NHS Providers

REDUCING HEALTH INEQUALITIES

A guide for NHS trust board members

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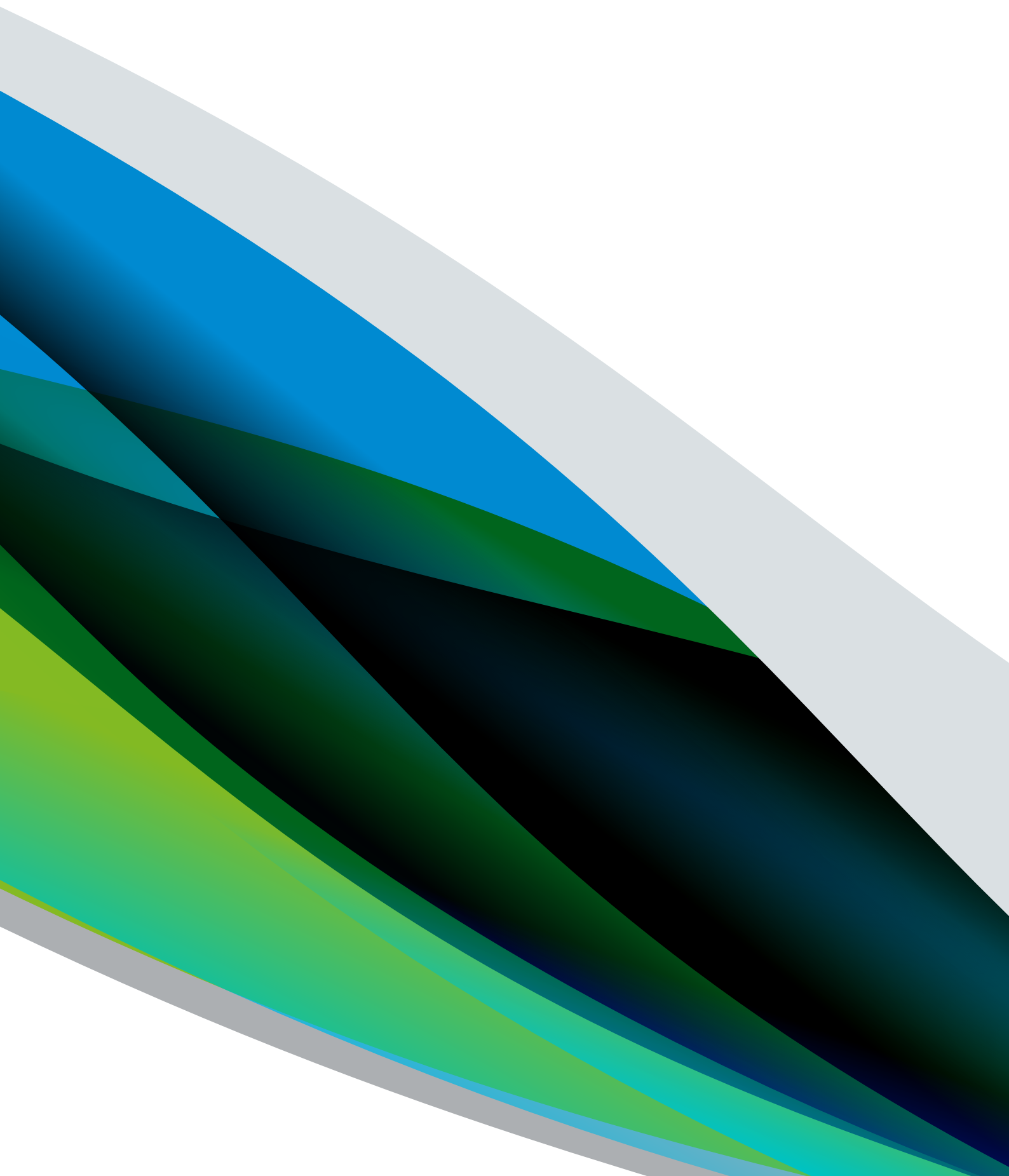

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INTRODUCTION

This is a practical guide to support NHS trust board members to address health inequalities as part of their core business. It outlines why trusts should act on health inequalities, includes a vision for what good looks like, a self-assessment tool for trusts to use to determine where they are in their journey and a list of suggested objectives for board members. It covers a wide range of trust work, from operational and clinical delivery of services, to the trust's role as an anchor institution and as an employer of NHS staff. The suggested objectives are drawn from NHS England (NHSE) policy, guidance, and good practice from the sector.

This guide is specifically designed for NHS trusts and does not cover the roles and responsibilities for addressing health inequalities at the wider system level. We recognise that tackling health inequalities often requires system-level solutions, by working in partnership with local authorities, integrated care systems (ICSs) and voluntary, community and social enterprise (VCSE) sector organisations. Collaborative working needs to be embedded across the work of NHS trusts to deliver on this agenda. Commissioners could also make use of the guide within planning discussions and are encouraged to share it with colleagues in trusts and wider systems.

WHY SHOULD TRUSTS ACT ON HEALTH INEQUALITIES?

2

Health inequalities are unjust and avoidable differences in people's health across the population and between specific groups. The need and desire to tackle health inequalities rose up the agenda in the wake of the Covid-19 pandemic as inequalities in health outcomes were laid bare. Data available within the healthcare system demonstrate stark inequalities for those from more deprived groups, from ethnic minorities, and for those with severe mental illness or learning disabilities, among others. Yet progress to reduce disparities has been slow in some areas and the role of NHS trusts in taking concerted action to reduce inequalities has not been clearly articulated. Though willing, NHS trust leaders may struggle to identify where to start as the nature of the topic itself covers so many elements and needs vary in different local areas.

