

REDUCING HEALTH INEQUALITIES ASSOCIATED WITH COVID-19

A framework for healthcare providers

Introduction

This framework sets out core principles for understanding and taking action on health inequalities that have developed or worsened as a result of the COVID-19 crisis. It is intended to support NHS trusts during delivery of surge plans, as well as in service restoration and recovery action.

It has been developed by the Provider Public Health Network, a group of public health professionals who work in or closely with NHS provider organisations, with support from Public Health England (PHE), and in conjunction with NHS Providers.

The Provider Public Health Network

The Provider Public Health Network is an independent forum, established in 2014, which is supported by the national Healthcare Public Health team within Public Health England.

Further details of members' work can be found [here](#).

The online forum for the network can be accessed [here](#).



Health and care services worldwide have faced an unparalleled challenge in responding to and managing the impact of COVID-19. The disproportionate impact of the virus has highlighted longstanding health inequalities – marked differences in health outcomes that have been described by The Kings' Fund as "*avoidable, unfair and systematic differences in health between different groups of people*",¹ for example for people from areas with higher levels of socio-economic deprivation, or for those from Black, Asian and minority ethnic (BAME) communities.

The Health Foundation has highlighted that for COVID-19 there are "*clear inequalities in exposure to infection, the ability to 'socially distance', and in who will bear the brunt of the longer term negative impacts from COVID*".²

1 Kings Fund. <https://www.kingsfund.org.uk/publications/what-are-health-inequalities>

2 https://www.health.org.uk/news-and-comment/blogs/how-the-nhs-can-use-anchor-strategies-to-build-a-healthy-and-sustainable?utm_campaign=11671193_NHSEI%20Partnership%20and%20ITT%20launch%20WARM&utm_medium=email&utm_source=The%20Health%20Foundation&dm_i=4Y2,6Y5JT,SZTBHJ,RYDRS,1

Response planning for NHS trusts to this crisis has been described as falling within three phases of pre-surge, surge, and restoration and recovery, while also preparing for and coping with a second surge. All underscored by the core NHS optimal care delivery principles (figure 1).

NHS trusts have been widely recognised for their significant and sustained efforts to both deliver a COVID-19 surge response, while also undertaking service restoration and recovery, to help meet the broader non-COVID population health and wellbeing needs.

To help address this disproportionate impact of COVID-19, NHS trust boards will be aware of the COVID-19 phase 3 implementation requirement that was introduced, for *"all systems and every NHS organisation should therefore identify, before October [2020], a named executive board-level lead for tackling inequalities"*.

Executive leadership can enable coordinated trust-wide efforts to help achieve the health inequalities-related priorities of the COVID-19 response phase 3:³

- reducing unmet need and tackling health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels
- specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment
- management of elective waiting lists and performance at system as well as trust level to ensure equal patient access and effective use of facilities.

NHS phase 3 work is also taking place within the context of a number of catch-up programmes, for example screening and routine vaccinations which were impacted by reduced coverage during the spring 2020 pandemic response, and programmes on deferred elective and other care needs where 89% of trusts had expected to see a backlog of people awaiting care.⁴ This is within a context of NHS trusts managing further outbreaks alongside planning for winter and other threats to health including seasonal influenza.

Figure 1
NHS Principles



³ NHS England Phase 3 Letter.
<https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic>

⁴ <https://nhsproviders.org/recovery-position-what-next-for-the-nhs/key-points>

This framework offers principles for a population health level approach to understanding and taking action on health inequalities which have developed or worsened as a result of the COVID-19 crisis that began in 2019/20. It focuses on what NHS acute hospital trusts and mental health and community trusts can do, working as part of an integrated health and care system. The framework is intended to help NHS provider trusts to systematically review, describe, prioritise and further develop their role in addressing health inequalities during response and recovery from the COVID-19 crisis and as part of their broader core efforts to meet the needs of their local population.

In addition to helping deliver against foundation trust and Social Value Act responsibilities, tackling health inequalities as part of core business has been shown to optimise patient outcomes from clinical interventions and surgical procedures.⁵

Some of these activities are already taking place in local government, within health and care partners, and NHS providers. However, systematically strengthening the focus on action to reduce health(care) inequalities is achievable and can make a significant difference in many situations.

This framework was developed by the Provider Public Health Network and builds on the *Population health framework*⁶ previously published with NHS Providers. Examples from practice in NHS trusts are also included in the document *COVID-19: Mitigating impact on health inequalities*⁷ developed by the Provider Public Health network in conjunction with the Royal College of Physicians, PHE and NHS Providers.

This framework is designed to assist NHS provider trusts to address three main areas:



5 WHO (2020) Tobacco and post-surgical outcomes, WHO Tobacco Knowledge Summaries. <https://apps.who.int/iris/bitstream/handle/10665/330485/9789240000360-eng.pdf>

6 <https://nhsproviders.org/population-health-framework>

7 <https://www.rcplondon.ac.uk/news/covid-19-and-mitigating-impact-health-inequalities>

Principles for action

- The impact on health inequalities among patients should be considered and set out prior to any changes in the commissioning or provision of health or social care. Tools from NHS England⁸ and PHE, The Association of Directors of Public Health (ADPH) and the Local Government Authority (LGA)⁹ may be helpful in this.
- Any interventions should be delivered as part of integrated, co-ordinated person centre care.
- Services – and recovery actions – should be made accessible for all, particularly those at risk of exclusion because of personal, economic or social factors with resources for those with **most unequal access and outcomes**.
- Where there is any flexibility, health and care services should always be allocated based on healthcare need, striving in particular for equity of outcome, with a principle of proportional universalism embedded.
- Wider determinants of health should be addressed and funded at a place-based level, harnessing available community assets. These assets may include libraries, community groups, education centres, leisure and sport facilities or resources to support local families.
- Health and care staff should be valued and supported to maintain wellbeing and to enable delivery of high quality person-centred care in all settings.

Why this is important

There is increasing awareness that COVID-19 has had a greater impact on disadvantaged populations. Health and care services need to consider mitigating any inadvertent impact that could arise during the pandemic response, which could risk an increase to existing population health inequalities. Some contributory factors¹⁰ highlighted for the increased impact of COVID-19 on disadvantaged populations include higher levels of occupational exposure, overcrowded housing, and insecure employment, which can also affect an individual's ability to isolate or quarantine.¹¹ There is broad recognition of the toll that the COVID-19 response is taking on the NHS workforce. In many areas of the UK, NHS staff (particularly those in pay bands 1-4) and patients may often be synonymous populations. This is particularly relevant for NHS trusts in the most deprived areas, where the health and care workforce often comprise 7-8% of the local resident working age population. Where workplace health or support incentives are offered, NHS trusts could also consider reviewing how these are organised, to maximise opportunities for supporting the wellbeing of all staff, and in particular those in pay bands 1-4, recognising this may include workforce from outsourced services. If trusts can also consider their own workforce as part of activity to identify local population needs, this could both help extend the reach of their workplace wellbeing offers and also strengthen contributions to improving the health of their local population.

