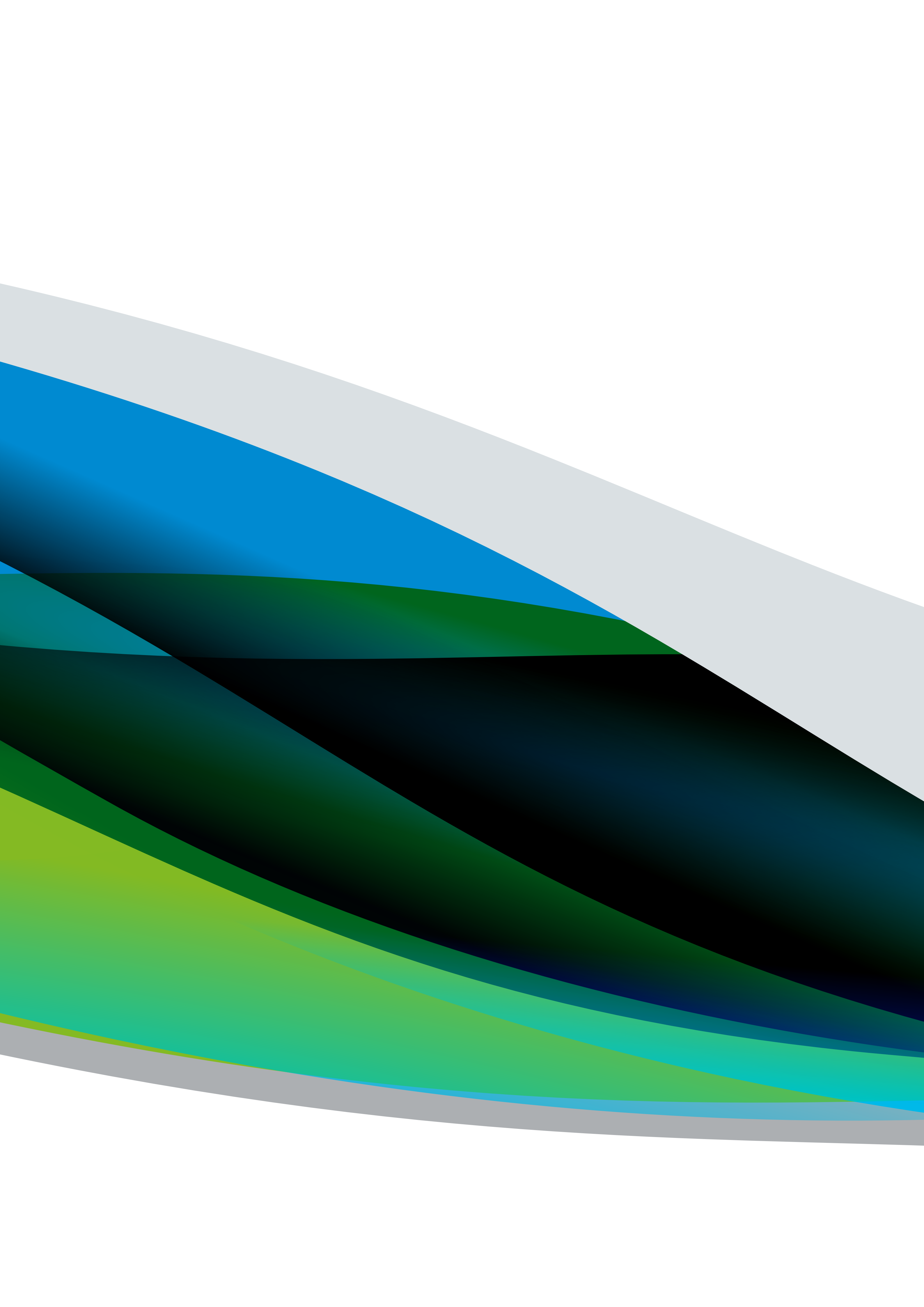
NHS Providers

UNITED AGAINST HEALTH INEQUALITIES

Moving in the right direction

MAY 2024



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KEY POINTS

- Since our last United against health inequalities report in 2022 (NHS Providers, 2022a), NHS trusts have taken strides in addressing health inequalities. They have made strategic commitments to act and have identified an executive lead on their boards to champion the agenda. Other common actions have included undertaking data analysis to understand trends by deprivation and ethnicity, and addressing inequalities within the workforce. But there remains much more to do.
- There is an opportunity for trusts to grow into a culture of business as usual in addressing health inequalities, by providing training in health inequalities, making more use of impact assessment tools, and utilising public health expertise in a more systematic way. There is also great potential for trusts to work closely with wider system partners and integrated care systems (ICSs) to develop and deliver on a shared vision for reducing health inequalities.
- Trusts have identified the main barriers preventing further progress as wider system pressures, operational challenges, lack of resource and financial constraints. Compared to three years ago they are now less likely to report data availability as a barrier, but data sharing/interoperability, ethnicity coding and lack of informatics and data analysis skills continue to limit what trusts can do with the data available on health inequalities.
- To shift the dial on health inequalities, trusts tell us they need both dedicated resource and investment and alignment on competing policy priorities. While NHSE policy and guidance relating to health inequalities is largely well known and applied among trusts, there is a lack of consistent messaging from the centre regarding the extent to which trusts should be prioritising this work. Trusts would welcome recurrent, protected, long-term funding streams for initiatives specific to improving health inequalities.
- There is a high level of confidence among trusts about their role as anchor institutions, particularly in improving access to employment opportunities and preventing inequalities among their workforce. They recognise there is scope for them to act on a wider range of issues that will have a positive impact on the local economy, such as via social value procurement opportunities, and to address challenges such as climate change.
- The NHS cannot resolve health inequalities alone. Only cross-government action to address the wider determinants of health will bring about real change. Shifting the dial requires action across all sectors that impact on the wider determinants of health – housing, education, local authorities, and the private sector. We need to build this into a model of care across government, making the NHS sustainable, and our national health and wealth prosper.

INTRODUCTION

1

Addressing health inequalities is vitally important for trusts in providing equitable access to services and ensuring patients receive the same level of care. The covid-19 pandemic sharpened policy attention on tackling health inequalities, including highlighting the role that the NHS could play. In January 2021, the National Healthcare Inequalities Improvement Programme (HiQiP) was established in NHS England (NHSE) to ensure equitable access to services and optimal patient experience and outcomes. Later that year, we surveyed trusts to gain an understanding of how trusts were responding to the shift towards a focus on health inequalities (NHS Providers, 2022a). We found that there were high levels of board commitment to tackling health inequalities, but that trusts were at different stages of rising to the challenge. In response, we launched our health inequalities programme to support boards in their role in reducing health inequalities.

Since then, evidence suggests that disparities continue to widen. Individuals living in the most deprived areas were more than twice as likely to wait for a year or more for their elective care treatment, in comparison to people in the least deprived areas in 2022 (Jeffries, 2023). They were also twice as likely to attend A&E in 2022/23 (NHS Digital, 2023). These inequalities in access are likely to have translated into poorer health outcomes for patients. For example, women living in the most deprived areas are twice as likely to die during pregnancy, compared to those in the least deprived areas, and Black women are four times as likely to die during pregnancy compared to white women (MMBRACE-UK, 2023). Recent data from the Office for National Statistics reveal declining rates of life expectancy in England (ONS, 2024), with deprivation associated with shorter life expectancy and less time spent in good health (Hiam et al, 2024).

There has been a positive increase in attempts to address inequalities within the NHS in recent years. The Health and Care Act 2022 ushered in a wave of reforms to the NHS, including new legislation for tackling health inequalities. The Act placed a legal duty on NHS bodies to have regard to health inequalities and to report on the extent to which they have met this duty each year (NHS Providers, 2022b). The Act also established integrated care systems (ICSs) as statutory bodies. Tackling health inequalities is central to NHSE's core aims for ICSs – including improving outcomes in population health, tackling inequalities in outcomes, experience and access, and supporting broader social and economic development (NHS England, 2021a). Expanding on this, NHSE have set out five strategic priorities for addressing inequalities, which have been carried through NHS operational planning guidance documents:

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.

There has been a growth in guidance on health inequalities from both NHSE and external organisations – including the Core20PLUS5 approach for reducing inequalities (NHS England, 2021b) and the statement on information on health inequalities (NHS England, 2023a). However, research has shown that the extent to which national policies have been successfully implemented locally has been variable and challenging for trusts and ICSs (Alderwick et al, 2024).

NHS services are facing huge operational pressures – including financial challenges, rising demand and ongoing industrial action – which limit the extent to which trusts can prioritise action on health inequalities. The cost-of-living crisis has also increased pressure on trusts and impacted people's health – in our 2022 survey, 95% of trust leaders reported that the crisis had worsened inequalities in their area and created significant challenges for NHS staff members (NHS Providers, 2022c).

Alongside this, government focus on tackling health inequalities has diluted over time. The Office for Health Improvement and Disparities (OHID) was established in 2021, following the restructure of Public Health England. At the time of launch, a key aim for OHID was to "*co-ordinate central and local government, the NHS and wider society to promote improvements in the public's health*", including working with partners inside of government to address the wider determinants of health (Foley et al, 2022). In 2022, the Levelling Up white paper outlined the government's commitments to addressing regional inequalities and committed to narrowing the gap in healthy life expectancy by 2030 (Department for Levelling Up, Housing and Communities, 2022). To meet this commitment, OHID was expected to publish a white paper on health disparities, which would enable the Department of Health and Social Care (DHSC) to "*work with the whole of government to consider health disparities at each stage at which they arise*" (Department for Levelling Up, Housing and Communities, 2022).

A dedicated, national plan on health inequalities did not come to fruition. Instead, action on health inequalities has been incorporated into DHSC's upcoming Major Conditions Strategy, which will be published in full later this year. The case for change and strategic framework – published in 2023 – outlined addressing health inequalities as an overarching aim across each of the priority areas, which are targeted at the health sector (DHSC, 2023). A cross-government plan for addressing health inequalities and the wider determinants of health would provide tangible steps to addressing the root causes of health inequalities, rather than short-term policy solutions that focus action within the NHS.

