South East Clinical Senate

South East

Clinical

senate

Health inequalities within the southeast region through a service change lens

DATE: September 2023

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Foreword

I am delighted to recommend this report prepared by Rachel Bracegirdle, Senate Clinical Fellow, on behalf of the South East Clinical Senate. The report is a guide for systems and senate council and review panel members. It is designed to inform their approach to assessing the extent to which inequalities in the system have been understood and considered within a given case for change. In guiding the Clinical Senate, the report also shares good practice in how health inequalities may be addressed and in doing so is an extremely useful adjunct for systems to also use as they develop their proposals. Planning healthcare services should always begin with a detailed understanding of the population for which those services are being developed and yet all too frequently this has fallen short of truly understanding the inherent inequalities. Cases for change also need to understand and address how those inequalities may change in an era of rising demand, complexity of conditions and expectations engendered, together with the increased comorbidity of an ageing population. Within the southeast region there are wide disparities in the social determinants of health with the greatest burden of disease concentrated in the lowest quintiles of Socio-Demographic Index who are least equipped and resourced to make the best and appropriate use of services available. This unmet need also spills over into prevention and early recognition and management of those at risk from disease. Rachel's report defines health inequalities, considers the national approach and the key drivers required to address the problem, before focussing on coastal communities and the southeast population demographics. The report then goes on to describe the areas for systems to consider with links to rich sources of further information and resources interwoven throughout.

Dr Paul Stevens,

Chair South East Clinical Senate

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1. Introduction

Service reconfiguration is a window of opportunity to drive forward the delivery of fair and equitable care. Both service providers and commissioners have a responsibility to support the triple aim of improving quality of care, reducing health inequalities across communities, and delivering the best value care.[1]

The aim of this report is to provide guidance to help both systems and review panels to ensure tackling health inequalities is a key consideration within service change proposals from the outset and to demonstrate 'what good looks like' for us as a Clinical Senate. The background provides an overview of the current issue of health inequalities and the need for action by implementing the Core20PLUS5 approach. Section 4 provides key questions for systems to review in relation to health inequalities when planning service changes, with examples of good practice. Particular consideration has been given to coastal communities within this report as they experience significant health inequalities and there are a large proportion of Integrated Care Boards (ICBs) within the southeast which serve coastal communities. Further information and resources are signposted in the final section of the report.

2. Background

What are health inequalities?

"Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society."[2] Table 1 summarises differences which exist between groups, that are associated with the risk of experiencing health inequalities. It is important to recognise that people can experience a combination of these factors.[3] Variations exist between the groups in terms of prevalence of health conditions, life expectancy as well as access to and experience of healthcare. Healthcare itself can exacerbate existing health inequalities, for example individuals coming from a lower socio-economic status have been shown to have higher risk of death from avoidable causes such as delayed healthcare interventions.[4]

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[1] NHS England. (2023) 2023/24 priorities and operational planning guidance. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf

[2] NHS England. What are healthcare inequalities? Available online from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/

[3] The Kings Fund. What are health inequalities? Available online from https://www.kingsfund.org.uk/publications/what-are-health-inequalities

[4] Office for National Statistics. Socioeconomic inequalities in avoidable mortality, England, and Wales: 2001 to 2017. Available online from

Table 1: Factors influencing health inequalities experienced between different groups[5]

Factor	Specific areas included within this factor
Socio-economic status	• Deprivation • Income • Housing • Employment status • Education
Protected characteristics	• Religion or belief • Sex • Sexual orientation • Age • Marriage and civil partnership • Pregnancy and maternity • Race • Disability • Gender reassignment • Employment status
Vulnerability	• Vulnerable people e.g., older, socially withdrawn, neuro-diverse people and those with learning and mental health difficulties. • Vulnerable groups e.g., travellers, homeless people, sex workers.
Geography	• Area of the county / system • Urban v rural areas • Coastal communities

Figure 1 represents the wide range of factors which influence our health.

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/measuringsocioeconomicinequalitiesinavoidablemortalityinenglandandwales/2001to2017

[5] NHS England learning and development programme for major service change module: Addressing health inequalities, equality, and diversity in your service change programme. 22nd February. Online training module.

Figure 1: Factors which influence health status[6]

The individual lifestyle factors referred to in figure 1 include health behaviours such as smoking, diet, exercise, and drug and alcohol misuse.

The 'Review of the Mayor of London's Health Inequalities Test'[7] distinguishes between the terms 'health inequalities' and 'health care inequalities.' Health inequalities are defined as "*the unequal distribution of disease and healthy life expectancy at birth, between different social groups, which are largely driven by social determinants of health, such as housing and deprivation*." On the other hand, 'health care inequalities' refer to the differences which exist between social groups in terms of healthcare access, experience, and outcomes. As already highlighted, social groups at higher risk of health inequalities, are also more vulnerable to healthcare inequalities. Within this report the term health inequalities will be used to describe both health and healthcare inequalities.

[6] The Kings Fund. What is a population health approach? Available online from https://www.kingsfund.org.uk/publications/population-health-approach

[7] Gainsbury S and Hutchings R; Nuffield Trust. (2021) Review of the Mayor of London's Health Inequalities Test. Available online from https://www.nuffieldtrust.org.uk/sites/default/files/2022-11/1667818147_nuffield-trust-mayor-of-london-s-health-inequalities-test-web.pdf

Health inequalities have widened over recent years[8] and the COVID-19 pandemic has shone a light on the extent of the issue.[9] Additionally, the current cost of living crisis is worsening existing health inequalities.[10] Dr Bola Owolabi, Director of Health Inequalities, NHS England, recognises that tackling health inequalities is everyone's business, and it is crucial that everyone in society plays their part.[11]

Tackling health inequalities requires a population health approach. Population health has been defined as "*An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional, or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies*."[12]

[8] Marmot et al. (2020) Health equity in England: The Marmot Review 10 Years on. Available online from https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[9] Public Health England. (2020). Disparities in the risk and outcomes of COVID-19. Available online from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf
[10] NHS providers. Rising living costs: the impact on NHS, staff, and patients. Available online from https://nhsproviders.org/rising-living-costs-the-impact-on-nhs-staff-and-patients/the-cost-of-living-and-peoples-health
[11] NHS England. (2021) Tackling health inequalities is everyone's business. Available online from https://www.england.nhs.uk/blog/tackling-health-inequalities-is-everyones-business/
[12] The Kings Fund. (2018) A vision for population health: Towards a healthier future. Available online from https://www.kingsfund.org.uk/publications/vision-population-health

NHS as an anchor institution

Anchor institutions are defined as *"large, typically non-profit, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve,"* such as NHS Trusts, local authorities, and universities.[13] The NHS can impact on health inequalities by both action on healthcare access, experience, and outcomes and through its ability to influence, support and take direct action on wider determinants of health. Figure 2 shows how the NHS working in partnership with communities, local authorities, educational organisations and Voluntary, Community and Social Enterprise (VCSE) organisations can maximise its social, economic, and environmental impacts to improve social determinants of health, health outcomes and ultimately reduce health inequalities in its local populations.[14] Given the high level of deprivation and subsequent health inequalities seen in coastal communities, anchor institutions have a key role in these areas.

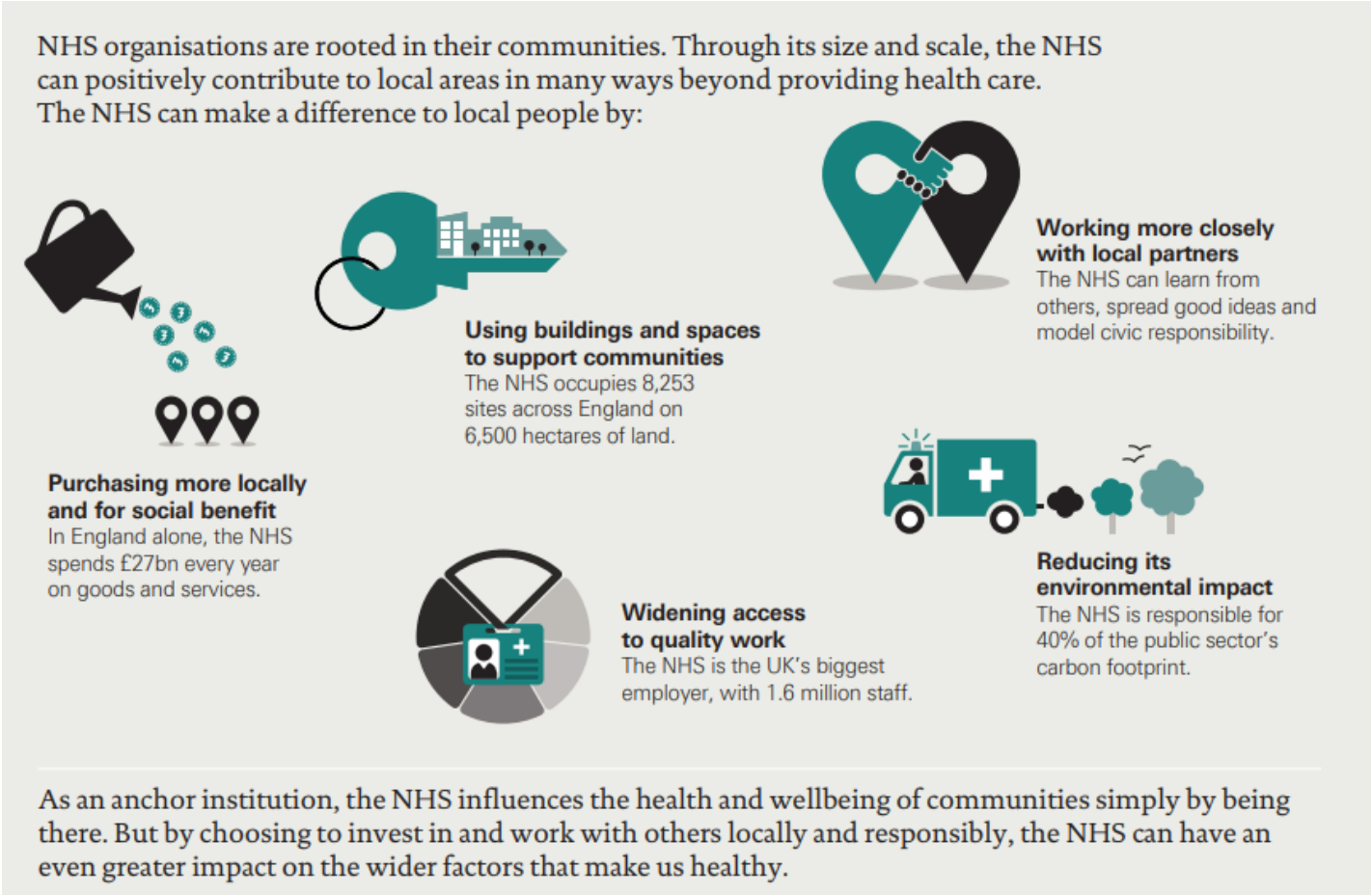

Figure 2: NHS as an anchor institution[13]

[13] Reed et al. (2019) Building healthier communities: the role of the NHS as an anchor institution. Available online from https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

[14] Health Anchors Learning Network. What is an anchor? Available online from https://haln.org.uk/what-is-an-anchor

A further way that NHS organisations can influence the communities that surround them is by truly looking after employees and their welfare. This has the potential to be an inspiring change, especially in small communities.

Key strategic drivers for tackling health inequalities

There are several strategic drivers from the NHS and government which inform and guide the work of the National Healthcare Inequalities Improvement team.

The NHS Long Term Plan (2019)[15] outlines the case for stronger action on health inequalities for reasons of both fairness and improvement of outcomes. Several commitments for how the NHS will strengthen its contribution to tackling health inequalities are detailed, which include:

- Ensuring a higher proportion of funding is disseminated to areas which have a higher prevalence of health inequalities.
- Supporting local planning and ensuring national programmes are focused on reduction of health inequalities.
- Focusing support on clinical areas known to have a high prevalence of health inequalities e.g., maternity, and severe mental illness.
- Ensuring an ongoing commitment to commission, partner with and champion charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups.

The 2022 Health and Care Act defined statutory duties of ICBs, which were reiterated in the 2022/2023 Priorities and Operational Planning Guidance,[16] which set out the 4 strategic priorities of Integrated Care Systems (ICSs):

- Improving outcomes in population health and healthcare.
- Tackling inequalities in outcomes, experience, and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development.

The 2023/2024 Priorities and Operational Planning Guidance,[1] published in December 2022 outlines the current priorities for the NHS which are:

1. Recover our core services and productivity.
2. Make progress against Long Term Plan ambitions.

[15] NHS England. (2019) The NHS Long Term Plan. Available online from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[16] NHS England. (2022) 2022/23 priorities and operational planning guidance. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf

3. Continue transforming the NHS for the future.

It is recognised that as these priorities are delivered action must continue to narrow health inequalities in healthcare access, outcomes, and experience. Additionally, the 5 strategic priorities for tackling health inequalities which were outlined in 2021/2022 as a response to COVID-19 must continue to be delivered against.[17] These priorities along with the actions which systems and providers need to embed are highlighted in table 2.

Table 2: 5 strategic priorities for tackling health inequalities[17]

Priority	Actions
1. Restore NHS services inclusively	• Analyse and understand waiting lists by demographic data, such as ethnicity and deprivation and develop SMART action plans if inequalities are evident.
2. Mitigate against digital exclusion	• Providers to offer face-to-face care to patients who cannot use remote services. • More complete data collection to identify who is accessing face-to-face, telephone or video consultations, according to relevant protected characteristics and health inclusion groups. • Providers to take account of their assessment of the impact of digital consultation channels on patient access.
3. Ensure datasets are complete and timely	• Improve completeness or quality of data collection required to examine health inequalities, specifically recording of ethnicity data.
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes	• Integrated Care Boards (ICBs) should set out progress against the secondary prevention activities set out in Core20PLUS 5 approach and implementation plans for Core20PLUS 5 for children and young people.
5. Strengthen leadership and accountability	• Systems and providers should have a named executive board-level lead for tackling health inequalities and should access training made available by the Health Equity Partnership Programme.

[17] NHS England. (2021) 2021/2022 priorities and operational planning guidance: Implementation guidance. Available online from https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

Legal duties to tackle health inequalities are outlined in the Health and Care Act 2022.[18] A new duty on health inequalities is that ICBs must have regard to:

- Reduce inequalities between persons with respect to their ability to access services.
- Reduce inequalities between persons with respect to the outcomes achieved for them by those services.

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the 'triple aim' duty in the Health and Care Act 2022. This requires these bodies to have regard to *"all likely effects"* of their decisions in relation to:

1. Health and wellbeing of people (including inequalities in respect to health and well-being).
2. The quality of health services provided to people (including inequalities in benefits from those services).
3. Efficiency and sustainability in relation to the use of resources.