8 <https://www.england.nhs.uk/ltphimenu>

9 <https://www.local.gov.uk/our-support/coronavirus-information-councils/covid-19-service-information/covid-19-public-health>

10 <https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all>

11 <https://www.tuc.org.uk/research-analysis/reports/insecure-work>

Workforce case study

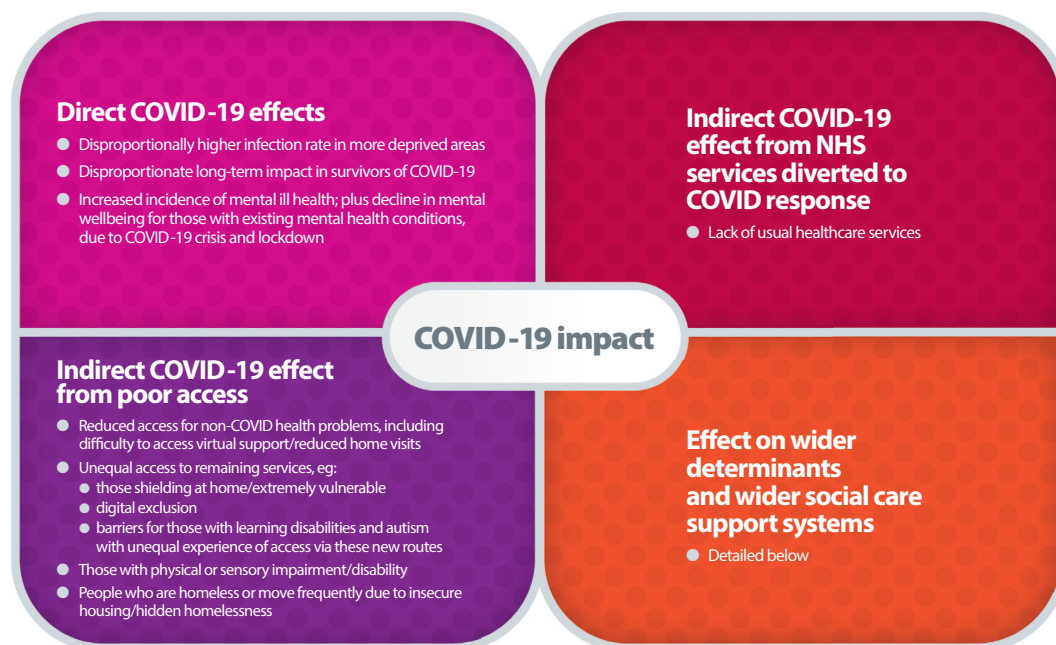
The Royal Free London NHS Foundation Trust had identified that a universal workplace health approach can lead to some hidden inequalities in uptake. They discovered only 10% of staff in Agenda for Change (AfC) bands 1-2 working at the trust were participating in the 'Fit at the Free' workplace wellbeing programme, while the cycle to work scheme was found to have a 91% take up amongst AfC bands 7 and above. To address this a 'health as a social movement' programme was developed, which included focused wellbeing activities for the facilities workforce across the trust (further detail in appendix 1).

COVID-19 has disproportionately affected particular groups, including men working in elementary occupations such as taxi drivers, bus drivers, chefs and retail assistants, who were found in 2020 to have the highest rate of COVID-19 related morbidity.¹² Also people of BAME populations have been found to have a significantly higher risk of death than those of white ethnicity (Black males 3.3 times higher, and Black females 2.4 times higher).¹³ A series of COVID-19 outbreaks in factories during summer 2020 highlighted an association between the virus outbreaks, working conditions and insecure employment. Pre-COVID, one in nine people in the UK were either self-employed, employed via an agency, casual or seasonal arrangements or were subject to zero-hours contracts. All of these factors can affect an individual's ability to isolate or quarantine if they have been exposed to SARS-CoV-2. Figure 2 outlines some of the direct and indirect ways that COVID-19 and the incident response has been found to exacerbate existing health and care inequalities.

12 <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020#main-points>

13 <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbyethnicgroupenglandandwales/latest>

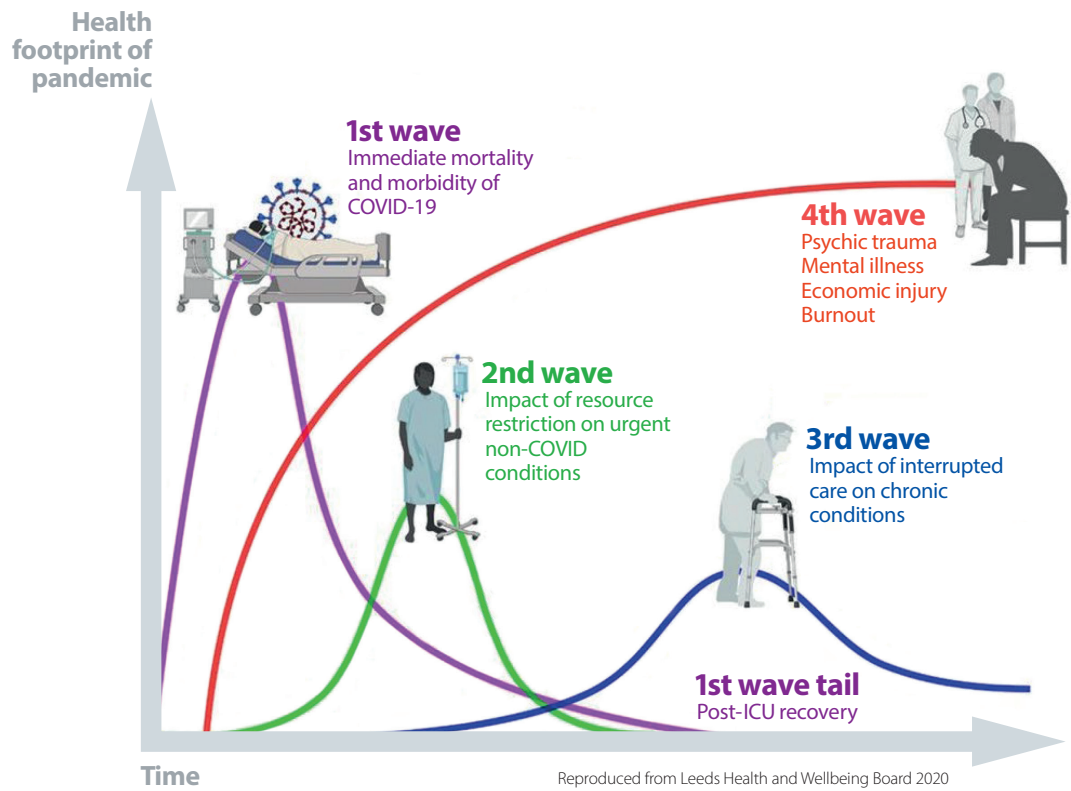
Figure 2
Impact of COVID-19



Effect on wider determinants and wider social care support systems

- Reduced ability to follow guidance in some communities because of financial, housing or social pressures.
- Staff shortages that affect deprived areas more than affluent areas.
- Reduced support from the voluntary sector.
- Decline in physical health e.g. from reduced/limited physical activity and poor diet – particularly neighbourhoods with limited green space, existing levels food poverty.
- Socioeconomic impacts of discrimination and its effect on the physical and mental health of those subject to discrimination including those with protected characteristics, and the wider impact across communities from this.
- Worsening child health due to school closures and an increase in risk for children known to social services or vulnerable, due to a loss or reduction of school support.
- Educational disadvantage in children.
- In the medium- to longer-term, a disproportionate impact on employment and income as a result of job loss and economic downturn.
- Social isolation as a result of lockdown and social distancing measures, and among clinically vulnerable and extremely vulnerable people.
- Mental health impact of lockdown, including as a result of pressures from a loss of income. This can particularly affect NHS providers given the increase in local population mental health service needs.

Figure 3
Impact of COVID-19 on health inequalities



Priority actions – examples from practice

2

1 Identify target population groups

NHS trusts will be aware of the risk factors that are now linked to a more severe course of illness and prognosis for those infected with SARS-CoV-2, as detailed in the NHS England risk stratification tool development.¹⁴

For provider organisations, identifying segments of the local population with these heightened risk factors for COVID-19 could provide a useful starting point in marshalling where services can have the greatest health impact on the needs of the local population.

This toolkit aims to highlight some routes previously taken by NHS trusts (some prior to the COVID-19 pandemic) that could help maximise the positive impact of NHS providers' services on the local population, and act as a building block for broader efforts to address health inequalities across the local population. Resources that may be useful for NHS trusts and partners include the updated PHE health equity assessment tool (HEAT) and HEAT e-learning¹⁵ for assessing and driving action on inequalities and equity. Some services have now embedded this process into their business planning or annual service reviews. Examples from practice below, demonstrate where NHS trusts and local health system partners have used routine data to identify local population needs. Additional PHE resources that may be of use include SHAPE¹⁶ to support service configuration, and the local health tools, which can help when considering indicators for small area geographies.¹⁷

14 <https://www.phc.ox.ac.uk/research/primary-care-epidemiology/covid-19-risk-tool>

15 <https://www.e-lfh.org.uk>

16 <https://shapeatlas.nets>

17 <https://www.localhealth.org.uk/#c=home>

Table 1

Approach	Example or tool	Outcomes/ learning to date
Equity analysis using routine patient data	<p>CASE STUDY Meeting the needs of the population</p> <p>Barts Health NHS Trust established a trust-wide commitment to address inequity, embedding "<i>meeting the needs of our population</i>" as one of their five strategic objectives. An equalities data working group has begun to identify if any parts of the trust population experienced inequity in access or health outcomes. This work examined an initial basket of indicators setting out to explore aspects of equity such as access, process and outcomes using routine quantitative data. It explored dimensions of equity such as gender, ethnicity, age and deprivation.</p>	<p>Examples of areas examined have included an analysis of DNAs by deprivation; and 28-day readmissions data by protected characteristics.</p> <p>Barts Health NHS Trust has also analysed qualitative indicators such as complaints and the experience of those with learning disabilities.</p>
Using trust profile data where available	<p>Catchment populations tool</p> <p>PHE NHS acute trust catchment populations tool¹⁸ provides estimates of the potential population which may access a trust's service. The tool includes data on trust catchment population by IMD deprivation quintile to help identify areas of inequalities by geography in proximity to a trust.</p> <hr/> <p>CASE STUDY Public health report</p> <p>Chelsea and Westminster Hospital NHS Foundation Trust has developed the trust's first public health report, which identifies the trust's core catchment area and describes the health profile of the local population that they serve. These insights will underpin the trust's work going forward, including delivery of COVID-19 response and recovery activity.¹⁹</p>	

18 <https://app.powerbi.com/view?r=eyJrjoiODZmNGQ0YzltZDAwZi00MzFmLWE4NzAtMzVmNTUwMThmMTVliwidCl6ImVIN-GUxNDk5LTRhMzUtNGlyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOj9>

19 <https://www.chelwest.nhs.uk/about-us/public-health>

**Use of
population
health
management
(PHM) data**

CASE STUDY

Barnsley vulnerability index

Before the pandemic, the local health and social care systems lacked information to understand service users' financial or social status, or what was available to them in their neighbourhood. Local systems data sharing had been seen as desirable, but it was not until the first week of the outbreak that this work was able to get underway.

A workforce of analysts from each of the organisations in the system, such as different local authority teams and NHS services, collaborated to develop the vulnerability index. Starting as a list of vulnerable people shielding due to underlying illnesses, it is now a much more sophisticated database which also identifies households experiencing financial difficulties or with safeguarding concerns. Having identified around 65,000 households with some form of vulnerability during COVID-19, this has improved the ability to anticipate and respond to people's needs.

Dr Andy Snell, Public Health Consultant at Barnsley Hospital: "We are able to risk stratify [people], knowing their risk of health problems, social problems and financial or other problems. We can identify what kinds of needs they have and prioritise support for them based on a much more holistic understanding of health. We've opened the doors to people who we didn't even know needed help. People who are depressed or experiencing hidden harm – they've always been there but we haven't always known about them. This crisis has at times pushed local systems to work better together in order to provide more effective support. It has also demonstrated how extensively people's health is shaped by social inequalities. Continuing to build on the collaborations formed through the crisis will increase the capacity and capability for local areas to adopt prevention-led strategies."

CASE STUDY

PHM linked dataset

Bristol, North Somerset and Gloucester clinical commissioning group (CCG) built on their integrated care system (ICS)/ sustainability and transformation partnership (STP) PHM linked dataset to identify at risk patients regarding COVID-19 vulnerability.