1

About our research

The themes in this report are informed by a recent survey of NHS trusts and ongoing conversations with trust executive leads for health inequalities (referred to as 'executive leads' in this report).

Our recent health inequalities survey provided an opportunity to reflect on the extent to which trusts have made progress in tackling health inequalities between 2021 and 2024. The survey was open between February and March 2024 and was designed for respondents to share their work on health inequalities, considering: approaches and actions taken, what is working well, barriers to progressing work, and the policy levers needed to enable trusts to take meaningful action. The survey was comprised of a mix of quantitative questions, and open text boxes.

We received 80 responses from 72 unique trusts, accounting for 33% of the provider sector (209 trusts in England). There were four respondents that had a position which covered two trusts. Of these responses, 34% were from Non-Executive Directors, 24% from chairs, 21% from chief executives, 4% from health inequalities specialists, and the remaining from other job categories. All regions and trust types – including acute, community, mental health and ambulance – were represented in the responses.

This report is also informed by conversations with NHS trust executive leads for health inequalities to capture rich qualitative insights. These conversations took place between August 2023 and March 2024. In total, we met with 39 individuals from 32 unique trusts – 24 of these people held board level roles within their organisation.

MOVING IN THE RIGHT DIRECTION

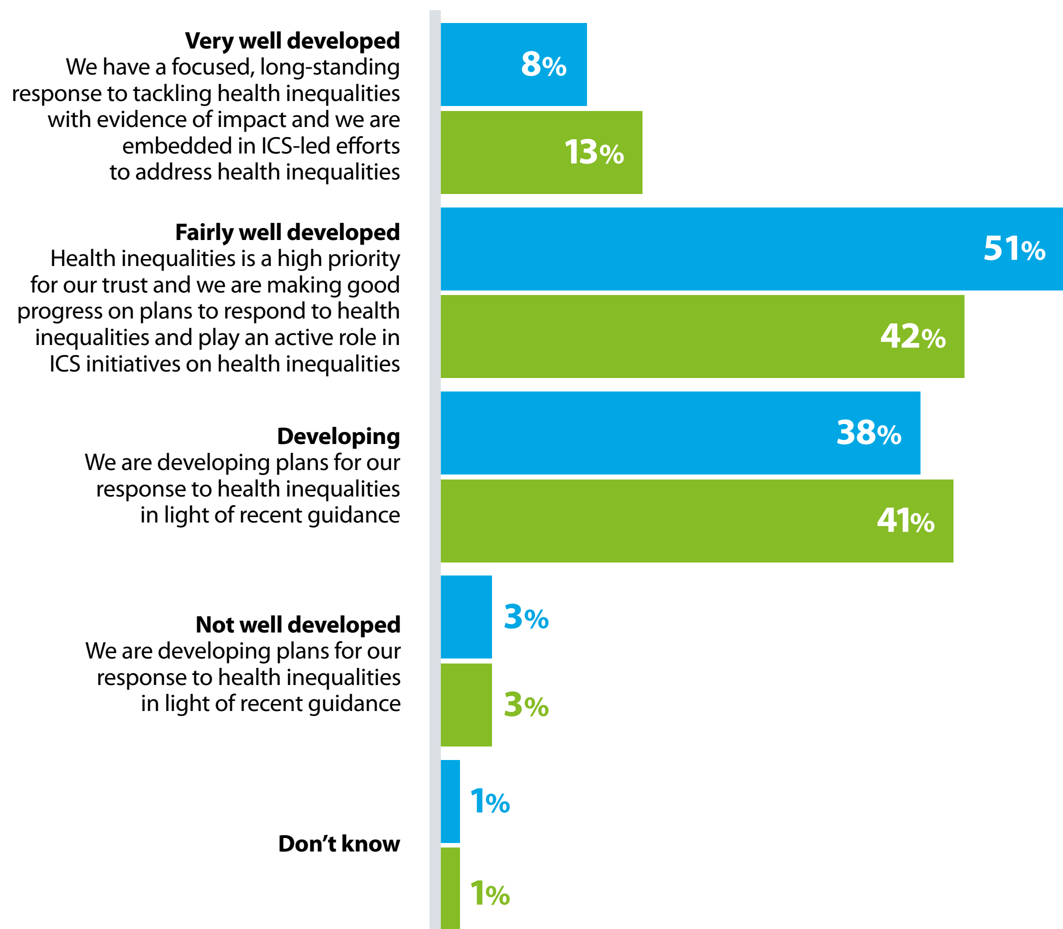
2

> *Things seem to be moving in the right direction... we need to do things differently and embed HI into our BAU work asap so it doesn't become another strand of things to do.*
>
> STRATEGY DIRECTOR, ACUTE TRUST

Our research looked at the extent to which trusts have made progress on tackling health inequalities in recent years. Findings show that there is considerable variation between the levels of progress trusts have made in acting on health inequalities. Action in this area began in earnest around two to three years ago, as health inequalities were prioritised in the wake of Covid-19. During that time frame, some trusts have developed strategies for addressing health inequalities, plans for operational delivery and metrics for measuring progress. While other trusts are at the start of their development journey and require more advice and guidance.

Figure 1

Overall, how would you describe your trust board's response to addressing health inequalities?



2

Over half of respondents (59%) said that their trust board's response is well developed (8% very well developed and 51% fairly well developed). There has been an increase in trusts reporting that their response is fairly well developed from 42% in 2021, to 51% in 2024 – indicating that more trusts are taking steps in the right direction. It is positive that the number of trusts reporting that their response to health inequalities is undeveloped has remained low (3%).

However, it is concerning that a lower proportion of respondents viewed their trust response to be 'very well developed', declining from 13% in 2021 to 8% in 2024. There also remains a considerable number of trusts in the developing stage (38%). These trends highlight the scale of the challenge of addressing health inequalities and that more support is required to translate board intent and strategic plans into action – without this there is a risk that inequalities may worsen over time.

Work is beginning in all areas but has to mature.

CHAIR, COMBINED MENTAL HEALTH/LEARNING DISABILITY AND COMMUNITY TRUST

Moving the culture of the organisation to more proactively focus on population health and inequalities is something that we are addressing but will take time to deliver, not least at board level.

CHIEF EXECUTIVE, COMBINED MENTAL HEALTH/LEARNING DISABILITY AND COMMUNITY TRUST

BARRIERS AND ENABLERS TO TACKLING HEALTH INEQUALITIES

3

The survey asked trusts to describe the barriers they face in addressing health inequalities. Figure 2 demonstrates the range of factors that can prevent trusts from taking action. However, if each of these obstacles could be overcome these would be enabling factors for achieving success.

The operational pressures trusts are facing have clearly had a stark impact on the ability of trusts to prioritise health inequalities. Close to three quarters of respondents (73%) selected 'wider system pressures and operational challenges', closely followed by 'lack of operational resource' (55%) and 'financial pressures' (53%). Each of these factors has increased in significance since the same question was asked in 2021. Another major barrier identified by trusts is 'lack of funding for health inequalities initiatives' (51%). This option was added to the survey in 2024 and we do not have comparative data for 2021, but it contributes to the broader picture of over-stretched demands on organisational finances.

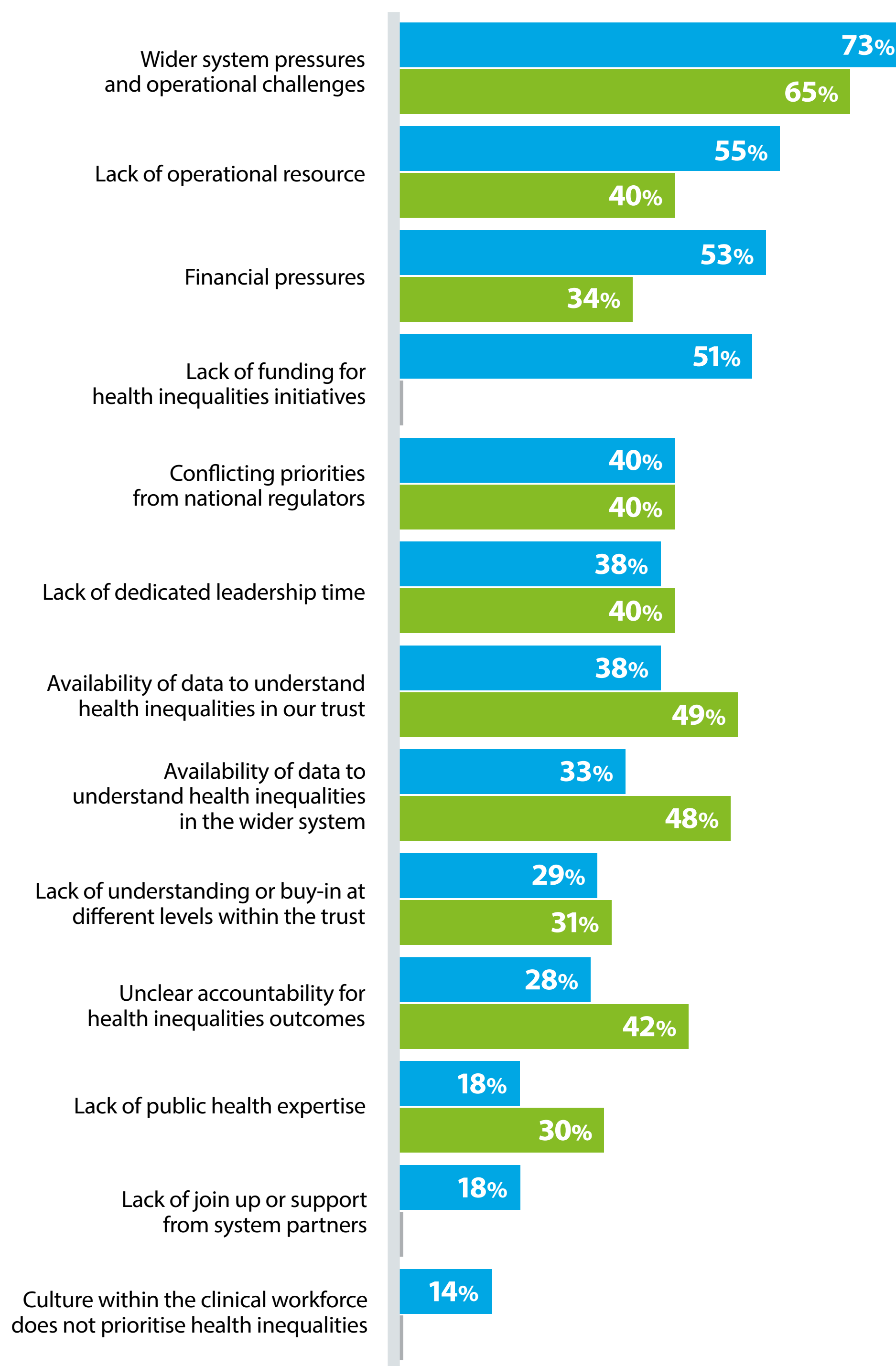
> *Sheer operational pressures of UEC, recruitment and retention and industrial action (it's been a killer).*
>
> CHAIR, ACUTE TRUST

