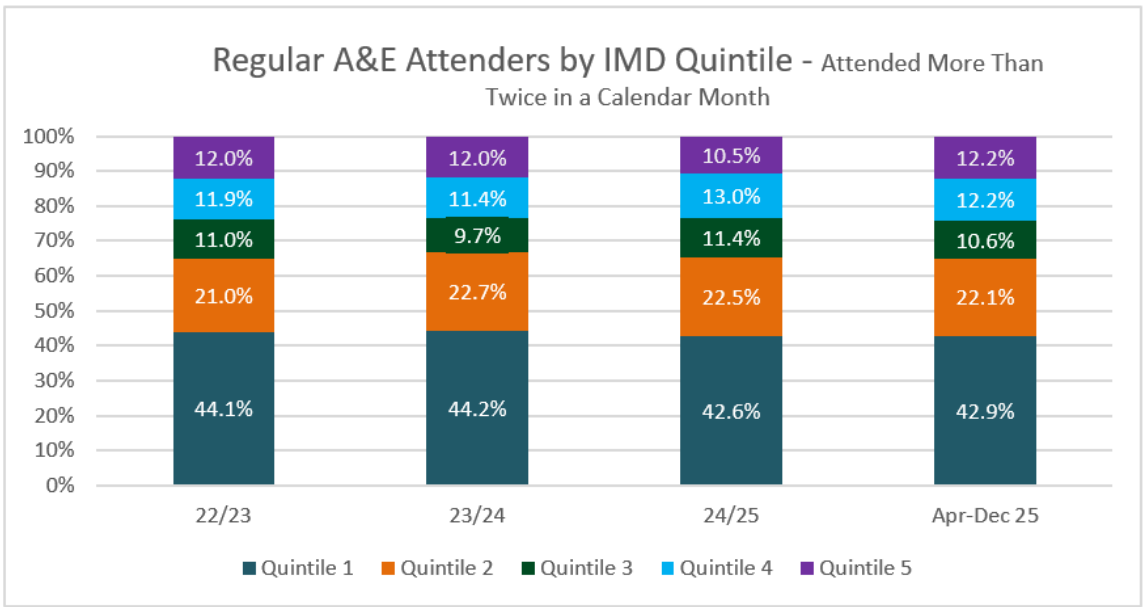


- DNA rates have reduced over time across all ethnicity groups; however, the chart demonstrates a persistent inequality gradient, with some groups consistently experiencing higher non-attendance than others. In every year shown, patients recorded as “Not known” and those in “Mixed / Multiple ethnic groups” have the highest DNA rates, while the “White” group has the lowest. Although the gap between groups has narrowed by April - December 2025, these differences remain, indicating that improvements have been unevenly realised. The continued prominence of the “not known” category also highlights a data quality inequality, where incomplete ethnicity recording may both mask true disparities and reflect lower engagement with services.

