NHS Providers

Briefing

September 2021

HEALTH INEQUALITIES

A core concern

Key messages

- The COVID-19 pandemic has played out against a backdrop of multiple inequalities, driven by a range of factors including levels of poverty and deprivation, safe and healthy housing, education, employment and access to healthy food and green space. Despite a gradual move towards embedding health inequalities and the wider determinants of health as a key responsibility of the health and care system, the NHS' potential to contribute towards a comprehensive approach to population health and narrowing health inequalities has not yet been fully realised.
- The 2021/22 operational priorities and planning guidance stipulates, for the first time, that people at risk of health inequalities must be prioritised for treatment as trusts work through their backlogs of elective care. The presence of a "gateway criterion" for the elective recovery fund, requiring trusts to address health inequalities to be eligible for additional funding, is evidence of the national bodies' increasing commitment to reducing health inequalities: financial incentives and operational requirements focused on addressing inequalities did not exist at the same level of priority before the pandemic.
- Forthcoming legislation firmly positions integrated care systems as the primary level at which partners will come together to make plans, including to address health inequalities. Meanwhile guidance issued by NHS England puts a welcome emphasis on the role of place-based arrangements in identifying and narrowing inequalities. It will be necessary therefore to avoid confused and conflicting accountability in this new system-wide focus on health inequalities.
- There is a risk that, if shorter-term financial and operational pressures dominate integrated care boards' attention, a focus on health inequalities could be lost, while valuable partnerships could be undermined in being drawn into transactional conversations about the distribution of scarce resources. A statutory duty upon integrated care systems to reduce inequalities may therefore strengthen the argument for interventions to be funded and supported. This will only be possible if integrated care systems (ICSs) themselves are given a realistic task.

- It will be crucial for national policymakers to enable and support trusts and systems to prioritise this focus on inequalities. Improvement in this area may take time, may bring additional costs, and could slow down broader efforts to reduce the size of waiting lists or return to expected productivity levels. Trusts need a policy environment in which targets for service recovery and objectives to reduce health inequality complement, rather than conflict with, each other.
- Evidence of the impact of recent measures taken to address health inequalities is still scarce. Where data collected by NHS England and NHS Improvement or Care Quality Commission reveal disparities in access and outcomes, there should be a defined outcome of such findings including clarity on what measures national bodies may take to ensure progress is made, and what further support may be offered to trusts and systems. There will be a need for data collected as part of new obligations on trusts to share metrics on their progress towards tackling health inequalities to be used to monitor impact and share learning on what works.
- The inclusion of health inequalities in the planning guidance and regulatory frameworks gives weight to the notion that health inequalities will be front and centre as the service rebuilds from the pandemic. New legislation, with its focus on collaboration between a broader range of partners within systems and at place level, appears to offer a genuine opportunity to create momentum. However, national leaders will ultimately need to set out a long-term framework for taking these actions further in a way that sustains improvements made in health inequalities.

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Introduction

The *Marmot review: 10 Years On* was published in February 2020 just as the world was beginning to recognise the magnitude of coronavirus. The report set out how, since 2010, the health inequalities gap had widened, and those who experience greater inequality also spend more time in ill health than they did ten years ago and can expect to live with a greater number of health conditions from a younger age. It concluded that health is very closely linked to the "conditions in which people are born, grow, live, work and age and inequities in power, money and resources". COVID-19 has only widened existing faultlines: the impact of the pandemic has fallen unequally across society, and people's experience has been influenced by their circumstances and health. Those who were most disadvantaged before the pandemic have borne the brunt of the virus and have been hit hardest by the measures that have needed to be taken to control it.

The pandemic has played out against a backdrop of multiple inequalities driven by a range of factors, including levels of poverty and deprivation, defined by the index of multiple deprivation (IMD 2019), safe and healthy housing, education, employment. These factors can also restrict access to healthy food and green spaces. The NHS has an important role to play in improving people's health beyond the services it provides: as an employer, an anchor institution for the communities it serves, and as a key partner within the integrated care system working with communities, local government, and VCSE (voluntary, community and social enterprise organisations) to address the wider determinants of health. This multi-faceted role has become clearer over the past 18 months as collaborative working has strengthened and the role of the NHS in helping staff and communities cope with the pandemic has become more visible and more widely understood. National NHS leaders are now looking to systems and trusts to take concerted action on the inequalities faced by those from deprived backgrounds, minority ethnic groups, autistic people and people with learning disabilities, and other protected characteristics.

There is an increasing policy focus on health inequalities and a commitment to addressing them from all angles is writ large across national leaders' efforts to shape the way the health service recovers from the pandemic. Tackling health inequalities is being woven into primary legislation in the form of the Health and Care Bill, to the way finances are allocated and how national regulators will measure trusts' performance and quality of care. This briefing maps how the impact of health inequalities is therefore becoming integral to how the NHS will operate in the years to come and explores what this means for trusts as they work to balance the challenging task ahead. It sets out principles for a supportive policy framework, as a crucial underpinning for local action at the level of system, place and individual trusts.

