HEALTH INEQUALITIES

Addressing health inequalities as business as usual

NHS Providers

Agenda

Welcome and introduction
Facilitated by Jenny Reindorp

Overview of NHS Providers health inequalities guide
Rachael McKeown – policy advisor, NHS Providers

Reflections from Professor Bola Owolabi - what is need to embed action on reducing health inequalities?
Professor Bola Owolabi – director, national healthcare inequalities improvement programme, NHS England

Case study: Implementation of health inequalities guide in Northern Care Alliance
Christine Camacho, public health consultant, Northern Care Alliance NHS Foundation Trust

Case study: Implementation of health inequalities guide in Hampshire and Isle of Wight
Jessica Berry – Associate director, personalised care and head of Health inequalities, NHS Hampshire and Isle of Wight ICB

Panel Q&A
Facilitated by Jenny Reindorp

Breakout discussions
Interactive discussion between delegates

Breakout feedback and group discussion
Facilitated by Jenny Reindorp

Close of event

Housekeeping

- Please note, Chatham house rule applies
- Please keep your camera on wherever possible
- If you lose connection, please re-join using the link in your joining instructions or email health.inequalities@nhsproviders.org
- Please ensure your microphone is muted during presentations to minimise background noise
- We will come to questions during the panel Q&A
- Please feel free to use the chat box to ask questions
- If you would like to ask a question audibly, please use the raise hand function during the Q&A section and we will bring you in
- Any unanswered questions will be taken away and answered after the event
- You will receive a link to an evaluation form at the end of the day, please take the time to complete it, we really do appreciate your feedback.

HEALTH INEQUALITIES

Poll

HEALTH INEQUALITIES

Rachael McKeown

Policy advisor, NHS Providers

The NHS Long Term Plan

Classification: Official

2024/25 priorities and operational planning guidance

REDUCING HEALTH INEQUALITIES

A guide for NHS trust board members

MARCH 2024

NHS equality, diversity, and inclusion improvement plan

Advancing mental health equalities strategy

September 2020

Classification: Official

NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)

27 November 2023

Integrated care boards, trusts and foundation trusts should use this statement to identify key information on health inequalities and set out how they have responded to it in annual reports.

Patient and Carer Race Equality Framework

Inclusive digital healthcare: a framework for NHS action on digital inclusion

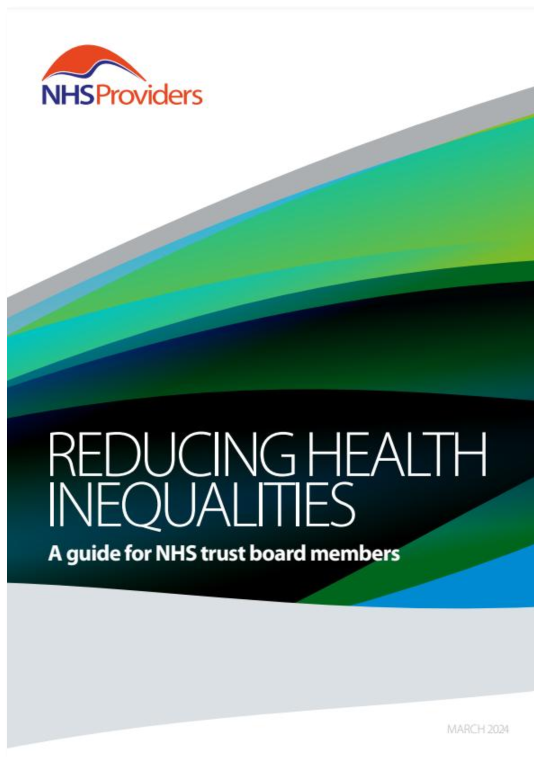
This document builds on previous NHS Digital guidance on digital inclusion for health and social care.

Use it to design and implement inclusive digital approaches and technologies, which are complementary to non-digital services and support.

A national framework for NHS – action on inclusion health

Use this framework to plan, develop and improve health services to meet the needs of people in inclusion health groups.

Key components



- The case for change
- Vision
- Objectives
- Self-assessment tool
- Policy and guidance

What's next?

HEALTH INEQUALITIES

NHSProviders

FOR HEALTHCARE LEADERS
HSJ

HENRY ANDERSON
NHSE's game of chicken with trusts' cash

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HEALTH INEQUALITIES

Tackling health inequalities should be core business for trusts

By Christine Camacho and Rachael McKeown | 27 March 2024

Rachael McKeown, Policy Advisor at NHS Providers

TACKLING HEALTH INEQUALITIES:

KEY STRATEGIES FOR SUCCESS

Click here for reader view

HEALTH INEQUALITIES

Professor Bola Owolabi

Director, national healthcare inequalities improvement programme, NHS England

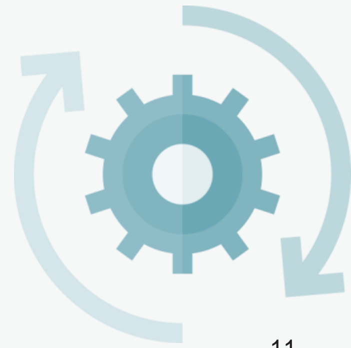
Professor Bola Owolabi MRCGP FRSPH

Director – National Healthcare Inequalities Improvement Programme, NHS England

10 February 2025

Healthcare inequalities improvement programme
england.healthinequalities@nhs.net

Context and case for change



Lord Darzi Independent Investigation of the NHS

NHS England

"The impact of the deterioration in access and the challenges around quality of care have not been felt equally. As we have seen, there are important disparities in almost all aspects of care. The 'inverse care law' seems to apply: that those in greatest need tend to have the poorest access to care[footnote 204]. In this section, we draw from the expertise of a number of charities and campaigners who have informed this report…"