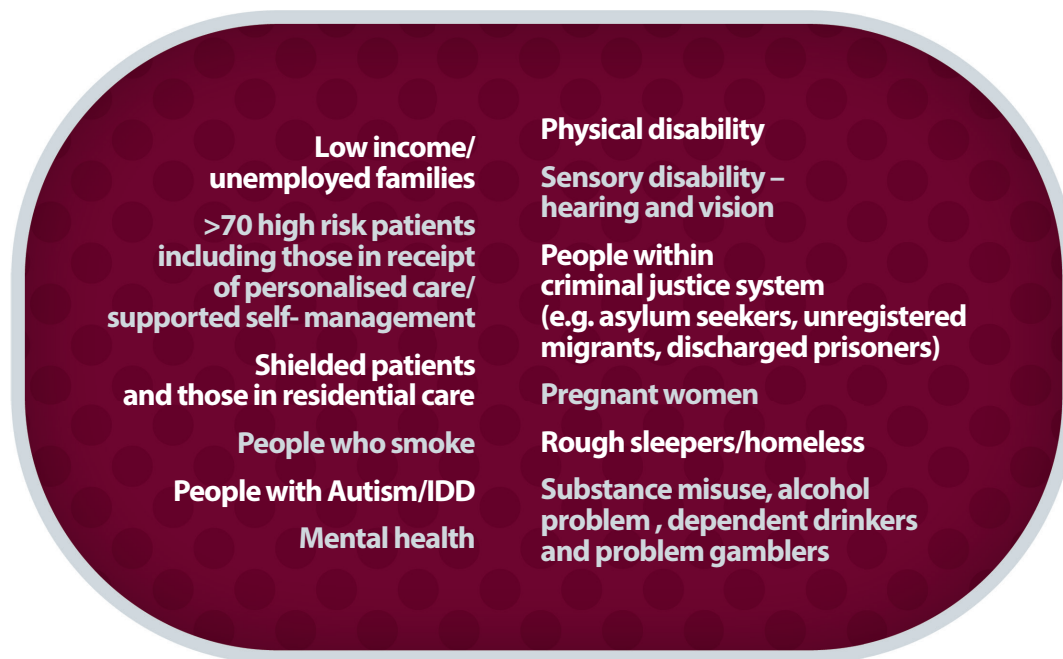
The local population was grouped into six clusters to help identify vulnerable patient groups in this work: complex mental health, older complex needs, younger population with asthma, recent cancer diagnosis, drug monitoring and low utilisation of COPD care services.

<p>Identifying at-risk population groups</p>	<p>CASE STUDY Data dashboard Nottinghamshire Healthcare Foundation Trust²⁰ worked with their local ICS, using a data dashboard this ensured those with severe mental illnesses were identified to receive support, as this group is often difficult to capture through primary care data alone.</p>	<p>The work enabled community and mental health services to identify individuals under their care who were at risk re COVID-19 (extremely vulnerable). It also helped ensure that the distribution of risk across deprivation and ethnic group categories amongst the local population was understood by all involved healthcare organisations.</p>
	<p>CASE STUDY Barts Health sexual health services routine data collection of protected characteristics and a yearly equity audit The trust reviewed public health datasets alongside clinic collected information to guide service strategy. Their outreach activity is closely aligned to public health datasets including sexual health reports, small area data and data on sexually transmitted infections and pregnancy, targeting those groups that are noticeably absent and not routinely engaging in mainstream services, e.g. vulnerable young people, refugees etc. A review of access to services by age highlighted age 16-25 years cohort were not accessing care. This led to development and implementation of in-reach and outreach clinics.</p>	<p>An audit found access was an issue for under-represented communities. Community events were established to increase engagement with the service. Audit of STI screening by user protected characteristics highlighted low screening offer rates for men. This was addressed via a service change being implemented, which resulted in a 98% screening offer for this patient group.</p>

<p>Identifying at-risk population groups continued</p>	<p>CASE STUDY Linking health and local government data to understand social determinants of health (Islington, London)</p> <p>This project aimed to help assess patterns in the social determinants of health for the local population, to identify unmet needs and inequalities. This involved developing an innovative linked dataset between local council data and NHS data using an encrypted (pseudonymised) unique property reference number (UPRN), which every address in Great Britain has, and is collected on NHS and local government datasets. This would help enable analysis of social determinants factors affecting health at a household level.²¹</p>	<p>The project identified optimal data flows for linking health care data and council data and developed a proposed data flow model and linkage method, as well as a data specification. A challenge regarding data access request services (DARS) has led to this work focusing on the local linkage of council and health care data using property data only, subject to information governance.</p>
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Figure 4
Population factors for COVID-19 risk and adverse outcomes

Some factors may be more relevant to particular types of trusts, while less relevant to others.



²¹ <https://phe.koha-ptfs.co.uk/cgi-bin/koha/opac-retrieve-file.pl?id=cbadc9b3da96ef86d4c047542afd2264>

2 Review and adapt approaches

With many innovative approaches introduced at pace²² during the COVID-19 response – for example integrated workforce and volunteer models – there is opportunity for NHS trusts to consider building on these to strengthen links with community assets and enabling effective prevention, care and rehabilitation pathways. With 92% of trusts reporting concerns about stress and burnout among their staff,²³ reviewing workforce health and wellbeing needs as part of this process will also be crucial.

The Health Foundation has highlighted how NHS trusts in their ‘anchor role’ can “support and accelerate local recovery from COVID-19”, while helping to mitigate some of the significant social and economic impact of the COVID-19 crisis on local populations.²⁴ NHS trusts are acknowledged as: “large, public sector organisation with a significant stake in local communities and potential to influence their health and wellbeing – [this] could help to mitigate some of the negative social and economic impacts of the pandemic”.

Table 2

Approach	Further detail/example	Outcomes/learning
Establish baseline of local population needs to inform recovery planning	Identify prevalence rates from published studies or reviews that can be applied to the local population. This will help to indicate the potential magnitude of future demand on services.	
Build on partnership working fostered during COVID-19 response	Build on recent collaborations with local primary care, health, social care, voluntary and community sector and housing partners to help increase capacity for meeting local population health needs. Examples detailed in Care Quality Commission’s COVID-19 insights. ²⁵ Review data sharing across providers including GP services.	

22 Providers Deliver report on prevention. <https://nhsproviders.org/providers-deliver-new-roles-in-prevention>

23 <https://nhsproviders.org/recovery-position-what-next-for-the-nhs>

24 <https://www.health.org.uk/news-and-comment/blogs/how-the-nhs-can-use-anchor-strategies-to-build-a-healthy-and-sustainable>

25 <https://www.cqc.org.uk/publications/major-reports/how-providers-are-working-together-across-systems-response-covid-19>

<p>Scenario planning/ modelling/ to inform recovery and service planning</p>	<p>Where possible, scenario plan and model to estimate expected capacity required to reinstate services and meet local demand. Include workforce, finance and infrastructure.</p> <p>As part of this, it will be useful to assess what impact the pandemic will have on future demand for services, including mental health services.</p> <p>Where possible, modelling of the impact of non-COVID-19 demand and a potential wave of late presentations will also provide useful insights for service planning.</p> <p>CASE STUDY Assessing demand for mental health care Lancashire and South Cumbria/ Midlands/Cambridge Partnership (further detail in appendix 2)</p>	<p>This work identified sub-populations potentially at higher risk of mental health morbidity in relation to COVID-19. Estimates of COVID-19 generated mental health demand in sub-populations were applied to local health authority populations. These assumptions were used to develop a dashboard for estimating current and future mental health implications of the COVID-19 pandemic.</p>
<p>Address health inequalities during service prioritisation</p>	<p>While planning for addressing backlog of activity built during COVID-19 management and response, consider the prioritisation of services/service user and population groups for greatest impact to help address inequalities.</p> <p>Information could include:</p> <ul style="list-style-type: none"> ● complexity of needs (population segmentation) ● impact of inequalities ● unintended consequences ● population groups that may require additional consideration, e.g. diabetes and CKD.²⁶ <p>Plan for how the service will address health inequalities, consider prioritising patients who historically have lower uptake of services.</p>	