Trusts must recover from the impact of the pandemic, which has resulted in long waiting lists and high unmet need, operate within a tight financial settlement, and accelerate integration and collaborative working in preparation for ICSs to become statutory bodies in 2022. Although health inequalities will be front of mind for trust leaders as they navigate this process, there are unanswered questions about how trusts will be able to prioritise these issues when financial objectives and operational targets create conflicting priorities. However, there is also a clear opportunity for trusts to make use of this focus and momentum to contribute to a lasting change in how inequalities in care are understood, acknowledged and dealt with across the NHS.

Context: a growing focus on health inequalities

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The pandemic has come amid a noticeable shift in national policy which has made health inequalities a key priority for trusts and systems. COVID-19 has laid bare the limited impact of previous efforts to tackle the issue. The pandemic has increased the prominence of health inequalities, both within and beyond the NHS, and has intensified policymakers' focus on the need for change.

Before the pandemic, the *NHS Long term plan* (NHS England 2019) emphasised preventative care and reducing health inequalities. It laid the basis for a more systematic approach for the NHS to tackle inequalities – for example making a commitment to continuing to target a higher share of funding towards geographies with high health inequalities and ensuring no area would be more than 5% below its new target funding share. The plan set out how the NHS would shift from a reactive model of care towards one built around active population health management, with ICSs laying the foundations for stronger partnerships between the NHS, local government and the voluntary sector. The long term plan set the basis for a national commitment to addressing health inequalities, but at the time of publication there were not clear governance, regulatory or legislative structures in place to support this work, and initiatives often relied on good relationships, a history of joint working, and the presence of a local 'champion' for the work.

The NHS people plan for 2020/21 (NHS England, 2020) detailed the inequalities prevalent within the NHS workforce. It set out how the treatment of staff from minority groups often falls short of expectations and prevents the NHS from closing the gap on health inequalities, and from achieving the service changes that are needed to improve population health. It acknowledged that the pandemic has had a disproportionate impact on people from minority backgrounds, on older people, on men, on those with obesity and on those with a disability or long-term condition. It also notes the role of ICSs in building on NHS organisations as anchor institutions – large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area (The Health Foundation, 2019) – to address inequalities.

More recently, national public health reform has also brought focus to the role of the NHS in improving population health and tackling health inequalities. In April 2021, Public Health England (PHE) was disbanded and the UK Health Security Agency was formed, with responsibilities around health protection, pandemic response and preparedness, and COVID-19 test and trace services (Department of Health and Social Care, 2021). PHE's health improvement functions have transferred to several bodies including the Department of Health and Social Care, NHS England and NHS Improvement and the Office for Health Improvement and Disparities (OHID). The health and care bill provides for the secretary of state to delegate the exercise of public health to NHS England or an integrated care board, meaning that ICSs and trusts may have a more direct role in the operation of public health services in the future.

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Despite a gradual move towards embedding health inequalities and the wider determinants of health as a core responsibility of the health and care system, the NHS's potential to contribute towards a comprehensive approach to population health and narrowing health inequalities will take time and continued focus to be fully realised. There is now a clear opportunity to build on the lessons learned during the pandemic and take advantage of numerous new policy drivers for a collective emphasis on reducing inequity in healthcare access, experience and outcomes.

System working as a vehicle to address health inequalities

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If COVID-19 has strengthened the understanding of health inequalities within the NHS, it is ICSs that national leaders will rely upon to bring different parts of the system together to address them.

System working has accelerated during the pandemic, bringing leaders together with the shared aims of supporting their communities through COVID-19, and keeping services on a sustainable footing in spite of restrictions and operational pressures. The health and care bill will put ICSs on a statutory footing with legal responsibilities to proactively reduce health inequalities and formalise relationships across a broad coalition of partners. It therefore offers a chance to solidify this focus on reducing inequalities and formalise structures being put in place to ensure accountabilities are clear.

We are now beginning to see health inequalities fully embedded alongside other operational priorities within documents setting out how NHS organisations must use resources, plan services, and deliver care for their local populations. There remain questions about how, in practice, ICS leaders will fulfil their duties to address health inequalities alongside their responsibilities in respect of managing budgets and ensuring the sustainability of services.

NHS England and Improvement's 'Integrating Care' paper

NHS England and NHS Improvement's ***Integrating Care paper*** (2020) outlined the intention to build relationships between the NHS and local authorities, and builds on The NHS Long term plan vision of joined up care centred around people's needs. This includes the observation that collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities. The paper sets out the intention for ICS leaders to be empowered to distribute resources in line with targeted local investment priorities on health inequalities, as well as meeting their obligations to other national spending rules such as the mental health investment standard.