Lord Darzi Independent Investigation of the NHS

NHS England

Health inequalities messages

- For the **most deprived** groups, A&E attendances are nearly **twice as high** and emergency admissions **68 per cent higher** that the least deprived.
- **Minority ethnic groups**, particularly Asian people, experienced **disproportionally longer waits** for elective care after the pandemic than those from white backgrounds.
- People facing **homelessness** do not receive the same level of care as those who have a safe place to call home, only **31 per cent** of people with no ID/address were able to register with a GP, despite this not being a legal requirement
- In **mental health**, people from **minority ethnic** groups experienced **worse outcomes**; waited longer for assessment; and were less likely to receive a course of treatment following assessment in the NHS Talking Therapies Programme
- People with a **learning disability** are **twice as likely to die** from preventable causes and four times as likely to die from treatable causes

Independent Investigation of the National Health Service in England

The Rt Hon. Professor the Lord Darzi of Denham OM KBE FRS FMedSci HonFREng

September 2024

The Business Case for Reducing Health Inequalities

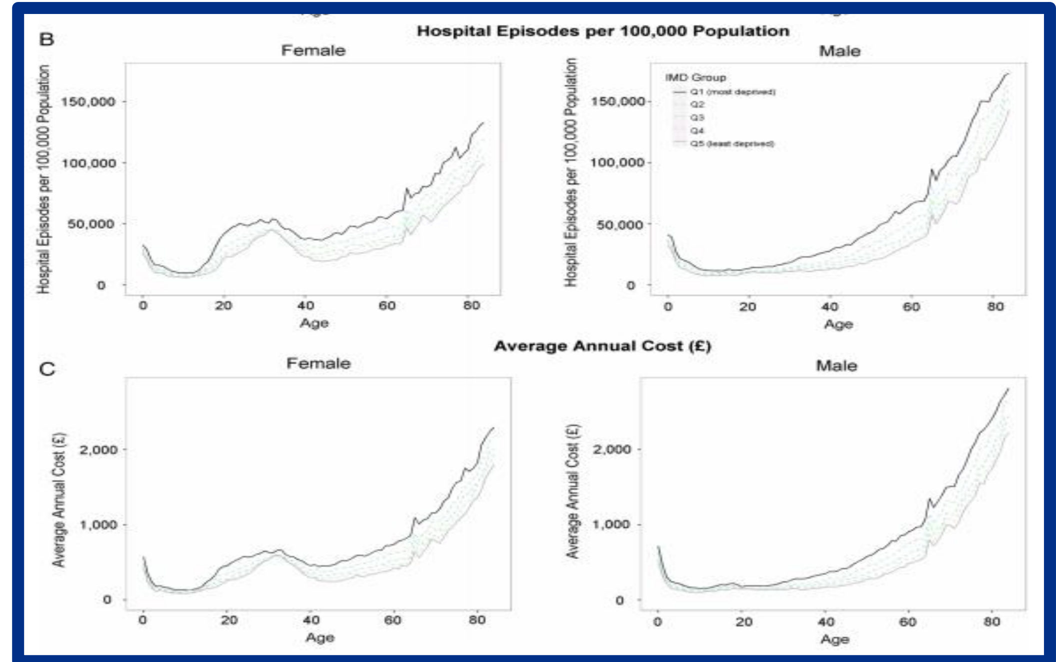
- Increased NHS treatment costs: **> £5 billion**

- **Losses from illness associated with health inequalities**

    - Productivity losses: **£31 billion - £33 billion**

    - Reduced tax revenue and higher welfare payments: **£20-£32 billion**

People from the most deprived areas have **a lower life expectancy** compared to those in more affluent areas, yet the per capita cost of healthcare due to emergency admissions, LTCs, prolonged LOS & **spend on healthcare** is higher for those from more deprived areas



Fair Society, Healthy Lives The Marmot Review of Health inequalities in England post 2010
https://www.slideserve.com/daniel_millan/fair-society

HIU case studies (Seen and Heard report – British Red Cross)

June*, 20-29 and member of an inclusion health group

June is a maths student and lives alone. She has a diagnosis of borderline personality disorder and a history of severe self-harm. She has been on antipsychotic and antidepressant medication since turning 18 and has been sectioned several times. She also has suspected autism and lives with chronic pain due to a hernia.

June has attended A&E frequently in the past following overdoses and self-harm episodes, when she struggled to access support due to being in a dissociative state. June manages her mental health through keeping busy. In addition to her studies, she runs a knitting club, and is a member of two sports teams and a book club. She has regular contact with her grandmother, but is estranged from her parents and siblings. Services play a pivotal role in June's life. She sees a therapist weekly and attends group therapy sessions. She also has access to a helpline for support.

June thinks that there needs to be better communication between services. She found the transition from child to adult mental health services particularly challenging. She says she went from having intensive support to having none while she was waiting for her case to be picked up, which resulted in her being sectioned. She also says she has found it very difficult to get a referral to mental health services, finding that things usually have to reach crisis point before a referral is made

**Not the real names of HIU clients*

Gary*, 60-69 and member of an inclusion health group

Gary is recovering from alcohol addiction and has multiple long-term conditions, including bipolar disorder and diabetes. He lives alone and, with no family nearby, often feels isolated.