²⁶ <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/clinical-topics/diabetes/delivering-diabetes-care-during-the-covid19-pandemic-120620.pdf?la=en&hash=64E18C46DCB23E2538E7BF94D68B99AD>

<p>Prevention</p>	<p>Review change in face-to-face preventative services by deprivation, for example smoking cessation support or weight management and dietetic services. Early indications are there is an association between smoking and COVID-19 severity²⁷ and a BMI over 30 and poor COVID-19 outcomes.²⁸</p>	
<p>Information</p>	<p>To complement existing NHS England and PHE monitoring already in place, e.g. data collection on immunisation uptake rates and trends, avoiding any duplication of reporting or datasets.</p>	
<p>Consider targeted interventions for population groups most at risk from COVID-19</p>	<p>CASE STUDY COVID-19 and homelessness Using existing capacity, South Warwickshire Foundation Trust and Public Health Warwickshire collaborated to deliver a project supporting people experiencing homelessness during the COVID-19 outbreak.²⁹</p> <hr/> <p>CASE STUDY Community COVID-19 testing 'Pop-up' COVID-19 test centre in Harehills, one of Leeds most deprived areas with a high number of BAME communities. In response to a clustering of cases, public health, communities and housing and adult social care, along with third sector volunteers, set up a COVID-19 test centre at the Bilal Centre. Household outreach to local homes and streets engaged residents raising awareness of key messages and the local testing offer. Voluntary Action Leeds supported the door knocking with community languages (Czech, Urdu and Punjabi). Local ward members played a key role in shaping the approach, promoting and engaging with local residents through posting repeatedly on the Inner East community committee Facebook page, and local radio – Breeze and Fever FM. The success of the centre is a testament to partnership working across the council and the wider health and care system.</p>	<p>This project included work to support people in this group vulnerable to COVID-19, to shield, to isolate where necessary, and to risk assess and enable improved physical health and wellbeing.</p> <hr/> <p>The centre was well attended by local residents and the testing positivity rate was high (suggesting effective engagement). Positive and strong communication through Bilal centre's Facebook and WhatsApp platforms helped raise awareness of the testing site with over 300 members. Cabinet Office COVID taskforce commended the project for displaying "huge evidence of collaborative approach across partners and engagement with communities".</p>

27 Grundy, EJ et al (2020) Smoking, SARS-CoV-2 and COVID-19: A review of reviews considering implications for public health policy and practice <http://www.tobaccoinduceddiseases.org/Smoking-SARS-CoV-2-and-COVID-19-A-review-of-reviews-considering-implications-for,124788,0,2.html>

28 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907966/PHE_insight_Excess_weight_and_COVID-19_FINAL.pdf

29 <https://www.rcplondon.ac.uk/news/covid-19-and-mitigating-impact-health-inequalities>

<p>New working practices</p>	<p>Identify effective new ways of working that emerged during the COVID-19 response. Explore how those of benefit can be embedded in delivery models.</p> <p>The development of options appraisal and business cases for some of the new service models established during COVID-19 response may help in embedding some of these approaches in practice.</p> <p>Review uptake of remote consultation use by providers, professionals and patients (including video consultation patterns in primary, community and mental health care). Review digital exclusion patterns, including for patients, provider organisations and across professional groups.³⁰</p> <hr/> <p>CASE STUDY Addressing digital access issues</p> <p>East London NHS Foundation Trust, a mental health and community trust, set out to address a digital inequity gap for many of their patients, which was of particular concern during the spring 2020 COVID-19 lockdown, regarding patients accessing virtual support and information from the trust. A cross-organisational programme enabled the refurbishment of old workplace smartphone and digital tablets and allocated to patients, along with support on their use to help reduce digital exclusion amongst this vulnerable population.</p>	<p>Many patients at ELFT have been supported to become more familiar with using smart phone or tablet and used their allocated device to keep in contact with their care coordinator, and some have been able to access support via this route.</p>
<p>Benefit across the life course</p>	<p>Identify whether systems still assess effect on medium and longer-term outcomes of service delivery decisions.</p>	

³⁰ Connectivity across the NHS may not always be reliable. Some short-term digital solutions during the immediate response to the COVID-19 pandemic may not be sustainable longer term, for example if higher volumes of activity, or if dependent on ongoing investment.

Figure 5
Procurement and Employment – NHS trusts as anchor institutions



Procurement and employment

NHS trusts, as local 'anchors' can help deliver positive local impact when economic, social and environmental wellbeing is considered during procurement. There are increasing numbers of examples of providers utilising their estate and workplace settings to help strengthen community assets, and of environmental sustainability and place-based collaborations³¹ with community groups.

Employment, procurement and commissioning – there is a clear opportunity for NHS organisations to use their role as employers to target volunteering and stable employment opportunities at local residents, particularly those furthest from the labour market.

CASE STUDY

Barts Health NHS Trust³² has launched Healthcare Horizons, a targeted local employment programme to help people develop careers in the NHS.^{33 34}

Further case studies with examples of 'anchor institutions' work delivered by trusts and links to relevant resources³⁵ can be found via this KHub site (free KHub sign-up is required to access this page).

A focused COVID-19 related community drive is aiming to deliver support to over 200 schools; and over 1,000 local students will be supported by the programme. While over 200 work experience placements and 200 apprenticeships with the trust are being created.

31 <https://publichealthmatters.blog.gov.uk/2020/06/01/the-community-response-to-coronavirus-covid-19>