The paper also describes how ICSs will serve four fundamental purposes, which include improving population health and healthcare, and tackling unequal outcomes and access. Tackling inequalities is also a prime focus for provider collaboratives and place-based partnerships, which have a crucial role in delivering ICSs' local plans to improve the health of their populations. It will be crucial for ICSs to involve local people and communities, particularly those affected by inequalities, in the ICS decision making and service design process.

The emphasis on providers and place as key to integrating care, and the acknowledgement of the need to collaborate on different footprints to achieve different objectives, provided a clear statement of the direction of travel for integrated care systems. However, it also raised important questions about the complexity of the landscape and the need for clear and effective guidance on governance and accountabilities.

Health and care white paper

The government's white paper laying the foundation for the health and care bill, *Integration and innovation: working together to improve health and social care for all* (Department of Health and Social Care, 2021), gave a stronger indication of forthcoming legislative proposals for integrated care systems. It positioned the Bill as the primary enabler of progress on health inequalities, stating: "we need the right legislative framework to support the recovery by improving outcomes, reducing health inequalities and making best use of limited resources".

Where Integrating care set out two potential options for the future of ICSs, the white paper cemented the government's intention to establish them as statutory bodies with a swathe of responsibilities including identifying and addressing population health needs, planning services, allocating budgets, and a duty to meet system financial objectives and deliver financial balance.

The paper also introduced the concept of a statutory 'ICS NHS body' (described in the Bill as the integrated care board) and a separate ICS health and care partnership, which would comprise of broader system partners to develop a plan that addresses the wider health, public health and social care needs of a system.

The ICS design framework

The ICS design framework (NHS England and NHS Improvement, 2021) builds on the vision outlined in Integrating care and the white paper, and sets out an operating model for ICSs from April 2022 following the enactment of the Health and Care Bill, which will put ICSs on a statutory footing.

The paper sets out how the integrated care board (ICB) will take on the commissioning functions of clinical commissioning groups (CCGs) and be accountable for planning to meet population health needs, allocating resources and overseeing delivery of services. Its board will be comprised of a chair, a chief executive, non-executive and executive directors and a minimum of three partner organisations representing trusts, primary care and local authorities. The integrated care partnership (ICP) will then bring together wider partners across health and care to align purpose and ambitions, improve the health and wellbeing of their populations, and influence the wider determinants of health.

This governance structure raises questions about how an emphasis on health inequalities will operate in practice. Trusts will be expected to work alongside system partners at place level to tailor their services to local needs and contribute to population health improvement as anchor organisations, and they will increasingly be judged on their contribution to the objectives of the ICS as well as their existing duties. Alongside this, the ICB will have duties in respect of population health and health inequalities, but it is the ICP which brings together the wider partners necessary to develop a truly holistic approach to addressing inequality.

Systems will need to ensure all parties agree to, and are fully invested in, their priorities and ambitions. ICBs will need to balance their regard for the ICP's strategy and ambitions to tackle health inequalities with their other responsibilities, such as operational performance and financial control.

Health and Care Bill

The government's **Health and Care Bill** (July 2021) focuses on developing and formalising system working, and putting ICSs on a statutory footing, building on proposals put forward by NHS England and NHS Improvement in Integrating care. In seeking to remove barriers to collaboration and remove the promotion of competition as a means to achieving good, sustainable healthcare services, the Bill offers an opportunity for the health and care system to work more closely, and benefit from the reduction in friction between different parts of the system.

To support the ambition for ICSs to improve population health outcomes and tackling inequalities, ICBs will have a statutory duty to reduce health inequalities. The Bill sets out that each ICB 'must, in the exercise of its functions, have regard to the need to a) reduce inequalities between patients with respect to their ability to access health services, and b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services'.

A new statutory duty to co-operate will also be fundamental to establishing the ICS as being jointly responsible for reducing health inequalities. The bill introduces a power for the secretary of state to make guidance on how the duty imposed on NHS bodies to cooperate with each other is discharged. It also imposes duties on NHS bodies and local authorities to cooperate with one another to advance the health and welfare of the people of England. This duty further strengthens a requirement for health and care partners to work together to improve population health, and although it does not explicitly refer to health inequalities, this is one of the primary goals around which system partners have, and continue to, convene. The practical implications of this duty are yet to be set out, and it remains unclear what cooperation between local authorities and the NHS might look like in practice given their vastly different funding flows and lines of accountability.

Opportunities and challenges

A significant challenge for trusts will be to navigate the changing landscape of system working, which will establish new and potentially complex accountabilities. Reducing health inequalities will require system partners to collaborate, and improvements will take time to be realised. The ICP will play a central role at system level in tackling health inequalities, as it will bring together the full range of partners, including local authorities and, potentially, voluntary and community organisations. A strong understanding of the inequalities endured by local communities, and the services they need to address them, will also be crucial at place level. Questions remain about how work to understand and reduce health inequalities at different levels of the system will interact and achieve the right outcomes. Access to

timely, accurate and complete granular data is an imperative in ICS' capability to surface health inequalities and to set in motion quality improvement actions to address them.