The causes of health inequalities are complex, but research has shown that the main drivers of health inequalities are social determinants; the environments people live in, access to employment, the kind of start they had in life (Bibby, 2018). Inequalities are also driven by the ways in which health services are designed, delivered, funded, and by the quality of clinical care received. The NHS plays a role in both mitigating against the impact of the wider determinants and in reducing healthcare-based inequalities. Addressing health inequalities will improve the quality of clinical care, patient outcomes and safety.

NHS services can address health inequalities by:

1. Ensuring fair access, experience and outcomes across different groups in the population.
2. Acting as an anchor institution to support work on the wider determinants of health (NHS Providers, 2023a).

As well as a moral and social responsibility, NHS trusts have a legal duty to consider health inequalities. They must have regard to the health and wellbeing of people and the quality of services provided to individuals, including in relation to inequalities (NHS Providers, 2022a). They must also describe the extent to which they have exercised their functions consistently with NHSE's views set out in the statement on information on inequalities (NHS England, 2023a). NHSE's leadership and competency framework for board members states that "promoting equality and inclusion, and reducing health and workforce inequalities" is one of six key leadership domains for trust boards (NHS England, 2024a).

Tackling inequalities in health and care is embedded in the Care Quality Commission's (CQC) 2021 strategy (CQC, 2021). Alongside the strategy, the CQC have published five equality objectives to support their role in addressing health inequalities (CQC, 2022). As an independent regulator, the CQC have stated they will take action if they identify examples of care not being good enough for people most likely to have difficulty in accessing care and people with poorer experiences of care. They encourage providers to actively seek out, listen and respond to these groups of people and will include this in their assessment frameworks.

There has been an increasing level of national government support and encouragement for the health sector to reduce health inequalities. The Department of Health and Social Care (DHSC) published the Major Conditions Strategy case for change and strategic framework in 2023, which outlines addressing health inequalities as an overarching aim across each of the priority areas (DHSC, 2023).

There is also an economic argument for addressing inequalities. In 2010 it was estimated that inequalities cost the NHS £5.5 billion annually and NHS treatment costs would be 15% lower if health inequalities were removed (Frontier Economics, 2010) – given the worsening inequalities over the intervening decade, we could realistically expect the financial cost to be even greater now. Tackling health inequalities leads to productivity and efficiency benefits for trusts, contributing to broader priorities such as reducing Did Not Attend (DNA) rates and high intensity use of emergency departments, as well as promoting inclusive elective recovery.

Health inequalities policy and guidance

In recent years, there has been a growth in guidance on the role of the NHS in addressing health inequalities, from NHSE and external organisations. Some of these provide statutory actions that trusts must take, while others are recommendations of good practice. As it is not always easy to keep on top of the various guidance documents pertaining to health inequalities, this guide aims to draw the various aspects together in one place. In the resources section we have provided a brief overview of each of these policy and guidance documents.

WHAT GOOD LOOKS LIKE FOR BOARDS ACTING ON HEALTH INEQUALITIES

3

Taking action to address health inequalities is an emerging priority for NHS trusts and we recognise that each trust will be at different stages of their development. In this section, we outline what good may look like for a trust that has embedded reducing health inequalities as core board business, to offer a vision to aspire to. From our work with trusts, we know that progress is achieved through leadership, enabling a strategic focus on inequalities, taking a data-driven approach, and is supported by public health expertise. We recognise that there are barriers preventing trusts from progressing, including ongoing operational and workforce pressures, lack of dedicated funding, limited access to data and the need for join up across systems. This vision for what good looks like is drawn from existing examples of good practice from trusts and we hope that the objectives in this guide will enable trusts to start embedding the reduction of health inequalities as core business.

Health inequalities – leadership

Appointing a board level executive lead for health inequalities is a requirement from NHSE, but this is just the first step in establishing leadership and accountability (NHS England, 2021a). The board has collective responsibility for championing and overseeing the reduction of health inequalities.

It is expected that the executive lead for health inequalities champions the agenda across the organisation and board-level discussions. Their role is to work with the board to establish a comprehensive governance structure for overseeing the trust's work and strategy on health inequalities. It is also expected that the executive lead is linked into broader system working on health inequalities, taking a proactive approach to collaborating with ICS and local authority colleagues, alongside VCSE and wider community organisations. The executive lead should be aware of regional and national work on health inequalities.

Addressing health inequalities should be viewed as part of core trust business and the board's leadership on this should foster a positive culture across the organisation. All executive and non-executive board members should take responsibility for the trust's work in reducing inequalities and feel confident talking about this work, in the same way that they would talk about finance, quality or governance. Executive directors should have specific objectives relating to health inequalities, as set out in this guide, which are supported by developing knowledge and skills through training.

Inequalities should be understood and considered across all aspects of the organisation and best practice should be shared and replicated across the trust. The trust might also consider being active in campaigning and advocacy around health inequalities and should consider its role as an anchor institution and the contribution it could make to the wider determinants of health.

3

Health inequalities – strategic focus

Where leadership provides oversight, accountability, and a culture of addressing health inequalities, strategic vision and direction provides a governance framework for delivering on commitments. Overall commitment to reducing health inequalities should be set out within the trust's organisational strategy and feature in all major trust strategies, recognising that this is core business for the trust.

The trust should develop a specific strategy or plan on health inequalities, which complements the trust-wide strategy. This should outline clear actions and outcome measures. The board should regularly review performance against the strategy, and progress should be publicly documented in the trust's annual report. Delivering the strategy should be a collective responsibility of the board, with oversight from the executive lead for health inequalities. Practical delivery plans and governance structures should be in place to support implementation. Health inequalities reporting should be firmly embedded in the governance structure, via committees that report into the board.