When he was drinking, Gary often collapsed. He was admitted to hospital 11 times in a four-month period. On several occasions, neighbours called an ambulance after finding him in the street or seeing him at home, through his window, unconscious. Other times, Gary called the ambulance himself after regaining consciousness. One admission saw him spend five days in intensive care.

Gary's experience with healthcare professionals has been mixed. While on some occasions he has received 'exemplary' care, at other times he has experienced negative or dismissive attitudes from hospital staff, particularly in relation to his drinking.

Drinking alcohol used to be a coping mechanism for Gary. Now, he receives support from a psychologist and from a British Red Cross HIU lead who comes to his home and gives him 1:1 coaching.

Together with his HIU lead, Gary is looking ahead, and open to exploring new support services and therapies. He feels it is important for there to be a compassionate and understanding approach to people who frequently attend A&E, and for any underlying issues to be addressed. Gary believes that there needs to be greater awareness and support for individuals facing similar challenges.

HIU services meet the dual purpose of addressing UEC productivity challenges whilst also narrowing health inequalities

There is a clear relationship between socio-economic deprivation and frequent A&E attendance. For example, research from the British Red Cross found:

- People who frequently attended A&E were **72% more likely to live in Dorset's most deprived areas.**
- Previous research also found that unpredictable high intensity use is greatest in areas of deprivation and, across all age groups, is associated with issues such as **homelessness, unemployment, mental health conditions, drug and alcohol problems, and loneliness / social isolation.**

High Intensity Use services are found to:

- Increase UEC productivity whilst decreasing health inequalities.
- Meet Health Inequalities legal duties as set out in the 2022 Health & Care Act,
- Align with the Core20PLUS5 approach
- Support ICBs' compliance with the requirements in NHSE's published Statement on Information on Health Inequalities by providing an evidence-based intervention.

Productivity

For systems supported by an HIU Service, the following is achieved within three months:

- Up to 84% reduction in A&E attendances and non-elective admissions among the HIU client cohort
- Up to 78% reduction in 999 calls and ambulance conveyances
- HIU service support also helps to reduce other avoidable unscheduled care contacts such as primary care.
- C.60% decrease in mental health attendances and admissions
- There is a 300-400% return on investment.

Health Inequalities

- 20% of clients live in the most deprived IMD decile
- 35% of clients live in the 'Core20' areas.
- There is a key link between mental health, including severe mental illness, and the HIU cohort (one of the five clinical conditions)

Source: Nowhere else to turn: exploring high intensity use of A&E / Seen and heard: understanding frequent attendance to A&E

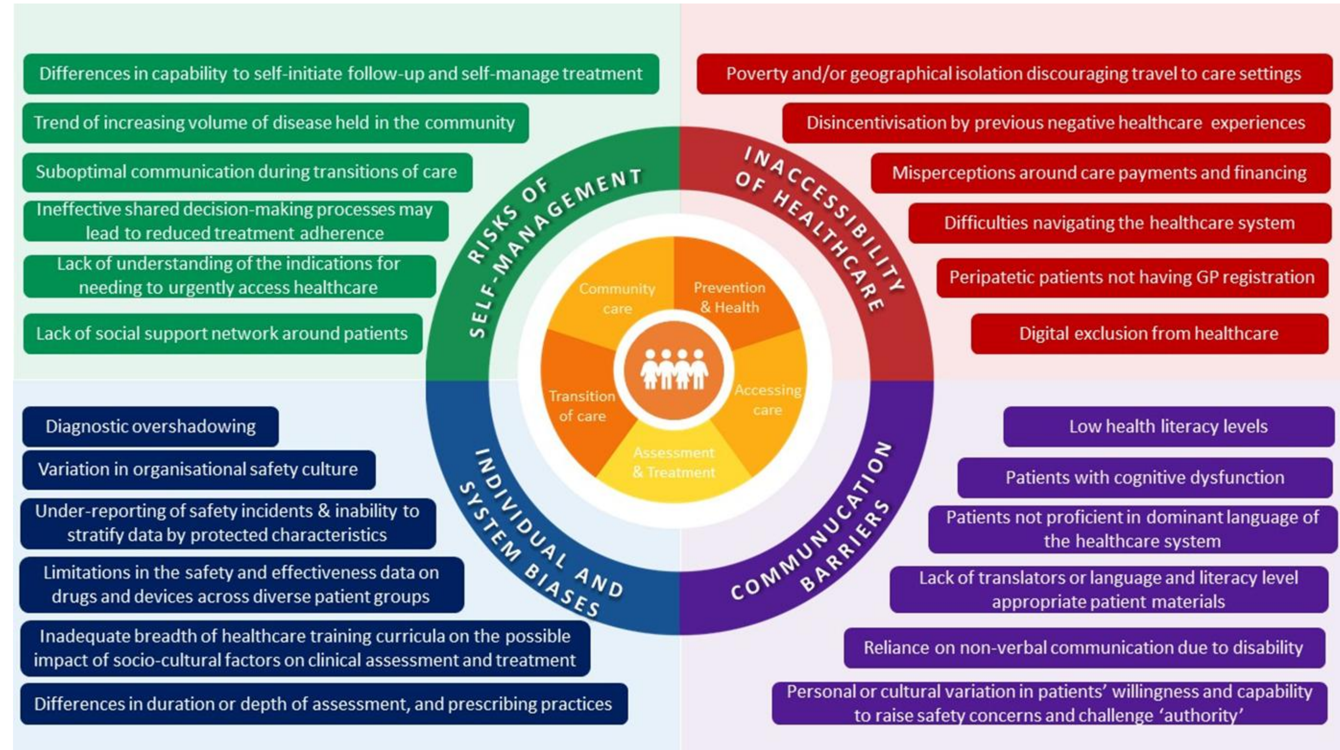
The relationship between patient safety and healthcare inequalities