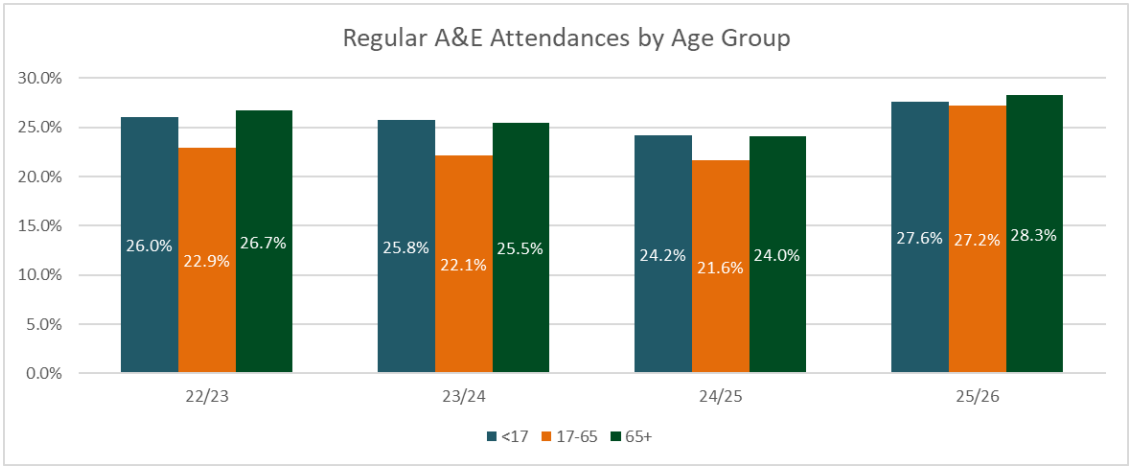


A&E Frequent attenders

- Patients living in the most deprived areas were found more likely to be an A&E regular attender. Reviewing the data for patients who attend more than twice in a calendar month, the most deprived quintile equated to between 42.6% and 44.2% for the time periods analysed, compared to the least deprived quintile ranging from 10.5% - 12.2%.
- This is consistent with the findings from previous years.



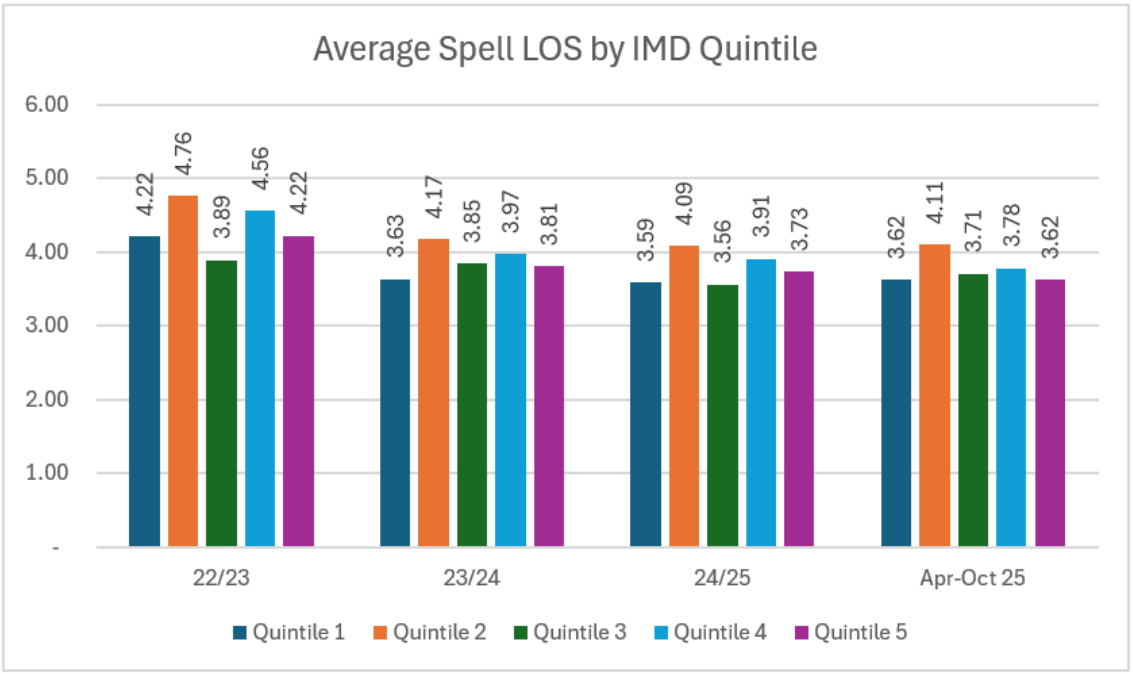
- A&E reattendance rates over the 4 years are highest amongst older age groups, closely followed by those in the <17 category.
- In terms of regular A&E attendance rate, there is a dip across all age groups in 2024/25 followed by a marked increase in 2025/26 across all age groups, indicating a broad rise rather than pressure within a particular age cohort.



- Across all time periods, the White ethnic group makes up the clear majority of regular A&E attenders, accounting for around 86–89% of attendances. All other ethnic groups individually represent small proportions, generally 1–3% each, including Asian / Asian British, Black / Black British, Mixed / Multiple ethnic groups, and Other ethnic groups. This reflects the ethnic make-up of the local population, and it is difficult to draw further conclusions due to small numbers.