Health inequalities – analysis and interpretation of data

Trusts need the necessary systems and digital infrastructure in place to support enhanced data capture and reporting on health inequalities. Trusts could use electronic patient records (EPR), or equivalent systems, to capture relevant data on health outcomes, access and experience. EPRs should be optimised to support population health analysis and be well implemented to ensure that staff can use them effectively. They should use their digital, data and technology teams to provide organisational capacity on population health data recording, reporting and analysis. Data analysts need the relevant training to support their knowledge and understanding of population health.

Data should be routinely available by deprivation, age, ethnicity and other relevant protected characteristics, and clinical staff should have the knowledge and confidence to use data to better understand their services and address health inequalities. Frontline staff should also understand the importance of accurately collecting and recording demographic data. The organisation should be able to demonstrate marked progress in data quality and completion, especially around ethnicity recording. Training should be implemented where staff need to build skills in data capture and recording.

Health inequalities data should be routinely incorporated into trust board papers and reporting processes, with data broken down by inequality related characteristics (for example deprivation and ethnicity). Staff should also be able to access the data they need easily, to use these data to inform their clinical and operational decision-making. Accessible methods, such as health inequalities dashboards, should be available and understood

by staff. Clearly defined and outlined metrics or measures should be in place to monitor improvements. There should be the knowledge and experience required to translate the data into intelligence, to inform data-driven decision-making within board leadership.

Trust-level data could be enhanced by data-sharing among relevant wider system partners, such as primary care, ICSs, academia and local authorities, to better understand the broader population health needs and the intersection between health outcomes and the wider determinants of health. Trusts could also be engaged in health inequalities research to drive innovations in fairer service delivery. Trusts who are mature in this area should triangulate data from numerous sources, including qualitative data from communities and service users. Most importantly, they should have several examples, evidenced by their data, of how they reduced health inequalities across their services.

Health inequalities – building capacity through public health expertise

Some trusts have found that employing a healthcare public health team within the trust ensures dedicated resource on health inequalities, prevention, and health promotion. The team could be led by a public health consultant, bringing together public health analysts, registrars and other professionals with relevant expertise and skills. There should be opportunities for role development and progression within the public health team, with staff being encouraged to progress into senior leadership positions. Ideally, there could be public health representation within the board, either via executive directors and/or non-executive directors. The team should be sustainable in the long-term, supported by dedicated organisational funding.

The public health team could build capacity for the trust to take meaningful action on health inequalities and bring expertise in data analysis and interpretation to ensure that the trust is guided by understanding the needs of the local population and identifying the inequalities in care that exist. In addition, the public health team could work with clinical and operational teams to develop interventions, actions and quality improvement processes within the organisation. This could involve providing outreach services to teams to conduct health inequalities impact assessments. The public health team could also assist in identifying training needs among the workforce and potentially facilitating the training and learning for other staff members.

4 HOW TO USE THE GUIDE

This section outlines how trust boards should use the self-assessment tool and objectives in the guide to inform their work on health inequalities. The frequently asked questions section provides more detail on areas not covered here.

Self-assessment tool

We recognise that trusts are all at different stages of their work on health inequalities and selection of objectives within this guide will depend on levels of progress and maturity.

We recommend that trusts complete the self-assessment tool which has been externally developed to use alongside the guide. The tool contains 25 questions across four domains:

1. Building public health capacity and capability
2. Data, insight, evidence and evaluation
3. Strategic leadership and accountability
4. System partnerships

The tool will provide a score and maturity rating of the trust's position in each of these domains. The different levels of maturity are:

- not started
- emerging
- developing
- maturing
- thriving

Based on the question responses, and current level of maturity, a bespoke set of health inequalities objectives will be suggested within the self-assessment tool. The tool generates a report with question responses, scores and objectives which can be downloaded as a PDF for future reference.

What to do with your results

We recommend using the self-assessment report as a starting point for a board level discussion. The objectives are intended to be broad, rather than prescriptive, and the list of suggested objectives is not intended to be exhaustive. Trusts may wish to select additional and/or different objectives from the full list of objectives. Trusts may also consider adapting the objectives to ensure they are relevant to their local context and setting.

Trusts could consider translating the objectives into SMART actions to support effective delivery (specific, measurable, achievable, relevant, and time-bound). Board members should identify who is best suited to take forward each chosen objective, which could be used in the annual objective setting cycle. Board members are encouraged to set appropriate objectives for their reports to help cascade this work through their organisation.

4

Reviewing and reporting progress

The self-assessment exercise could be repeated annually, to provide trusts with a mechanism for benchmarking progress over time. The format of the self-assessment tool and objectives could be used as a template for consistent board reporting on health inequalities and trusts may choose to include the self-assessment results as part of their annual health inequalities reporting. The guide should be viewed as a long-term tool for trusts, acknowledging that different objectives will be implemented at different stages, depending on the progressing level of maturity of the trust.