NHS England

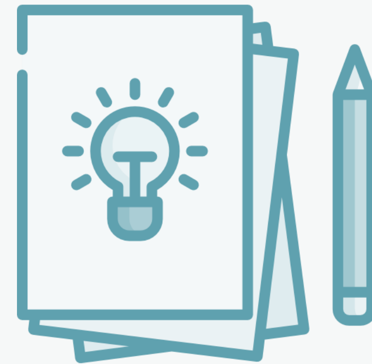
Work with NHSE Patient Safety team and NHS Resolution to better articulate intersection between Patient Safety & Health Inequalities

[Action on patient safety can reduce health inequalities | The BMJ]

Cian Wade et al.

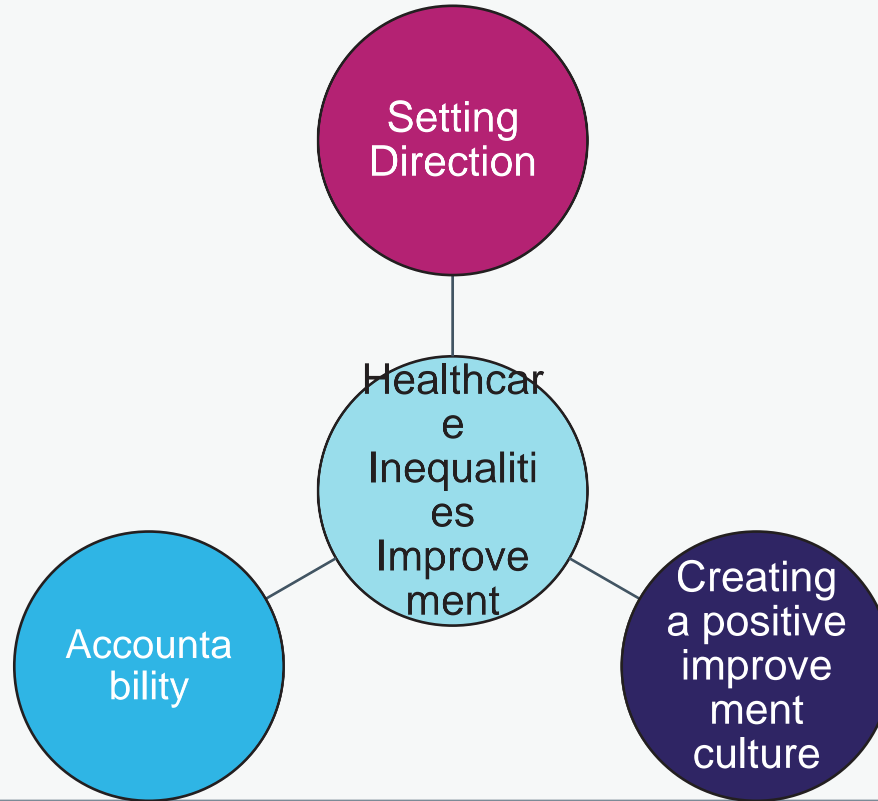


Creating change



Embracing our Agency to Act

Healthcare Inequalities – Role of Leaders



SROs for health inequalities will play a key role in retaining the spotlight on inequalities across the system

Role

All NHS organisations will appoint a named *executive level senior responsible owner (SRO)* for health inequalities, to lead and champion strategies, plans and action on health inequalities in their organisation and system

Responsibilities

- Stewardship of health inequalities legal duties
- set direction for health inequalities activity, ensuring organisational or system strategy includes a clear commitment to addressing inequalities
- ensure there is a clear organisational or system level governance approach for addressing health inequalities
- create a positive improvement culture, ensuring health inequalities delivery plans are in place
- work collaboratively with senior leaders and health inequality leads across the integrated care system, provider organisations, provider collaboratives and primary care networks

Resources

- Health inequalities - NHS Providers Health inequalities objectives for NHS Trust Boards
- Supporting health inequalities leads on NHS Boards

Selected actions

- Ensure there is a health inequalities delivery plan, with clear deliverables, milestones, action owners and measures of success identified
- Embed use of tools to address health inequalities such as the health inequalities planning matrix and health equity assessment tools
- Work with partners, including VCSE and local government to ensure services and plans are coproduced and codesigned with people and communities
- Work collaboratively with system partners, including the local Director of Public Health to triangulate data and maximise resources
- Ensure there are systems in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation
- Engage with digital leaders to ensure digital inclusion plans are in place
- Take action to ensure data is disaggregated by ethnicity and deprivation and improve quality and completeness of reporting
- Provide regular updates, performance and progress reports on health inequalities to the board to ensure visibility.

Tackling Health Inequalities – the roles of the NHS

Service Commissioner & Provider

ICS Partner

Anchor Institution

(social value as a criterion for procurement decisions, proposed new NHS Provider Selection Regime)

Core20PLUS5 – Tackling health inequalities in the most deprived areas

The five priorities for healthcare inequalities improvement

Originally set out in March 2021 priorities and operational planning guidance.