Public sector bodies also need to comply with the Public Sector Equality Duty[19] (s.149 of the Equality Act 2010), which is to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by or under the Equality Act 2010.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

Additional policy drivers which have not already been referred to are summarised in appendix 1. In addition to all the policy drivers, tackling health inequalities is one of the priorities of the medical directorate in the South East, with the 2022/23 business plan highlighting the overarching aim to reduce health inequalities *"through the provision of safe, sustainable, high-quality, affordable equitable care delivered with efficiency and with a shift towards prevention."*

[18] UK Public General Acts. (2022) Health and Care Act 2022. Available online from https://www.legislation.gov.uk/ukpga/2022/31/pdfs/ukpga_20220031_en.pdf
[19] Ministry of Justice. (2012) Public sector equality duty. Available online from https://www.gov.uk/government/publications/public-sector-equality-duty

The National Healthcare Inequalities Improvement Programme

The COVID-19 pandemic not only revealed the real issue of health inequalities within our society, but also widened the health inequalities gap further. In response to this, alongside continued efforts on COVID-19, a priority *"was action on inequalities and prevention"* and planning health service recovery *"in a way that inclusively supports those in greatest need."*[20]

As a result, the National Healthcare Inequalities Improvement Programme (HiQiP) was established in January 2021 by NHS England and Improvement (NHSEI). The programme has a clear vision which is to deliver **"***Exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes".* To achieve this, it aims to work with a variety of stakeholders including other programmes and policy areas across NHS England, partners in the wider system, patients, and communities.[21] Figure 3 outlines the purpose, vision, priorities, framework for delivery and the strategic drivers for the HiQiP.

[20] NHS England. (2020) Third phase of NHS response to COVID-19. Available online from https://www.england.nhs.uk/coronavirus/documents/third-phase-of-nhs-response-to-covid-19/
[21] NHS England. National Healthcare Inequalities Improvement Programme. Available online from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/

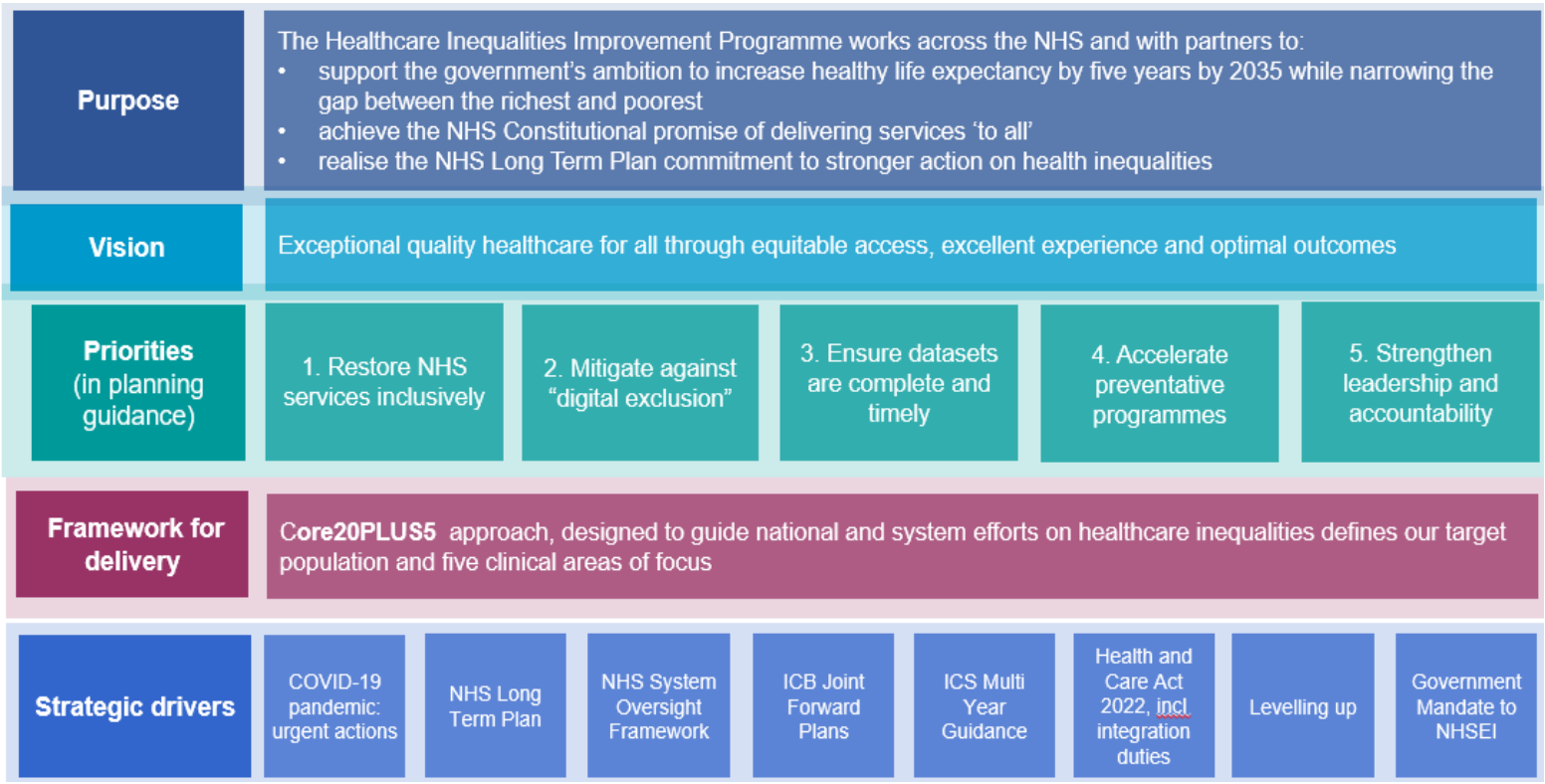

Figure 3: Overview of the National Healthcare Inequalities Improvement Programme (HiQiP) [22]

Core20PLUS5

Core20PLUS5, developed by the Health Inequalities Improvement Team, informs action to reduce healthcare inequalities at both national and system levels.[23] The target population is defined as the 'Core20PLUS.' The 'Core20' refers to the most deprived 20% of the national population, as identified by the national index of multiple deprivation (IMD). There are 7 domains of deprivation, which combine to create the IMD,[24] these are:

- Income
- Employment
- Education
- Health

[22] Senghera R, (2022) Black health and wellness – healthcare inequalities improvements and how they impact on me Healthcare Inequalities Improvement Programme. Available online from 2022_ASALH_Medical_Narrative_12042020.pdf

[23] NHS England. Core20PLUS5 (adults) – an approach to reducing healthcare inequalities. Available online from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

[24] Ministry of Housing, Communities & Local Government. The English Indices of Deprivation 2019. Available online from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833959/IoD2019_Infographic.pdf

- Crime
- Barriers to Housing and Services
- Living environment

The 'PLUS' refers to population groups who have not been captured under the 'Core20' but have been identified by the local Integrated Care System (ICS) as those who experience poorer than average health access, experience and/or outcomes, and may not already be captured by the 'Core20.' Examples of population groups include:

- Ethnic minority communities.
- People with a learning disability and autistic people.
- People with multiple long-term health conditions.
- Groups that share protected characteristics.
- Groups experiencing social exclusion, known as inclusion health groups.
- Coastal communities.

The 5 refers to the 5 clinical areas which require a key focus to reduce health inequalities in adults. Further information on Core20PLUS 5 is detailed in figure 4.[23]

The Core20PLUS5 approach has also been adapted for children and young people, which is detailed in figure 5.[25]

[25] NHS England. Core20PLUS5 – An approach to reducing health inequalities for children and young people. Available online from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

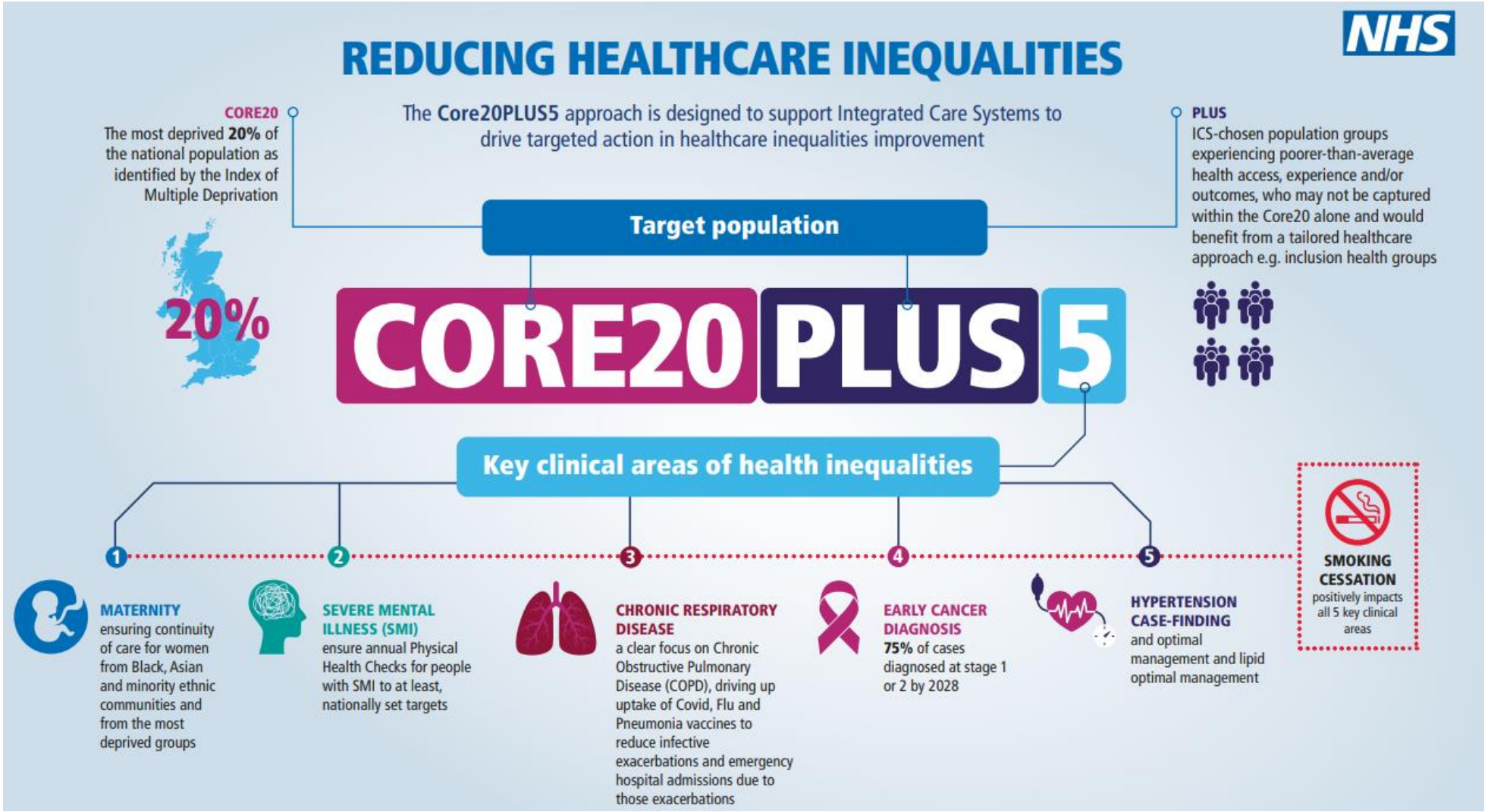

Figure 4: Reducing health inequalities in adults through the Core20PLUS 5 approach

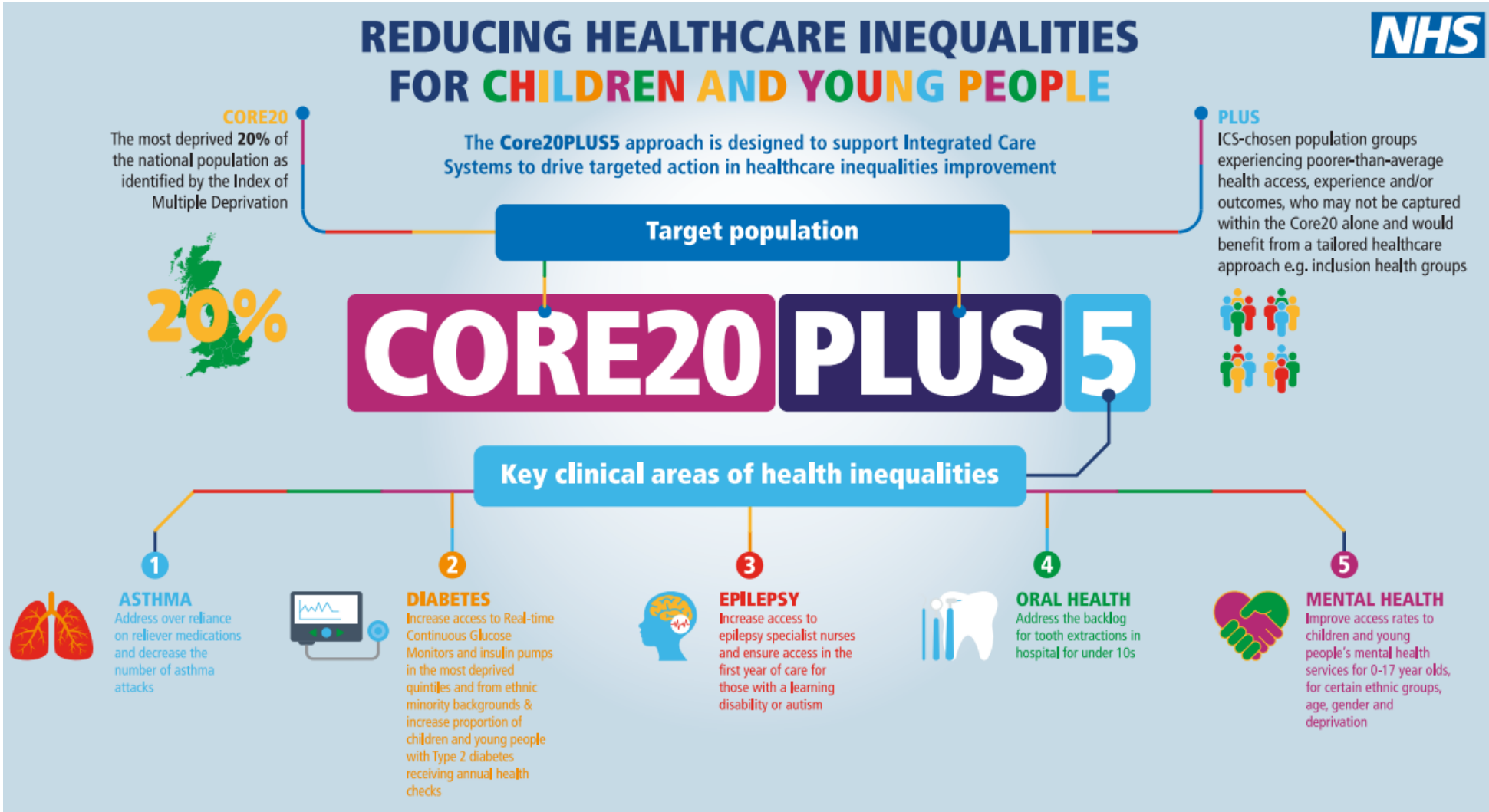

Figure 5: Reducing health inequalities in children and young people through the Core20PLUS 5 approach

The HiQiP have collaborated with Accelerated Access Collaborative and the Academic Health Science Network (AHSN) to develop the Innovation for Healthcare Inequalities Programme (InHIP), which is delivered in partnership with ICSs. The InHIP aims to address local healthcare inequalities through local projects which aim to improve access to the latest health technologies and medicines and are focused on 5 clinical areas which are aligned to Core20PLUS5.[26]

Tailored support is in place to deliver the Core20PLUS5 approach in the form of community connectors, ambassadors, and Institute for Healthcare Improvement accelerator sites. Further information on this can be found on the NHS England website.[27] Each originally focused on the adults Core20PLUS5 framework, but the next round of connectors and ambassadors are likely to be more geared towards action on children and young people health inequalities.