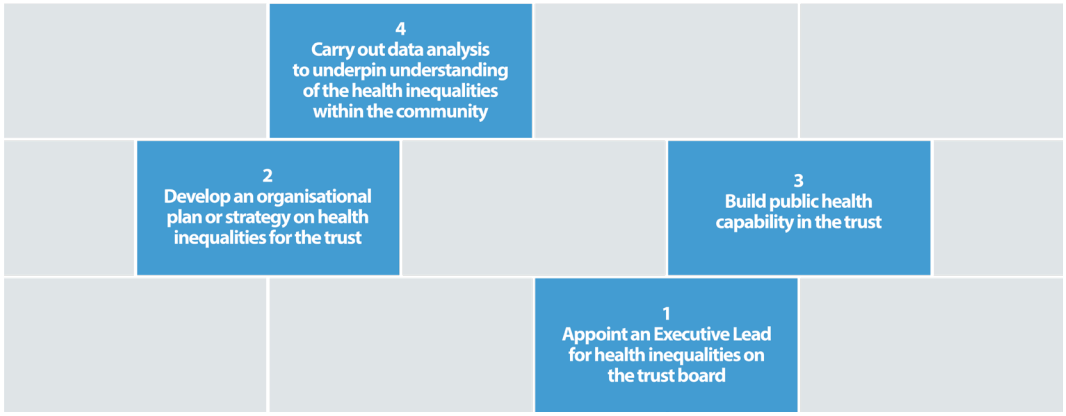
Priority objectives

The key building blocks for trusts starting work on health inequalities relate to strategic direction, action planning, understanding the needs of patients and local populations, and embedding public health capability within the trust's workforce. We have recommended key areas for action for all trusts to consider:

1. Appointing a board level executive lead for health inequalities is a requirement from NHSE (NHS England, 2021a) and therefore should be the first step for all trusts to ensure leadership and accountability (Objective 3.4).
2. Develop an organisational plan or strategy on health inequalities for the trust (Objective 6.1).
3. Build public health capability in the trust (Objectives 3.5 and 4.7).
4. Carry out data analysis to underpin understanding of the health inequalities within the communities the trust serves (Objectives 3.9 and 9.3).

Figure 1

The building blocks: priority objectives for emerging trusts



5 OBJECTIVES FOR TRUST BOARD MEMBERS

These objectives have been collated from relevant NHSE policy and guidance documents, alongside recommendations gathered from trusts that have notable experience in population health management and reducing health inequalities. They have been grouped into indicative areas of board-level responsibility, but this is not intended to be exhaustive or prescriptive. Board composition and executive portfolios vary across trusts, and it is recognised that there will be cross-over of areas of responsibility between different job roles. The guide reflects the unitary nature of trust boards, with objectives for both executive and non-executive board members.

Objectives related to sustainability and Equality, Diversity and Inclusion (EDI) have been included where there is an overlap with health inequalities. Other sustainability and EDI objectives are outside of the scope of this guide, though remain important areas for trust boards. We also recognise the overlap between prevention initiatives and reducing health inequalities but have kept prevention outside the scope of this guide.

The priority objectives for emerging trusts have been identified in **bold**.

1 Chair

1.1 Assure themselves that there is adequate strategic intent, relevant oversight (including clear governance approach and senior accountability) for addressing health inequalities.

1.2 Working alongside the chief executive, set specific health inequalities objective(s) for the chief executive.

2 Non-executive directors (NEDs)

2.1 NED membership and representation on relevant oversight committees within the trust governance structure with oversight for health inequalities work.

2.2 All NEDs to undertake baseline training on health inequalities, which is refreshed as needed and provided within the induction process for new NEDs.

2.3 All NEDs to seek opportunities for personal development on health inequalities.

3
Chief executive

3.1 Establish health inequality oversight within the trust governance structure.

3.2 Work with the strategy director and executive lead for health inequalities to include a commitment to reducing health inequalities in the trust's organisational strategy.

3.3 Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these.

3.4 **Identify an executive lead for health inequalities on the board.**

3.5 **Ensure the board receives annual training on health inequalities, with priority for the board member appointed as executive lead for health inequalities. Training should be refreshed, as relevant, and provided in induction processes.**

3.6 Set health inequalities objectives in annual objectives for all executive board members.

3.7 Ensure trust representation on appropriate Integrated Care System (ICS) group(s) (and other system level groups) to contribute to system wide decision making on population health and tackling health inequalities.

3.8 Ensure that executive board members, senior leaders (Band 9 and very senior managers) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities – this could include through appraisal processes.

3.9 **Set an expectation on executive board members to routinely report to the board on performance and outcomes data broken down by relevant characteristics (where available), such as ethnicity and deprivation.**

3.10 Include equality and health inequalities related impacts and risks in board and committee papers (including minutes), alongside actions for how they will be mitigated and managed.

3.11 Engage the company secretary to ensure that the board agenda framework includes regular oversight on health inequalities.

3.12 Identify a trust lead for digital inclusion and provide supporting governance.

4
Executive lead for health inequalities

4.1 Provide strategic oversight of organisational health inequalities work and encourage other executive board members to embed an equity lens to their work programmes.

4.2 Ensure integrated working with HR and equality, diversity and inclusion (EDI) executive leads to achieve strategic alignment for workforce EDI and tackling inequality.

4.3 Publish an annual health inequalities report and/or update for the board.

4.4 Lead development of a trust level strategy or delivery plan for health inequalities, working with the strategy director, which sets out a workplan and measures of success.

4.5 Establish a working group(s), steering group(s) or committee(s) to coordinate the organisation's work on health inequalities.

4.6 Provide executive oversight of external reporting on the trust's health inequalities work.

4.7 **Develop in-house public health capacity and capability to support the delivery health inequalities work.**

4.8 Work collaboratively with senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems.

4.9 Embed the use of tools such as the health equity assessment tool across your organisation when making decisions about service delivery.

4.10 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 and establishing learning networks or communities of interest for health inequalities.

4.11 Work collaboratively with executive board members leading on the organisation's anchor institutions work, to ensure alignment with the health inequalities agenda.