Priority 1	**Restoring NHS services inclusively**: where performance reports will be broken down by patient ethnicity and IMD quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations.
Priority 2	**Mitigating against 'digital exclusion**': ensuring providers offer face to face care to patients who cannot use remote services; and ensure more complete data collection, to identify who is accessing face to face/telephone/video consultations **is broken down by patient age, ethnicity, IMD, disability status etc.**
Priority 3	**Ensuring datasets are complete and timely:** to continue to improve data collection on ethnicity, across primary care/outpatients/A&E/mental health/community services, specialised commissioning and secondary care Waiting List Minimum Dataset (WLMDS).
Priority 4	**Accelerating preventative programmes:** covering flu and Covid-19 vaccinations; annual health checks for people with severe mental illness (SMI) and people with a learning disability; supporting the midwifery continuity of maternity carers and targeting long-term condition diagnosis and management. (Noting September 22 letter to systems on Midwifery Continuity of Carer: B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf (england.nhs.uk))
Priority 5	**Strengthening leadership and accountability:** Supporting PCN, ICS and Provider health inequalities SROs to access training and wider support offer.

Neighbourhood health guidelines 2025/26

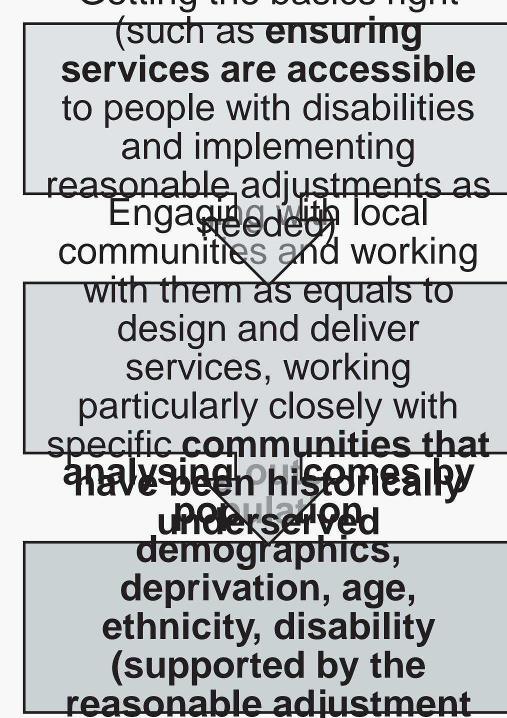
Ambition:

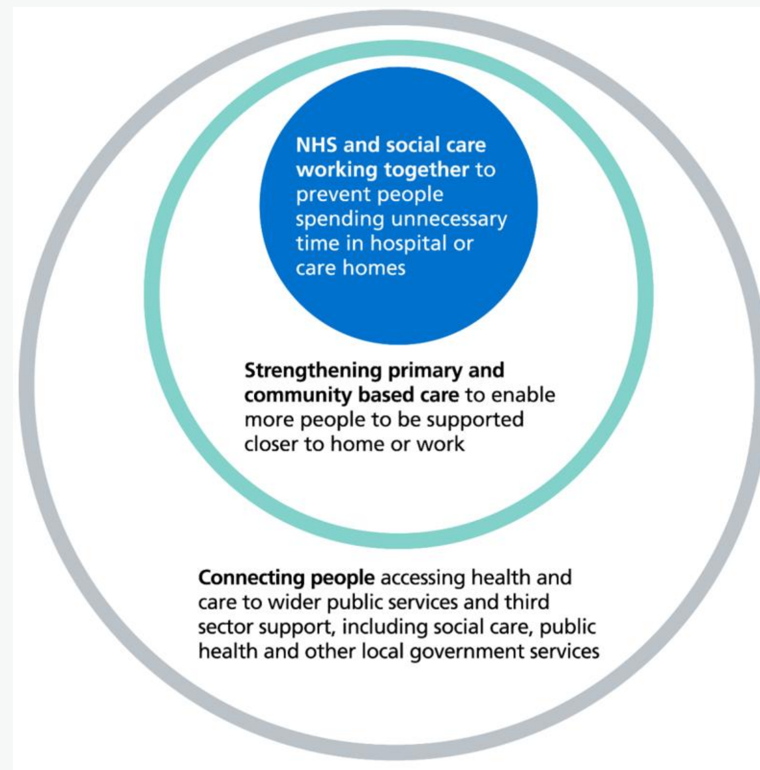
Support the move to a **neighbourhood health service** that will deliver more care at home or closer to home, **improve people's access, experience and outcomes**

Supports three key shifts outlined in Government's health mission

1. **Hospital to community** – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
2. **Treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
3. **Analogue to digital** – greater use of digital infrastructure and solutions to improve care

Key elements of a response to health inequalities through Neighbourhood Health





Elective reform plan: implications for healthcare inequalities

Healthcare inequalities commitments

NHSE will:

- collate and publish data to help improve the uptake of national health inequalities initiatives, throughout 2025/26

ICBs will:

- set a clear local vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges – March 2025

NHS providers will:

- implement agreed local interventions to reduce disparities for groups who face additional challenges accessing healthcare

Cross-cutting enabling commitments

Utilisation of technology and AI to improve information sharing, choice and efficiency. By March 26, the FDP will be adopted by 85% of all secondary care trusts. By March 27, the NHS App will be significantly expanded to improve information for patients and carers. By March 29, significantly increase the uptake of PIFU to at least 5% of all outpatient appointments, including through AI identification.

Collating and publishing data to improve uptake of national health inequalities initiatives will be a focus throughout 25/26, ensuring completeness and accuracy of recording practices, **including ethnicity and housing status coding**, by using relevant SNOMED codes.

Delivering a robust elective performance oversight programme, aligned to the new NHS Oversight and Assessment Framework tiering, to enable transparency on performance and incentivise inclusive recovery.