[26] NHS England. Innovation for Healthcare Inequalities Programme. Available online from https://www.england.nhs.uk/aac/what-we-do/innovation-for-healthcare-inequalities-programme/
[27] NHS England. Core20PLUS Accelerator Sites. Available online from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/accelerator-sites/

Workstreams and associated deliverables of the HiQiP

Figure 6 summarises the various workstreams and key deliverables which are the focus of the HiQiP for 2022/2023.[22]

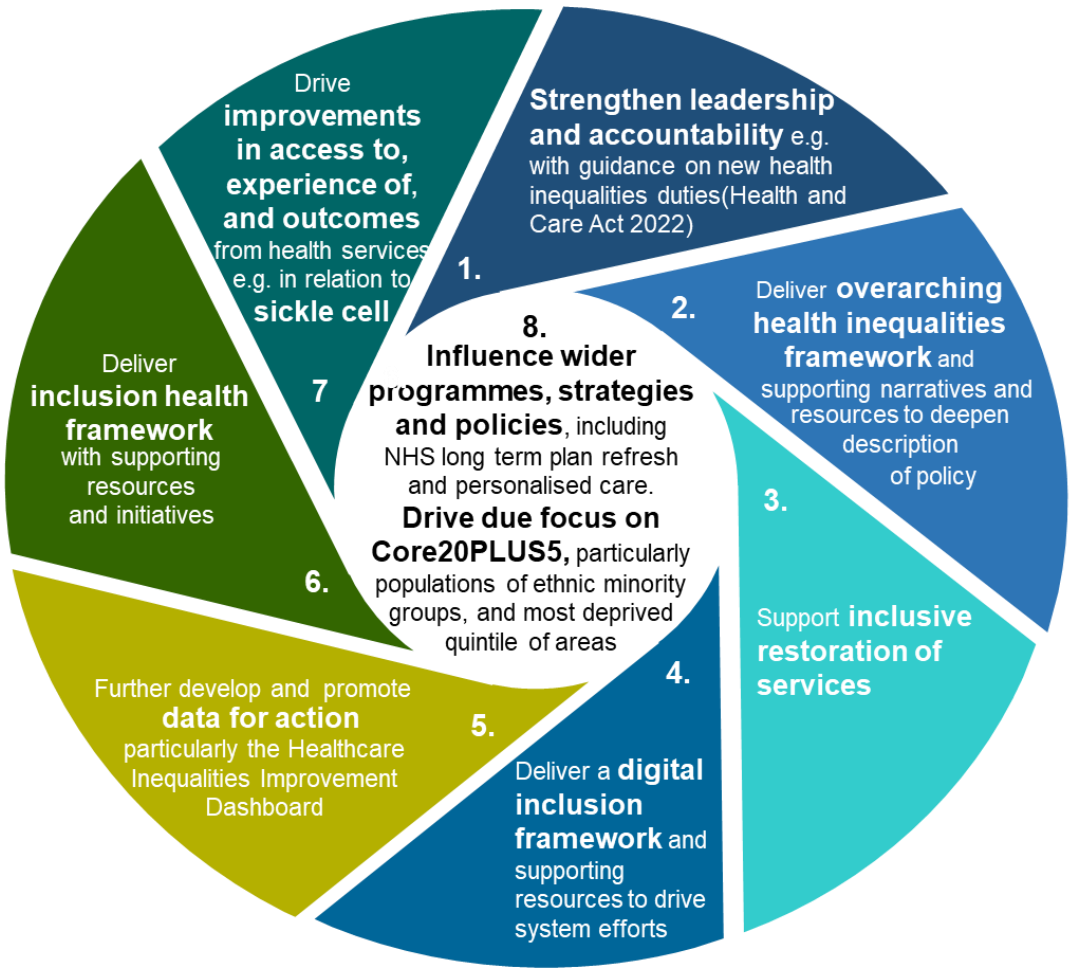

Figure 6: Workstreams and key deliverables of the HiQiP

Health inequalities and service change

Service reconfigurations within the NHS can either have a positive or negative influence on healthcare inequalities and the social determinants of health for its local population, including its own staff.[7]

The need to strengthen leadership and accountability to effectively tackle health inequalities is well recognised. Strong leadership is needed in healthcare to clearly communicate that delivering unequal safety of patient care demonstrates failure of a

healthcare system and that we all have a duty to collectively tackle health inequalities.[28] Clinical senates work collaboratively to provide a source of strategic, objective advice and leadership to support systems and act as ambassadors and advocates, working with the patient and public voice, to advocate for addressing health inequalities within any service change proposals. Service reconfiguration is a window of opportunity to drive forward the delivery of fair and equitable care. Health inequalities will continue to exist unless we actively take steps to address them, and service reconfiguration is an ideal opportunity to do this.

The London Clinical Senate identified three key themes summarised in table 3, to describe what success looks like in terms of considering inequalities and how we can go above and beyond to seek equity beyond equality. **Equality** refers to when individuals or groups are given the same resources or opportunities, whereas **equity** recognises that everyone is an individual and has different requirements for resources or opportunities, to achieve an equal outcome.[29]

Table 3: Key themes which emerged from the London Clinical Senate workshop on 'What good looks like for achieving equity beyond equality'[30]

Communication	Embedding	Representation
• Ensure equality and equity objectives and principles are clearly explained. • Maintain strong relationships with other bodies to learn about best practice. • Ensure the language used is clear and simple for all to understand.	• Challenge data and initiatives from an equality and equity perspective. • Be flexible – rather than just focusing on Core20PLUS5, understand the wider needs of the population and where resources would be most benefical. • Utilise all senate groups and ensure co-production.	• Ensure greater diversity on all groups. • Always consider unintended consequences that may lead to one group being disproportionately disadvantaged, even when it appears equal. • Ensure data highlights where the support is needed and ensure consideration is given to those who are entirely missing from the data to start with.

Overall, the importance of embedding health inequalities within everything the clinical senate does and reviews, emerged as the key theme recognised by clinical senate council members.

[28] Wade et al. (2022) 'Action on patients safety can reduce health inequalities'. *BMJ*. 376:e067090
[29] Miken Institute School of Public Health. Equity v Equality: Whats the Difference? Available online from https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/
[30] Health Inequalities Improvement – Emerging Leaders Network. Whitehead F. London Clinical Senate Health Inequalities Workshop. 26.1.23. Available online from https://future.nhs.uk/InequalitiesImprovement/view?objectId=157412709

Figure 7 summarises the stages at which inequalities need to be considered throughout the programme of change.[31]

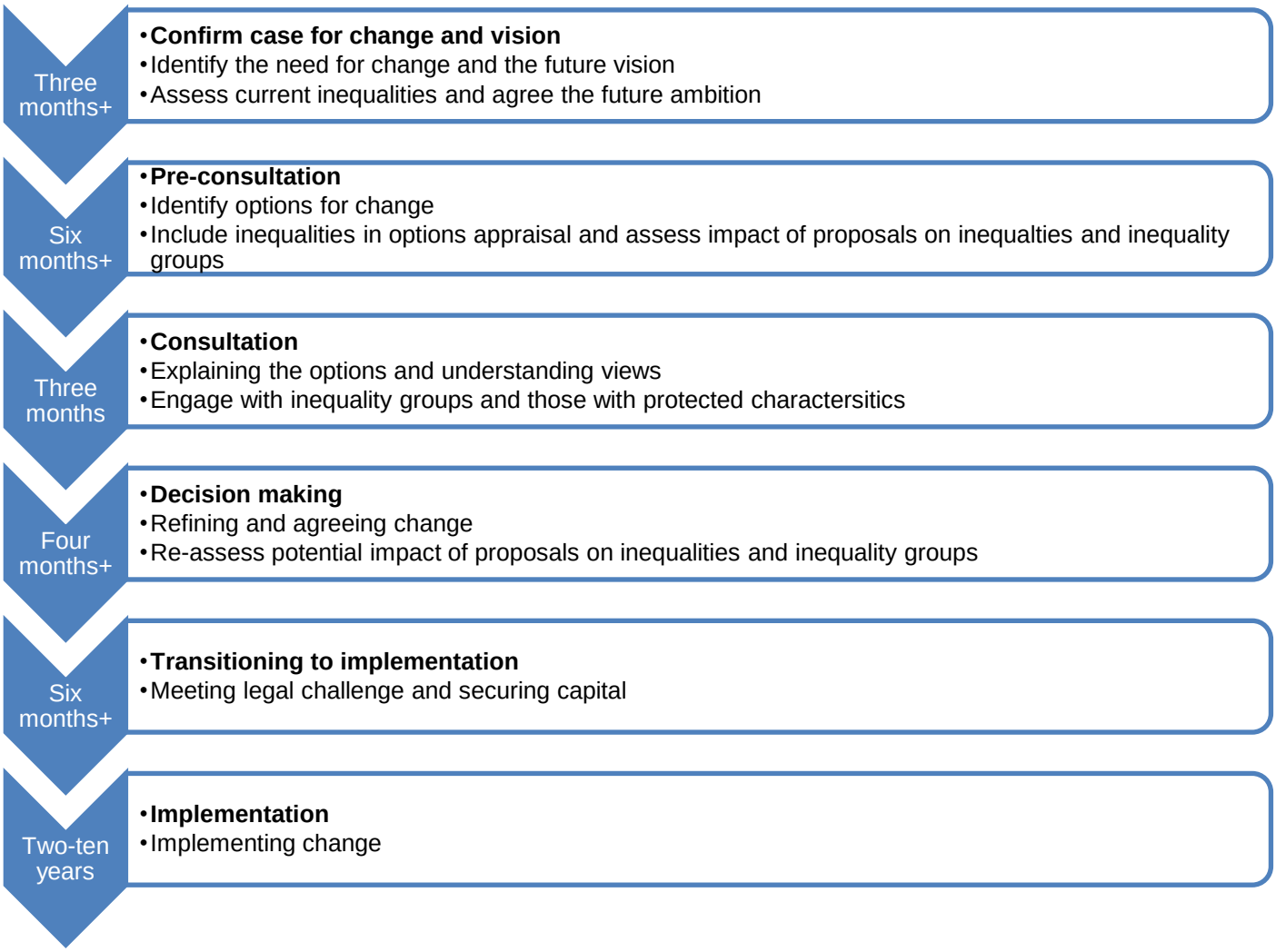

Figure 7: Considerations for inequalities within service change

Given that coastal communities experience a high level of health inequalities and there are a large proportion of ICBs within the southeast which serve coastal communities, this is an important area for the South East Clinical Senate to focus on when reviewing service change proposals from these areas.

[31] Image by Carnall Farrar. NHS England learning and development programme for major service change module: Addressing health inequalities, equality, and diversity in your service change programme. 22nd February. Online training module.

Health inequalities within coastal communities

Coastal communities are identified within the 'PLUS' population group defined by Core20PLUS5, as a group known to experience poorer than average health access, experience and/or outcomes. Coastal villages, towns and cities are known to have some of the worse health outcomes in England, with low life expectancy and high rates of many major diseases.[32] The reasons for this are vast and include:[32, 33]

- **Older population** – an aging population is inevitably associated with increasing health problems.
- Higher levels of **deprivation** - associated with higher rates of obesity, smoking, alcohol and drug misuse.
- **Migration** – there is an in-migration of elderly residents and a younger vulnerable population and an out-migration of a younger population seeking employment opportunities. Additionally, there are communities with a high prevalence of migrants from various countries, with a variety of different languages.
- **Poor education attainment and employment** prospects. Education predicts factors such as employment, income, psychosocial well-being, and health behaviours. There is a significantly higher proportion of children and younger adults who are admitted to hospital following health risk behaviours, such as self-harm, alcohol, and drug misuse, in coastal versus non-coastal areas. Therefore, it is arguably the single most important modifiable social determinant of health.[34]
- **Poor quality housing**.
- **Geography** of coastal communities – including inadequate transport, issues with digital connectivity and being more vulnerable to the impact of climate change.
- **Challenges with recruitment and retention** of the NHS workforce.

All the above factors contribute to coastal areas having a higher prevalence of disease and health risk factors, compared to their non-coastal counterparts. This includes a higher burden of disease for cancer, mental health, coronary heart disease (CHD), diabetes, and Chronic Obstructive Pulmonary Disease (COPD), most of which are clinical areas referred to in the Core20PLUS5. Detailed data on this has been obtained by attributing the GP-

[32] Whitty C. (2021) Chief Medical Officer's Annual Report 2021 Health in Coastal Communities – Summary and recommendations. Available online from https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities

[33] UK Parliament. (2019) Seaside towns must be inspired to reinvent themselves, says Lords report. Available online from https://www.parliament.uk/external/committees/lords-select/regenerating-seaside-towns/news/2019/seaside-report-published/

[34] The Lancet Public Health. (2020) 'Education: a neglected social determinant of health'. *The Lancet Public Health*. 5(7):e361.

level Quality Outcomes Framework (QOF) disease prevalence data to Lower Layer Super Output Areas (LSOAs). LSOAs are defined as "*small geographic areas produced by the Office for National Statistics (ONS) to enable reporting of small area statistics in England and Wales"*. There are 32,844 LSOAs in England, each having a population of approximately 1,500.[35] The boundaries of LSOA's can be accessed on the ONS website.[36] A LSOA is defined as coastal if it included or overlapped a built-up area and was within 500m of the mean high-water mark (excluding tidal rivers).

After adjusting for factors such as age and deprivation, there is still a higher prevalence of disease (apart from diabetes) and health risk factors in coastal compared to non-coastal areas, which is known as a 'coastal excess*'.*[32] A health service deficit has also been evidenced in coastal areas, with unfavourable data available on meeting service standards e.g., NICE guidelines, cancer indicators and emergency admissions in coastal versus non coastal areas.[32] All these factors contribute to coastal areas having higher Standardised Mortality Ratios (except for CHD) and significantly lower life expectancy, healthy life expectancy and disability free life expectancy, compared to non-coastal areas. This data is based on analysis of data from Middle layer Super Output Areas (MSOAs). MSOAs are usually made up of 4-5 LSOAs, having a population between 5,000 and 15,000.[37] MSOAs were identified as those with at least 50% of their populations residing in a coastal LSOA.