32 <https://www.bartshealth.nhs.uk/healthcarehorizons>

33 <https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution>

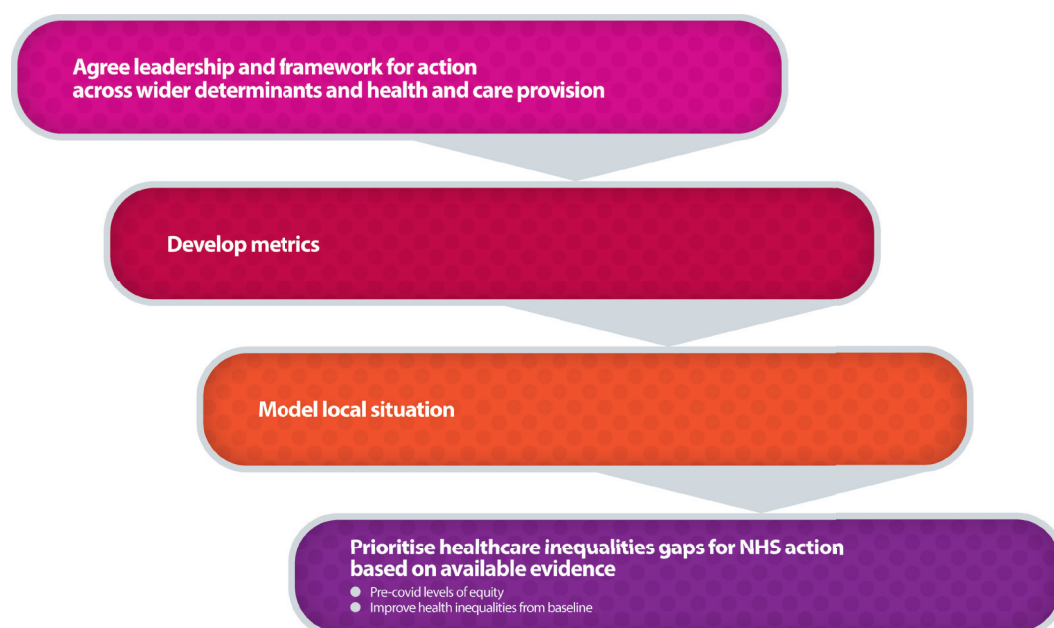
34 <https://www.england.nhs.uk/ltphimenu/wider-social-impact/wider-social-impact-nhs-as-an-anchor-institution>

35 <https://khub.net/group/health-inequalities-and-inclusive-growth/group-home>

Staff risk assessment	<p>Outcomes from workforce risk assessment may help influence working patterns and opportunities for development moving forwards in NHS trusts.</p> <p>Sources of feedback could include absence data due to COVID-19, any worker deaths due to COVID-19, staff survey data, workforce race equality standard and workforce disability equality standard data, and any COVID-19 related pulse survey data.³⁶</p> <p>Communicate with staff and consult with staff networks and trade unions regarding the approach to be taken to risk assessment and agreeing how a continued dialogue can be maintained.</p> <p>NHS Employers COVID-19 guidance³⁷ includes:</p> <ul style="list-style-type: none"> ● Occupational health ● Supporting vulnerable staff ● Staff returning to work ● Workforce supply and deployment ● Enabling staff movement <p>Psychological first aid.³⁸</p>
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3 Action plan

Figure 6



36 <https://www.nhs.uk/apps-library/nhs-pulse>

37 <https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff>

38 <https://www.futurelearn.com/courses/psychological-first-aid-covid-19/1>

4 Integrated care/system collaboration

Undertaking a review to identify and map local population inequalities gaps against a selection of targeted services delivered within NHS organisations will help identify where efforts will have the greatest impact, as well as highlighting potential areas of unmet local population need. This process can also help generate insights on how work already underway within trusts could help to mitigate against a widening of inequalities (and variation in health outcomes) during local health system COVID-19 recovery phase.

Reviewing population inequality gaps across a system can help identify priority actions for service providers, while also strengthening coordination and consistency of approach across partners during the local COVID-19 recovery phase. STPs/ICSs could be a helpful convenor for these conversations, recognising that different system partners will have a variety of intelligence that they can contribute, for example local authorities being well placed to help identify at risk populations. This concerted effort can help to identify populations at increased risk of SARS-CoV-2 transmission and/or more severe consequences of infection, such as people with complex needs and potentially currently underserved populations, for example traveller communities, BAME populations, or those who are homeless. A cross system review could help to identify what is working well, sources of local assets, and to also help avoid pockets of duplication.

Reviewing data sharing and information governance agreements in place across providers – including GP services – can also enable improved integrated care.

The use of a matrix approach has been adopted across Cambridge, Lancashire and South Cumbria, and the Midlands, to review evidence, identify population needs and to assist prioritisation (see appendix).

5 Leadership actions

As mentioned previously, ICSs can provide useful cross-partnership leadership support for the coordination of locality services and identifying system-wide needs. Alongside this, leadership at trust-level – including crucially from within NHS trust boards – is pivotal in identifying and addressing local health inequalities, particularly as ICSs can be quite large. Where geographies are diverse, a place-based approach may allow for a more locally tailored response.

The contribution that provider organisations can bring to tackling health inequalities – both those impacted by COVID-19 and those affected by underlying existing inequity – is recognised by NHS England's reference to having "*a named executive board-level lead for tackling inequalities*" as part of phase 3 COVID-19 response.

Provider-level leadership for addressing health inequalities both during COVID-19 restoration and recovery, and beyond will help to inform coal face action in the first instance. This local intelligence can then be reviewed at ICS level for wider evaluation of how this works out and impacts across the ICS population, on service variations and population health outcomes.

This requires a consistent process to enable both local and ICS level accountability for reporting, reviewing and taking action for the ICS population, based on local intelligence.

Individual health and care providers can do much internally to measure, take action, and advise on prioritisation of actions during recovery phases. Recognising that most interventions will take place locally at a neighbourhood level, data analysis and leadership/coordination might take place more at place- and system-level. Local leadership in the first instance is key and may also involve collaboration from NHS trusts with primary care and social care.

Metrics

Examples of potential metrics are included in the table below. An example of how these may be considered and applied by NHS trusts to specialities is included in appendix 3. Some indicator groups may be of particular relevance for some types of provider trusts, while some indicators may not all apply to every type of provider.

Table 3

Area	Metric details
<p>Overarching approach</p>	<ul style="list-style-type: none"> ● Embedding actions to address inequality – of both access to services and health outcomes – within trust-wide processes and strategy has been identified by several trusts as a key enabler for broader, trust wide traction. Having an executive champion and health inequalities as part of an executive level portfolio, as now detailed in the COVID-19 phase 3 implementation guidance can also help to consolidate and marshal trust-wide action.
<p>Baseline: establishing impact from any delays to care</p>	<ul style="list-style-type: none"> ● Examine the trust risk stratified cohorts and profile them to help quantify any delays to care that have been introduced, and the impact on disease progression as a result of COVID-19 response. ● Draw on local system Joint Strategic Needs Assessment data and reports and Population Health Management and inequalities dashboards and linked datasets can help during this stage to provide granularity on location of these local needs. ● This process can help when evaluating the backlog of care to be addressed and help ensure that prioritisation is appropriate and will not risk the widening of existing inequalities when services resume.
<p>Clinical risk indicators or other known trust socio-economic patient data</p>	<p>CASE STUDY Equity reviews using routine data</p> <p>Barts Health NHS Trust has undertaken a series of equity reviews using existing patient data which has included analysis of 28-day re-admissions by protected characteristics. Further detail on aspects of this work can be found in section ‘step one: identifying target population groups’.</p> <p>As part of recovery planning, providers should be looking at their service activity by demography and deprivation. The indicators below may help during this work, to aid profiling of the local populations. Providers will also need to profile their patient/client populations and relate this to the wider local population – this stage can often be missing or may be conducted in isolation of each other. Understanding both the patient population and the local population are key to addressing unintended inequalities.</p>