Comparing the responses to this question between 2021 and 2024, we can see that improvements have been made to overcome some of these barriers. Both the availability of data at trust-level and system-level were major barriers for trusts in 2021 (49% and 48%), but these have now fallen and are less of a priority problem in 2024 (38% and 33%). Similarly, 'unclear accountability for health inequalities outcomes' was a barrier for 42% of respondents in 2021 and just 28% in 2024. 'Lack of public health expertise' was a barrier for 30% in 2021 and this has fallen to 18%. These results are heartening and demonstrate progress in key areas, but there remains more to be done to fully overcome these barriers.

3

Figure 2

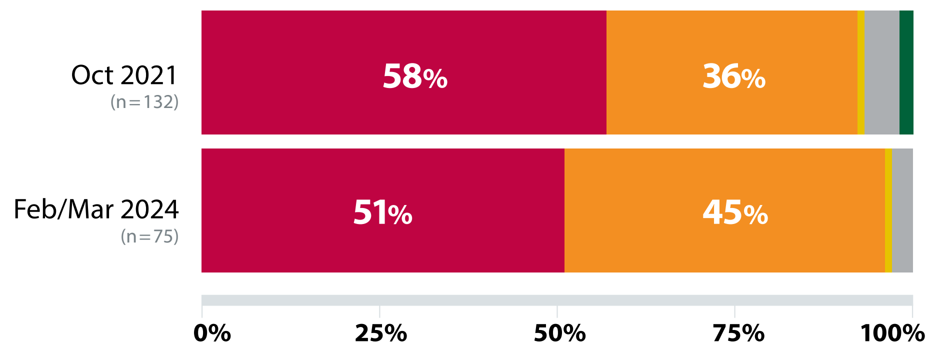
What are the greatest barriers to your board's ability to proactively address health inequalities? Please select all that apply.



The wider context and external environment have also exacerbated inequalities and impacted on the ability of trusts to effectively mitigate against diverging health outcomes during this period. Survey responses suggest that the knock-on impact of the cost-of-living crisis on health has stayed consistently high over time. In 2024, over half (51%) of respondents said that the cost-of-living crisis was 'significantly worsening' health, in comparison to 58% in 2022. This is directly impacting upon the way in which patients access healthcare services.

Figure 3

How do you believe that the cost of living crisis is affecting health in your local area?



It is disproportionately affecting areas of higher deprivation... "I can't afford to take time off work to see a doctor" is common. The gap in life expectancy between IMD Quintile 1 and 5 in our main town is widening between areas that are just a mile or two apart.

TRUST LEAD, ACUTE TRUST

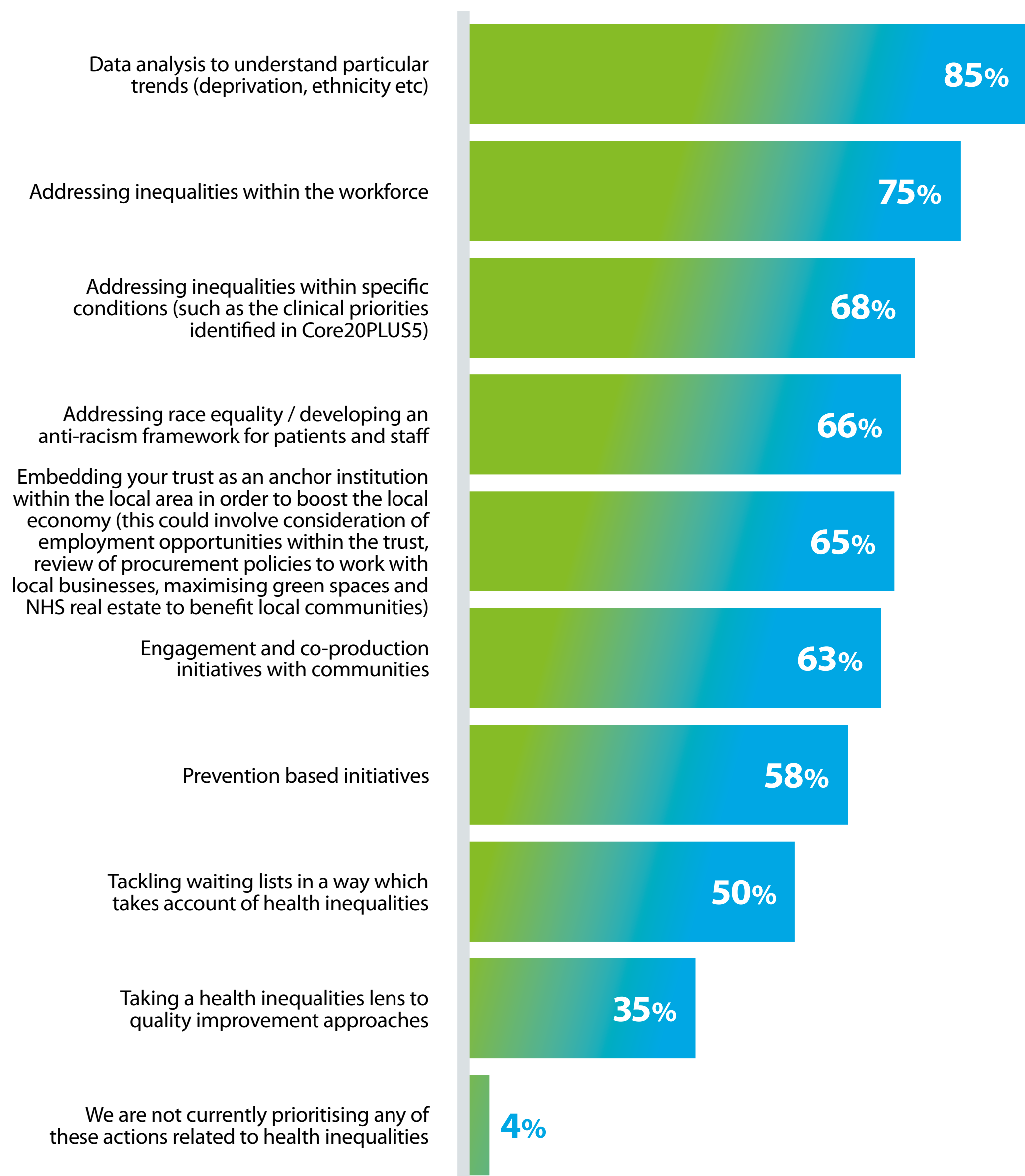
Identifying priorities

There is a large amount of variation in the approaches trusts are taking to address health inequalities, as action is needed across a range of different activities and areas, and the priorities for each trust will be dependent on the needs of its population. Identifying priorities is important for trusts to focus their attention on areas where they are likely to have a bigger impact in addressing inequalities within their local communities.

Figure 4

What areas of work has your organisation taken action on to address health inequalities? Please select all that apply.

(n=80)



Our survey asked respondents to identify the main areas of work their organisation has chosen to address health inequalities. The results show relatively high responses to each of the options – indicating the range and spread of activity in this area. The most common approach within trusts was 'data analysis to understand particular trends' (85%). Understanding data trends underpins much of the other activity, as it can highlight where trusts need to prioritise effort and action. 'Addressing inequalities within the workforce' (75%) and 'addressing inequalities within specific conditions' (68%) were also common areas of focus.

Sometimes there is a need to remind ourselves of the key priorities rather drowning in a very broad range of smaller initiatives.

DEPUTY CHIEF EXECUTIVE, ACUTE TRUST

Fewer respondents selected 'taking a health inequalities lens to quality improvement (QI) approaches' (35%) – suggesting that this approach is potentially not well embedded among trusts. This is perhaps reflective of the relatively new creation of NHS Impact, which represents the NHS's shared improvement approach, which may not yet be well understood across all trusts.