The Chief Medical Officer's Annual Report 2021: Health in Coastal Communities, highlighted three key recommendations, followed by several specific recommendations:

1. There should be a national strategy to improve the health and wellbeing of coastal communities, which must be cross-government given the many wider determinants of health.
2. The current mismatch between health and social care worker deployment and disease prevalence in coastal areas needs to be addressed.
3. The issue of limited available data and research into the health needs of coastal communities is striking and needs improvement to assist the formulation of policies to improve the health of coastal communities.

Furthermore, in 2020, the National Institute for Health Research Public Health Programme issued a call for research on reducing health inequalities in coastal towns and communities.[38]

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[35] Public Health England. (2018). Research and analysis: Methods, data and definitions. Available online from https://www.gov.uk/government/publications/health-profile-for-england-2018/methods-data-and-definitions

[36] Office for National Statistics. (2021) LSOA (Dec 2021) Boundaries Full Clipped EW. Available online from https://geoportal.statistics.gov.uk/datasets/ons::lsoa-dec-2021-boundaries-full-clipped-ew-bfc/about

[37] Office for National Statistics. (2021) Census 2021 geographies. Available online from https://www.ons.gov.uk/methodology/geography/ukgeographies/censusgeographies/census2021geographies

[38] Asthana S and Gibson A. (2022). 'Averting a public health crisis in England's coastal communities: a call for public health research and policy'. *Journal of Public Health*. Vol 44. 3, pp 642–650.

South East population demographics and health inequalities

Within the southeast 50% of ICBs are located on the coast and therefore affected by coastal deprivation, as shown in Figure 8. There are 5,229 LSOAs in the southeast, with an average population size around 1700. 156 (3%) of these are in the national bottom 10% of IMD scores 2019, and of these, 143 (92%) are in coastal areas.

Several health indicators for southeast coastal areas are significantly worse than the rest of England including:

- Child poverty.
- Older people living alone.
- Overcrowded housing.
- Hospital stays for self-harm.
- Limiting long term disability.
- Standardised mortality ratios for; all ages, all causes <75, cancer, all age circulatory disease and causes considered preventable in under 75s).

This highlights the need to focus on tackling health inequalities within the southeast coastal communities and service change is a critical time to take action to achieve this.

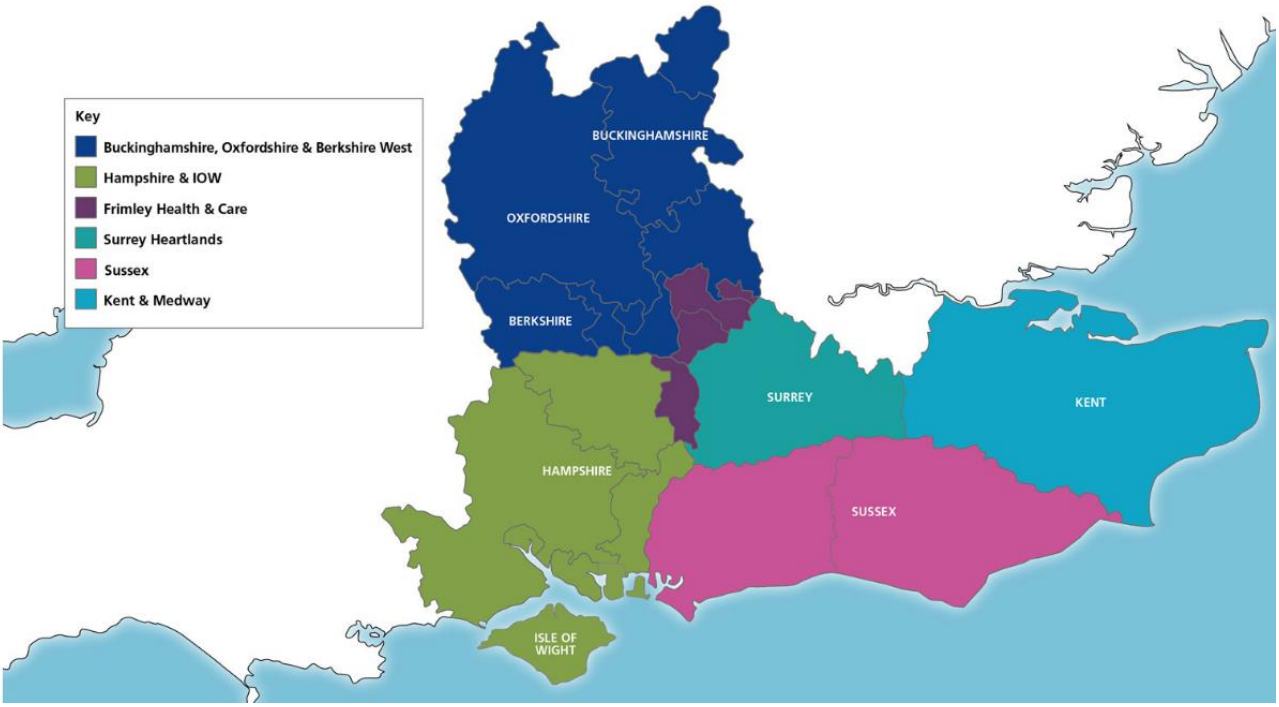

Figure 8: Location of Southeast ICBs

Further data on health inequalities within the coastal MSOAs in the southeast can be accessed from the Office for Health Improvement and Disparities, which can be used to produce reports for specific areas.[39]

Contribution of workforce issues to health inequalities within coastal regions

Despite the issues highlighted with the health of those who live in coastal communities, they have a smaller workforce to care for patients and to tackle these issues. There are several reasons for this including understaffed services and the impact on staff satisfaction at work and professional isolation, exacerbated by factors such as poor access to broadband and the influence of geographical location on increased travel times.[40] Overall, there are 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient in coastal compared to non-coastal communities.[32] Commitments around workforce in relation to inequalities are highlighted in the NHS Long Term Plan,[15] the Interim NHS people plan[41] and NHS Long Term Workforce Plan,[42] and summarised in table 4 below.

[39] Office for Health Improvement and Disparities. Local Health. Available online from https://www.localhealth.org.uk/#c=home
[40] Royal College of General Practitioners and Rural Strategy Group, Scotland. (2014) Being Rural: exploring sustainable solutions for remote and rural healthcare RCGP Scotland Policy Paper. Available online from https://www.srmc.scot.nhs.uk/wp-content/uploads/2020/04/RCGP-Being-Rural-policy-paper-and-appendix-2014.pdf
[41] NHS England. (2019). Interim NHS People Plan. Available online from https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/
[42] NHS England. (2023). NHS Long Term Workforce Plan. Available online from NHS Long Term Workforce Plan (england.nhs.uk)

NHS Long Term Plan	Interim NHS People Plan	NHS Long Term Workforce Plan
Our aim is to ensure a sustainable overall balance between supply and demand across all staff groups. ***For doctors, we will focus on reducing geographical and specialty imbalances."*** *"We will also work to ensure specialty choices made by doctors are better aligned to geographical shortages."* ***"****development of incentives to ensure that the specialty choices of trainees meet the needs of patients by* ***matching specialty and geographical needs,*** *especially in primary care, community care and mental health services".*	*"Continue to create innovative training opportunities to enhance recruitment and retention within the NHS, develop new skill-mix models, and* ***address geographical and specialty shortages****."* *"Establish a* ***national programme board to address geographical and specialty shortages in doctors****, including staffing models for rural and coastal hospitals and general practice"*	*"The location of training posts…does not always mirror current or future patient need, leading to inequitable access to services in some areas. There are, similarly, entrenched inequalities in the distribution of staff –* ***with disadvantaged areas, particularly some coastal communities, finding it harder to attract and retain staff – that need to be addressed****."* *"Imbalances in geographical distribution of training posts is not confined to medical training. Other professional groups also require a more equitable spread of training opportunities, based on current and future patient need"*

Table 4: Commitments around workforce in the NHS Long Term Plan, Interim NHS People Plan and NHS Long Term Plan

Additional work is already underway and much needed to maintain focus on the current and proposed future medical education reforms, which includes the geographical redistribution programme. This is highlighted within the Chief Medical Officers report, 2021 and summarised in figure 9.

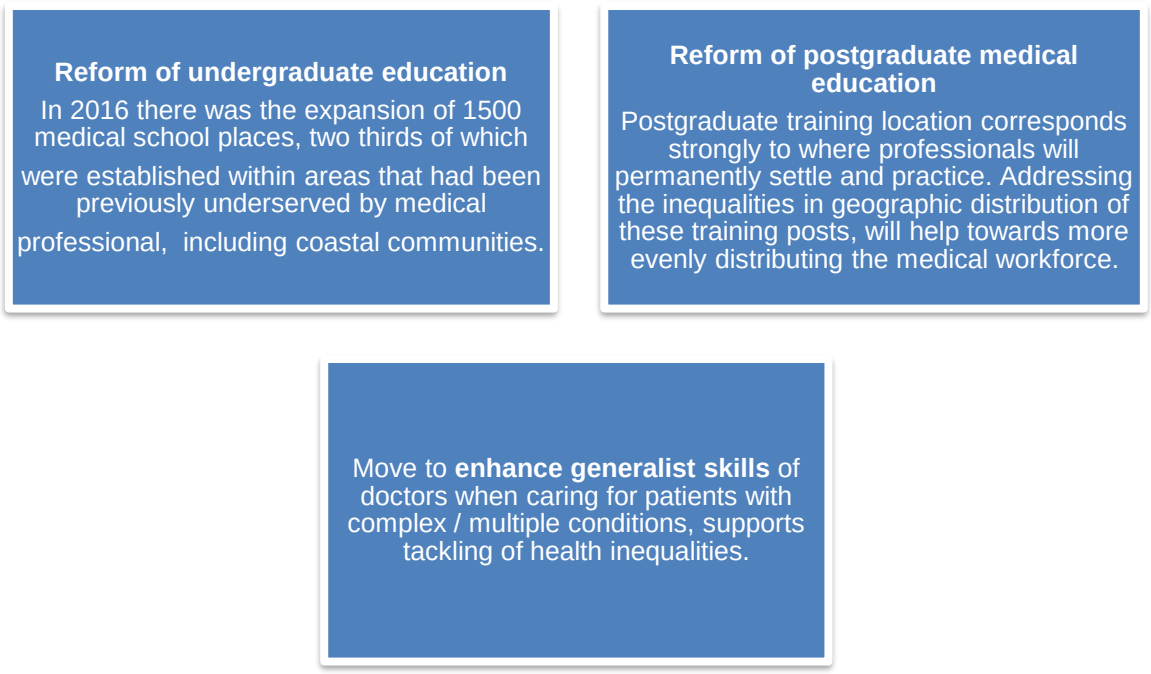

Figure 9: Work required to tackle workforce issues within coastal communities

Simply increasing the supply of new doctors undertaking undergraduate education is not enough, there needs to be an increased focus on postgraduate training opportunities once doctors are trained and a focus on improving working conditions, to ensure staff retention.[43]

The wider NHS workforce also needs to be considered, including reviewing whether the current funding arrangements are a disincentive to GP, nursing and other NHS and social care workers moving to coastal areas.

Vulnerability of coastal communities to the impact of climate change

The UK coast is highly vulnerable to climate change. Flooding may become an increasingly important risk factor for poor health, with coastal communities being particularly vulnerable to these risks.[32] Several local authorities in coastal regions have already declared a climate emergency. Climate change disproportionately effects the most vulnerable and disadvantaged, widening the health inequalities which already exist in

[43] Hadlow J and Farmer C. (2023). 'More medical school places will not automatically create more doctors.' The New Statesman. Available online from https://www.newstatesman.com/spotlight/healthcare/2023/05/medical-schools-doctors-nhs-workforce-shortage-postgraduate-training

society.[44] In 2020, the NHS launched its campaign 'For a Greener NHS'[45] and became the first healthcare system in the world to commit to delivering net zero carbon healthcare. An expert panel set out an evidence-based path to achieve 'a net zero NHS' and published the 'Delivering a net zero NHS'[46] report. Climate change needs to be tackled alongside tackling social inequalities, and the link between the two is clear.[8]

3. Methodology

Relevant literature and current policies around health inequalities were reviewed through a service change lens. Stakeholders working within the area of interest of health inequalities and public health were engaged. The initial draft report was shared within relevant stakeholders and feedback on the report was welcomed and actioned.

4. Areas to consider for systems

The information within this section summarises key considerations for systems to implement when reviewing service change through a health inequalities lens. The following areas will be addressed within this section:

1. Leadership
2. Healthcare access
3. Workforce
4. Engaging local communities: Co-produced delivery models and community participatory research
5. Partnership working
6. Data, modelling, and health equity audits
7. Assessment tools

[44] Munro, A et al. (2020) Advisory Group Reports for the UK committee on Climate Change: Sustainable Health equity: Achieving a Net Zero UK. Available online from https://www.theccc.org.uk/publication/ucl-sustainable-health-equity-achieving-a-net-zero-uk/
[45] NHS England. Greener NHS. Available online from https://www.england.nhs.uk/greenernhs/
[46] NHS England. (2022) Delivering a 'Net Zero' National Health Service. Available online from B1728-delivering-a-net-zero-nhs-july-2022.pdf (england.nhs.uk)

Leadership

Table 5 provides information on leadership in relation to health inequalities, including key questions for systems to ask themselves when considering service change and an example of good practice.

Table 5: Leadership and health inequalities considerations.

Leadership	
Overview	Strengthening leadership and accountability is a key strategic priority for tackling health inequalities, outlined in 2021/2022 operational planning guidance.[17]
Key questions which need to be reviewed when considering service change in leadership and health inequalities	• Is there an executive level senior responsible officer (SRO) for health inequalities in place at ICB level, and in all provider trusts? • Will the SRO be involved in the performance rating of the service to monitor the progress for addressing health inequalities? • Are PCN health inequalities leads in place?[47] • Are the senior leaders in the field of health inequalities e.g., SRO / PCN health inequalities leads involved with the service change proposals and discussions? • Are issues around health inequalities (with supporting data) raised routinely at boards and meetings which are attended by senior leaders? The aim of this being to increase awareness, engagement, and action from the top level.[48] This may include discussing unwarranted variations in waiting lists according to ethnicity / IMD. • Does the ICS have a shared vision for reducing healthcare inequalities?[48] • Are initiatives to tackle health inequalities recognised and rewarded by senior leaders?

[47] NHS England South East. (2022). 2022/23 Regional Healthcare Inequalities Improvement Stocktake: Q2 update. Powerpoint presentation from 3rd October 2022.
[48] NHS Insight. Available online from https://www.england.nhs.uk/ourwork/insight/

	• Are tackling health inequalities embedded into leadership, decision-making, strategies, and delivery plans, rather than seen as a separate entity?[49] • Do system and provider health inequality leads have access to complete relevant training?
Further information	• **Leadership Framework for Health Inequalities improvement** – support and guidance for stronger NHS leadership action on health inequalities.[50] • **Health inequalities leadership framework: Board assurance tool** - assisting board members to assess strategies, delivery plans or other initiatives for their impact on health inequality.[49] • **Leadership action on health inequality –** practical approaches to tackling health inequality webinar series.[51]
Example of good practice	**Alliance for Better Care (ABC) - GP teams work together with members of health inequality groups to expand their COVID-19 vaccine equity project**[52] **Background and aim:** In 2020, the GP federation, Alliance for Better Care (ABC), was tasked to run a COVID-19 vaccination programme across Crawley, East Surrey, and Mid-Sussex. The leadership team set out to find new ways to assist the local clinical commissioning groups (CCG) in reaching out to vulnerable groups to come forward for the COVID-19 vaccination.