Alongside this, the ICB will have its own statutory duty to reduce health inequalities in relation to patients' access to services and outcomes achieved for them. This offers a clear mandate for the NHS, through integrated care systems, to embed health inequalities improvement into the way it plans and delivers services. Again, there will be a need for a strong relationship and clear communication between the role of the ICP and that of the ICB in tackling inequalities – where the ICB works to improve inequalities in access and outcomes in NHS services, the ICP will play a role across the wider determinants, pathways between NHS and other services such as social care and contribute a broader understanding of the breadth and complexity of inequalities people face.

The role of wider partners, such as voluntary organisations, in improving access to health and care services and reducing health inequalities is also becoming increasingly recognised. For example, in Bradford and Craven, six trusts used horizontal integration to strengthen a focus on wider inequalities and population health, and vertical integration with primary care and the voluntary sector to improve continuity of care and improve outcomes. The collaborative put in place governance arrangements to support this work, rather than the other way round, and ensured the involvement of the voluntary and social enterprise sector in decision-making.

The ICS model offers a new opportunity for trusts to contribute to a wider partnership, working towards a shared goal. But ICSs remain at different maturity levels when it comes to addressing health inequalities within their footprints. The challenge of determining the right scope and resource required to deliver changes amid the backdrop of continued operational pressures should also not be underestimated.

The acceleration of system working offers an opportunity for trusts and wider system partners to address the wider determinants of health and tackle health inequalities. There is increasing recognition that improving people's health goes beyond healthcare, but that as an anchor in communities, trusts can also offer a gateway to people receiving support for other services as well as being a healthy employer. A statutory duty upon integrated care systems to reduce inequalities may strengthen the argument for interventions to be funded and supported, leaving trusts with headroom to respond proactively to the needs of their patients. However, this will rely on ICSs having a realistic task themselves. There is a risk that, if shorter-term financial and operational pressures dominate ICBs' attention, that a focus on health inequalities could be lost, while valuable partnerships could be undermined in being drawn into transactional conversations about the distribution of scarce resources.

The forthcoming comprehensive spending review will set the resource available to fund the NHS's recovery from the pandemic. Trust leaders are concerned that the settlement will be tight, and there remains a need for national leaders to consider how the development of policies to support system working will enable systems to prioritise tackling health inequalities, embedding this into their approach to managing the immediate operational pressures rather than introducing unhelpful trade-offs.

4 The task of COVID-19 recovery and addressing unmet need

COVID-19 had a rapid and significant impact on the health service, which had already dealt with several years of substantial annual rises in demand, outstripping growth in available resource. Although trusts continued to provide cancer services, and urgent and emergency care (including for mental health), from the beginning of the first wave and in subsequent waves, the pandemic has severely limited trusts' ability to deliver elective and outpatient services.

The pressures created by COVID-19, and the need to reconfigure services, redeploy staff and delay planned care to enable the NHS to respond to the virus, meant that by May 2021, there were 5.5 million people waiting to begin hospital treatment (NHS Providers, 2021) – the highest figure since records began.

Within this backlog is an underlying picture of substantial inequality between those living in the most and least deprived areas. The Strategy Unit, for example, carried out analysis of the drivers of inequality in access to planned hospital care (May 2021). It found that rates of access to planned care overall are higher among those living in the most affluent areas. When adjusted for levels of need, however, activity was skewed towards the early stages of care pathways for the most deprived communities – for example primary care management – for each of four common conditions (chronic obstructive pulmonary disease, heart failure, arthritis of the hip and cataracts). Meanwhile, secondary care treatment including surgery was skewed towards the most affluent areas. In some cases, the report notes that levels of emergency hospital spells and deaths in hospital are higher among those living in more deprived areas and suggests that intervention earlier in the care pathway had not necessarily had the impact of reducing unplanned care.

In exploring the drivers of this imbalance, the research found that the skew in type of activity between the most and least deprived populations emerged in recent years and may have been driven by policy initiatives introduced to improve or control access to secondary care treatments. Similarly, while waiting times reduced overall between 2000 and 2014, before starting to lengthen again, a disparity emerged wherein the most deprived areas had longer waiting times for elective care. The report suggests that policies which may disproportionately impact those living in the most deprived areas include referral management and lifestyle-based eligibility criteria, while waiting time targets and patient choice policies, as well as NHS-funded access to private treatment, may have disproportionately benefited the least deprived populations.

NHS England and NHS Improvement has, through a series of interventions over the past year, set out an expectation that the NHS will address this backlog with health inequalities at the forefront of its mind. For the first time, the planning guidance stipulates that people at risk of poorer outcomes due to the inequalities that they face should receive priority for treatment, setting the bar for how systems should use the concerted effort to reduce the care backlog as an opportunity to narrow gaps in access and outcomes.