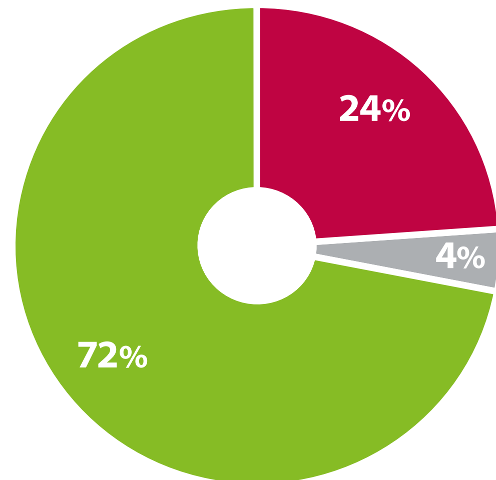
Inclusive recovery of NHS services was identified as one of the five strategic priorities for tackling health inequalities in the 2021/22 NHSE operational planning guidance. Systems were asked to identify inequalities in NHS performance by ethnicity and deprivation and to prioritise service delivery by taking these factors into account (NHS England, 2021c). Over time, however, national focus on inclusive recovery has declined, and while the latest 2023/24 planning guidance reiterates the call to deliver against the five priorities, it does not explicitly mention inclusive recovery or outline a specific objective on it (NHS England, 2024). Instead, the focus on elective recovery is on eliminating 65-week waits by September 2024, reducing the overall list size and improving productivity. It is therefore unsurprising that only half of respondents (50%) indicated that their trust is focusing on 'tackling waiting lists in a way which takes account of health inequalities'. Executive leads tell us that where this work is taking place, it is being targeted at specific services rather than taking a whole-organisation approach. Some trusts have also been reviewing cancellation and Did Not Attend (DNA) rates by deprivation and ethnicity to target interventions in reducing waiting lists.

A key component of NHSE's Core20PLUS5 framework for reducing health inequalities is identifying 'PLUS' groups that require targeted support and interventions (NHS England, 2021b). Our survey results found that nearly three quarters of respondents (72%) are prioritising their health inequalities work on improving outcomes for specific population groups. Over half of respondents said that they had prioritised by ethnic group. Other population groups that trusts are prioritising included homeless populations, asylum seekers and migrants, prisoners, LGBTQ+ communities and children and young people. Trusts are encouraged to understand their local need, through data analysis and interpretation, considering the full range of protected characteristics and inclusion health groups (NHS England, 2023c).

Figure 5

Has your inequalities work focused on improving outcomes for specific population groups (such as those with protected characteristics or inclusion health groups)?

(n=76)



> *Non-white ethnicity groups – disparities are evident across all of our services, and there is a significant intersection with deprivation.*
>
> DIRECTOR, ACUTE TRUST

> *People experiencing homelessness. Homelessness is a health and social care problem ... homeless patients attend A&E six times as often as housed people. They are admitted to hospital four times as often and stay twice as long. Numbers of people experiencing homelessness are rapidly increasing, and the number receiving enhanced primary care has increased by 90% over the past four years, from circa 720 to 1,300.*
>
> CONSULTANT IN PUBLIC HEALTH MEDICINE, ACUTE TRUST

Trusts identified that being selected as a pilot site for specific policies or guidance implementation successfully enabled the trust to dedicate attention and resource to the agenda. For example, one trust was piloting the Equality Delivery System and had developed a comprehensive action plan around this.

Employing public health consultants has supported some trusts to excel in the operational delivery of their health inequalities work. Healthcare public health professionals (both registrars and consultants) were recognised as having the right knowledge, expertise and skill set (especially in data analysis and interpretation). Whether trusts employed a public health workforce or not seems to separate out trusts that are developed or underdeveloped in the health inequalities space. Trusts with access to public health expertise stated the clear benefits of this staff group – one trust recommended that their main advice around health inequalities was to "*invest in public health*". However, employing public health colleagues is not widespread across all trusts. Some trusts we spoke to were looking to build their public health capacity but noted a lack of funding to resource public health consultants. There was little awareness of how trusts could offer training placements for public health registrars. Trusts are encouraged to work with public health colleagues in local authorities.

> *We have developed a public health consultant JD, which got the necessary approval last week. We are due to go out to recruitment. The plan is that this post holder will be key to moving this agenda forward in a considered and evidence based way.*
>
> CHIEF EXECUTIVE, MENTAL HEALTH/LEARNING DISABILITY TRUST

The scope and breadth of health inequalities work can in and of itself present a challenge for trusts in prioritising specific areas of work and determining a strategic direction of travel. While the 2024/25 planning guidance requires ICBs to publish joined up action plans to address health inequalities and implement the Core20PLUS5 approach (NHS England, 2024), publication of a national strategy on health inequalities, with a specific set of priorities, could meaningfully drive collective action, whilst also providing flexibility for trusts to respond to local need. A strategy would give trusts clarity on a core set of asks, that could be used to benchmark progress and guide accountability structures. We understand that NHSE is intending to publish a national health inequalities strategy later this year.

Leadership and accountability

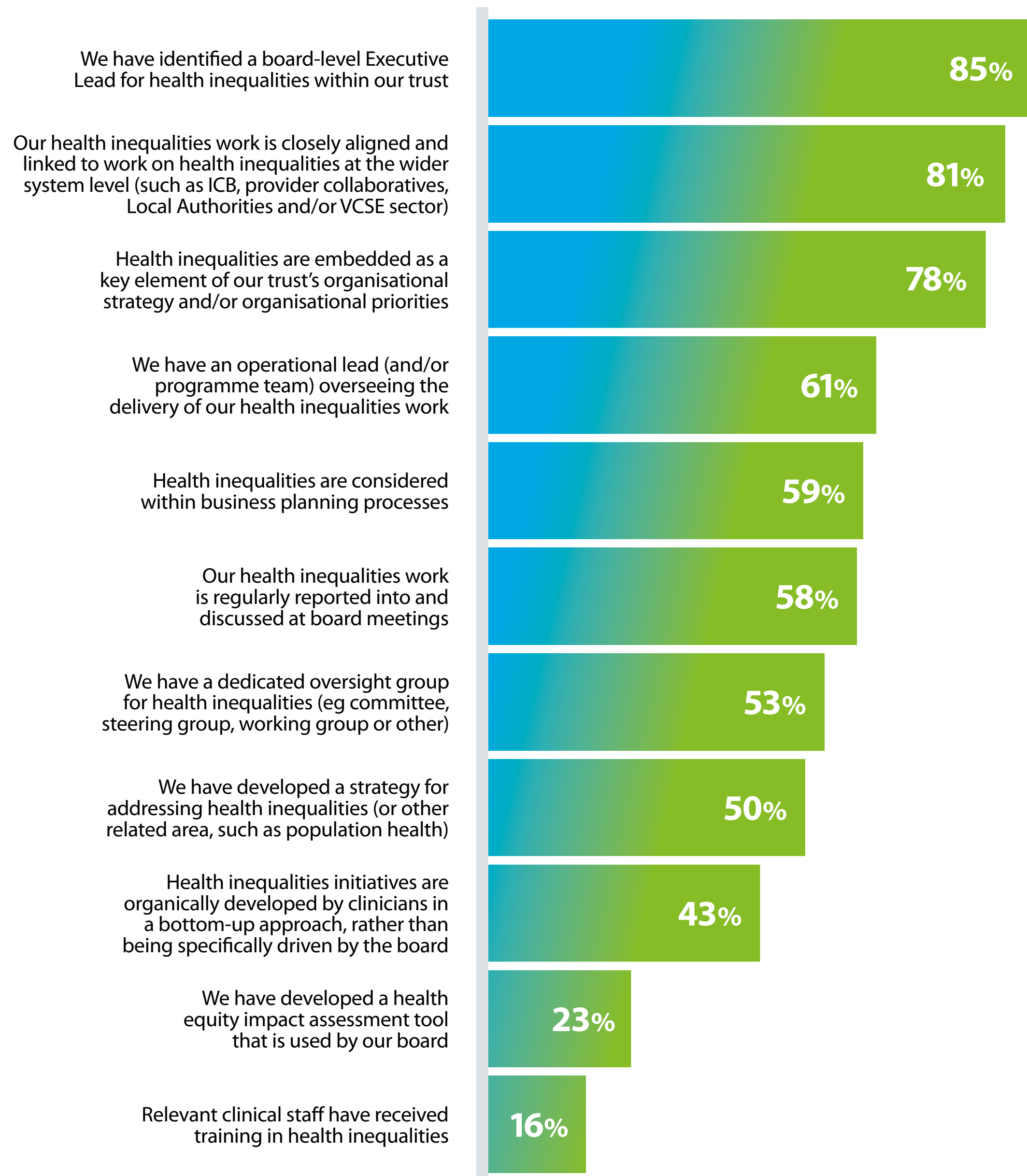
Our guide for NHS trust board members – *Reducing health inequalities* – sets out a vision for what good looks like for addressing health inequalities, alongside a set of actions for trusts to take (NHS Providers, 2024a). Leadership and strategy are key components of effective health inequalities action. In practice, this means appointing an executive lead for health inequalities within the board – which is a requirement from NHSE (NHS England, 2021c). It also involves establishing robust accountability mechanisms, outlining commitments within strategy documents and providing a governance framework to monitor delivery. This could include establishing health inequalities working groups or committees that report their progress into the board.

It is encouraging to see that the majority of trusts have board commitments and established internal structures to oversee their health inequalities work (Figure 6). The commitment is demonstrated through high responses to 'we have identified a board-level executive lead for health inequalities' (85%) and 'health inequalities are embedded as a key element of our trust's organisational strategy and/or organisational priorities' (78%). Feedback from executive leads highlighted that good practice involved reviewing data to inform the strategy development. Others have worked in partnership at place and system level to develop their strategy with wider system partners. The challenge noted for trusts relates to transforming strategy into action and implementation. A number of trusts reported a sense of feeling "*stuck*" in strategic mode, which involves lengthy discussions on long-term vision and aspirations rather than focusing on practical actions to address immediate concerns. It is important that trusts are enabled to transform their strategy into delivery by addressing the barriers that are set out in this report.

Figure 6

What approaches have you adopted to embed health inequalities (HI) within the work of your trust? Please select all that apply.

(n=80)



There were particularly low responses to 'relevant clinical staff have received training in health inequalities' (16%) and 'we have developed a health equity impact assessment tool that is used by our board' (23%) – without which, the ability to embed a culture of addressing health inequalities as business as usual will be limited.