[49] NHS confederation. Health Inequalities Leadership Framework: Board Assurance Tool. Available online from https://www.nhsconfed.org/system/files/2021-11/Board%20Assurance%20Tool%20-%20%20Leadership%20Framework%20for%20Health%20Inequalities%20Improvement.pdf
[50] NHS confederation. (2022) Leadership Framework for Health Inequalities Improvement. Available online from https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement
[51] NHS confederation. (2022) Leadership Action on Health Inequality. Available online from https://www.nhsconfed.org/articles/leadership-action-health-inequality
[52] NHS England. (2022) GP teams work together with members of health inequality groups to expand their COVID-19 vaccine equity project. Available online from https://www.england.nhs.uk/gp/case-studies/gp-teams-work-together-with-members-of-health-inequality-groups-to-expand-their-covid-19-vaccine-equity-project/

	Approach: The first ever vaccine equity co-ordinators were recruited in July 2021. The aim of their role was to support vulnerable local people to take up the vaccine, including Gypsy Roma Travellers (GRT), minority ethnic groups, people experiencing homelessness, asylum seekers, refugees, and those on low income and/or receiving benefits. The following work was undertaken by the equity co-ordinators, leading on the project: • Utilised data from local public health, CCGs, and primary care to identify areas where uptake of the COVID-19 vaccine was low. • Built connections with communities where the update of the vaccine was low to find out the barriers to uptake. • Collaborated with communities to design the most appropriate interventions e.g., creating information in a range of languages. • Introduced 17 outreach clinics at churches, mosques, temples, community centres, homeless shelters, and sheltered housing sites. • Set up adapted roving teams to deliver the vaccine to vulnerable groups in familiar settings e.g., at 80 GRT sites, homeless hostels, refuges, prisons, and asylum seeker/refugee hotels. **Outcomes:** • Vaccine uptake in some refuges slowly increased as the equity co-ordinators became more familiar to the residents. • More than 1,100 patients received vaccinations at pop-up sites across East Surrey, including more than 150 homeless patients, 400 asylum seekers and 350 members of the GRT community. • There has been significant increase in uptake in some communities e.g., a 26% increase in vaccine uptake since August 2021 within the Asian/British Asian community in parts of Crawley. • To date, the 10 vaccination sites, roving team and mobile vaccination unit have administered more than 720,000 vaccinations.

Healthcare access

Table 6 provides information on healthcare access in relation to health inequalities, including key questions for systems to ask themselves when considering service change and an example of good practice.

Table 6: Healthcare access and health inequalities considerations.

Healthcare access	
Overview	Ensuring everyone can access healthcare services equitably is a key priority for the NHS.[53] Equity is "*the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality e.g., sex, gender, ethnicity*."[54] Equity recognises that everyone is an individual and has different requirements for resources or opportunities, to achieve an equal outcome. For healthcare access to be equitable accessible information needs to be provided alongside accessible services and support. An 'access pathway' describes the various steps involved in service users accessing services, which is demonstrated in figure 11.[7]

[53] NHS England. Healthcare Inequalities Improvement Planning Matrix. For NHSEI programmes and workstreams. Available online from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/contacts-and-resources/healthcare-inequalities-improvement-planning-matrix/

[54] World Health Organisation. Health Equity. Available online from https://www.who.int/health-topics/health-equity#tab=tab_1

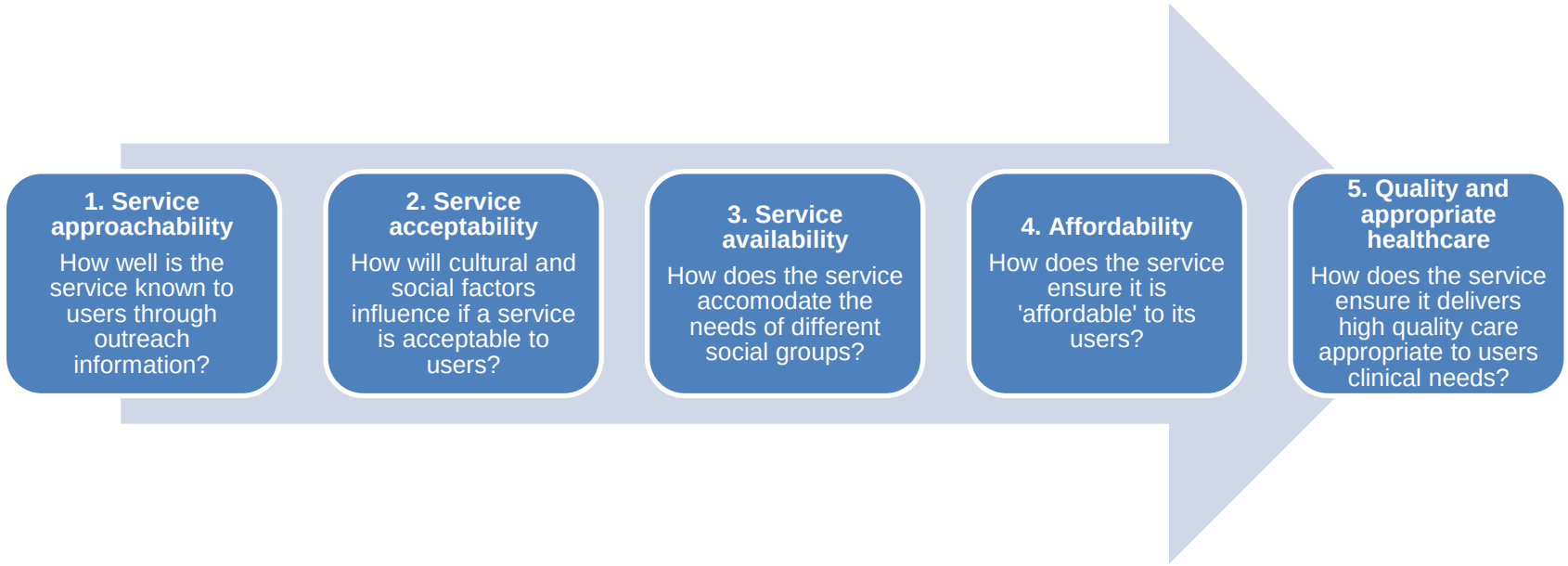

Figure 10: Healthcare access pathway

For any service change, consideration needs to be given to those groups who are vulnerable to experiencing health inequalities, at each stage of the access pathway, to work towards reducing the health inequalities gap in terms of healthcare access.

Workforce can impact healthcare access, for example access to a GP partly depends on the availability of GPs within the area. Table 6 below shows the staff full time equivalent (FTE) for GPs, per 100,000 patients in the southeast ICBs located within coastal regions. This shows that all the ICBs located within coastal regions have a lower number of GPs per head of population compared to the rest of England.[55]

Table 7: GP per head of population figures in ICBs located in southeast coastal regions compared to England

[55] NHS England. (2023) General Practice Workforce Interactive dashboard. Available online from https://app.powerbi.com/General Practice Workforce Interactive Dashboard

Area	GP FTE per 100,000 patients
England	44
NHS Hampshire and Isle of Wight ICB	33
NHS Kent and Medway	37
NHS Sussex (West)	42
NHS Sussex (East)	42

Key questions which need to be reviewed when considering service change in relation to access of services

- Will the service change increase or decrease inequalities in access and outcomes? For example, will the service change ensure the service is more accessible to groups vulnerable to experiencing health inequalities? It is a legal requirement to test if there is a disproportional impact of the service change on groups with protected characteristics, compared to the general population.[5]

Service approachability

- Does the information provided by the service consider health literacy? For example, are users involved in its development and is the information easy to access, use and navigate. See further information below for additional reading on this topic.
- Is the information provided by a service available in different languages?
- Have a range of outreach methods been considered? For example, utilising community centres to increase the awareness and understanding of a service. Factors known to influence service approachability could be addressed in these familiar community settings, such as service user's beliefs and trust in health care professionals.[7]
- Have the legal standards outlined in the 'accessible information standard' been implemented, ensuring the communication needs of those with a disability, impairment or sensory loss are met?[56]

[56] NHS England. Accessible Information Standard – Overview 2017/2018. Available online from https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf

and health inequalities	**Service acceptability** • Have ways to tackle any social or cultural factors which influence the acceptability of the service to its users been addressed? For example, a barrier to accessing a service could be around trust of the healthcare system and potential fear of discrimination and/or stigma, rooted by social and cultural factors. Working towards increasing the diversity and representation of healthcare staff and role models could be one way to tackle this barrier in accessing services. **Service availability** • Does the service offer a flexible range of appointment times, care close to home and options for accessing services through digital means where appropriate, to mitigate for the common barrier of work commitments to not accessing services? • Is the complete patient journey, into and between services fully understood including each point at which vulnerable groups experience barriers in accessing the service? • If the service is changing its geographical location, has the impact of this on travel for service users been assessed fully? In particular, the specific impact on vulnerable groups should be considered. Factors such as distance, travel time, options for public transport, encouraging active travel and cost all need to be considered. • Have factors to mitigate against digital exclusion been considered (particularly for the most vulnerable groups)? Consider digital availability, connectivity, digital poverty, and ability of users to access digital services (including digital skills/literacy). Are alternative options offered to vulnerable groups who may not be able to attend virtual appointments? For example, offering the option of face-to-face appointments. See further information below for additional reading on this topic. • Has the service considered the use of existing non healthcare venues, for example schools, community centres, libraries, shopping and sports centres? • Have recommendations from the Topol report[57] been considered, which includes preparing the healthcare workforce to deliver the digital future? • Has the service considered the physical access for elderly and disabled users? For example, wheelchair access, suitable transport options, and parking. • Has the service considered how to mitigate for any communication difficulties experienced by users, for example translators for users who English is not their first language and British Sign Language Interpreters for the deaf community. Refer to the accessible information standard for further information. • Is there sufficient support to encourage those who are able and motivated to be proactive in their own healthcare to self-manage?

[57] NHS Health Education England. (2019) The Topol Review Preparing the healthcare workforce to deliver he digital future. Available online from https://www.hee.nhs.uk/our-work/topol-review

	Affordability • Are low-cost travel options in place to access the service? • Is travel provided where appropriate? • Are there alternative options available to access the service for those users where work / caring commitments are a barrier? For example, flexible appointments and/or option for a virtual appointment, where appropriate. • Are service users clear on what services they are entitled to access by providing clear information? **Quality and appropriate health care** • What is the impact of the service change on the quality of care and are there specific populations who will be more impacted over others?[5] • Is there any focus on prevention in the care pathway? • Is there a focus within the services model of care on promoting community wellbeing, through social value projects and social prescribing, as examples?[5] • Is 'proportionate universalism'[58] applied to the resourcing and delivering of services? For example, acting with increased scale and intensity for those with existing health inequalities. • Does the service provide care for any of the 5 clinical areas identified in the Core20PLUS5? If so, have mitigations been considered for how inequalities will be reduced in the new service model?

[58] Public Health Scotland. (2014) Proportionate Universalism Briefing. Available online from https://www.healthscotland.com/Proportionate Universalism

Further information	• **Improving access for all: reducing inequalities in access to general practice services** - provides guidance for general practice to identify and address barriers around accessing services.[59] • **Tackling inequalities in healthcare access, experience, and outcomes -** aims to support NHS systems in reducing healthcare inequalities and compliments the Healthcare Inequalities Improvement Dashboard and Actionable Insights tool.[60] • **Health literacy matters – we need information health for all** – overview of statistics around health literacy.[61] • **Local action on health inequalities Improving health literacy to reduce health inequalities** - presents factors affecting access to public health services and illustrates approaches to make changes.[62] • **Health literacy toolkit** - a collection of health literacy tools for healthcare staff and carers.[63] • **NHS Standard for creating health content -** outlines some essential requirements and best practice guidance for creating high quality health content.[64] • **Health inequalities and mitigating risks of digital exclusion** - a guide for policy makers, providers, and commissioners from a voluntary and community sector perspective.[65] • **NHS digital – How can we support digital inclusion –** practical steps for supporting digital inclusion locally.[66] • **British Red Cross: Offline and isolated –** outlines the impact of digital exclusion on access to healthcare for people seeking asylum in England.[67]

[59] NHS England. (2017) Improving access for all: reducing inequalities in access to general practice services. Available online from https://www.england.nhs.uk/publication/improving-access-for-all-reducing-inequalities-in-access-to-general-practice-services/
[60] NHS England. (2022) Tackling inequalities in healthcare access, experience, and outcomes. Available online from https://www.england.nhs.uk/publication/tackling-inequalities-in-healthcare-access-experience-and-outcomes/
[61] Patient Information forum. (2021). Health literacy matters – We need health information for all. Available online from https://pifonline.org.uk/download/file/521/
[62] Public Health England. (2015) Local action on health inequalities: Improving health literacy to reduce health inequalities. Available online from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/460709/4a_Health_Literacy-Full.pdf
[63] Digital Team. (2018). Health literacy – All documents. Available online from https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FHealth%20literacy&p=true&ga=1
[64] NHS England. Content style guide: Standard for creating health content. Available online from https://service-manual.nhs.uk/content/standard-for-creating-health-content
[65] Good things Foundation. Health inequalities and mitigating risks of digital exclusion. Available online from https://www.goodthingsfoundation.org/insights/health-inequalities-and-mitigating-risks-of-digital-exclusion/#section1

Example of good practice	**Kent and Medway – Isle of Sheppey, Pulmonary Rehabilitation[68]** **Background and aim:** The Isle of Sheppey is an island off the North Kent Coast. It suffers from the coastal deprivation effect, with high levels of deprivation and poor access to education, employment, and healthcare. It has a noticeable excess in rates of respiratory disease, including COPD. There is a significant difference in life expectancy between the Isle of Sheppey and its neighbour, Sittingbourne, of 10 years. This is partially due to poor access to primary care, with it having one of the worse GP to patient ratios in the UK. The aim of this project was to set up a pulmonary rehabilitation (PR) service which aimed to: • Reduce health inequalities. • Improve course completion rate against baseline. • Reduce emergency hospital admissions and A&E attendances for COPD. • Improve measures of breathlessness, quality of life, wellbeing. • Offer patients ongoing support around lifestyle, social and financial factors in COPD. **Approach:** • Sheppey PCN worked with ICB Primary Care Transformation Team and Medway and Swale Commissioning Team to commission an **accessible** pilot PR hub for a small cohort of Sheppey patients with COPD. • Service met key British Thoracic Society (BTS) PR standards, e.g., the chosen location was accessible by public transport/transport was offered to patients that need it. • Access to extra support during and beyond the PR course was provided for lifestyle, social and financial factors in COPD, ensuring integrated and holistic care was provided to patients. This included support offered by various VCSE organisations and social prescribing.