Average length of stay

- The average length of stay shows a general downward trend across all quintiles over time.
- Average length of stay is a similar when comparing quintile 1 (most deprived) to quintile 5 (least deprived), whilst quintile 2 consistently shows the highest length of stay. It is unclear why we observe this trend, and it may warrant further investigation.

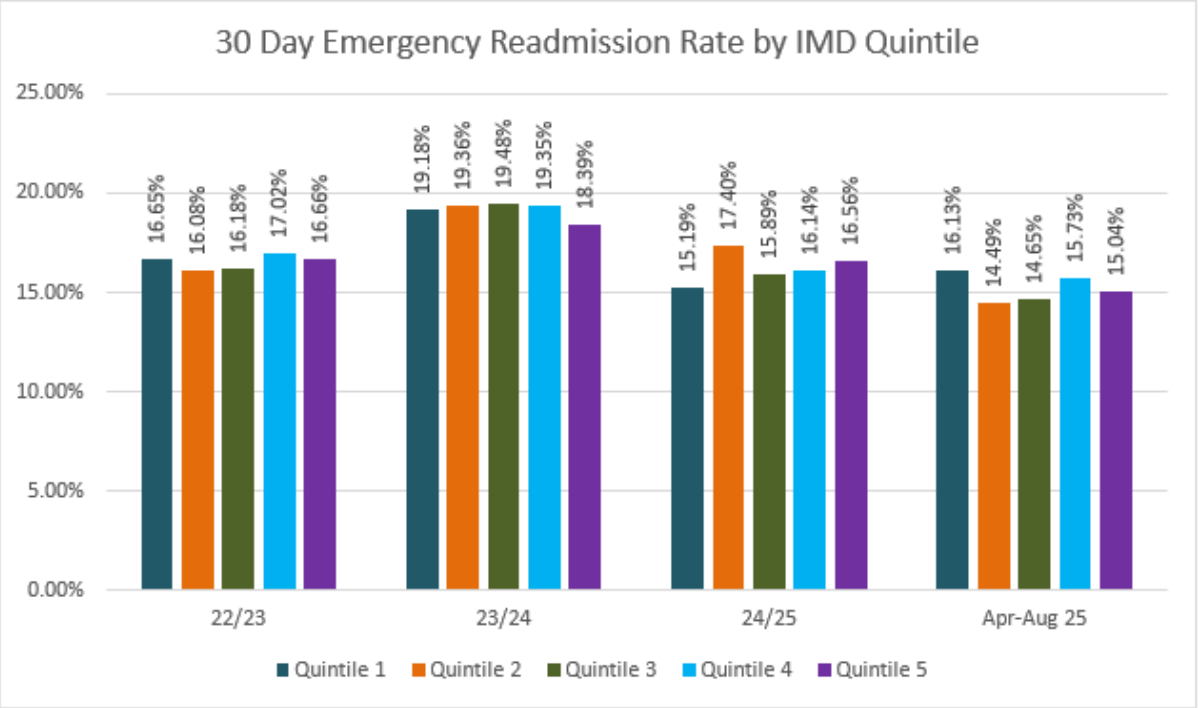


Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

Readmissions

- There is no consistent pattern to show that more or less deprived patients are more likely to be readmitted within 30 days.
- During April - August 2025, the lowest rate was in quintile 2, 14.49% and the highest rate in quintile 1, with 16.13%. However, this is inconsistent with previous years, meaning that the

significance is unclear - during 2022/23 and 2023/24 there was little variation in 30-day readmission rate between the quintiles. During 2024/25 quintile 1 had the lowest level of 30-day readmission rate at 15.19% and quintile 2 saw the highest rate at 17.4%.