<p>Clinical risk indicators or other known trust socio-economic patient data continued</p>	<p>Customised profiles – using indicators such as those within PHE Fingertips tools – can help build insights on the local population, particularly for factors relevant for coronavirus high risk groups and the local socio-economic context:</p> <ul style="list-style-type: none"> ● clinical risk factor and social vulnerability³⁹ ● COVID-19 clinical risk factors – respiratory⁴⁰ ● COVID-19 clinical risk factors – non-respiratory e.g. chronic heart disease and diabetes prevalence, obesity, flu vaccination coverage⁴¹ ● COVID-19 deprivation, demography and context e.g. deprivation, economic inactivity, ethnicity⁴² ● COVID-19 deprivation, demography and context.⁴³
<p>Wider determinants metrics via integrated care partnership</p>	<ul style="list-style-type: none"> ● These wider determinants indicators are increasingly available to trusts via pooled or linked system datasets, through local integrated care partnership or other cross-partner forums. ● Data sources could include local authority collections e.g. education, economic markers, air quality, transport, wellbeing, housing and homelessness.
<p>Social and personal care</p>	<ul style="list-style-type: none"> ● Safeguarding (adults and children) trends. ● Domestic Violence activity.
<p>Measure trends in service usage</p>	<ul style="list-style-type: none"> ● Analyse by deprivation quintile, age, gender, by BAME status and other protected characteristics, as well as physical or sensory disability.
<p>Prevention services</p>	<ul style="list-style-type: none"> ● Smoking cessation referrals and completed quit attempts (including patients with severe mental health illness and pregnant women and their partners). ● Referral, uptake and outcomes from exercise, dietetics and weight management services. ● Alcohol and substance misuse brief interventions conducted and referral and outcomes to support services. ● Gambling support referral and uptake. ● Screening programmes referral and uptake/outcomes.

39 <https://fingertips.phe.org.uk/indicator-list/view/hThVtOH4CU/page-options/oww-do-0>

40 <https://fingertips.phe.org.uk/indicator-list/view/7DVXEB34E2>

41 <https://fingertips.phe.org.uk/indicator-list/view/V8BMKjkgU>

42 <https://fingertips.phe.org.uk/indicator-list/view/G8UcFiedVE>

43 <https://fingertips.phe.org.uk/indicator-list/view/G8UcFiedVE>

<p>Primary and community care</p>	<ul style="list-style-type: none"> ● Consultation rates. ● Remote consultation rates (particularly changes in access from historical consultation rates, exploring both the distribution and nature of access. Are certain groups experiencing better access? Are other groups impacted by reduced access? Are there economic and/or physical barriers to not attending services). ● Immunisation and screening (national programmes) uptake. ● Routine long-term condition management activity for example, the percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months or the percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March. ● Delayed presentation for maternity care, late uptake of 12-week booking appointment.
<p>Secondary care</p>	<ul style="list-style-type: none"> ● Remote consultation rates and any changes in access based on comparison with historical consultation rates such as for cardiac care, ophthalmology services. ● DNA rates for services that have been maintained. ● Referral rates for 2-week wait cancer diagnosis. ● Cancer staging at first diagnosis. ● A&E activity. ● Admission rates for heart attacks and strokes, time from symptom onset to first clinical presentation; and outcomes.
<p>Workforce</p>	<p>Capturing data on workforce (all groups) is crucial especially since health settings and occupational exposure are a key factor in transmission.</p> <p>It is suggested that NHS provider trusts:</p> <ul style="list-style-type: none"> ● report on overall findings of workforce risk assessment by demographic characteristics and staff groupings* ● report on workforce COVID-19 test results, with point prevalence at given time intervals by demographic characteristics and staff groupings.* <p>* Reporting should be anonymised, taking account of small numbers in the usual way.</p>
<p>Mental Health</p>	<ul style="list-style-type: none"> ● Deliberate self-harm and suicide profile trends. ● Mental Health Crisis activity, including presentations at A&E. ● IAPT activity (incl. treatment completions, outcomes and PROMs).

Conclusion

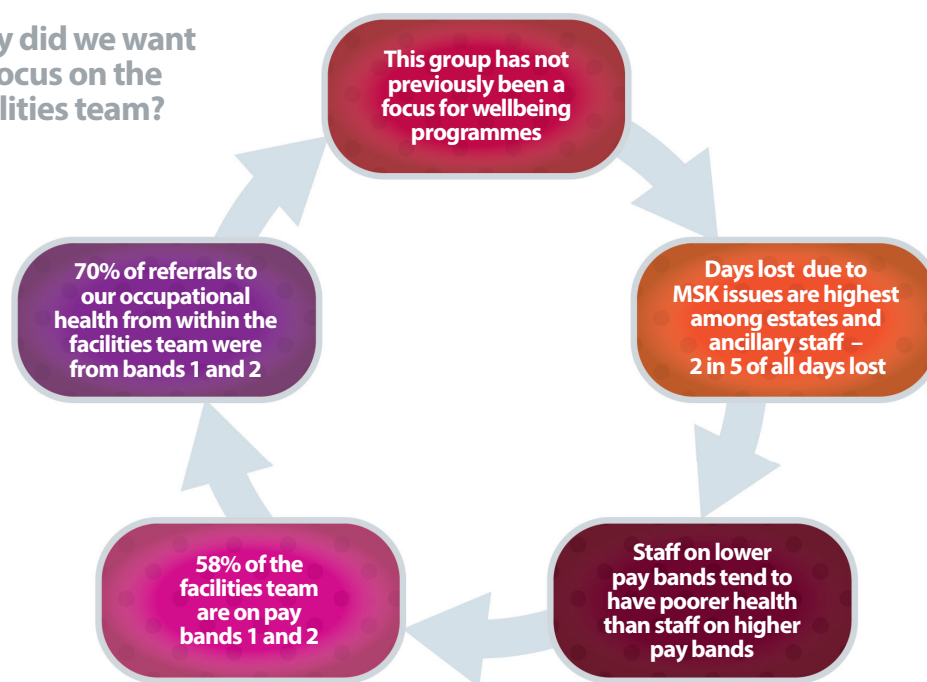
NHS providers can have a far-reaching impact on helping to address health and care outcomes through existing delivery as part of ICSs, their work on equitable service delivery and sustainability, and staff health and wellbeing.

This framework provides a fresh perspective for examining healthcare activity data and patient experience to shed new light on health inequalities, which is within the capability of NHS provider trusts, and enabling them to have a better understanding of their patient and local populations.

Appendix 1

Figure 7
Focused workplace wellbeing programme
Royal Free London NHS Foundation Trust

Why did we want to focus on the facilities team?