[66] NHS Digital. How we can support digital inclusion. Available online from https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/digital-inclusion/supporting-digital-inclusion-locally
[67] British Red Cross. (2023) Offline and isolated. Available online from https://www.redcross.org.uk/offline-and-isolated
[68] The Southeast Primary Care Transformation. Driving Innovation and Taking Primary Care Forward - Southeast virtual event. Isle of Sheppey case study presentation. 21st March.

	Outcomes: • The PR course was completed over 6 weeks, with 12 sessions. • Reduced health inequalities, by offering patients who were previously unable to access PR immediate access and therefore reducing health inequalities which exist between neighbouring Medway and Sittingbourne. Ease of access to the service was a primary focus of the service. • There was a high completion rate (89%). High levels of deprivation and co-morbidities present in this cohort, which are usually associated with a lower completion rate, highlight this as a particularly favourable outcome. This is likely due to be related to a combination of factors, including the high level of individualised care which was provided, as well as the ease of access provided by a good venue location and the offer of transport for those patients who needed it. • Positive feedback was receiving from patients and participating organisations. • Additional data is yet to be analysed.

Workforce

Table 8 provides information on workforce in relation to health inequalities, including key questions for systems to ask themselves when considering service change and an example of good practice.

Table 8: Workforce and health inequalities considerations

Workforce	
Overview	Workforce issues specific to coastal communities, such as the difficulties with recruitment and retention of staff are explored on page 23. In addition, inclusive recruitment is an important part of the workforce and inequalities considerations. The NHS People Plan recognises that improvements are required in the recruitment process to ensure the workforce reflects the diversity of the communities it serves. See further information below for additional reading on this topic.
Key questions which need to be reviewed when considering service change in relation to workforce	**Recruitment and retention (in areas known to experience a high burden of health inequalities e.g., coastal regions)** • Are there incentives to encourage greater recruitment and retention of the workforce (including medical, nursing/midwifery, allied health care professionals, healthcare scientists and pharmacy) to work in areas known to experience high levels of health inequalities? • Are there opportunities for the workforce to have portfolio careers? For example, joint clinical and managerial/research roles. Evidence shows portfolio careers can increase happiness of the workforce, which in turn can improve retention and increase productivity.[69] • Has the potential positive impact of digital technology on workforce been considered? For example, for staff experiencing burnout, could virtual clinics which may increase opportunities for flexible working be utilised? Utilising technology where appropriate to virtually review patients in remote areas, which are typically difficult to recruit to can reduce workforce pressures within these areas.[70]

[69] Pathiraja F and Wilcon M.C. (2011) 'The rise and rise of the portfolio career.' BMJ. 342:d149.
[70] Nuffield Trust. Friday FAQs: James Hadlow and Mike Bedford. Available online from https://www.nuffieldtrust.org.uk/news-item/friday-faqs-james-hadlow-and-mike-bedford

and health inequalities	• Is there a focus on health and wellbeing of staff? • Are staff surveys completed and relevant actions made? • Are exit interviews being conducted? Consider how these are being conducted to ensure the most accurate information is obtained and how the information is being used to inform future decisions around workforce and service planning. • Are there opportunities for staff around training and development, to encourage retention? • Are there opportunities for flexible working? For example, flexible hours, shift patterns and opportunities for portfolio careers. **Inclusive recruitment and workforce** • Is data available on what the current workforce profile of the service looks like in comparison to the local community it serves?[71] • Is there is a large discrepancy between the representation in the current workforce and local community? If so, consider potential reasons for this and ways to increase the diversity of the workforce. Local organisations may be able to support with this, through focus groups, ambassador schemes, and alternative career pathways, where appropriate, such as apprenticeships. • Have diversity targets for recruitment been set and is it clear who is accountable for these outcomes? • Have actions for inclusive recruitment, outlined in the document 'NHS People Plan Inclusive recruitment'[72] been considered? • Are there opportunities for people from across all geographic and social regions to enter the workforce, for example through non-graduate training and education routes such as T-levels and apprenticeships? • Does the service consider the 4 pillars of 'the NHS people plan',[73] which will have a positive impact on the workforce and include: ➢ Looking after our people ➢ Belonging in the NHS ➢ New ways of working and delivering care ➢ Growing for the future
Further information	• **Tackling health inequalities through inclusive recruitment** -information and prompts for the NHS workforce leads to consider local approaches.[71] • **NHS People Plan inclusive recruitment – opening the door to diverse communities** – practical resource providing guidance on inclusive recruitment.[72]

[71] NHS employers. (2022). Tackling health inequalities through inclusive recruitment. Available online from https://www.nhsemployers.org/publications/tackling-health-inequalities-through-inclusive-recruitment
[72] NHS employers. NHS People Plan Inclusive recruitment – opening the door to diverse communities. Available online from https://www.nhsemployers.org/system/files/media/NHS-People-Plan-Inclusive-Recruitment_0.pdf
[73] NHS. (2020) We are the NHS: People Plan 2020/21 – action for us all. Available online from https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf

	• **NHS People Plan** – sets out a range of actions to achieve the key ambition Which is for more people, working differently in a compassionate and inclusive culture.[73] • **Workforce race inequalities and inclusion in NHS providers** - **h**ighlights key interventions to address race inequalities in the NHS workforce.[74] • **Looking after our people – retention hub** – provides a range of interventions aimed at improving the experience of those working within the NHS.[75] • **NHS England – Workforce planning and resource management** – links to further information on workforce planning and resource management including information on retention.[76] • **NHS England - Workforce equality and inclusion** – useful further information on the topics of equality and inclusion in the workforce and signposting to further reading.[77] • **The Messenger review** - highlights recommendations around the importance of equality, diversity, and inclusive leadership.[78] • **The Kings fund – NHS workforce: our position** – overview of the current NHS workforce issues with a focus on inequalities.[79]
Example of good practice	**East Kent Hospitals University NHS Foundation Trust – Family First Bid[80]** **Background and aim:** East Kent Hospitals University NHS Foundation Trust experiences significant challenges with recruitment and retention of staff, related to its location and demographics.

[74] The Kings Fund. (2020). Workforce race inequalities and inclusion in NHS providers. Available online from https://www.kingsfund.org.uk/publications/workforce-race-inequalities-inclusion-nhs
[75] NHS England. Looking after our people – Retention hub. Available online from https://www.england.nhs.uk/looking-after-our-people/
[76] NHS England. Workforce planning and resource management. Available online from https://www.england.nhs.uk/mat-transformation/matrons-handbook/workforce-planning-and-resource-management/
[77] NHS England. Workforce equality and inclusion. Available online from https://www.england.nhs.uk/about/equality/workforce-eq-inc/
[78] NHS England. (2023) New figures show NHS workforce most diverse it has ever been. Available online from https://www.england.nhs.uk/2023/02/new-figures-show-nhs-workforce-most-diverse-it-has-ever-been/
[79] The Kings Fund. (2022) NHS workforce: our position. Available online from https://www.kingsfund.org.uk/projects/positions/nhs-workforce
[80] NHS East Kent Hospitals University NHS Foundation Trust. 'Family First' bid to improvement recruitment. Available online from https://www-archive.ekhuft.nhs.uk/patients-and-visitors/news-centre/news-archive/news-archive-2021/family-first-bid-to-improve-recruitment/

	The aim of this pilot scheme was to address some of the barriers to recruitment, such as family relocation to a more remote, rural, and coastal area. **Approach:** • 'Family first' is an ongoing pilot which encourages recruitment of staff by offering roles to partners of prospective consultants. The pilot has now evolved to a change in practice where the trust supports recruitment on an individual basis wherever possible as part of being a supportive and inclusive employer. • This was a Trust wide initiative with a focus to support recruitment at the QEQM Hospital in Margate, known to have challenges, due to it being located within a coastal area. • The family members were required to demonstrate they meet the minimum criteria for any role advertised to request consideration under the Family First scheme. If there was no suitable job advertised, and they are already working in a job that could be accommodated within the Trust, they were offered a role on a supernumerary basis for up to two years and supported to apply for a substantive position when one comes up. • The trust has plans to expand the scheme to other partners in the region to move to a 'place-based' recruitment approach and further enhance the benefits of the scheme. • In addition to the 'Family First' scheme, additional work was being carried out by the Trust to improve the recruitment of staff, including a focus on improving job description and application packs. **Outcomes:** • Data is still being collected as the pilot is ongoing. The data is being collected as part of a new data dashboard the trust is building.

Engaging local communities: Co-produced delivery models and community participatory research

Table 9 provides information on co-produced delivery models and community participatory research in relation to health inequalities, including key questions for systems to ask themselves when considering service change and an example of good practice.

Table 9: Engaging local communities and health inequalities considerations.

Co-produced delivery models and community participatory research	
Overview	*"Co-production is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities."*[81] Working in partnership with local communities and local authority colleagues ensures better decisions are made about service changes. It improves population health and the effectiveness in tackling health inequalities, by better understanding communities needs and jointly developing solutions.[82,83] Including diverse voices from those with lived experience within service design is essential to understand the potential causes for health inequalities, for example barriers around access to services. Co-produced delivery models should be the standard, with the patient and public voice being included at the start, wherever possible.[53] Community participatory research is where researchers and communities engage as equal partners in the research process to understand the various factors, such as the cultural, social, and economic determinants of health and healthcare access. The aim is to

[81] Social Care Institute for Excellence. (2022) Co-production: what it is and how to do it. Available online from https://www.scie.org.uk/co-production/what-how/
[82] NHS England. (2023) Working in partnership with people and communities: Statutory guidance. Available online from https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/
[83] Fuller C. (2022) Next steps for integrating primary care: Fuller Stocktake report. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

	utilise the increased understanding and knowledge to develop interventions to reduce health inequalities and improve health outcomes.[84,85]
Key questions which need to be reviewed when considering service change in relation to co-production and community participatory research and health inequalities[5,53]	• Have patients and communities who will be most impacted by the potential service changes been engaged at each stage during any decision-making processes? • Have all those involved within the decision-making processes been recorded, including their contribution and a demographic analysis of the contributors? • Have recruitment methods used to engage with the local communities been carefully considered? For example, using multiple methods for recruitment rather than one method, which may exclude certain groups. Particular effort should be made to seek out those groups vulnerable to experiencing health inequalities. • Have trustful relationships been developed with local communities to enable open and honest discussions to explore barriers to accessing the service (and how this may be overcome) and how the proposed service change is anticipated to influence health inequalities in particular groups? • Have a variety of research methods been used to gather feedback from the local communities on the service change, for example surveys, interviews, focus groups? Both qualitative and quantitative research is required to understand barriers and motivators for service change. • Have local communities, patients and those with a lived experience been engaged to co-create information which uses 'culturally competent communication'? This will ensure any messaging is clear and relatable to the target audience. As well as engaging with local communities, the NHSEI Communications professionals should also be involved within the co-creation of healthcare information.[53] • Have key stakeholders been involved who are known to have established and invaluable links with the community? For example, community influencers, connectors, faith leaders, voluntary sector leaders and Healthwatch. • Have professionals working within the service who have connections with the service users, for example, those from the same ethnic group, been engaged? • Are the local community kept up to date on the progress of the service change at appropriate, regular intervals? • Are there measures in place to evaluate the effectiveness of co-production with local communities?

[84] NHS Health Education England and Healthy Dialogues. (2022) An Evaluation of the South East England Community Participatory Action Research Training and Mentoring Project: Summative report. Available online from https://thamesvalley.hee.nhs.uk/An Evaluation of the South East England CPAR Training and Mentoring Summative Evaluation

[85] NHS England. Implementing the strategy. Available online from https://www.england.nhs.uk/south-east/health-equalities/turning-the-tide/implementing-the-strategy/

Further information	• **Working in partnership with people and communities: Statutory guidance** – guidance which supports effective partnership working with people and communities, to improve services and meet the public involvement legal duties.[82] • **Health inequalities: place-based approaches to reduce inequalities** - guidelines to support local action on health inequalities.[86] • **Inclusive and sustainable economies: leaving no one behind (executive summary)** – document supports place-based action on inclusive and sustainable economies as a mechanism to reduce health inequalities through improving the health of people and communities.[87] • **Public Health Messaging for Communities from Different Cultural Backgrounds** – provides clear guidance and evidence for public health messaging for those from different cultural backgrounds.[88] • **Asset based community development -** ambition is to support the proliferation of inclusive, bottom up, community driven change.[89] • **National voices - Six principles for engaging people and communities** – provides guidance for creating person-centred, community-focussed approaches to health, wellbeing, and care.[90] • **Co-create -** develop effective, sustainable ways of involving people in decision-making in health, community, and organisational settings.[91] • **VCSE health and wellbeing alliance –** online tool which can be used to audit organisations engagement with inclusion health groups.[92]

[86] Public Health England. (2019) Tools to support 'Place-based approaches for reducing health inequalities' Available online from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/825133/Tools to support Place-based approaches for reducing health inequalities. Tool A

[87] Public Health England. (2021) Guidance: inclusive and sustainable economies: leaving no one behind (executive summary). Available online from https://www.gov.uk/government/publications/inclusive-and-sustainable-economies-leaving-no-one-behind/inclusive-and-sustainable-economies-leaving-no-one-behind-executive-summary

[88] Scientific Pandemic Influenza Group on Behaviours (SPI-B). (2020) Public Health messaging for communities from different cultural backgrounds. Available online from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/914924/s0649-public-health-messaging-bame-communities.pdf

[89] Nurture development. Asset based community development. Available online from https://www.nurturedevelopment.org/asset-based-community-development/

[90] People and Communities Board. (2016) Six principles for engaging people and communities. Available online from https://www.nationalvoices.org.uk/sites/default/files/public/publications/six_principles_-_putting_into_practice_-_web_hi_res_-_updated_nov_2016.pdf

[91] Co-create. People centred change. Available online from https://www.wearecocreate.com/

[92] VCSE health and wellbeing alliance. VCSE Health Audit Tool. Available online from https://www.inclusion-health.org/

	• **Increasing diversity in research participation –** a good practice guide for engaging with underrepresented groups.[93] • **National Voices** – a leading coalition of health and social care charities in England.[94] • **Community-centred public health Taking a whole system approach** – summarises the key elements, core values and principles that are needed to make a shift to whole system approaches to community-centred public health.[95] • **University of Reading: Participation Lab Co-producing knowledge for social change** – shared learning about facilitating participatory, creative methods, community-led, action-oriented research approaches and public engagement to enable people's voices to be heard.[96] • **Communications and Engagement Toolkit for Socio**-economically deprived areas – a toolkit for work in socio-economically deprived areas.[97]
Example of good practice	**Morecambe Bay: Engaging to tackle health inequalities[98]** **Background and aim:** This project was undertaken by Morecambe Bay Clinical Commissioning Group, Morecambe Bay Primary Care Networks (PCNs), Integrated Care Communities (ICC), Co-create and other local partners. The aims of the project were to: • Reduce local health inequalities with a focus on the most vulnerable communities. • Support PCNs to develop skills to utilise population health management and engagement approaches.