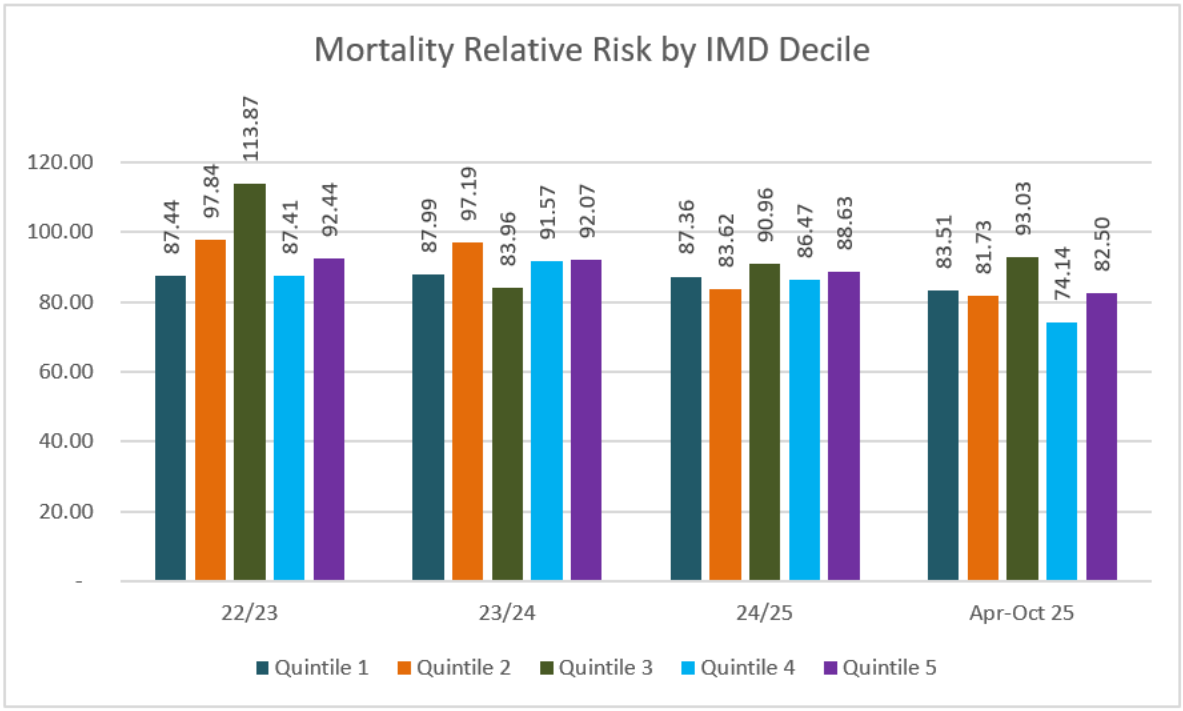


Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- As age increases, the rate of readmission also increases. During 2022/23 19.65% of patients aged 75 years and above were readmitted into hospital within 30 days of discharge; the figure for 2023/24 was 21.24%, for 2024/25 was 20.73% and for April - August 2025 was 21.11%.