4.12 Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations.

4.13 Ensure the equality impact assessment process takes into account existing health inequalities in the population and provides assurance that service developments will not exacerbate these, and where possible they will aim to reduce them. There should be specific consideration to those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups.

5
People – including HR directors and people directors

5.1 Ensure all staff have training and development opportunities in health inequalities, with priority for induction programmes and leadership and development programmes. Training should be refreshed, as relevant.

5.2 Ensure all frontline staff have training and development opportunities in 'Making Every Contact Count'. Training should be refreshed, as relevant.

5.3 Establish programmes to improve access to employment for those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups in your trust.

5.4 Maximise use of the apprenticeship levy to improve pathways into employment, either internally for existing staff or externally targeting groups from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups.

5.5 Establish mechanisms to support staff from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups with leadership development opportunities to ensure adequate representation across the organisation.

5.6 Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles.

5.7 Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed, as relevant.

5.8 Work in collaboration with the executive lead for health inequalities to understand and address health inequalities experienced by staff.

5.9 Consult with staff to provide appropriate support initiatives to address health inequalities in the workforce. This could include offering access to staff networks and peer support opportunities, employee wellbeing assistance, financial support services and/or food banks for staff.

6 Strategy

6.1 **Work with the chief executive and executive lead for health inequalities to include a commitment to reducing health inequalities in the trust's organisational strategy, which reflects national and system requirements alongside local need.**

6.2 Embed an equity lens across all organisational priorities, strategic documents and annual planning processes.

6.3 Ensure the trust's work programme for reducing health inequalities includes engagement and co-production with local communities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms.

6.4 Develop a strategic focus on the trust's role as an anchor institution, considering employment opportunities, organisational supply chains, supporting local housing and access to green spaces.

6.5 Work in collaboration with the executive lead for health inequalities, people and estates teams, amongst others, to deliver anchor institutions work.

7 Finance

7.1 Embed health inequalities as part of financial decision making in the trust – including pathway review and design, business case approval and cost improvement programmes.

7.2 Work with commissioners and external organisations to identify funding opportunities for health inequalities initiatives.

7.3 Ensure opportunities are identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits.

7.4 Purchase supplies and services from organisations that embed social value to make positive environmental, social and economic impacts.

7.5 Procure goods and services locally (within the catchment area of the trust) to boost local economies and reduce inequalities.

8
Operations / delivery

8.1 Identify divisional, below-board level, health inequalities lead(s) to drive the agenda at site and/or service level.

8.2 Ensure a trust wide focus on inclusive recovery and operational improvement through an equity lens.

8.3 Establish a culture of data reporting among staff on health inequalities outcomes, and on the impact of health inequality initiatives.

8.4 Consider staff training to enable staff to feel confident in asking questions around demographic characteristics, such as ethnicity. Training should be refreshed, as relevant.

8.5 Ensure that care pathways are reviewed to consider the extent to which they enable equitable access, experience, and outcomes. Transformation and quality improvement approaches should aim to reduce inequalities.

8.6 Enable services to embed co-production principles to inform work on health inequalities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms.

8.7 Ensure that services prioritise equity of access, experience and outcomes for the most deprived 20% of the population, inclusion health groups, those with protected characteristics (and other relevant 'PLUS' groups) as per 'Core20PLUS5' (NHS England, 2021b; NHS England, 2022a).

8.8 Work with the communications lead to review trust communications with patients (such as leaflets and letters) in response to the health literacy and digital literacy levels of your patient population. Refresh and update communications accordingly.

8.9 Integrate equality impact assessment tools across clinical delivery.

9 Data, digital and information

9.1 Respond to the data indicators set out in the statement on information on health inequalities within annual reports, ideally setting out plans on how to improve outcomes in areas identified (NHS England, 2023a).

9.2 Datasets (including patient experience, patient safety, operational and clinical measures) to be broken down as a minimum by ethnicity, deprivation, age and sex. Where available, data on other protected characteristics and inclusion health groups could be considered.

9.3 **Assess the baseline and set targets to improve data reporting by ethnicity, deprivation and protected characteristics.**

9.4 Set local metrics to monitor progress over time and ensure these are available in a timely manner to monitor services and support timely decision-making to ensure equity.

9.5 Build in-house capacity and capability for analytical work, including investment in digital, data and technology teams.

9.6 Consider how digital technology, such as electronic patient record systems, could be used to support health inequalities decision making.

9.7 Review relevant data sources to inform the strategic development of health inequalities measures, such as Joint Strategic Needs Assessments (JSNA), OHID's fingertips and trust catchment area tools.

9.8 Engage with regional/ICS population health analytics teams, and local authority public health teams to make use of existing population health data and support whole system approaches to tackling health inequalities. Where possible consider data sharing agreements and interoperability with local systems.

9.9 Collect qualitative data through engagement with population groups to incorporate patient's views into health inequalities work (such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups).

10
Clinical, quality and research – including medical directors and nursing directors

10.1 Support the delivery of quality improvement work or change programmes related to health inequalities.

10.2 Apply a health inequalities framework across quality improvement and research work, to ensure that systems and programmes do not exacerbate or perpetuate inequalities.

10.3 Maximise research assets and expertise to develop programmes of work which have the potential to reduce health inequalities.

10.4 Include reference to health inequalities within all pillars of clinical governance (e.g. patient safety, audit), including learning for individual cases and overarching themes relating to health inequalities.

10.5 Work with research partners and in partnership with other NHS organisations to ensure participation in relevant research related to health inequalities, to develop an evidence-base on the effectiveness of provider led interventions to tackle inequalities.