Community diagnostic centres and 'collective care' approaches (e.g. group appointments, one-stop clinics) will be expanded to increase capacity, **support community outreach and remove barriers to access**. By Sept 25 a consistent model of collective care approaches will be agreed, and by March 26 elective pathways will be improved by extending the minimum standards for CDCs, which will be expected to be open 12 hrs/day and 7 days/week.

Patient choice will be encouraged to **drive equitable and inclusive reform**. By Sept 25 the minimum standards patients should expect to experience in elective care will be published, with named directors for improving patient experience in each ICB and provider.

Further Faster 20 (FF20) programme will be mobilised with 20 trusts in areas of high economic inactivity to rapidly reduce waiting times and support people returning to the workforce.

NHS

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

Target population

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

CORE20 PLUS 5

Key clinical areas of health inequalities

1.
MATERNITY
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2.
SEVERE MENTAL ILLNESS (SMI)
ensure annual Physical Health Checks for people with SMI to at least, nationally set targets

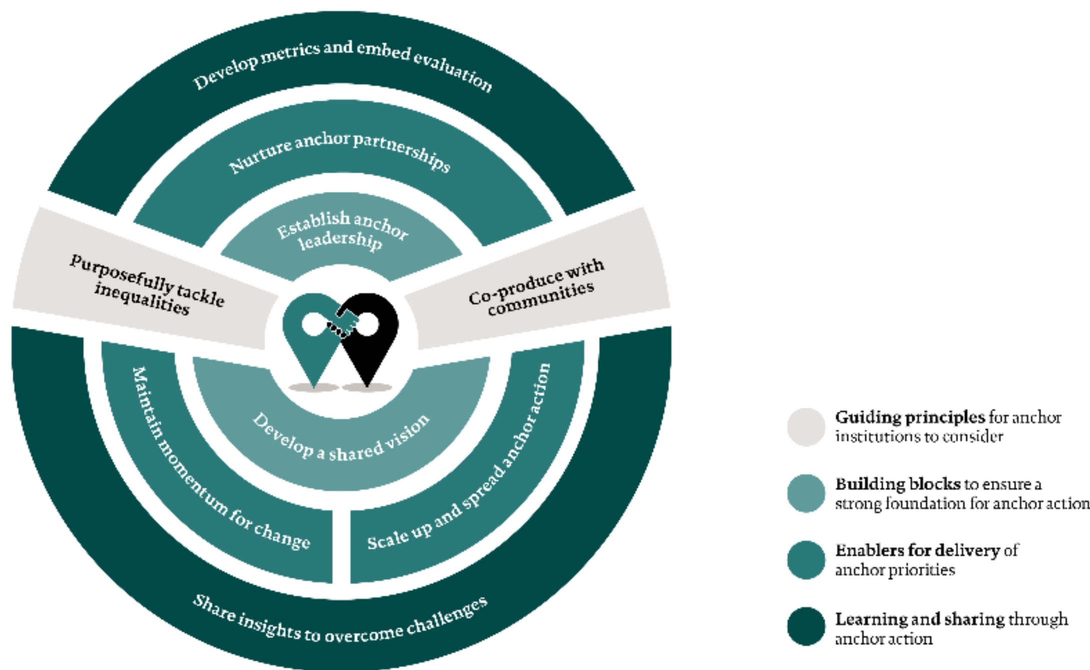
3.
CHRONIC RESPIRATORY DISEASE
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4.
EARLY CANCER DIAGNOSIS
75% of cases diagnosed at stage 1 or 2 by 2028

5.
HYPERTENSION CASE-FINDING
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

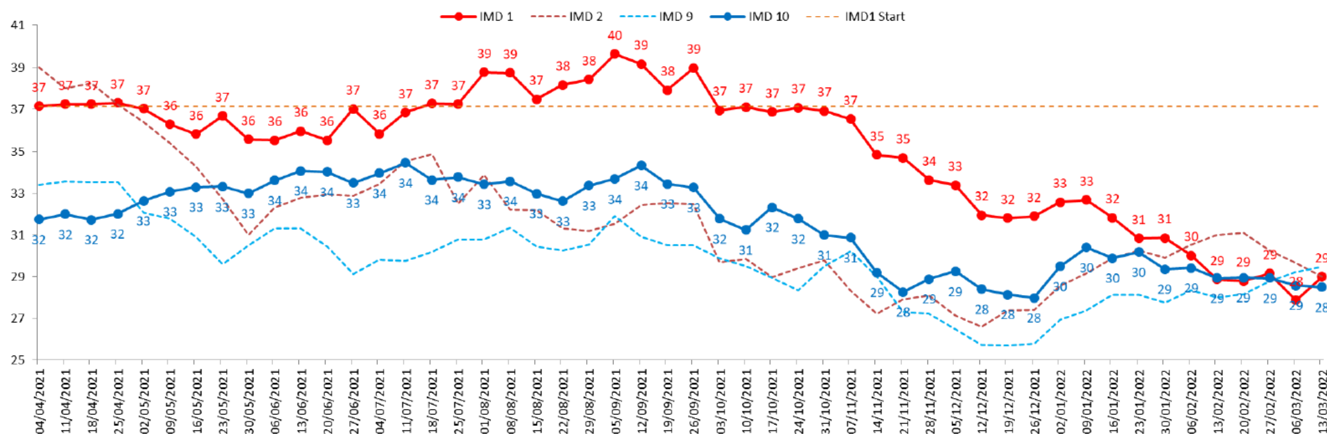
Translating Strategy to Action



https://www.health.org.uk/publications/long-reads/anchors-in-a-storm

- Do you know NHSE's 5 Strategic Priorities for Health Inequalities?
- Are you familiar with the Core20PLUS5 approach?
- Do you know the data that your organisation must collect & report on health inequalities?
- How is your organisation leveraging its Anchor role?
- How are you measuring the impact of health inequalities improvement activities?