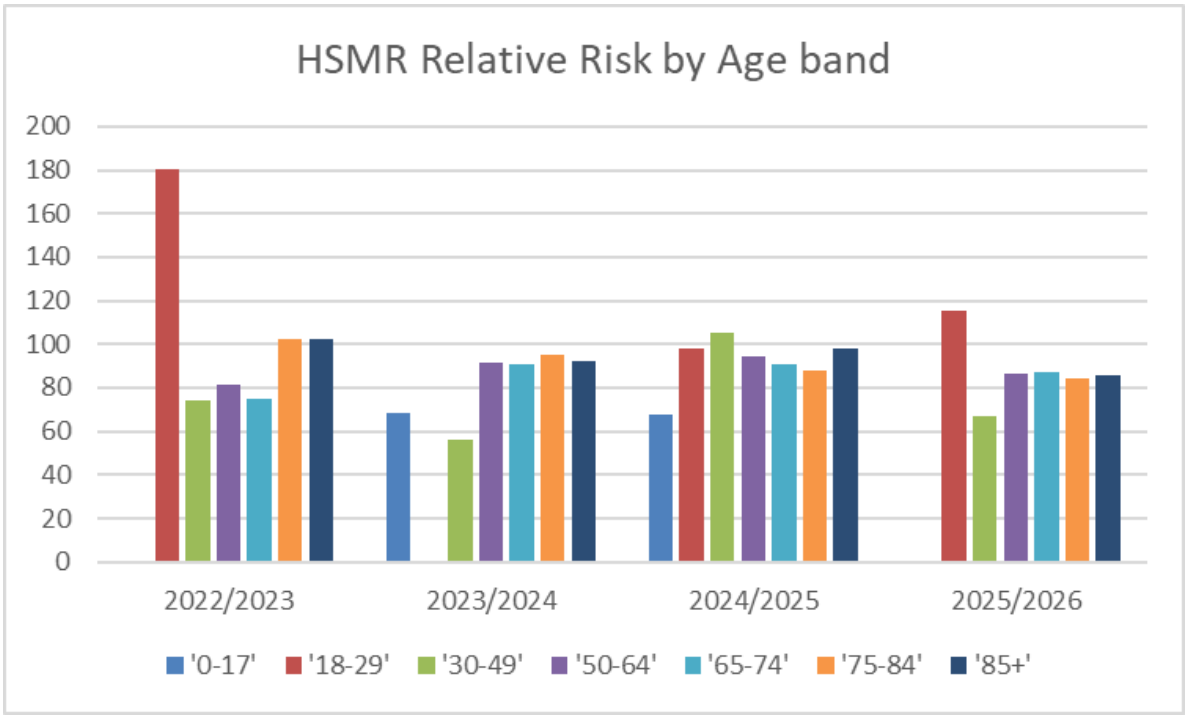
In hospital mortality

- In hospital mortality relative risk has been calculated using 'Dr Foster Limited' methodology. Dr Foster's Hospital Standardised Mortality Ratio (HSMR) Relative Risk is a statistical measure used to compare the number of observed in-hospital deaths within a trust or specialty to the number of deaths that would be *expected* based on national benchmarks. The national benchmark position compares relative risk to 100; below this number is a more favourable comparison.
- In 2022/23, quintile 3 is above the threshold, at 113.87. Whilst for 3 of the 4 time periods, quintile 3 is the highest reported relative risk, this has been below 100 since 2023/24, suggesting that deaths are within what is expected.
- There are no notable inequalities by deprivation.



Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- HSMR Mortality Relative Risk is calculated for individual patients and rates are reported within or outside of expected ranges. Although some levels are above the national 100 benchmark, all levels are within expected ranges, with the 18-29 age banding having 1-2 deaths per year. The majority of relative risk relating to in hospital standardised mortality ratios have reduced across all age bands.



HSMR Relative Risk by age group	2022/2023	2023/2024	2024/2025	Apr-Nov 25
'0-17'	0.00	68.18	67.44	0.00
'18-29'	180.34	0.00	98.28	115.17
'30-49'	74.14	56.25	105.20	66.78
'50-64'	81.75	91.24	94.18	86.79
'65-74'	75.10	90.65	90.92	86.83
'75-84'	102.45	95.28	87.96	84.55
'85+'	102.61	92.47	97.79	85.93

Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- The relative risk for both sexes converge over time, latest figures females 83.5, males 86.5, both significantly under the 100 national benchmark.

Index of Disparity

The Index of Disparity (IoD) is a summary measure used to quantify relative inequality across multiple groups for a given indicator. The table below gives a breakdown of the inequality measures for the metrics included in this paper. It is calculated by measuring the disparity between different groups from the average. The groups used in calculating the IoD are: Age, Gender, Deprivation Quintile and Ethnicity.

To illustrate how the index of disparity works take the following example:

If 5 people have an average of 10 sweets in a bag the disparity would be how far away from 10 sweets each person actually had. If all 5 people had 10 sweets each, then disparity would be 0. If some people had much higher or lower than 10 sweets the bigger the disparity would be.

Metric Name	Age	Gender	IMD Quintile	Ethnicity	Total IoD
DNA Rate	0.34	0.14	0.22	0.12	0.21
Average Length of Stay	0.38	0.03	0.04	0.2	0.16
RTT - 52+ Week Waiters (Rate)	0.48	0.05	0.08	0.42	0.26
Hospital Standardised Mortality Ratio (HSMR)	0.1	0.18	0.04	0.24	0.12
30 Day Readmissions	0.31	0.08	0.04	0.23	0.16
A&E Frequent Attenders	0.01	0.01	0.03	0.42	0.12

In summary:

- This approach is new to the Trust and represents an innovative way of working that is not yet routinely used within the NHS. It is being trialled as part of the NHS commitment to addressing health inequalities. As this work is still at an early stage, the results should be interpreted with caution while we continue to develop our understanding of its usability and limitations.
- The analysis suggests higher levels of overall inequality in DNA rates and waits of over 52 weeks.