Trusts are considering how to restore their services equitably and take advantage of opportunities to reduce inequalities facing those from deprived backgrounds, minority ethnic groups, autistic people and people with learning disabilities, and other protected

characteristics. This includes carrying out analysis to identify disparities in access, outcomes and experience, and committing to narrowing these gaps through their prioritisation of their waiting lists.

National policy drivers

NHS England and NHS Improvement phase three letter – urgent actions to address inequalities in NHS provision and outcomes

As the NHS began to plan its recovery from the impact of coronavirus, the letter setting out measures for the third phase in the NHS's response to COVID-19 (NHS England and NHS Improvement, 2020) in July 2020 set out urgent actions to address inequalities in NHS provision and outcomes. It asked trusts to work collaboratively with their partners on eight steps to restoring NHS services inclusively, and increase the pace of progress in reducing health inequalities:

- **Protect the most vulnerable from COVID-19**, by ensuring those who may be clinically extremely vulnerable to COVID-19 were identified and supported to follow shielding recommendations. This was underpinned by a call to consider risks associated with people's protected characteristics and demonstrate their insight into the risks faced by their communities through population health management and risk stratification approaches.
- **Accelerate their return to near-normal levels of non-COVID health services**, with a focus on doing this inclusively, including supporting people with unequal access to diagnosis and treatment, with proactive outreach to those at risk. Monthly reporting will include measures of performance in relation to patients from the 20% most deprived neighbourhoods and compare service use and outcomes to develop metrics on clinical need, activity and outcomes to identify and address disparities between groups.
- **Develop digitally enabled care pathways** in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways.
- **Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes**; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.
- **Particularly support those who suffer mental ill health**, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring.
- **Strengthen leadership and accountability**, with trusts and systems asked to identify a named executive board member responsible for tackling inequalities.
- **Carry out work to ensure datasets are complete and timely** to underpin an understanding of inequalities, with a particular focus on the accuracy and completeness of ethnicity data.

- **Collaborate locally in planning and delivering action to address health inequalities**, including outlining in local plans how systems will: better listen to communities and strengthen local accountability, deepen partnerships with local authorities and the voluntary and community sector and maintain a focus on implementation of these actions, resources and impact.

These eight urgent actions are the underpinning for the national position on tackling health inequalities and restoring services inclusively. They lay the foundations for further action, including work to address challenges across the wider determinants of health and enhance prevention.

2021/22 operational planning guidance and elective recovery fund

Building on the actions set out in the Phase Three letter, the 2021/22 priorities and operational planning guidance (NHS England and NHS Improvement, 2021) identified five key priorities for trusts to focus on in the first half of the 2021/22 financial year. These develop the urgent actions from phase three and guide systems on how to embed them into their day-to-day operational working:

- supporting the health and wellbeing of staff and taking action on recruitment and retention
- delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19
- building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- expanding primary care capacity to improve access, local health outcomes and address health inequalities
- transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay.

Among these, the guidance emphasises the importance of ensuring health inequalities are tackled throughout plans to address the longest waiters and working collaboratively across systems to deliver on these priorities.

The letter sets out how systems which achieve activity levels above the levels funded from core system envelopes would have access to the elective recovery fund (ERF). Acute providers need to meet 'gateway criteria', including addressing health inequalities, transformation of outpatient services, implementing system-led elective working, tackling the longest waits, and supporting staff.

The presence of a gateway criterion for health inequalities in the ERF is evidence of the national bodies' increasing commitment to reducing health inequalities: financial incentives and operational requirements focused on addressing inequalities did not exist at the same level of priority before the pandemic.

However, the ERF has only been made available to acute providers, and so as systems take stock of the health inequalities across their patch, there is a risk of an undue focus on elective care recovery and focus on acute services when in reality all sectors face unique challenges and unprecedented levels of demand. It is crucial to recognise the complexity of the task of addressing health inequalities, particularly for people who may require support from multiple services, have mental health needs, receive care from community services, or who more frequently need ambulance services. The ERF is a non-recurrent pot of funding for a defined purpose and is therefore not a suitable long-term lever for permanent change in the way systems think about health inequalities. It does, however, have the potential to help galvanise a focus on health inequalities in trusts' operating model.

Opportunities and challenges

Trusts now have an opportunity to use the challenge of tackling waiting lists and high levels of demand to find, and address, disparities in access and outcomes for people who endure health inequalities. Trusts are asked to prioritise according to which groups of patients face the greatest inequalities, either in how long they have waited for care or who may be at risk of the poorest outcomes due to the broader inequalities they face. This will need to be balanced with an approach which ensures all those in the greatest clinical need receive care as a priority.

National leaders will need to consider the equalities impact of policies to improve access to elective care given the evidence suggesting previous attempts to do so have disadvantaged people living in the most deprived areas. With ICSs increasingly taking on responsibility for planning care according to population need, national leaders should bear in mind the impact of local decision making introducing the potential for variation across the country and how to mitigate against the risk of widening health inequalities while also adapting to meet local needs.