Trauma & Orthopaedics
Inpatients – T&O Average Wait Time (Weeks) – narrowing the gap



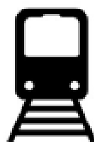
For T&O the most deprived (IMD 1) have reduced from 37 weeks to 29 weeks wait on average (a reduction of 8 weeks). During the same period the least deprived (IMD 10) reduced from 32 weeks to 28 weeks – a reduction of 4 weeks.

NHS
University Hospitals
Coventry and Warwickshire
NHS Trust

Inclusive recovery case studies

Royal Free London

The Royal Free London NHS Foundation Trust (RFL) has established an **Equitable Recovery Programme** (ERP); a pilot programme working with a small number of specialities, **including Ear Nose and Throat (ENT), maxillofacial (Max Fax) and dermatology,** to embed equity and reduce inequalities during the accelerated recovery programme. The project has focused on u**nderstanding the drivers for disparities in DNA rates** and waiting times and **developed tools for addressing these inequalities.**



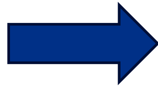
Analysis of Royal Free London data showed inequalities in waiting times for planned care by ethnicity and deprivation. It also highlighted that variation in Did Not Attend (DNA) rates was a large driver of inequalities in overall waiting times. The trust's **data-led approach also identified outliers in ethnicity recording.**

A small **Access Support Team** was established, made up of **two patient navigators and one analyst** and was led by the Group Head of Equality, Diversity and Inclusion (EDI) for Patients and Carers. The aim of the team was to identify and reduce health inequalities in patients on the RFL waiting list. The **patient navigators called patients, one week prior to their outpatients' appointment** which helped the trust to identify where there were inequities in access to services by ethnicity, age, gender and deprivation. The team developed a script and **standard operating procedure** for patient navigators to handle each call. This included calls to cancel or rearrange appointments and to arrange additional support, for example BSL translators.

Quantitative data to date demonstrates that **473 DNAs were avoided during the pilot** and **cost savings associated with this are likely to be between £47,300 and £75,680.**

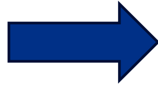
‘*Was not brought*’ - case studies

Birmingham Women’s and Children’s Hospitals NHS Foundation Trust



Children living in areas of high deprivation benefitted from pilot programme for free transport to hospital appointments.

Sheffield Children’s NHS Foundation Trust



Targeted support to families most at risk of not being able to attend by providing transport

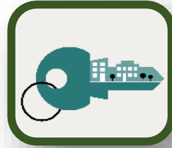
More details here:

NHS England » Free transport reduces ‘**was not brought’** rates for children at Midlands trust

Was Not Brought, Sheffield Children’s NHS Foundation Trust

Anchor Institutions – Using Estates for Healthcare Equity

Sandwell and West Birmingham NHS Trust



"A Home, Job & Career for Young People"

Providing **housing on the hospital site for young people who were homeless or at risk of homelessness, alongside paid apprenticeships in the hospital.**

LIVE & WORK SCHEME

A HOME AND A JOB FOR YOUNG PEOPLE

St Basils

STBASILS.ORG.UK

Sandwell and West Birmingham Hospitals NHS

University Hospitals Birmingham NHS

Two new Hospitals of the Future – Leeds Teaching Hospitals

- **Social value was incorporated into the invitation to tender documentation for the consultant design team appointments**
- Initiatives focus on those in **Leeds City Council's Priority Neighbourhoods** and areas surrounding the new development
- Opportunities are targeted at **those facing the greatest structural barriers to training, skills, and employment opportunities**

Pioneer Cavells

A) **Derby** – Medium

B) **Hucknall** – Medium

C) **Staines** – Small

D) **Sleaford** – Small

E) **Plymouth** – Large

F) **South Shrewsbury** - Large

Social value is central to primary care Cavell Centres – location, multi functional, sustainable

Board Leadership Frameworks

Download the Health Inequalities Board Assurance Tool (pdf)

Utilise the NHS Providers board objectives tool

Use our Board Reporting Template (.doc) to help you report back to your board

Use the scorecard to help benchmark your journey when using the tool (xls)

Read our Leadership Framework for Health Inequalities Improvement FAQs - a collation of questions and answers gathered during our seminars

Leadership Framework for Health Inequalities Improvement | NHS Confederation

Read NHS Confederation: Putting money where our mouth is?

Get more information on HI in trusts: Tackling health inequalities should be core business for trusts - NHS Providers

NHS England

Thank You

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england.nhs.uk

HEALTH INEQUALITIES

Christine Camacho

Public health consultant, Northern Care Alliance NHS Foundation Trust

Health Inequalities Workplan 2024/25

Build public health capacity and capability	All Board members to receive health inequalities training in 2024/25
	Public health consultant in post
	Introduction to health inequalities included in trust induction
Strategic leadership and accountability	Health inequalities implementation plan for 2025/26 agreed by board
	Population health and health inequalities oversight group established
Population health data, insight and intelligence	Develop local metrics to monitor progress in addressing health inequalities over time
	Routine reporting at Board meetings of performance and outcomes data by ethnicity & deprivation

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HEALTH INEQUALITIES

Jessica Berry

Associate director, personalised care and head of health inequalities, NHS Hampshire and Isle of Wight ICB