- There is variation by age across DNA rates, average length of stay, waiting times and readmissions.
- Deprivation (IMD quintile) appears to be a less consistent driver of inequality across the selected metrics, except for DNA rates, where the gradient remains strong.
- Ethnicity appears to influence waiting times, HSMR, readmissions and A&E frequent attenders suggesting potential inequalities. However, these findings should be interpreted with caution due to small sample sizes and incomplete ethnicity recording.

To strengthen our ability to identify and act on inequalities, the Index of Disparity will be introduced into key metrics within the Trust's integrated performance report, with opportunities to extend its use across other strategic and operational reporting. Using a single, comparable measure will support prioritisation, enable monitoring of progress over time, and raise the visibility of inequalities within routine reporting to drive discussion and action.

Improving data quality, collection and analysis

Accurate, comprehensive and consistently recorded data is essential for identifying health inequalities and taking effective action. Incomplete or inconsistent data limits our ability to understand whether services are meeting the needs of all population groups.

Ethnicity

For this report, it has not been possible to present all metrics disaggregated by ethnicity due to small sample sizes, which would risk presenting misleading conclusions. This reflects both the demographic profile of Wigan Borough, where 95% of residents identify as White British, and incomplete ethnicity recording across Trust services. A high proportion of patients continue to have 'unknown' or 'not recorded' ethnicity, highlighting the need for improvement.

Ethnicity recording rates for April - December 2025 are shown in the table below. The proportion of patient records with valid ethnic group codes exceeds the national averages reported in NHSE's Ethnicity Recording Improvement Plan. It is positive that no records contain a blank or null ethnicity field. However, there remains room for improvement in the use of 'not stated' and 'not known' codes, which appear to be used more frequently in outpatient data.

Core measures for A&E attendances / DNAs / inpatient admissions April - December 2025			
Core measures	A&E attendances	DNA (Outpatient)	Inpatient admissions
Percentage of records with blank or null codes for ethnicity	0.0%	0.0%	0.0%
Percentage of records with residual ethnic codes including – not stated, not known	1.6%	9.1%	2.9%
Percentage of patient records with a valid, non-residual ethnicity code in data sets	98.4%	90.9%	97.1%

In 2024, our data, analytics and assurance (DAA) team reviewed ethnicity recording across inpatient, outpatient and emergency care contacts. The review identified inconsistent recording practices, variation in data completeness between services, and the absence of a standard operating procedure. Since then, system change recommendation to mandate ethnicity recording on the Leigh Urgent Treatment Centre has been implemented and has resulted in improving completion from 78% to 86%. In addition, protected characteristic fields are now embedded within core Qlik applications, and the DAA team continues to apply a health inequalities lens where data allows. Continued work to further standardise ethnicity recording across our services will help strengthen data quality and consistency.

Although local analysis is challenging, national evidence and local deep dives, such as the review of inequalities in endoscopy care in 2024, confirm that racial inequalities do exist. Work is underway to address this, including the development of the Trust's Anti-Racism Strategy, improvements to equality impact assessments, and actions to strengthen data quality as set out in the Health Inequalities and Prevention Plan and ethnicity data review.

Community Paediatrics
Long waiting times in community paediatrics were evident during April - September 2023 and April - September 2024, with around two-thirds of patients waiting over one year. During April - September 2024, 62% of patients waiting more than one year for an ENT admission were children. Due to data quality issues, it has not been possible to review this information for 2025. This has been identified as a risk, and work is planned to address the data quality concerns while improvements continue through the clinical cervices redesign transformation programme in community paediatrics.