Trusts initially need a means of identifying these disparities (if they do not have them already), so they can understand the characteristics of their waiting lists, and identify any unintended consequences caused by how their services are designed. For example, patient data must be coded by their index of multiple deprivation (IMD), ethnicity, and other protected characteristics such as learning disability or LGBTQ+ identity so waiting list data can be analysed by those characteristics and disparities identified. Analytical capacity can be a barrier to trusts, with variation across the sector in how much analytical resource is available to attach IMD or ethnicity data. The planning guidance asks trusts to focus in particular on strengthening the robustness of their data, but the effect will take time to be seen in full and the availability of accurate, national level data for comparison may be limited until all trusts meet this target.

NHS England and NHS Improvement is developing a national health inequalities improvement dashboard to support systems to improve their intelligence on health inequalities in their areas, and some trusts have already identified ways of prioritising patients for care based on health inequalities data. For example, Calderdale and Huddersfield NHS

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Foundation Trust reviewed waiting list data and found "unexplained variation" in waiting times for surgery between different ethnic groups, and also took into account health inequalities faced by people with learning disabilities. In light of this analysis, the trust made the decision to prioritise people with learning disabilities and people from Black, Asian and minority ethnic backgrounds for elective treatment.

Trusts then need to understand where these disparities arise: a patient with a learning disability may be referred to a service in a more advanced clinical state than someone without, due to problems with the referral pathway which prevented them from being identified sooner, leading to worse outcomes. Similarly, people living in more deprived circumstances may find it difficult to accept elective surgery if they are unable to afford to take time off work prior to admission to self-isolate, causing them to wait longer.

When trusts have identified whether structural factors are influencing inequality among their patients, they can take steps to address those inequalities, as part of a wider system effort to tackle to wider determinants of health. Trusts are clear that this takes visible, committed leaders who are able to have important conversations with their service managers and consultants about how they can work as a trust to reduce inequalities when they arise. Trust leaders say that compassionate leadership and avoiding blame culture is fundamental to creating a shared understanding of the drivers of inequity in their services and make progress on these. It also requires robust and consistent capacity for the type of analysis required to identify inequities hidden within their datasets.

It will be essential for national policymakers to enable and support trusts and systems to prioritise this focus on inequalities. It will be particularly important to remember that improvement in this area may take time, slow down broader efforts to reduce the size of waiting lists or return to expected productivity levels or cost more. Trusts need a policy environment in which targets for service recovery and objectives to reduce health inequality complement, rather than conflict with, each other.

5 Supportive regulatory models

There have been longstanding challenges in the way regulatory frameworks align with policy priorities. Trusts need an enabling regulatory environment to meet their health inequalities objectives. This should provide the right incentives to take the steps needed to reduce disparities and operate services in ways which help to reduce inequity in access and outcomes. Where financial requirements outweigh other objectives and are incompatible with wider system goals, ambitions which have not been embedded into regulatory models can easily fall by the wayside. To cement a long-term commitment to improving health inequalities as part of their 'day-to-day business', trusts will need a supportive infrastructure which measures and rewards progress on health inequalities as much as good operational and financial performance.

The impact of new regulatory models on health inequalities improvement.

Care Quality Commission (CQC) published *A new strategy for the changing world of health and social care* in May 2021.The strategy outlines a commitment to supporting and enabling health and care providers and wider systems to reduce health inequalities within services and the wider population, for the first time. Running throughout is an ambition to improve people's care by looking at how well health and care systems are working and how they're acting to reduce inequalities. This marks an important shift in how CQC is thinking about its role as a quality regulator, including identifying progress and action on health inequalities as a key indicator of good culture, leadership and responsiveness to population need.

Similarly, NHS England and NHS Improvement's new *System oversight framework 2021/22* and accompanying metrics (2021) builds on their Integrating care paper and the intention for ICSs to focus on improving population health and tackling unequal access, experience and outcomes.. The new approach to oversight also aligns with the priorities set out in the 2021/22 operational planning guidance (NHS England and NHS Improvement, 2021) to address health inequalities in the first half of 2021/22. NHS England and NHS Improvement will take into account ICSs' performance in tackling variation across the system and reducing health inequalities when it makes a decision about eligibility for entry into the highest performing segment, segment 1.

It is crucial that this focus on health inequalities within the new regulatory environment is supported by tangible metrics to ensure it does not unintentionally get side-lined by more immediate priorities and pressures that are easier to measure and quicker to improve. Some trusts have highlighted their concerns that while it is helpful to have this focus within their system boundaries, it can take years before changes have their intended impact and therefore it remains easier for regulators and local organisations to focus improvements on other measures, such as reducing waiting lists. NHS England and NHS Improvement's system oversight metrics for 2021/22 include three welcome deliverables focused around preventing ill health and reducing inequalities:

- restoring NHS services inclusively, measured at ICS, CCG and trust level
- COVID-19 vaccination uptake for black and minority ethnic groups and the most deprived quintile compared to the national average, measured at ICS level
- ensuring datasets are complete and timely, measured at ICS, CCG and trust level.