NHS
Hampshire and Isle of Wight

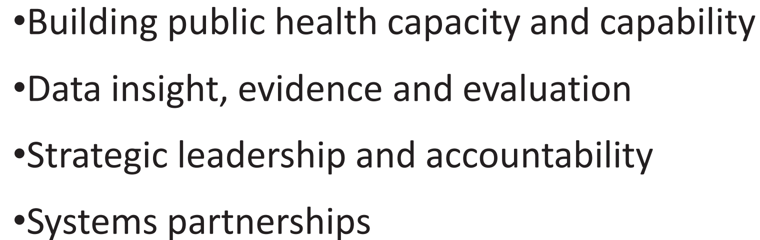
Health Inequalities Community of Practice

NHS
Hampshire and Isle of Wight

Health Inequalities Self-Assessment Tool – NHS Providers

This self-assessment tool is designed to be used alongside the Reducing Health Inequalities Guide for NHS Trust Board Members.

The tool contains 25 questions across 4 domains:



Hampshire and Isle of Wight

Findings

Building public health capacity & capability
- Board and staff training on health inequalities
- Sharing best practice

Data, insight, evidence and evaluation
- Completeness of ethnicity data and use of deprivation data
- Engagement

Strategic leadership & accountability

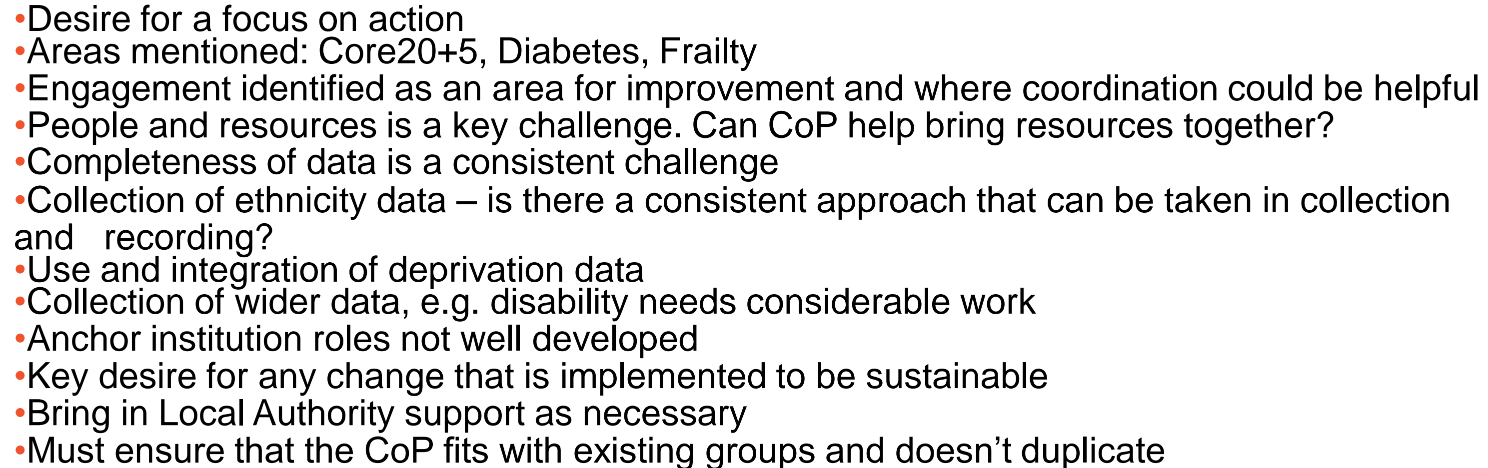
- Clear governance structure
- Using an equity lens across all organisational priorities
- Use of health inequalities impact assessment tools
- Allocation of resources to invest in services for longer term benefit

System partnerships

- Improving access to employment to underrepresented groups
- Embedding co-production principles to inform work on health inequalities

NHS
Hampshire and Isle of Wight

Meetings with HI Leads



First Community of Practice - 5th Dec 2024

- Broad agreement to keep the group as a Community of Practice.
- Initial ask for monthly meetings while priorities are identified and then move to quarterly.
- Potential to have a rolling agenda, returning to topics as needed
- Agreement that external organisations, such as NHSP or Wessex Cancer Alliance would be helpful depending on focus for the meeting.
- Bring in specialists as required but generally keep membership to HI and exec leads.
- Children and PLUS groups need to have a focus
- Decision to ask for Trust work plans to identify common work areas.

HEALTH
INEQUALITIES

Panel Q&A

NHS Providers

HEALTH INEQUALITIES

Breakout discussions

NHS Providers

HEALTH INEQUALITIES

Book now

Monday 10 March | Does digital exacerbate or reduce health inequalities?

Join us to explore whether digital innovation can reduce health inequalities or risk compounding them. As part of ongoing Digital Boards and Health Inequalities programmes, this event will provide critical insights, practical tools, and real-world examples to help NHS trusts apply an equity lens to digital transformation.

Tuesday 25 March | Delivering the shift to prevention

Join us to explore whether digital innovation can reduce health inequalities or risk compounding them. As part of ongoing Digital Boards and Health Inequalities programmes, this event will provide critical insights, practical tools, and real-world examples to help NHS trusts apply an equity lens to digital transformation.

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HEALTH INEQUALITIES

Tell us what you think

Your feedback helps us shape future events.

Please take five minutes to complete our evaluation.

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HEALTH INEQUALITIES

Visit our website

Discover further topics on how to address health inequalities including:

- Anchor institutions
- Partnership and system working
- Approaches for reducing health inequalities
- Embedding prevention

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Thank you for attending

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