Evaluation and outcomes

- Staff reported feeling in better physical and mental health as a result of attending the walking activities (scheduled for end of facilities staff shifts) and other activities.
- Many individuals referred to completing a Snowdon expedition as part of the programme as their greatest physical achievement. Increasing their physical activity: staff reported this was something they did not think they were capable of and would not have had the opportunity to do without the support of the programme.
- Managers reported improved attendance at work by individual staff members who have previously had very high rates of sickness absence.
- Following the programme, there was a 71% response rate to the staff survey by facilities staff (trust average of 42%); and improved attendance and involvement at facilities team meetings by lower band staff.

Appendix 2

CASE STUDY

Assessing the demand for mental health services generated by the coronavirus pandemic

Public health specialists working in NHS provider organisations can make many contributions to population health.⁴⁴

One example is from a group of public health specialists (based in Cambridge, Lancashire and South Cumbria, and the Midlands), most in mental health trusts, who took an evidence-based approach to assessing the demand that would be placed on those trusts as a result of people's pandemic experience. Although there has been recognition that the pandemic will have a significant impact on population mental health and, consequently, potential demand for mental health services,^{45,46,47} no attempts to quantify this demand were found. This group, therefore, addressed this gap through the development of a series of assumptions that enables COVID-19 generated demand for mental health services to be estimated for local areas across England. These early estimates were used to inform local restoration and recovery service planning. This work also promotes awareness of the extent of mental ill-health that could arise from the pandemic.

Connections that existed as a result of the national provider network led to the formation of a group who over a two-month period, searched and assessed grey, pre-publication and peer-reviewed literature. Papers were included if they contained prevalence figures of mental illness and used a hierarchy relating to disease or event (e.g. specific to COVID-19 was the highest ranking), alongside quality appraisal of the papers. From this sub-populations that were potentially at higher risk of mental health morbidity secondary to the pandemic were identified. The estimates of COVID-19 generated mental health demand within each sub-population were then applied to the local health authority populations, see figure 1. Where no evidence was identified, expert consensus was sought from academic consultant psychiatrists. The suite of estimates was finalised in June 2020. The assumptions were also used by the Midlands Partnership Trust to develop an analytics model dashboard which estimates current and future mental health implications of the COVID-19 pandemic.

44 <https://nhsproviders.org/media/644142/population-health-framework-1f.pdf>

45 https://www.centreformentalhealth.org.uk/sites/default/files/2020-05/CentreforMentalHealth_COVID_MH_Forecasting_May20.pdf

46 E. Holmes, R. O'Connor, H. Perry, I. Tracey, S. Wessely, L. Arseneault and „, "Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. Position paper," *Lancet Psychiatry* [online], vol. 7, no. 6, p. 547, 2020.

47 <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0388-after-care-needs-of-inpatients-recovering-from-covid-19-5-june-2020-1.pdf>

Figure 8
Example of application of published studies to local populations

Stage of life course; followed by sub-groups	Total number of people in this life course group, followed by approximate numbers in sub-groups pre-pandemic				Rate applied from the literature				Estimated demand for support or service			
	Blackburn with Darwen	Blackpool	Lancashire	South Cumbria	Blackburn with Darwen	Blackpool	Lancashire	South Cumbria	Blackburn with Darwen	Blackpool	Lancashire	South Cumbria
Working age adults (19-65 years)	88,321	81,868	711,881	97,441								
Bereaved (including prolonged traumatic grief and complicated grief)	540	808	5,447	980	9.80%				53	79	534	96
Unemployed	3,500	3,800	16,900	2,100	18%				378	410	1,825	227
Front-line staff:	30,050											
Anxiety					23.2%				6,972			
Depression					22.8%				6,851			
PTSD					19.0%				5,710			
People suffering from domestic abuse	21,897			1,986	10%				2,190		199	
People who have developed mental ill-health as a wider result of the pandemic (e.g. as a result of social and economic restrictions, media coverage and worry about becoming infected)	18% for anxiety; 11.1% for depression				21.63% for anxiety and 22.63% for depression							
Depression	9,804	9,087	79,019	10,816	19,987	18,527	161,099	22,051	10,183	9,439	82,080	11,235
Anxiety	15,898	14,736	128,139	17,539	19,104	17,708	153,980	21,076	3,206	2,972	25,841	3,537
People hospitalised	2,921											
Anxiety					30.04%				877			
Depression					33.20%				970			
PTSD					18.96%				554			
People with existing mental health conditions:												
Psychosis	2,057	2,377	9,512	3,072	10% relapse amongst known patients during first 6 months of pandemic				206	238	951	307
					20% relapse amongst known patients between 6-12 months of pandemic				411	475	1,902	614

Appendix 3

Figure 9

Renal example – the use of routine data to help reduce health inequality

A model for the collection of data by speciality services to help reduce health inequality has been developed with the Royal College of Physicians Health Inequalities group and Renal Research UK colleagues at Barts Hospital.

POPULATION CHARACTERISTIC	POTENTIAL METRICS / INDICATORS OF RENAL DISEASE AETIOLOGY AND HEALTH SERVICES HEALTH INEQUALITIES
<p>Analyse individual level patient data by:</p> <ul style="list-style-type: none"> • Deprivation quintile • Age <ul style="list-style-type: none"> • Children • Adults • Over 65 • Gender • BAME status • Severe mental illness • Intellectual disability • Other protected characteristics • Distance from district hospitals and specialist renal units 	<p>Prevention services</p> <ul style="list-style-type: none"> • Community rates of smoking, alcohol misuse, obesity • Rates of access to prevention services, including Diabetes Prevention Programme <p>Primary and community care</p> <ul style="list-style-type: none"> • Long-term condition consultation rates • Routine long-term condition management activity for CKD • GP recorded rates of smoking, alcohol misuse, obesity, hypertension, diabetes, established CKD <p>Secondary care</p> <p>Renal services:</p> <ul style="list-style-type: none"> • Rates for first and follow up appointments for renal services • DNA rates for first and follow up appointments for renal services • Rates of <ul style="list-style-type: none"> • Renal failure • Renal dialysis • Transplant
<p>Wider determinants</p>	<p>Rates of GP renal disease stage, renal failure/dialysis and deaths due to renal disease expressed as place-based statistics on education, economic markers, air quality, transport, wellbeing, housing and homelessness</p>
<p>Social and personal care</p>	<p>Access to renal services expressed in terms of levels of access to social care</p>
<p>Data should be expressed as numbers (to assist service planning) and as direct standardised rates (to allow comparison and benchmarking across time periods)</p>	

Royal College of Physicians

We hope you found
this briefing useful.
Your feedback
is very welcome –
please contact

leanora.volpe@nhsproviders.org

For more information:

www.nhsproviders.org/reducing-health-inequalities-associated-with-COVID-19

Suggested citation:

NHS Providers and The Provider Public Health Network (November 2020),
Reducing health inequalities associated with COVID-19: A framework for healthcare providers.