10.6 Build in-house capacity and capability for health inequalities research work.

10.7 Review trust data on the five clinical priorities from 'Core20PLUS5' to inform the development of specific work programmes in these areas (NHS England, 2021b; NHS England, 2022a).

10.8 Use available data and insights to identify the most deprived 20% of the population and agree 'PLUS' groups within the 'Core20PLUS5' framework on which the trust will focus (NHS England, 2021b; NHS England, 2022a).

10.9 Consider active case finding approaches to reduce health inequalities, such as hypertension case finding and early cancer diagnosis.

10.10 Evaluate the impact of trust initiatives to address health inequalities.

10.11 Engage with groups that may not be traditionally involved in research or quality improvement, such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups.

6 HEALTH INEQUALITIES RESOURCES FOR BOARDS

In recent years, there has been a growth in guidance on the role of the NHS in addressing health inequalities, from NHSE, CQC and external organisations. Some of these provide statutory actions that trusts must take, while others are recommendations of good practice. In this guide, we have collated actions relevant to health inequalities from within NHSE policy and guidance.

Policy and guidance documents

Operational planning guidance

In the first half of 2021/22 systems were asked to focus on five priority areas outlined in the NHSE priorities and operational planning guidance (NHS England, 2021a). These were distilled from the eight urgent actions outlined in guidance with respect to the 'phase 3' response to the Covid-19 pandemic.

The eight priority actions were refined into five priorities:

1. Restoring NHS services inclusively.
2. Mitigating against digital exclusion.
3. Ensuring datasets are complete and timely.
4. Accelerating preventative programmes.
5. Strengthening leadership and accountability.

These five priority actions on health inequalities should continue to be addressed by Integrated Care Boards (ICBs) currently. NHSE also states that trusts should have a nominated executive lead for health inequalities, while also implementing national initiatives such as Core20PLUS5.

The 2023/24 operational planning guidance states that ICBs and system partners should continue to address health inequalities and deliver on the Core20PLUS5 approach (NHS England, 2023b).

NHS Long Term Plan

Published in 2019, NHSE's Long Term Plan provides a ten year vision for NHS services, with actions and commitments required to provide "services fit for the future" (NHS England, 2019). The plan was developed by frontline NHS staff, patient groups and national experts. Chapter two of the plan sets out specific commitments to deliver "more action on prevention and health inequalities" – with a targeted focus on smoking, obesity, alcohol, air pollution, and anti-microbial resistance.

Core20PLUS5 for adults and children and young people

Core20PLUS5 is NHSE's approach to reducing healthcare inequalities at a national and system level (NHS England, 2021b). "Core20" represents the population living in the most deprived quintile identified by the Index of Multiple Deprivation (IMD). Nationally, this represents 20% of the population, but the proportion will vary depending on the catchment area of the trust. 'PLUS' represents population groups who are at risk of social exclusion, such as inclusion health groups, and others sharing protected characteristics – this may include people experiencing homelessness, people with learning disabilities and people who may have language/communication barriers. 'PLUS' groups should be defined locally, according to need. Lastly, '5' represents five clinical priorities that require accelerated improvement. For adults these are: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and cardiovascular disease prevention. For children and young people the five clinical priorities are: asthma, diabetes, epilepsy, oral health and mental health (NHS England, 2022a). The five clinical priority areas guide clinical focus, but the 'Core20' and 'PLUS' elements can be applied to all clinical areas.

There are specific clinical targets that ICBs are expected to reach as part of the Core20PLUS5 approach. ICBs are encouraged to create Core20PLUS5 Ambassador roles to embed the framework locally.

Statement on information on health inequalities

NHSE's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) sets out the powers available to trusts around data, provides a list of data indicators that trusts will be expected to report on, and identifies opportunities for how trusts could make use of these data (NHS England, 2023a). The purpose of the statement is to help trusts and ICBs to identify key data and information on health inequalities and outline how they have responded to this information within their annual reports.

NHSE requires foundation trusts to include information on the extent to which it has exercised its functions consistent with the statement within their 2023/24 annual report (NHS England, 2024b) and this expectation will continue on an annual basis. It is expected that the legal duty on trusts to include information on health inequalities within their annual reports will encourage better quality data, increase transparency, and provide a tool to monitor improvements in reducing inequalities.

The statement prioritises a small number of data indicators and a limited number of expectations on how the information should be used – so as not to place a high demand on NHS bodies. These indicators are:

- Aligned to NHSE's five priority areas for addressing healthcare inequalities set out in the operational planning guidance and Core20PLUS5.
- Already available on existing dashboards (or will be within the timeframe of the statement).
- To be disaggregated by a limited number of variables (age, sex, deprivation and ethnicity), where available.

Our NHS Providers briefing on the statement provides more information on the data indicators that trusts are expected to respond to in their annual reports (NHS Providers, 2023b).

Long Term Workforce Plan

The NHS is one of the largest global employers. NHSE's long term workforce plan, released in 2023, sets out a strategy to grow, retain and reform the workforce over the next 15 years (NHS England, 2023c). This includes plans to:

- Increase the specialist public health workforce by 13%.
- Embed public health core skills and knowledge across the wider NHS workforce.
- Equip the NHS workforce with the right skills and knowledge to shift care towards prevention and early intervention.

The plan recognises the pivotal role of frontline staff, who engage in over a million patient interactions daily. Specific training goals involve enhancing capabilities in Making Every Contact Count (MECC), smoking cessation, the use of screening tools, and the recognition and care of individuals with co-occurring mental health and substance use conditions. Collaboration with local authorities and the promotion of relevant e-learning modules are crucial elements in achieving these workforce development objectives.