Areas of Progress

During 2025/26, the Trust has strengthened its approach to health inequalities by embedding an equity lens more systematically into planning, governance and operational delivery. The Health Inequalities and Prevention Plan was finalised and implementation has begun, setting a clear strategic direction and establishing six priority areas: strengthening governance, improving data quality, developing an empowered workforce, addressing inequalities in access, experience and outcomes, advancing neighbourhood and population health, and embedding prevention in practice. A new Health Inequalities and Prevention Steering Group will oversee delivery, and the integration of health inequalities considerations across board subgroups will support action and provide challenge across all areas of activity.

Health inequalities reporting
Where possible, data within on-demand reporting is disaggregated by age, sex, ethnicity and IMD, to enable more consistent and systematic monitoring of inequalities. Work is underway to incorporate the Index of Disparity into the integrated performance report, enabling the board to routinely identify and act on inequalities. Further analytical work has strengthened understanding of variation within specific pathways. An alcohol and inequalities report (March 2025) identified a strong correlation between deprivation and alcohol-related harm, with the most deprived deciles accounting for the majority of alcohol-related A&E attendances and admissions. A specific piece of work is underway to understand inequalities in access to cardiology investigations.

Developing an empowered workforce
This year, progress includes staff education and awareness sessions, expansion of training opportunities, and the appointment of a joint Consultant in Public Health, with Wigan Council, and a

WWL-based youth worker. This approach supports the development of a confident workforce equipped to recognise and act on health inequalities.

Addressing inequalities in access, experience and outcomes
Targeted work has begun to improve health literacy, including redesigning outpatient communications, alongside specific service-level projects such as those within speech and language therapy. In relation to DNAs, the text reminder service, which was implemented following the development of a DNA predictor, was extended to two reminders for all appointments, leading to a further reduction in DNA rates. However, inequalities persist, and the Trust is exploring additional targeted action.

Working in partnership to advance neighbourhood and population health
A neighbourhood-focused approach has been initiated, beginning with Scholes in Central Wigan, to understand and address inequitable access at community level. The Integrated Delivery Board, co-chaired by the Trust's Chief Executive and Wigan Council's Director of Public Health, continues to drive system-wide action. Joint analyses with Wigan Council have informed targeted respiratory support in high-need areas, and wider neighbourhood health models are being developed through the Healthy Wigan Partnership. WWL services, are scoping and trialling new ways of working, such as 'Work Well' models, supporting people into employment, and community appointment days within musculoskeletal services.

Embedding prevention in practice
Preventative approaches continue to expand, including the trial of opportunistic inpatient flu vaccination to improve uptake among underserved groups. Joint work with Wigan Council seeks to further embed prevention into clinical pathways, with an initial focus on smoking cessation and wider determinants.

Summary and Next Steps

Analysis of elective and urgent and emergency care data shows clear and persistent inequalities across age and deprivation. DNA rates remain twice as high for patients living in the most deprived areas compared with the least deprived, despite an overall downward trend. Younger age groups (0–19) and males aged 20–54 continue to have the highest DNA rates. Inequalities are also evident in urgent and emergency care, with 43% of all A&E frequent attenders coming from the most deprived quintile. And readmission rates increase steadily with age, highlighting the need for targeted support for older adults.

Alongside this, the Trust has made year-on-year progress in strengthening its approach to health inequalities. The Health Inequalities and Prevention Plan provides a clear strategic framework, and through this, work is underway to improve data quality, deepen insight, empower the workforce and embed prevention and neighbourhood-based approaches. The evidence presented reinforces the need to accelerate this work and ensure that health inequalities are consistently addressed across transformation programmes, service design and operational decision-making.

Next Steps
Building on progress to date, the Trust will continue to strengthen its approach to health inequalities in 2026/27 by:

- **Launching the Health Inequalities and Prevention Steering Group** to oversee delivery of the health inequalities and prevention plan, and ensure a coordinated, system-wide approach.
- **Strengthening the use of the NHS England Statement on Information on Health Inequalities**, identifying a core set of metrics aligned to Trust priorities and reviewing these throughout the year to maintain a consistent narrative, and ensure timely action.
- **Introducing the Index of Disparity** within our integrated performance report and other strategic and operational reporting to support routine identification and action on inequalities.
- **Embedding health inequalities and prevention within strategic planning, transformation programmes and core business functions**, ensuring that reducing inequalities is a central priority across all Trust activity.