These steps will help reassure providers that regulators intend to use this focus as a genuine opportunity to prioritise and address health inequalities. Alignment with the urgent actions listed in phase three of the response to coronavirus, and the planning guidance, offers helpful consistency in the national priorities. Measurement of these three outcomes at the relevant levels of scale provides a clear framework and incentive for progress, but the SOF aims to assess trusts against a wide-ranging set of outcome measures, and this creates a risk of conflicting priorities. Furthermore, where metrics are being assessed at multiple levels – for example at both ICS and individual trust level, it may ultimately become unclear who is accountable.

Most of the metrics relating to health inequalities in the system oversight framework will be assessed at the ICS level, with trusts asked to focus on restoring services inclusively and ensuring data is collected about patients' ethnicity. Systems will be assessed on their progress to accelerate preventative programmes. Many of these are delivered through primary care but trusts will also expect to be asked by their systems to contribute – metrics which are being measured at ICS level will undoubtedly filter down to their component organisations as the unit of delivery.

There are still unanswered questions around the role of non-NHS organisations, such as local authorities, social care and voluntary organisations, as well as the independent sector partners supporting with the backlogs, which play a vital role in addressing the complex factors driving health inequality. Where regulators and national bodies need to make an effective judgement on the performance of ICSs and trusts in how they are addressing health inequalities, they will need to take into account the role of non-NHS organisations to ensure providers are not measured on outcomes that are not wholly within their control. It is, as yet unclear what intervention from regulators will look like where progress on health inequalities is insufficient.

Supporting people and communities

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Trusts' role as anchor institutions

The term anchor institution does not feature in guidance setting out how organisations will work at system and place to deliver services and meet communities' needs. However, NHS England and NHS Improvement has partnered with the Health Foundation to form the health anchors learning network to support NHS anchors to develop strong local partnerships, develop capacity and capability to improve socio-economic conditions and reduce health inequalities. It also aims to grow the evidence base for the role and importance of NHS anchors and help scale anchors across the UK.

As large, public sector organisations rooted in a local area, with significant assets and influence in the local economy, trusts are ideally placed to act as anchor institutions. The pandemic and its wider social and economic impacts have widened inequalities in society (The Health Foundation, 2021) . A recovery planned with these inequalities in mind should therefore take a multi-pronged approach, not only restoring services to meet the needs of communities, but also playing a role within the wider local economy.

As organisations with large purchasing power, there is also an opportunity for trusts to build on the partnerships created with local businesses in response to the pressing needs of the pandemic and support the wellbeing of staff. For example, at the height of the first wave, Northumbria Healthcare NHS Foundation Trust worked with local textiles manufacturers (NHS Providers, 2020) to meet their immediate needs for personal protective equipment, creating local jobs and supporting local industry. The economic impact of the pandemic has been substantial and as anchors trusts can play a role in bolstering the resilience of local businesses and investing in local communities through by choosing local firms as contractors or suppliers and employing staff from the local area where possible. Trusts play a pivotal role in their local communities as employers and have substantial economic influence in their local area. Across England as a whole, health and social care provides 12% of all employment, and is uniquely placed to use its resources and influence to improve the wellbeing of the local population and reduce health inequalities.

Addressing workforce inequalities

The NHS workforce is large and diverse and as such reflects wider society. NHS staff face the same inequalities as the broader population, and where there is clear evidence that COVID-19 had a disproportionate impact on Black, Asian and minority ethnic communities, this has also proved to be true for the NHS staff affected by coronavirus. While 21% of all NHS staff are from ethnic minority backgrounds, these individuals made up 63% of all healthcare workers, and 95% of doctors, who died in the first wave of the pandemic.

The pandemic had a profound impact on the NHS workforce, and research found disparities in how medical staff from BAME background experienced working in the NHS during the pandemic. For example, the British Medical Association found that doctors from Black, Asian and minority ethnic backgrounds felt less confident that adjustments had been made to mitigate risk, less confident about PPE provision and reported higher rates of bullying and harassment during the pandemic.

In response, NHS England and NHS Improvement asked all NHS employers to carry out risk assessments for staff and take steps to mitigate any risks identified, either through modified duties or redeployment. Trusts are clear on the need for compassionate leadership and effective staff engagement when supporting their workforce through a challenging period.