Equality, Diversity and Inclusion Improvement Plan

NHSE's equality, diversity, and inclusion (EDI) improvement plan was published in 2023 (NHS England, 2023d). The aim of this plan is to improve EDI and to enhance the sense of belonging for NHS staff to improve their experience. The improvement plan identified six high impact actions for trusts, two of which are particularly relevant for this guide:

- Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
- Develop and implement an improvement plan to address health inequalities within the workforce.

6

Equality Delivery System

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments (NHS England, 2022b), while meeting the requirements of the Equality Act 2010 (UK Gov, 2010). The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice. An updated version of EDS was developed in 2023, which aligns with the NHS Long Term Plan and implementation is mandated for providers through the NHS standard contract (NHS England, 2023e).

The EDS consists of 11 outcomes organised into three domains:

- Domain 1 – Commissioned or provided services.
- Domain 2 – Workforce health and wellbeing.
- Domain 3 – Inclusive leadership.

Actions within the EDS related to health inequalities have been included in this guide, but actions related to workforce have not.

Inclusion health framework

Inclusion health is an umbrella term to describe socially excluded groups, including:

- People who experience homelessness.
- People with drug and alcohol dependence.
- Vulnerable migrants and refugees.
- Gypsy, Roma, and Traveller communities.
- People in contact with the justice system.
- Victims of modern slavery.
- Sex workers.

Social exclusion involves extreme inequality and multiple interacting risk factors for poor health. Although there is limited data collection obtained regarding inclusion health groups, existing national evidence identifies various barriers in accessing healthcare services and multiple risk factors resulting in poorer health.

NHSE's inclusion health framework, published in 2023, sets out action on inclusion health across the system (NHS England, 2023f). The key action for trusts is to ensure inclusion health groups can access the best possible healthcare.

Digital inclusion framework

The adoption of digital technologies by both patients and staff has significantly increased over the last few years, however the benefits are not yet accessible for everyone. Digital exclusion can compound health inequalities by exacerbating challenges with access to healthcare, skills and capability to navigate and use services, and the general resources needed to lead a healthy life.

NHSE's digital inclusion framework, published in 2023, identifies the following groups as being at higher risk of digital exclusion (NHS England, 2023g):

- Older people, especially people over 75 years old.
- People in more socio-economically disadvantaged groups, such as people that have lower incomes or who are unemployed.
- Inclusion health groups.
- Disabled people and people with life-impacting conditions.
- People living in areas with inadequate broadband and mobile data coverage – more likely in rural and coastal areas.
- People less fluent in understanding the English language.

The key action for trusts is to consider and take steps to address the digital barriers to healthcare that some groups of people may face.

Advancing mental health equalities strategy

NHSE's advancing mental health equalities strategy aims to provide systems and trusts with the tools they need to address inequalities in mental health services (NHS England, 2020). The strategy highlights actions and goals within the following areas:

- Supporting local health systems.
- Data and information.
- Workforce.

Implementation of the strategy is overseen by the Advancing Mental Health Equalities Taskforce at NHSE.

Patient and Carer Race Equality Framework (PCREF)

NHSE rolled out the Patient and Carer Race Equality Framework (PCREF) as mandatory for all mental health trusts and service providers in 2023 (NHS England, 2023h). PCREF provides an anti-racism framework for trusts to co-produce actions that reduce racial inequalities within their services. The framework supports improvement in three main areas:

- Leadership and governance.
- Data.
- Feedback mechanisms.

This framework is applicable to mental health trusts only.

Anchors and social value

NHSE have collated guidance and resources for NHS services to fulfil their function as anchor institutions within their local communities (NHS England, 2021c). Anchor institutions are large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. NHS services can deliver their role as an anchor institution through:

- Widening access to quality work.
- Purchasing for social benefit.
- Using buildings and spaces to support communities.
- Reducing environmental impact.
- Working closely with communities and local partners.

UCL Partners have developed an anchor institution measurement toolkit for NHS trusts and their partners to assess their current level of anchor related activity, with examples and case studies of anchor measurement in action (UCL Partners, 2023).

Equality and Health Inequalities Impact Assessment

NHSE have provided a template Equality and Health Inequalities Impact Assessment for NHS trusts to complete and use within their own services (NHS England, 2022c).

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Health inequalities resources

There are numerous relevant health inequalities resources and documents developed by think tanks, third sector organisations and membership organisations, which provide useful recommendations on tackling health inequalities within NHS services. As the membership organisation for NHS trusts in England, our NHS Providers health inequalities support programme seeks to embed health inequalities as core business in trusts. The programme has developed the following relevant resources and recommendations for trusts:

- Reducing health inequalities faced by children and young people (NHS Providers, 2023c)
- Being an anchor institution: partnership approaches to improving population health (NHS Providers, 2023a)
- Tackling health inequalities with effective data and insight (NHS Providers, 2022b)

NHS Confederation is a membership organisation for healthcare systems in England, Wales and Northern Ireland. Their equality, diversity and inclusion (EDI) programme supports members to improve EDI accountability and leadership, tackling inequality through our EDI networks and partnerships. The Health Inequalities Leadership Framework board assurance tool is to assist board members in the assessment of any strategies or plans for their impact on health inequality (NHS Confederation, 2023). NHS Confederation have also published a toolkit for integrated care systems, to inform spending and embed action on health inequalities (NHS confederation, 2024).

The Association of Ambulance Chief Executives (AACE) represents and supports NHS ambulance services in the UK. Alongside NHSE, NHSP and other system partners, AACE published their consensus statement on health inequalities, outlining the role that ambulance trusts play (AACE, 2023).