Executive leads highlighted the beneficial role of steering groups and committees to manage and oversee the action plans and projects of work targeted at reducing health inequalities, which then report their work into the board. This was seen to be particularly effective where trusts have appointed a health inequalities team and/or project manager dedicated to embedding health inequalities across the organisation. However, survey results show that while this may be best practice, these actions are not widespread across all trusts – with only 53% of respondents reporting to have 'a dedicated oversight group for health inequalities'.

Health inequalities board reports six-monthly to board.

EXECUTIVE MEDICAL DIRECTOR, MENTAL HEALTH/LEARNING DISABILITY TRUST

Divisional areas of the business are developing local plans for reducing inequalities alongside organisational 10 priorities for tackling inequalities.

DIRECTOR, ACUTE TRUST

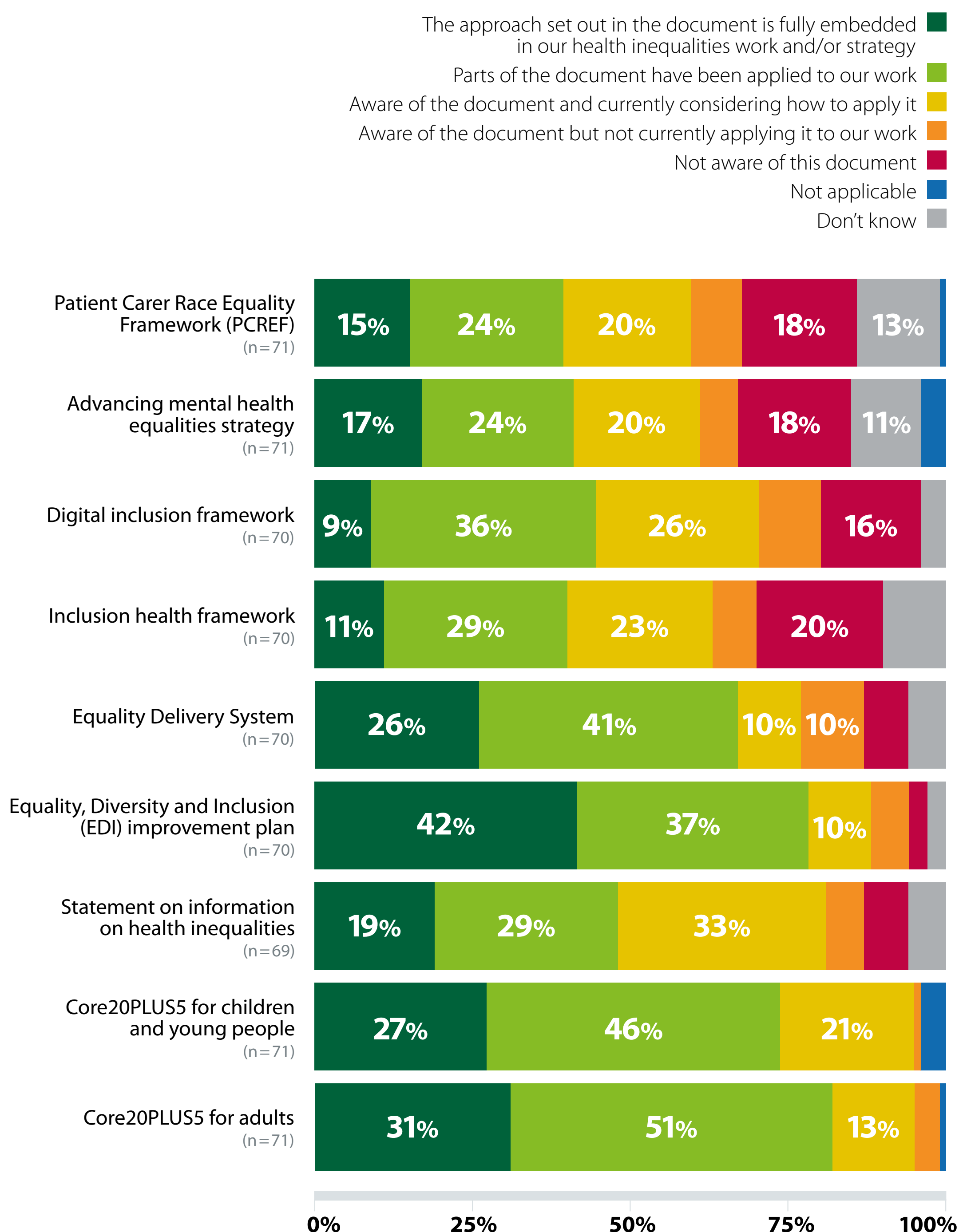
Understanding and application of national policy

In recent years, there has been a growth in guidance on the role of the NHS in addressing health inequalities, particularly from NHSE. In our guide for NHS trust board members – *Reducing health inequalities* – we have collated and summarised the key policy documents relevant to trusts (NHS Providers, 2024a). In our survey, we were keen to determine the extent to which these national policies have filtered down into local priorities for trusts.

Respondents were most likely to say that the Core20PLUS5 for adults was fully embedded or partly applied in their health inequalities work and/or strategy, with 82% of respondents selecting fully embedded (31%) or partly applied (51%) for this policy document. 74% of respondents stated that the Core20PLUS5 for children and young people was embedded. Core20PLUS5 is NHS England's framework for reducing health inequalities (NHS England, 2021b). It encourages NHS trusts and ICSs to prioritise attention on specific patient population groups and clinical areas. Feedback from executive leads suggests that Core20PLUS5 is well known and understood by the majority of trusts – most executive leads referenced that the framework shaped their health inequalities work, which has contributed to trusts taking a condition-specific approach to their work (Figure 4). However, some executive leads we spoke to from specialist providers felt that the five clinical areas were not applicable to them and there were suggestions for future versions of the framework to include rare diseases and other conditions where inequalities are known (such as sickle cell and HIV).

Figure 7

Over recent years, NHS England has published a range of policy and guidance documents to support NHS trusts and ICSs to take action on health inequalities. How is your trust applying each of these documents to your work?

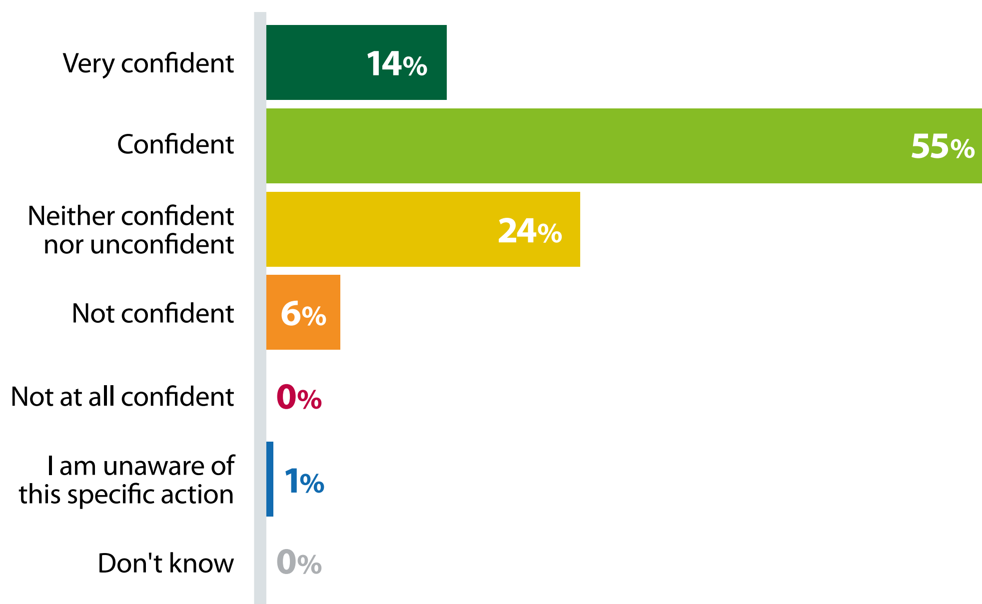


42% of respondents stated that NHSE's equality diversity and inclusion (EDI) improvement plan (NHS England, 2023b) was 'fully embedded in our health inequalities work and/or strategy'. The EDI improvement plan (NHS England, 2023b) sets a specific action for trusts to target inequalities within the workforce by April 2025. There are high levels of confidence among trust leaders that their organisation will be able to make progress on this action – with 14% of respondents very confident and 55% confident they will reduce inequalities within the NHS workforce. Also, an earlier survey question found that 75% of trusts are taking action on 'addressing inequalities within the workforce' (Figure 4). There were a range of approaches trusts are taking in this area – such as offering free Vitamin D supplements or access to smoking cessation services. Others were focused on improving staff wellbeing and mental health.

Figure 8

How confident are you that your organisation will be able to make progress on reducing inequalities within the NHS workforce?

(n=71)



The least well-known and embedded national policy documents among the survey respondents were the inclusion health framework (20% not aware), the advancing mental health equalities strategy (18% not aware), Patient Carer and Race Equality Framework (PCREF) (18% not aware) and the digital inclusion framework (16% not aware). PCREF, the digital inclusion framework and the inclusion health frameworks were all released in 2023 – it may take time before trusts are fully aware of and embedding these documents within their health inequalities work. Feedback from a small number of executive leads expressed a want and desire to do more work on digital inclusion specifically, identifying it as a current blind spot.

Both PCREF and the advancing mental health equalities strategy are applicable to mental health trusts, which may explain why the broader range of trusts involved in our survey were not aware of these. Looking at the responses from mental health trusts specifically, there are higher levels of awareness of these guidance documents. PCREF is 'fully embedded in our health inequalities work and/or strategy' within 39% of mental health trusts, compared to 15% of all trusts. Similarly, the advancing mental health equalities strategy, is 'fully embedded' in 43% of mental health trusts, compared to 17% of all trusts.