To address and monitor concerns about inequalities faced by Black, Asian and minority ethnic communities, the government set up a race disparity unit. This committed to publishing four quarterly reports over a year, reporting on progress to address COVID-19 health inequalities. Its report earlier this year was unhelpful in denying the link between structural racism and wider health inequalities. However more recently it has published a report that has summarised work across government and the health service to improve vaccine uptake among ethnic minorities. The NHS has worked with local partners to increase uptake of the COVID-19 vaccine in communities with higher levels of vaccine hesitancy. For example, during Ramadan, places of worship were used as vaccination centres (Strategy Unit, 2021). Since February, the NHS has allocated around £7m to ICSs to support targeted engagement (NHS England and NHS Improvement, 2021) in areas with health inequalities and high levels of vaccine hesitancy. However, it is worth noting that much of the outreach into communities with higher levels of hesitancy will happen at place, rather than ICS, level. This further highlights the importance of partnerships beyond the NHS to achieve health equity rather than relying on ICBs to deliver improvements alone.

7 Principles for a supportive policy framework

Since the height of the pandemic, national policy development on health inequalities has moved beyond broad ambition, to measurable and actionable reality. Trusts and systems acknowledge the impact of COVID-19 on some of the most marginalised communities in England and are now taking steps to address these inequalities as part of the recovery task.

This shift in mindset is now being supported by a shift in policy direction. National leaders have recognised that to drive a wholesale change in the NHS's approach to health inequalities, the underpinning infrastructure and funding mechanisms need to act as an enabler. By aligning the ambitions, objectives and responsibilities of trusts and systems so that no single imperative draws trusts' attention away from the task of addressing health inequalities, systems and their component organisations can build on constructive relationships to meet this shared aim.

Measuring impact

Understanding and measuring health inequalities and the impact of COVID-19 on disparities in access to care lays the foundations for concerted action and improvement. The national bodies are committed to making a transformational change in the way health inequity is treated in the health service.

There will be a need for this to be underpinned by clear accountability at the right level. Where metrics collected by NHS England and NHS Improvement, or thematic analysis of health inequalities by CQC, identifies disparities in access and outcomes for populations facing health inequalities, there should be a defined outcome of such findings including clarity on what measures national bodies may take to support progress, and what further support may be offered to trusts and systems. Where progress is made, this should be celebrated and built upon so that the wider system can learn from what works to act on inequalities elsewhere. Without this, the potential of clear direction-setting by national leaders in key policy documents will not be fully realised.

Evidence of the impact of recent measures taken to address health inequalities, including commitments made in the long term plan, as well as shorter-term interventions to tackle inequalities in the wake of the pandemic, is scarce. There is a role for NHS England and NHS Improvement to monitor and report on national progress, support the sharing of learning about what interventions work well, and continue to provide an enabling environment for strong and effective collaboration at place, and the health inequalities improvement dashboard in development by NHS England and NHS Improvement will be pivotal in understanding the impact of the interventions set out in this report. It will take a consistent impetus and focus from all parts of the system to maintain progress, such that in several years' time there will be evidence of sustained improvement attributable to initiatives being developed now.

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Recommendations for national leaders

It will be necessary for national bodies to consider how ICSs will be able to prioritise tackling health inequalities, and what support will be available to trusts to make progress while continuing to manage the immediate operational pressures. The risk of confused accountabilities and its potential impact on systems' ability to act effectively in partnership should not be underestimated – national bodies must measure the right outcomes at each level and set out clearly how these interact.

Policy frameworks, political imperatives, and funding streams must be aligned to enable a focus on health inequalities without financial or operational targets taking precedence. Interventions aimed at improving the financial or operational position should not be structured in a way that widens inequalities. National bodies should learn from historical evidence of how policy interventions to shorten waiting times, increase sustainability of services or control volumes of activity may have widened inequalities in the past, and act to ensure that the health inequalities impact of any new approach is positive.

Finally, the five key priorities developed by NHS England and NHS Improvement are a valuable starting point for a focused and intensive effort on health inequalities. They set out a clear course of action to begin embedding a health inequalities improvement approach into the COVID-19 recovery. The inclusion of health inequalities in the planning guidance and regulatory frameworks gives weight to the notion that health inequalities will be front and centre as the service recovers from the pandemic.

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Conclusion

The pandemic has exacerbated deep-seated inequalities prevalent in society and leaders across the health and care system are now coalescing around the shared aim of narrowing the significant gaps in access and outcomes faced by key groups and communities. For the first time, this is being consistently underpinned by a national policy framework which prioritises health inequalities and empowers trusts, in partnership with their local systems, to design concerted action on health inequalities into their plans for recovering from the COVID-19 pandemic. New legislation, with its focus on collaboration and place, appears to offer a genuine opportunity for long-term momentum. However, over the coming months national leaders will ultimately need to set out a long-term framework for taking these actions further in a way that sustains improvements made in health inequalities.

Your feedback on this briefing and the development of our wider offer is very welcome – to share your learning so far or offer feedback on our approach, please contact leanora.volpe@nhsproviders.org

For more information:
www.nhsproviders.org/health-inequalities-a-core-concern

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