[93] NHS. Increasing diversity in Research Participation: a good practice guide for engaging for underrepresented groups. Available online from https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2023/02/B1905-increasing-diversity-in-research-participation.pdf
[94] National voices. Available online from https://www.nationalvoices.org.uk/about-us
[95] Public Health England. (2020) Community-centred public health: taking a whole system approach. Available online from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/857029/WSA_Briefing.pdf
[96] University of Reading. Participation Lab Co-producing knowledge for social change. Available online from https://research.reading.ac.uk/participation-lab/
[97] NHS England. (2023) Communications and Engagement Toolkit for Socio-Economically Deprived Areas. Available online from https://www.wypartnership.co.uk/application/files/7516/7836/5886/21-086784-01_NHSE_Health_Inequalities_Toolkit_FINAL_CLEAN_PUBLIC_030323.pdf
[98] NHS. Statutory Guidance on Working with People and Communities 2022: case study example. Morecambe Bay: Engaging to tackle health inequalities. Available online from https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2022%2F07%2FMorecambe-Bay-Engaging-to-tackle-health-inequalities.doc.docx&wdOrigin=BROWSELINK

	• Identify and engage with local communities to understand the issues important to them and co-produce solutions. This included exploring what access issues and inequalities were being experienced by a range of health inclusion groups and other key groups. 'Inclusion group' is an umbrella term used to describe people who are socially excluded, who experience multiple risk factors for poor health.[99] • Develop and deliver learning that can be replicated in other areas in the Lancashire and South Cumbria ICS and across England. • Develop engagement with local authority and voluntary sector partners. **Approach:** • A population health management approach to identify groups of patients that may experience health inequalities, was used with 7 PCNs. • 'Co-create' facilitated an asset mapping process with each PCN group to identify local people and organisations that could potentially support with the work. • Different groups were engaged including: ➢ 16–21-year-olds in Kendal. ➢ Women eligible for a smear test in Skerton, Lancaster. ➢ Adults with learning disabilities and their carers in Morecombe Bay. ➢ Hospitality workers from migrant communities in Grange-over-Sands and The Lakes. • Methods of engagement were surveys, local voluntary sector organisations speaking to people they worked with, phone calls, social media, and face to face work at local schools and colleges. • Workshops supported people to plan how they would share what they had found and actions they planned to take following this engagement with the communities. **Outcomes:** There were several tangible outcomes and plans from the work in Morecambe Bay including staff planning to take learning from engagement activities to: • Shape services being developed for 16–21-year-olds in Kendal, build on relationships developed with secondary schools and continue to have a youth rep on the ICC.

[99] NHS England. Inclusion health groups. Available online from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/

	• Improve access to cervical smear uptake in Skerton by improving information and providing a short explanatory video for patients to view on their website. • Reassess how the annual learning disability health checks are organised, ultimately aiming to improve uptake, and focusing on providing care which makes patients feel comfortable, cared for, and listened to. Positive feedback from the project was received by staff involved, including that it improved confidence with engaging local communities and improved understanding of the local population needs, to inform ways to improve services.

Partnership working

Table 10 provides information on partnership working in relation to health inequalities, including key questions for systems to ask themselves when considering service change and an example of good practice.

Table 10: Partnership working and health inequalities considerations.

Partnership working	
Overview	Partnership working can maximise the social, economic, and environmental impacts to improve social determinants of health, health outcomes and ultimately reduce health inequalities in its local populations. The NHS as an anchor institution works with a range of partners including:[100] • **Local authorities** – have a statutory role in public health, discharged by the Director of Public Health and their teams and includes prevention and action on the wider determinants of health. There are multiple points of contact with local authorities who may have different concerns around the impact of proposals on inequalities including the health overview and scrutiny committees, health and wellbeing boards, elected members, and officers. • **Voluntary, Community and Social Enterprise (VCSE) organisations** – have a role in improving health and tackling health inequalities through service delivery, raising awareness, influencing and research. These organisations are well trusted so are an important link to vulnerable communities. • **Local businesses** – role to act as anchor institutions to utilise spending power and scale social value. • **Wider public sector** – role in partnership working to address wider determinants of health and direct causes of health inequalities. • **Healthwatch** – an independent statutory body which utilises feedback to help improve health and care services for all.[101]

[100] Office for Health Improvement and Disparities. (2022) Guidance: Health disparities and health inequalities: applying All Our Health. Available online from https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health

[101] Healthwatch. Available online from https://www.healthwatch.co.uk/what-we-do

Key questions which need to be reviewed when considering service change in relation to partnership working and health inequalities[82]	• Is there an awareness of the various VCSE sector organisations within the local area who support vulnerable and disadvantaged communities? • Have the roles of all the potential partner organisations been considered for how they may be utilised within any service change proposals? (From a health inequalities perspective). • Have the VCSE and Healthwatch been engaged with the service change proposals and their roles utilised on their knowledge of the local community and to assist with reaching out to them? • Does the service provide care to any of the clinical areas highlighted in the Core20PLUS 5? If so, have local groups, such as charities been identified to collaborate with in terms of how best to tackle health inequalities within the service / clinical area? • Has the use of language with partner organisations been carefully considered? For example, focusing conversations on mitigations as much as potential issues with the service change? • Have all conversations with partners been documented, including information on how they have fed into proposals? This information may be required for judicial review. • If collaborating with VCSE sector organisations, has it been considered if they will require additional financial support? • Are there plans in place for how to communicate clear updates to partner organisations on the service change plans? • Has there been considerations for how the services premises may be used by community and VCSE organisations? For example, use of the land for social prescribing and/or community projects. • Are considerations in place for how the service may support local businesses during its development? For example, considering supporting local businesses with procurement.
Further information and reading	• **Office for Health Improvement and Disparities – Guidance: Health disparities and health inequalities: applying All Our Health** – a guide which helps health care professionals and the wider workforce prevent ill health and promote wellbeing as part of their everyday practice.[100] • **Tools to support 'Place-based approaches for reducing health inequalities'** – guidelines to support local action on health inequalities.[86] • **NHS England - Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance** – provides an overview of VCSE organisations and signposts to specific organisations.[102] • **Working in partnership with people and communities: Statutory guidance.**[82]

[102] NHS England. Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance. Available online from https://www.england.nhs.uk/hwalliance/

	• **The Health Anchors Learning Network** – provides a platform to learn how anchor institutions can improve social determinants of health to help reduce health inequalities.[103] • **Community-centred public health Taking a whole system approach** – summarises the key elements, core values and principles that are needed to make a shift to whole system approaches to community-centred public health.[95] • **The Kings Fund - Improving partnership working to reduce health inequalities** - brief overview of some key principles for partnership working.[104]
Example of good practice	**Healthwatch and Sussex ICS[105]** **Background and aim:** The ICS views local Healthwatch as a strategic partner, involved in decision making. The ICS Associate Director of Public Involvement is the main relationship holder with the local Healthwatch. A specific example of how local Healthwatch and Sussex ICS worked together was in a project to understand system pressures. Local Healthwatch in Sussex were commissioned to support the ICS to understand patient experience of access to healthcare services (primary care, acute care, and social care) as the lockdown eased. Within Sussex inequalities exist with deprivation, rural isolation, and coastal communities. **Approach:** Local Healthwatch collaborated and used existing evidence and insight from public feedback. This was from a range of methods including feedback centre information, GP reviews and survey results. Using this data, they were able to report on where most pressures are experienced.

[103] Health Anchors Learning Network. Available online from https://haln.org.uk/what-is-the-health-anchors-learning-network
[104] The Kings Fund. (2009) Improving partnership working to reduce health inequalities. Available online from https://www.kingsfund.org.uk/publications/articles/improving-partnership-working-reduce-health-inequalities
[105] Healthwatch. (2022) ICS and Healthwatch working together. Available online from https://network.healthwatch.co.uk/sites/network.healthwatch.co.uk/files/20220407%20-%20Promising%20practice%20case%20studies.pdf

	Outcomes: The findings from this work support the hypothesis that if GPs were able to offer more appointments, in a way that meets the needs and preferences of patients, this may result in fewer people presenting at Emergency Departments and Urgent Treatment Centres. The local Healthwatch provided seven recommendations from this work, which informed wider action for the ICS. Recommendations included encouraging GPs to maximise the mechanisms by which patients can contact them and ensuring greater consistency in messaging on websites and out of hours phone messages. Sussex NHS commissioners undertook appropriate work to address the issues identified by Healthwatch and recognised the importance of feedback from the public to improve services.[106]

[106] Healthwatch in Sussex. (2021) Healthwatch in Sussex Insight: Health and Care Pressures 2021. Available online from https://www.healthwatchbrightonandhove.co.uk/sites/healthwatchbrightonandhove.co.uk/Health Watch in Sussex Insight: Health and Care Pressures 2021

Data, modelling, and health equity audits

Table 11 provides information on data, modelling, and health equity audits in relation to health inequalities, including key questions for systems to ask themselves when considering service change and an example of good practice.

Table 11: Data, modelling and health equity audits and health inequalities considerations.

Data, modelling, and health equity audits	
Overview	The use of data to drive actionable change is an integral part of the work within the HiQiP. Accurate data is required to understand where and why health inequalities exist to effectively drive improvements to tackle them. A strategic priority is to 'Ensure data sets are complete and timely.'[16] Health equity audits (HEA) can identify health inequalities between different population groups, in terms of health determinants, access and related outcomes, this can help identify actions needed to tackle the inequalities. It is helpful to complete a HEA at the beginning of a service change, to understand the population groups who require the greatest level of support. A Health Equity Assessment Tool (HEAT) has been produced, with the aim to enable professionals systematically address health inequalities, equity-related to a service and identify action which needs to be taken to reduce health inequalities and promote equality and inclusion. Further information on this can be found online from the Office for Health Improvement and Disparities.[107,108,109.]
Key questions which need	• Has accurate data been collected and analysed from the current service, to understand variations between population groups, which can help to inform priority groups within any service design? This may include: ➢ Reviewing waiting lists by IMD and ethnicity (this falls into the strategic priority 'Restore NHS services inclusively')

[107] Office for Health Improvement and Disparities. (2020). Guidance: Health equity audit guide for screening providers and commissioners. Available online from https://www.gov.uk/government/publications/nhs-population-screening-a-health-equity-audit-guide/health-equity-audit-guide-for-screening-providers-and-commissioners
[108] Public Health England. (2020) Health Equity Assessment Tool (HEAT). Available online from https://www.gov.uk/government/publications/health-equity-assessment-tool-heat
[109] NHS England. Health Equity Assessment Tool. Available online from https://www.e-lfh.org.uk/programmes/health-equity-assessment-tool-heat/

to be reviewed when considering service change in relation to data, modelling and health equity audits and health inequalities	➢ Reviewing attendances, DNA rates and cancellations by age, IMD, ethnicity, mode of appointment e.g., face to face v virtual[110] • Are there plans for how accurate patient and population data will be collected in any new service design on factors such as ethnicity, IMD and vulnerable groups? Has consideration been given to how this data will be used and analysed to ensure continuing improvement of the service in terms of tackling inequalities? Specific consideration needs to be given to the steps being taken to improve the completeness and/or quality of data needed to examine health inequalities (specifically ethnicity recording). • Has 'insight' data been collected, which can be used to evaluate patients experiences of care within the existing service? For example, surveys, friends and family test and patient reported outcome measures. This information can be used to inform improvements for future service design. Further information on 'insights' can be found on the NHS website.[48] • Is effective data and information sharing between partners allowed according to information governance agreements?[111] • Have key stakeholders who are experts within this area been engaged to utilise their knowledge and skills to ensure data is analysed in the most accurate and effective way? For example, data analyst teams, data scientists and NHS digital.
Further information	Several tools are available which provide invaluable data, which is needed to tackle health inequalities: • **The Healthcare Inequalities Improvement Dashboard** – provides data on a number of dimensions of inequality, including deprivation and ethnicity. Access can be requested from the Healthcare Inequalities Improvement Programme on the FutureNHS Collaboration Platform.[112] Additional tools and resources available on the same platform include: ➢ **Priority neighbourhoods for unplanned hospitalisations dashboard –** provides data on local areas which have a high level of unplanned hospitalisations, by indices including age, sex, ethnicity, and deprivation and provides comparative data for similar areas to benchmark against. ➢ **Actionable insights tool –** presents data on health inequalities in various formats including maps and sentences, assisting with the interpretation of the data.

[110] NHS England South East. (2022). 2022/23 Regional Healthcare Inequalities Improvement Stocktake: Q2 update. Powerpoint presentation from 3rd October 2022.
[111] NHS England. Tackling inequalities in healthcare access, experience, and outcomes. Actionable insights. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/07/B1779-Actionable-Insights-Tackling-inequalities-in-healthcare-access-experience-and-outcomes-guidance-July-202.pdf
[112] Healthcare inequalities improvement programme on NHS Futures. The Healthcare Inequalities Improvement Dashboard. Available online from https://future.nhs.uk/connect.ti/InequalitiesImprovement/view?objectId=42238064

	➢ **Primary Care Networks dashboard –** provides a standardised and comparable view of information to support tracking and delivery of Primary Care Networks services. • **Health inequalities dashboard** – provides data on factors such as life expectancy, smoking prevalence, to support evidence of health inequalities in England.[113] • **NICE** have a health inequalities page whereby relevant NICE guidance are mapped to the 5 clinical areas of the Core20PLUS5 approach and the six policy objectives to reduce health inequalities, summarised in the Marmot review.[8] Additionally, the NICE guidance which can help ICSs when developing approaches to address health inequalities are all signposted to on the page.[114] • **SHAPE** - an online, interactive, data mapping, analysis and insight tool that supports strategic planning of services and assets across the public sector. It can be used to guide commissioners on the service reconfiguration which provides the most affordable access to care.[115] • **Segment tool** - provides information on the causes of death and age groups that are driving inequalities in life expectancy at local area level.[116] • **Fingertips** - a large public health data collection which provides access to a rich source of indicators across a range of health and wellbeing topics.[117] Further useful reading includes: • **Department of Health - Putting data, digital and tech at the heart of transforming the NHS** – independent review which considers how to ensure a coherent approach to digital transformation in the NHS.[118] • **NHS England and NHS Improvement - The Core20PLUS5 and data for improvement presentation** – slides outlining considerations for using data to drive improvement and signposting to useful further information**.**[119]

[113] Office for Health Improvement and Disparities. Health Inequalities Dashboard. Available online from https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/
[114] NICE. NICE and health inequalities. Available online from https://www.nice.org.uk/about/what-we-do/nice-and-health-inequalities
[115] Department of Health and Social Care. SHAPE tool. Available online from https://shapeatlas.net/
[116] Office for Health Improvement and Disparities. Segment Tool. Available online from https://analytics.phe.gov.uk/apps/segment-tool/
[117] Office for Health Improvement and Disparities. Public health profiles. Available online from https://fingertips.phe.org.uk/
[118] Department of health and Social Care. (2021) Independent report: putting data, digital and tech at the heart of transforming the NHS. Available online from https://www.gov.uk/government/publications/putting-data-digital-and-tech-at-the-heart-of-transforming-the-nhs/putting-data-digital-and-tech-at-the-heart-of-transforming-the-nhs
[119] NHS England and NHS Improvement. (2021) The Core20PLUS 5 and data for improvement. Available online from https://www.nhsconfed.org/system/files/2021-11/Data%20for%20Improvement%20-%20Leadership%20Framework%20for%20Health%20Inequalities.pdf