NHSE's statement on information on health inequalities expands on the legal duty on trusts to address health inequalities, by outlining a set of data indicators (broken down by factors such as deprivation and ethnicity) that trusts and systems are expected to monitor and report on annually (NHS England, 2023a). Only 19% of respondents said that it is 'fully embedded in our health inequalities work and/or strategy' – however, this is perhaps unsurprising since the statement was published towards the end of last year, leaving little time for review and implementation ahead of the annual reporting process. We welcome the value that the statement provides in standardising the approach for collecting, analysing and publishing information on health inequalities, providing a key set of indicators to measure progress in tackling health inequalities over time (NHS Providers, 2023a).

Trusts highlighted a tension and misalignment between the national guidance on health inequalities and other national policies and targets that prioritise action in other areas and may inadvertently exacerbate inequalities, such as those that prioritise performance and activity, rather than health outcomes and meeting the holistic needs of patients. This includes the inconsistent focus on inclusive recovery, as mentioned above, and shortening appointment times. Most trusts want to take a more proactive approach to their inequalities work but are limited in their capacity. Trusts need consistent messages from NHSE, from both national and regional teams, on the extent to which they should be prioritising this work. There is also a need for a longer-term approach to operational and financial planning that prioritises health inequalities and prevention.

> *Operations team are focused on reducing long waiters and backlogs. To them, addressing health inequalities could feel like an additional thing they need to do when they are struggling with workforce challenge, backlog, etc. The board recognises addressing health inequalities as a priority, but it is not yet as well integrated into existing governance structure and business planning as it could be. Contracts and performance targets measures processes (e.g. number of patients waiting under 52 weeks) rather than health outcomes.*
>
> PROGRAMME MANAGER, ACUTE TRUST

> *There is pressure on the delivery of financial balance and national activity targets. This does not always allow for consideration of actions that impact health inequalities in the short term and the medium term.*
>
> DIRECTOR AND DEPUTY DIRECTOR, ACUTE TRUST

Data

Access to accurate, timely data is a crucial step in developing a robust response to inequalities in access, experience and outcomes. It is an essential part of understanding how best to provide services that meet the needs of patients and communities that are more likely to experience marginalisation (NHS Providers, 2022d). It is imperative that all trusts are supported with data analysis and interpretation resource, expertise and capabilities to embed a focus on inequalities.

Our survey results show that trusts have made improvements in capturing and using data to harness action on health inequalities from 2021 to 2024. 85% of survey respondents in 2024 reported that they are undertaking 'data analysis to understand particular trends'

> *We are moving to having no narrative without data and no data without narrative. With this in mind we have been developing our data, looking at population health.*
>
> CHIEF EXECUTIVE, MENTAL HEALTH/LEARNING DISABILITY TRUST

> *We have data coming out of our ears about which groups of patients are suffering from the results of health inequity, but joining this up to the clinician on the ground, who is already incredibly busy is the issue.*
>
> MEDICAL DIRECTOR, COMMUNITY TRUST

Data provide the necessary evidence base for trusts to target their health inequalities interventions. We heard from trusts that have excelled in this area and developed metrics and data dashboards to monitor the impact of their health inequalities work.

Yet over a third of our survey respondents cite lack of data availability at both the trust and wider system level remains to be a barrier (Figure 2). Feedback from executive leads demonstrates the variation between where trusts are at. There was a general sense that trusts are more data rich than they were three years ago, but there is a way to go to ensure parity between trusts around data availability and use. Responses from trusts ranged from "*we have more than enough data on health inequalities*" to "*data is a significant challenge*". On average, most trusts fall within the middle, with many reporting that they are in a "data diving" type phase, which involves exploration of available data and attempts to analyse this by inequality measures.

Insight from executive leads shed light on what the specific issues with data are that trusts are grappling with. Regarding data availability, trusts flagged a lack of data relating to specific population groups that aren't routinely captured in healthcare datasets (particularly those that might fall into the category of 'PLUS' within the Core20PLUS5 framework). Other concerns related to lack of interoperable data systems to provide a comprehensive view of population health – with specific challenges around linking data between primary, secondary and community care. Trusts would welcome improved data infrastructure at the national level to manage data requests and linkage, particularly with

support for implementation of electronic patient records. Without good quality, joined up data sets, the aspirations to effectively track, measure, and make evidence-based decisions to reduce health inequalities cannot be realised.

There are specific problems around ethnicity data coding and reporting, which are related in some part to limited staff confidence in asking sensitive questions in busy clinical settings. Feedback highlighted that there are low levels of trust among certain ethnic minority communities, which can make asking for ethnicity data particularly challenging. Most trusts reported concerns around ethnicity data, with high levels of 'not stated' information in patient records. Trusts would welcome insights on good practice for ethnicity coding, such as through staff training and patient awareness campaigns.

> *Data – issues with incorporating Index of Multiple Deprivation score data into our wider datasets, meaning inequalities relating to deprivation are difficult to determine. Also issues with the reliability of ethnicity data. Issues around lack of available data in relation to 'Plus' groups. These issues could be overcome by having a standard minimum dataset that incorporated 'Plus' characteristics available nationally.*
>
> CONSULTANT IN PUBLIC HEALTH, ACUTE TRUST

> *By removing barriers to data-sharing across public services we can enrich intelligence for segmentation and predictive analytics to target preventative actions more effectively.*
>
> CHIEF EXECUTIVE, COMBINED MENTAL HEALTH/LEARNING DISABILITY AND COMMUNITY TRUST

For trusts that have access to data, separate challenges were raised in relation to lacking the skills and expertise to understand and interpret the data to take meaningful action. Feedback from executive leads highlighted the benefit and value of dedicated data teams or individual data leads to undertake health inequalities data analysis and interpretation. It was noted that existing data teams often do not have capacity or resource to focus on health inequalities due to pressures around existing data reporting requirements. Without dedicated technical skills and resource to deliver the work, trusts are lacking in their data capabilities. A national long-term digital workforce plan is expected to be published by NHSE this year, this should include plans to increase investment in digital, data and technology teams as well as improve digital and data analytic skills across the NHS workforce.

When trusts have access to a comprehensive data set, it does not tell the whole story in relation to health inequalities – highlighting the need to also engage with communities directly. We heard positive examples of trusts engaging directly within communities most likely to experience inequalities and voluntary, community and social enterprise (VCSE) partners to co-design and co-produce services. Our report *Co-production and engagement with communities as a solution to reducing health inequalities* provides case studies from trusts that have effectively embedded engagement methods within their trust (NHS Providers, 2024b).

> *The challenge is resource to disaggregate data – BI resource is limited and challenged with wider mandated functions.*
>
> HEAD OF STRATEGY AND PARTNERSHIPS, COMBINED MENTAL HEALTH/LEARNING DISABILITY AND COMMUNITY TRUST

Funding

Our survey results show that 'lack of funding for health inequalities initiatives' is a key barrier preventing trusts making progress in reducing health inequalities, selected by over half of respondents (51%). This factor is further compounded by broader financial pressures facing trusts – representing a barrier to taking action for 53% of trusts (Figure 2). In considering the solutions for enabling more work on inequalities, 72% of respondents said that 'improved funding streams to deliver health inequalities initiatives' would drive action (Figure 11). During our calls with executive leads, lack of funding and resource was raised by nearly all as the main barrier to making progress.

> *All projects have generally be done by re-allocating exiting resource or non-recurrent funds.*
>
> STRATEGY DIRECTOR, ACUTE TRUST

> *Addressing health inequality and inequity is a long term challenge, on top of an already challenged day-to-day health service. Whilst benefits, including financial, will be delivered, they are years away. Funding for this work has not found its way to our Trust, and if/when it does it will be subject to the usual short termism. We need specific long term recurring investment in this area to support plans that can be developed and funded over strategic timescales.*
>
> TRUST LEAD, ACUTE TRUST

Funding that trusts do receive for health inequalities was described as short-term, last minute, one-off, and typically externally funded (eg via third sector grants and research grants). This is a stark contrast to the nature of health inequalities, which are a long-term, complicated problem. The level of funding currently available does not match the scale of the challenge. In comparison, trusts would welcome permanent, protected, long-term funding streams. Despite NHSE providing an additional £200 million of ringfenced health inequalities funding for ICBs in 2022/23, which has now been made recurrent for 2023/24, we are aware that some systems have used this funding to support their bottom-line due to scale of their financial challenge, rather being in a position to protect it for specific health inequalities projects (Bagnall et al, 2024).

> *Core20plus5 money for the place was absorbed to fill budget deficits within the ICB.*
>
> PUBLIC HEALTH SPECIALIST, ACUTE TRUST

Where funding has been made available the processes for accessing it was noted as complex and time-consuming. Trusts are often expected to bring together multiple funding pots to piece together enough money to deliver a work programme. Collaborating with VCSE partners on health inequalities was also raised as a challenge, as partner organisations often have different funding and finance flows.

Some trusts are looking internally at how they can demonstrate an in-year return on investment for the inequalities work they deliver, to make the case for future investment.

System and partnership working

ICSs have a clear remit in improving outcomes in population health and tackling inequalities in outcomes, experiences, and access. There is a great potential for trusts to collaborate with their system partners to drive forward work on health inequalities. There is a sense from trusts that ICSs could provide an opportunity for providing overall strategic direction, alongside sharing good practice and facilitating collaborative working on joint health inequalities projects. However, rates of development and maturity vary between places, which has impacted on the extent to which ICSs have prioritised or focused on the topic of health inequalities. Trusts also recognised the value of working with other system partners on the health inequalities agenda, such as local authorities and VCSE organisations.

We asked trusts about their involvement in system approaches to reducing health inequalities, with the vast majority (61%) positively selecting that 'our ICS/s have a developed health inequalities plan and we are actively involved in delivering it'. In another survey question (Figure 6), 81% of respondents said that their 'health inequalities work is closely aligned and linked to work on health inequalities at the wider system level (such as ICBs and provider collaboratives)'.