The Office for Health Improvement and Disparities (OHID) have created a dashboard on trust catchment populations, to help trusts understand the needs of the populations that they serve (OHID, 2022). A large collection of public health data, including inequality tools, are available through the OHID fingertips profiles (OHID, 2024). OHID – formerly Public Health England – have also developed the Health Equity Assessment Tool which provides a structure to assess health inequalities in relation to programmes and services and supports professionals to take action to tackle inequalities (Public Health England, 2020). They have also published a population intervention triangle, which provides a framework for action to reduce health inequalities (Public Health England, 2021).

The Department of Health and Social Care have statutory guidance on the development of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which aim to reduce health inequalities and improve the health and wellbeing of local populations (Department of Health and Social Care, 2013).

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The National Institute for Clinical Excellence – formerly The Health Development Agency – produced a Health needs assessment at a glance, which provides a practical guide for services looking to undertake a health needs assessment (Health Development Agency, 2005).

The Provider Public Health Network, an independent forum of healthcare public health professionals, have developed a population health framework for healthcare providers in collaboration with NHS Providers (NHS Providers, 2019). The framework sets out principles for a population health approach, including actions around health inequalities and the wider determinants.

The specialty specific medical Royal Colleges also have dedicated resources relating to health inequalities that are useful for trusts to consider relating to the range of services they provide, specifically targeted towards different practitioner groups.

Contact information

NHS England National Healthcare Inequalities Improvement Team

The Healthcare Inequalities Improvement team supports trusts and systems with their approach to reducing healthcare inequalities, by focusing on the needs of the population to narrow inequalities.

Get in touch: england.healthinequalities@nhs.net

NHS Providers

Our Health Inequalities programme for trust boards aims to help trust leaders make sense of health inequalities and embed it as part of core business, with resources informed by our research and engagement with trust leaders, through webinars, briefings and peer learning events.

Get in touch: health.inequalities@nhsproviders.org

APPENDICES

Appendix one – Frequently asked questions

My trust is at the early stages of embedding health inequalities work and there are lots of objectives in this guide – where should we start?

We recognise that trusts will be at different stages. For trusts who are starting out with this work, we have recommended a small set of objectives to help build the foundations for reducing health inequalities.

How do these objectives relate to wider work in the NHS on quality improvement and reducing unnecessary variations in care?

Addressing inequalities is as a crucial part of the quality agenda and continuous improvement approaches should endeavour to take an equity lens. NHS Impact (Improving Patient Care Together) provides a single improvement approach to support providers to develop their strategy for continuous improvement (NHS England, 2023i).

There are several objectives related to health inequalities training, where can I access training tools?

Training events, resources, and tools on the topic of health inequalities are available nationally and we have outlined some options below, although this is not an exhaustive list. Trusts may also wish to consider training opportunities and resources that are available locally or regionally. Trusts could also seek to develop their own training resources that can be embedded within their organisational learning processes.

Training for clinicians and practitioners includes:

- eLearning for Health – Health inequalities training
- NHSE (formerly Health Education England) webpage on health inequalities
- NHS Leadership Academy course on tackling inequalities through population health management
- Royal College of General Practitioners – Health inequalities training

For training resources applicable to NHS board level, we recommend NHS Providers Health Inequalities programme for trust boards. The programme aims to help trust leaders make sense of health inequalities and embed it as part of core business, with resources informed by our research and engagement with trust leaders, through webinars, briefings and peer learning events.

NHS Confederation offer an EDI Directors programme, for strategic leaders delivering improvement through tackling inequity.

We also recommend exploring the Health Inequalities Improvement Programme section of NHS England's Futures NHS webpage, which brings together the latest information and resources relating to health inequalities. There are also networking and forum opportunities on the NHS Futures site.

My ICB has its own strategy for health inequalities, how does that relate to this guide?

Alongside these national documents, trusts are encouraged to review local and system level policies and resources to ensure that actions and strategies relating to health inequalities are aligned.

How often should the self-assessment tool be completed?

There are no requirements in relation to the self-assessment tool, it is a tool to inform where the trust could prioritise their actions on health inequalities. We recommend completing the self-assessment tool at appropriate intervals for the trust to monitor organisational progress (e.g. annually).

What happens to my data when I complete the self-assessment tool?

The self-assessment tool will not store any of your data and NHS Providers are not able to access your data. When you close your web-browser, any data entered will be erased. When you select 'download' a PDF document will be downloaded to your device, please download before exiting the tool. The PDF contains a unique link, when you click the link, the tool will re-generate your answers using a unique code. Your responses are not retained anywhere. You may share this as you choose.

I work in an ambulance trust, should I use the self-assessment tool recommended in this guide?

The Association of Ambulance Chief Executives (AACE) have a programme of work in place to support ambulance trusts in reducing health inequalities. As part of this, there is sector specific maturity matrix tool, which should be used by ambulance trusts to guide the choice of objectives from this guide. The questions in both self-assessment tools are similar.

Will the guide be updated?

NHS Providers will plan to update this guide on a regular basis, to incorporate any additional relevant guidance on health inequalities that are applicable to trust boards. If you have any comments or suggestions, please contact: health.inequalities@nhsproviders.org

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We collected feedback from trusts from a range of provider settings to ensure the guide is relevant to all sectors. We appreciate the expert recommendations and feedback from trusts that have shaped this guide.

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Interactive version

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www.nhsproviders.org/reducing-health-inequalities-a-guide-for-NHS-trust-board-members

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £115bn of annual expenditure and employing 1.4 million staff.

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