	• **Understanding consistency of ethnicity data recorded in health-related administrative datasets in England: 2011 to 2021** – comparisons showing differences in the recording of ethnicity data between health administrative datasets.[120]
Example of good practice	**Wessex Cancer Alliance and Dorset Cancer Partnership - Effectiveness of a Primary Care Video Text Reminder to those never attending Cervical Screening in areas of greater deprivation.** **Background and aim:** Uptake of cervical screening is found to be much lower in areas of deprivation. Deprivation is associated with low levels of literacy and consequently low levels of health literacy. It is reported that this can lead to lack of understanding and compound fear and anxiety about what cervical screening is, what is involved and how painful it might be. The use of text messaging has grown exponentially in healthcare especially in the last two years. It is well documented that this is an effective communication method and in groups who experience health inequalities. Text messaging interventions have been shown to moderately increase screening rates for cervical screening. The aim of the pilot was to test effectiveness of sending third reminders via video texting to encourage participation in cervical screening in areas of high deprivation. **Approach:** Four GP practices with the highest deprivation and lowest screening uptake in Dorset were selected using PHE fingertips data and the patients targeted with the intervention were: • 30–34-year-olds who have never attended for cervical screening • 49–54-year-olds who have missed the last two screening rounds for cervical screening

[120] Office for National Statistics. (2021). Understanding consistency of ethnicity date recorded in health-related administrative datasets in England: 2011 to 2021. Available online from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/articles/understandingconsistencyofethnicitydatarecordedinhealthrelatedadministrativedatasetsinengland2011to2021/2023-01-16

	The participating practices ran a search on their clinical systems and sent a bulk text message to all the patients that fell into the eligible criteria which included a video (content signed off by NHSE) of a local GP and practice nurse explaining the importance and pros and cons of cervical screening. **Outcomes:** Early findings are that participating practices have reported that 5-9% of all patients that were sent the video message, attended their cervical screening appointments within a 2-month timeframe of the invite. The analytics of the video has also been analysed to understand number of views. The next step is to explore the patient level data to understand the demographics of the patients that engaged and didn't engage with cervical screening following the video texting intervention (A DPIA and data sharing agreement is in place to enable us to obtain this patient information from the GP practices to analyse.)

Assessment tools

Integrated impact assessments support the evaluation of the reasons for a proposed change to services and the impacts (positive and negative) on:[5]

- Health, quality, and outcomes
- Access, travel time and choice
- Other providers
- Sustainability
- **Inequalities**

Equality and Health inequalities Impact Assessments (EHIAs) are tools aimed to help with assessing the impact of a policy or service change on different groups, within its local population. EHIAs are aimed to ensure legal duties around tackling health inequalities are met and should be initiated at the earliest opportunity within service change proposals.[121] Further information and guidance on EHIAs has been developed by the Patient Equalities Team, which includes a detailed guidance document[122] and an assessment template.[123]

Figure 11 provides guidance on all the key considerations for undertaking integrated impact assessments.[31]

[121] NHS. Equality Diversity and Inclusion. Equality and Health Inequalities Impact Assessments. Available online from https://nhsengland.sharepoint.com/sites/EDI/SitePages/Equality-Impact.aspx
[122] NHS England and NHS Improvement. (2020) Guidance notes: Developing Equality and health Inequalities Impact Assessments. Available online from https://nhsengland.sharepoint.com/sites/EDI/EHIA Guidance Notes
[123] NHS England and NHS Improvement. (2022) Equality and Health Inequalities Impact Assessment. Available online from https://nhsengland.sharepoint.com/Equality and Health Inequalities Impact Assessment (EHIA) template

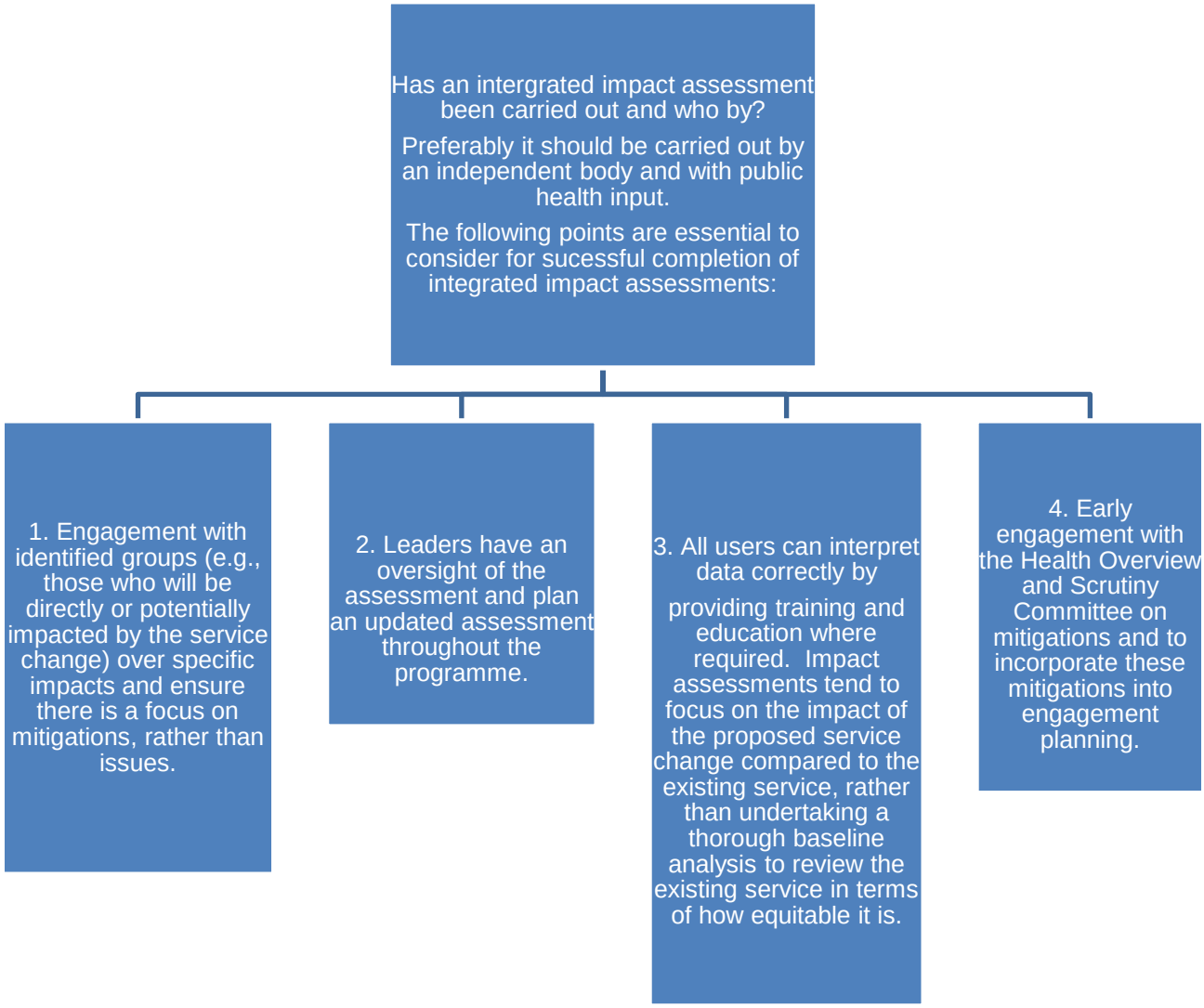

Figure 11: Considerations for successfully undertaking integrated impact assessments

There are several assessment tools available, all of which have similarities and slight differences. It is important to choose the tool which most suits the service transformation, rather than undertaking them all.

5. Further information and resources

Key contacts to access further information on health inequalities are listed below:

- **The local authority public health directors and teams** – have a role of advocating for the health of the local population and can support ICS/ICBs around population health. Being a source of expertise on inequalities they can work with communities to bring this into discussions.[124]
- **The National Healthcare Inequalities Improvement team** – supports organisations and wider systems with their approach to reducing healthcare inequalities. Email contact: england.healthinequalities@nhs.net.
- **National Patient Equalities team** – provides advice in relation to patient equalities within legislative commitments and support with completing an Equality Impact Assessment. Email contact: england.eandhi@nhs.net.
- **The South East Region Healthcare Inequalities** group - meet regularly to discuss healthcare inequalities within the local area and produce useful monthly newsletter updates provided by the South East regional HIIP lead.

Additional links which contain useful information on health inequalities include:

- Health Inequality Networks - NHS England » Networks
- The Equality and Health Inequalities Hub - NHS England » The Equality and Health Inequalities Hub
- Healthcare Inequalities Improvement Programme - Healthcare Inequalities Improvement Programme - FutureNHS Collaboration Platform
- Equality and Health Inequalities Network on FutureNHS Collaboration Platform - Equality and Health Inequalities Network - FutureNHS Collaboration Platform
- Royal Society for public health vision, voice, and practice - an independent campaigning and educational charity dedicated to improving and protecting the health of the public RSPH | Health Inequalities
- Health and Wellbeing of Coastal Communities in Kent – Annual Public Health Report 2021.[125]

[124] Department of Health. The new public health role of local authorities. Available online from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213009/Public-health-role-of-local-authorities-factsheet.pdf

[125] Kent County Council. (2021) Health and Wellbeing of Coastal Communities in Kent. Available online from https://www.kpho.org.uk/__data/assets/pdf_file/0003/138270/Kent-APHR-2021-Coastal-Communities.pdf

- Healthcare Financial Management Association – Health inequalities: establishing the case for change.[126]

Table 12 signposts to useful courses which are available to expand knowledge on the topic of health inequalities.

Table 12: Health inequalities courses

Course	Information	Link to course
Cultural Competence programme	Support clinicians in the NHS to gain knowledge and understanding of the issues around culture and health and how this might influence health care outcomes.	Cultural Competence - elearning for healthcare (e-lfh.org.uk)
Health inequalities programme	Topics on specific areas of Sickle cell disorder and Core20PLUS 5.	Health Inequalities - elearning for healthcare (e-lfh.org.uk)
Health Equalities Framework programme	An interactive e-learning resource providing a practical introduction to the Health Equalities Framework tool.	Health Equalities Framework - elearning for healthcare (e-lfh.org.uk)
Fairhealth	Charity offering a range of courses within the area of health inequalities including inclusion health and a practical guide to reducing health inequalities within primary care.	Courses (fairhealth.org.uk)

There are several examples of good practice of how health inequalities are being tackled. The following links can be used to access further examples of case studies:

- **Proactive care document repository** – provides examples of good practice and evidence-based interventions to address the health inequity challenges in primary care.[127]
- **The National Healthcare Inequalities Improvement Programme on FutureNHS** – provides links to several examples of good practice.[128]

[126] Healthcare Financial Management Association. (2023) Health inequalities Establishing the case for change. Available online from https://www.hfma.org.uk/docs/default-source/publications/briefings/health-inequalities-establishing-the-case-for_farida-khawaja.pdf?sfvrsn=b4cb4de7_6
[127] NHS Futures, South East Region Primary Care Transformation. Proactive Care document repository. Available online from https://future.nhs.uk/SEPrimaryCareNetwork/view?objectID=864708
[128] NHS Futures, Healthcare Inequalities Improvement Programme. Available online from https://future.nhs.uk/InequalitiesImprovement

- **Royal Society for public health vision, voice, and practice** – provides links to allied health profession case studies.[129]

6. Conclusion

Urgent action is required to tackle health inequalities and we all have a duty to act towards achieving this. Health inequalities will continue to exist unless we actively take steps to address them, and service reconfiguration is a window of opportunity to drive forward the delivery of fair and equitable healthcare for all. Tackling health inequalities needs to be a focus in all service change proposals. Not only should careful consideration be given to mitigate for any potential increase in health inequalities experienced by a service change, but emphasis must also be placed on implementing measures to ensure the service change has a positive impact on narrowing the health inequalities gap. Every opportunity needs to be taken in any decision-making processes around service change to tackle health inequalities and ensure our healthcare system is one which is fair, equitable and safe for all.

7. Acknowledgments

The South East Clinical Senate would like to thank the following people for their input into this report:

- Dr Michael Baker, Deputy Director of Healthcare, NHS England, South East
- Helen Davies, Health Inequalities Programme Manager, NHS England (South East)
- Dr James Hadlow, Associate Medical Director – Remote and Rural Strategy, East Kent Hospitals University NHS Foundation Trust
- Sindie Clark, Deputy Director for Primary Care Transformation – Proactive Care
- Pat Haye, Deputy Director Clinical Strategy – NHS England South East

[129] Royal Society for Public Health Vision, Voice and Practice. Available online from https://www.rsph.org.uk/our-work/resources/allied-health-professionals-hub/case-studies.html

Appendix 1

Table 1: Additional policy drivers for addressing health inequalities

Policy	Link to health inequalities
NHS Oversight Framework (2022/2023)[130]	• Aligned to ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance. • 5 national themes of the NHS Oversight Framework are: ➢ Quality of care, access, and outcomes ➢ Preventing ill health and reducing inequalities ➢ People ➢ Finance and use of resources ➢ Leadership and capability
Joint Forward Planning Guidance[131]	• Supports ICBs and their partner NHS Trusts to develop their first 5 year forward plans with system partners. • Includes the legislative requirements of ICBs to have a duty to: ➢ Promote integration by improving quality of services and reducing inequalities in access and outcomes. ➢ Have regard to wider effect of decisions e.g., reducing inequalities with respect to health and wellbeing and quality of healthcare received. ➢ Improve quality of services by using the Core20PLUS5 approach to ensure that inequalities are considered. ➢ Reduce inequalities in access to and outcomes from services. ➢ Involve people and communities in decisions about the planning, development and operation of services commissioned and provided,

[130] NHS. (2022) NHS Oversight Framework. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf
[131] NHS (2022) Guidance on developing the joint forward plan. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf

	particularly those who face the greatest health inequalities. ➢ Promote innovation, that aligns with population health needs and address health inequalities. ➢ Address the needs of victims of abuse, to include related health inequalities. ➢ Considerations around reducing digital inequity and inequalities and developing approaches to better understand population needs and outcomes (including health inequalities).
Next steps for integrating primary care: Fuller Stocktake report[83]	• Sets out the vision for integrating primary care, improving the access, experience, and outcomes for communities by: ➢ Streamlining access to care and advice. ➢ Providing more proactive, personalised care. ➢ Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention. ➢ It is recognised that this is only achievable through working in partnership to address health inequalities through the Core20PLUS5 approach and taking action to address the wider determinants of health.

Appendix 2

Further acknowledgements:

- Emma LeatherBarrow, Equality Lead, Wessex Cancer Alliance.
- Victoria Wright, Non-clinical Primary Care Lead, Wessex Cancer Alliance.
- Vikki Andrews, Project Manager, Dorset Cancer Partnership.
- Lucy Asquith, Senior Programme Manager, Community Involvement and Evaluation Community Involvement & Workforce Innovation - Oxford AHSN