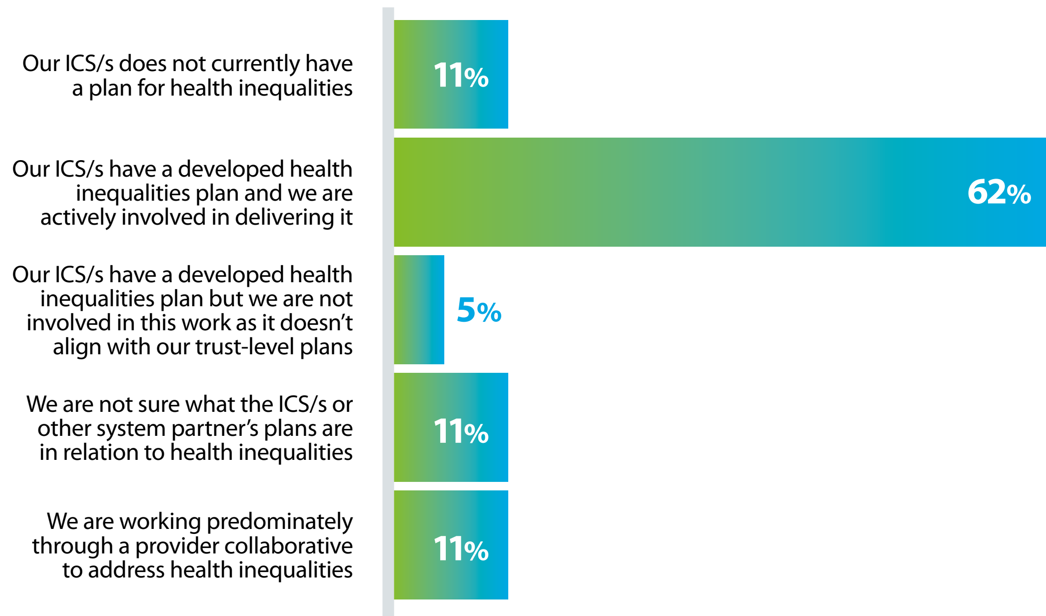
> *By aligning goals and priorities across ICS and Place, and across Places, we can achieve maximum impact for the population we serve. Mutual reinforcement of a smaller number of priorities would increase the focus of effort in our partnerships and the chance of improvement at a time when services are under considerable pressure.*
>
> CHIEF EXECUTIVE, COMBINED MENTAL HEALTH/LEARNING DISABILITY AND COMMUNITY TRUST

> *There is a need for system working but it is difficult to work across the system... this is improving but it is slower than we would like.*
>
> ASSOCIATE MEDICAL DIRECTOR, COMMUNITY TRUST

Figure 9

How would you best describe your system's approach to reducing health inequalities?

(n=74)



It is welcome to see that 11% of respondents are working through provider collaboratives to deliver their health inequalities work. Elsewhere, we have highlighted the benefits of working in these models around population health – see this case study from the West Yorkshire Mental Health, Learning Disabilities and Autism Collaborative.

However, Figure 9 shows that there are a large number of trusts (27%) that are not engaging with their system on health inequalities work – with 11% of respondents 'not sure what the ICS/s or other system partner's plans are in relation to health inequalities', a further 11% stating that 'our ICS/s does not currently have a plan for health inequalities', and 5% where the ICS has a health inequalities plan but the trust is not involved as it doesn't align with the trust's plans on health inequalities.

Feedback from our insight calls with executive leads provides a mixed picture on how well system working around health inequalities is going. Levels of maturity have impacted on the speed that ICSs have made progress on addressing health inequalities.

The main concern noted by trusts was around a lack of focus and unclear responsibility and accountability structures at system level. Trusts raised a need to clearly outline who within the system is best placed to lead on different aspects of reducing health inequalities.

For some, their ICB had not outlined what the role of providers was and for another the system-focus on health inequalities was aimed solely at primary care. In reality, this lack of join up has led to a sense of confusion, with providers 'doing their own thing', resulting in everyone doing different things and having to have repetitive conversations across the system.

> *The ICS is developing a strategy for health inequalities – the trust is slightly ahead of this and already has approved strategy and work programme.*
>
> STRATEGY DIRECTOR, ACUTE TRUST

> *System could better coordinate between different sectors and convene more – has a slightly scatter gun and uncoordinated approach.*
>
> CHIEF EXECUTIVE, COMBINED ACUTE AND COMMUNITY TRUST

Ambulance trusts noted sector specific problems relating to system working. They typically cover a broader geography and so are required to work with multiple ICBs, each of which are likely to be at different stages of development, not in communication with each other and operate with different commissioning and data sharing arrangements.

The requirement for ICBs to develop joined-up action plans to address health inequalities and implement the Core20PLUS5 approach is a welcome opportunity to streamline approaches and take a collaborative approach, with clear expectations for each part of the system (NHS England, 2024).

> *Trust has brought together key, partner organisations and fellow anchor institutions... These include public health representatives from the two local authorities; Higher Education Institutes (HEIs) – university and colleges; Healthwatch; Youth Zone; Local Constabulary; Voluntary, Community, Faith and Social Enterprise (VCFSE) sector; local Community Football Trusts amongst others. The group meet every six weeks to table and discuss health equity problems pertinent to the area. It is envisaged that by fostering strong community relationships, a wider health equity lens can be applied to specific projects that originate via the trust and vice versa.*
>
> DEPUTY DIRECTOR, ACUTE TRUST

ADDRESSING THE WIDER DETERMINANTS OF HEALTH

4

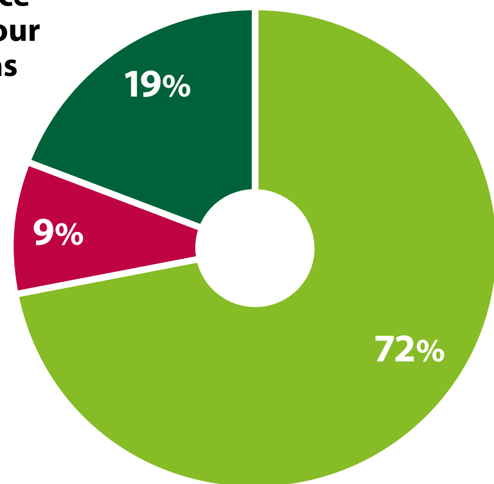
Research has shown that the main drivers of health inequalities are the wider determinants of health – the environment people live in, access to employment, and the kind of start they had in life (Bibby, 2018). Targeting action on the wider determinants of health is often considered out of the scope of NHS services and more naturally within the domain of national government and local authorities. However, through their role as anchor institutions, trusts can positively influence the local social, economic and environmental conditions for population health (NHS Providers, 2023b).

Trusts are overwhelmingly positive about their ability to influence the wider determinants of health in their area – with 72% of respondents reporting that they 'somewhat' influence these factors and a further 9% reporting they can influence 'to a great extent'. Clearly, there is more work to be done to shift the extent to which trusts feel they can have an influence.

Figure 10

To what extent are you able to influence the wider determinants of health in your area? This could include factors such as employment, education, housing, community engagement.

(n=74)



To a great extent
Somewhat
Very little

I meet the leaders of partner organisations every two months to discuss health inequalities and shared priorities. Our health inequalities strategy is explicit about our anchor institution responsibilities.

STRATEGY DIRECTOR, COMBINED ACUTE AND COMMUNITY TRUST

Feedback from executive leads revealed a range of good practice in anchor institution working. Some trusts have embedded anchor principles within their organisational strategy documents and are embedding these across different divisions within their organisation, including corporate services. One exemplar trust was working to gain Marmot Trust status. Another trust mentioned that they have developed a clean air policy to tackle their organisation's contribution to climate change.

For the majority of trusts the scope of their anchor work is mostly focused on the provision of employment opportunities – largely around improving access to work for local people. This has included providing training opportunities in areas where there are high health inequalities, working with partners to provide a skills academy for entry level jobs, hosting recruitment events, and simplifying application processes to remove barriers that some individuals may face. This is an important contribution that trusts can make, however there are a range of other ways that trusts can positively influence their local economy – such as through procurement, housing, and access to green spaces.

> *We do try to be a good partner in our system. We are a key employer and have hyper-local recruitment to get people into work who would ordinarily not consider the NHS. We have made significant strides in "growing our own" providing local educational and training opportunities to improve employment prospects (and help our workforce shortages.) We speak with housing associations about both housing for key workers and for service users but progress is very slow. Housing is extremely expensive in our county as the market is dominated by second and holiday homes contributing to difficulties in recruiting as well as ensuring citizens have decent, affordable and safe housing.*
>
> CHAIR, COMBINED MENTAL HEALTH/LEARNING DISABILITY AND COMMUNITY TRUST

WHAT IS NEEDED TO FURTHER SHIFT THE DIAL ON ADDRESSING HEALTH INEQUALITIES?

5

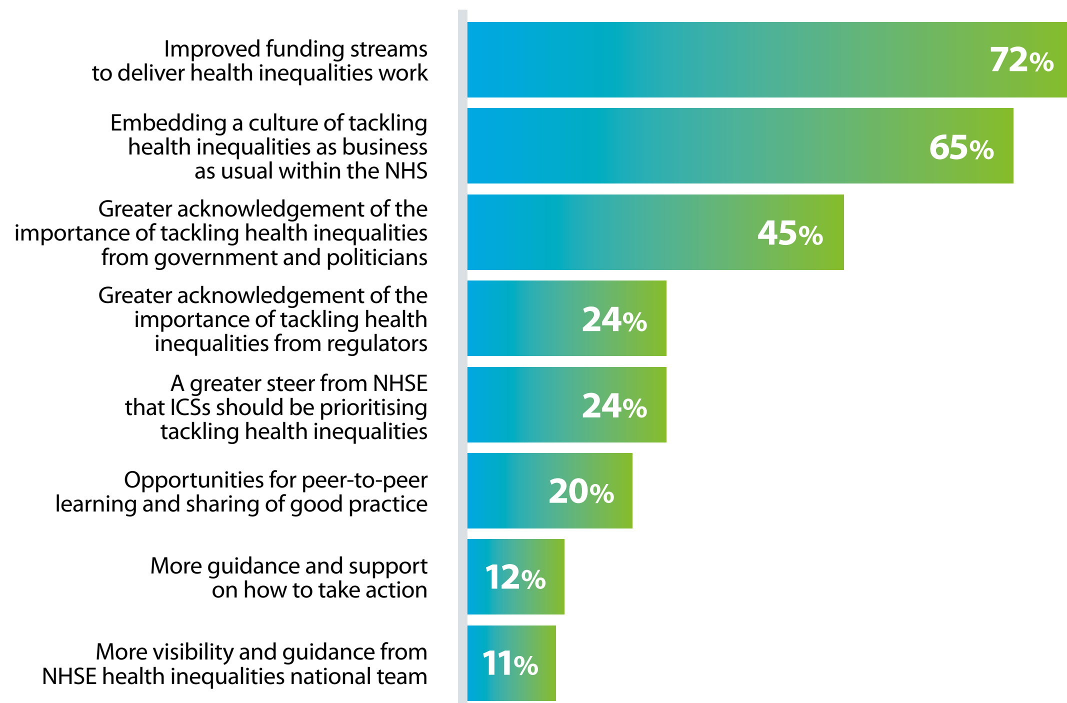
We have seen many positive improvements in how trusts are addressing health inequalities, yet there is still much more to be done to shift the dial and see demonstrable progress in improving health outcomes across the population. Operational pressures have intensified in recent years, leaving trusts little headspace or resource to prioritise efforts on actions considered to be not immediate or urgent. But not addressing health inequalities now will increase the burden and pressure on health services later down the line – this is the time to act.

Our research has shown that trusts know and understand the scale of the challenge ahead of them. The evidence-base is clear and the policies that exist provide a roadmap to change. Trusts are not calling for more guidance and support (12%). The overwhelming majority of trusts (72%) say they require 'improved funding streams to deliver health inequalities work'. Without investment and resource, well intentions to reduce inequalities are hampered. Many trusts have requested long-term, ring-fenced funding to deliver on this agenda.

Figure 11

What would enable you to do more work on health inequalities? Please select the top three answers.

(n=75)



As discussed, clarity is also needed on the different demands placed on trusts from NHSE and national bodies, which don't always prioritise or incentivise action on health inequalities. In fact, sometimes national policies can exacerbate trends in inequalities. There is a desire for improved alignment on policy priorities from the centre and development of a national NHS strategy for tackling health inequalities.

> *The culture of the NHS is currently one of reaction; this is not unique to our trust. The national direction from NHSE is clear, but the national imperative from central government contradicts this and therefore NHSE are limited in their ability to mandate this work. The CMO's annual report is helpful, but is advisory at best. Short term performance improvement lays the foundation for long term cultural change, but the long term cultural change has to be an equal priority, not an afterthought.*
>
> DIRECTOR, ACUTE TRUST

In order for meaningful change to occur, tackling health inequalities cannot be viewed as one part of the trust's operation. Siloing action may mean that the rest of the activity in the organisation is worsening inequalities elsewhere. Trusts have identified that 'embedding a culture of tackling health inequalities as business as usual within the NHS' is a key enabler to making progress (65%). Our guide for NHS trust board members *Reducing health inequalities* provides a set of objectives for trust boards to address health inequalities outlining the different responsibilities of each member of the board (NHS Providers, 2024a). Setting a culture of shared responsibility at the top of the organisation could reap benefits across the wider trust.

Executive leads shared with us the challenges of establishing a culture of business as usual in addressing health inequalities. For some, there is a sense that it is viewed as an addition to the day job, with one trust asking "*how can you add these responsibilities onto an already exhausted workforce?*". Trusts may look to provide training for different staff groups to better understand the role they can play in tackling disparities.

> *Capacity – it is still seen as a nice to do which is cultural but when facing extreme system pressures this is one of the first areas to be paused.*
>
> STRATEGY DIRECTOR, ACUTE TRUST

The NHS cannot tackle health inequalities alone. Shifting the dial requires action across all sectors that impact on the wider determinants of health – housing, education, local authorities, and the private sector. Spending power in local authorities has fallen by 26% between 2010/11 and 2020/21 (National Audit Office, 2021). The public health grant – which provides resource for delivering preventative services, such as weight management and smoking cessation – has been cut by 28% on a real-terms per-person basis since 2015/16, and the largest cuts have been seen in the most deprived areas of the country (Finch, 2024). Trusts in our research have called for greater investment in upstream services that will prevent inequalities and reduce the burden on the NHS, including investment in local government functions.

As we are approaching a general election we have outlined shared commitments for working with government to deliver the next generation NHS and create a picture of health that is responsive, effective and continuously improving (NHS Providers, 2024c). We are calling for collaborative action to address the wider determinants of health, including implementation of a whole-government health and care strategy which looks across the

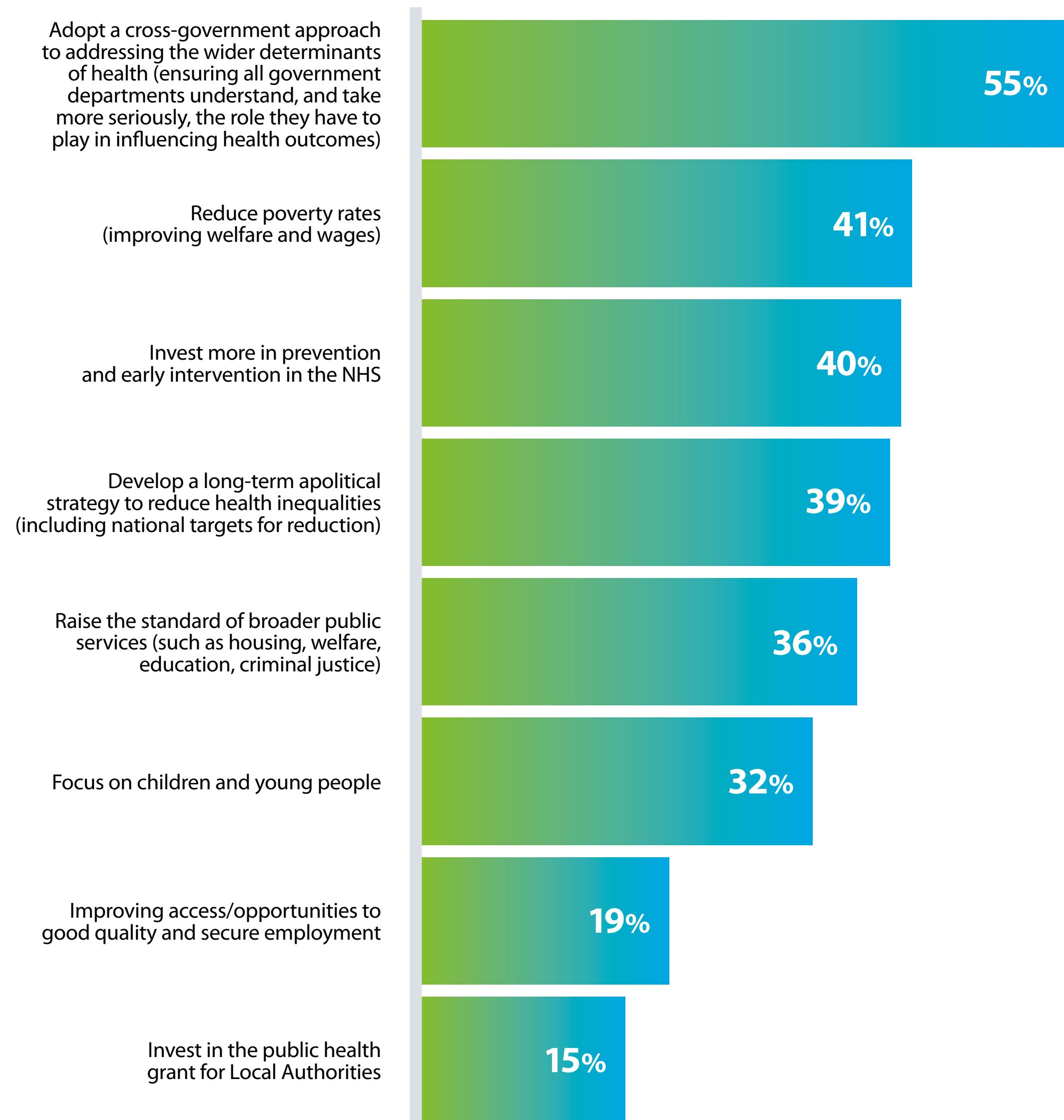
needs of the whole population, now and over the decades to come. Our survey respondents agree, when asked what changes they would like to see within national government, over half (55%) said 'adopt a cross-government approach to addressing the wider determinants of health'.

> *We need to see services such as housing and employment as part of the wider determinants of health AND as key contributors to care pathways.*
>
> CHAIR, MENTAL HEALTH/ LEARNING DISABILITY TRUST

Figure 12

What policy changes would you like to see within national government to support a reduction of health inequalities? Please select the top three options.

(n=75)



> *The country needs a long term strategy on improving health that doesn't change with each incoming government. Improve overall public services, e.g. everyone to have basic level of income, secure employment and housing. This will help improve health outcomes when people don't have to stress and worry about heating their homes or putting food on the table.*
>
> PROGRAMME MANAGER, ACUTE TRUST

How is NHS Providers responding?

The insights from this research will inform the work of our organisation on the topic of health inequalities. We will utilise the results to advocate on behalf of our member's needs to achieve the changes we are all striving for in the reduction of health inequalities.

We are also supporting members to identify and fulfil their role in addressing inequalities. Our support offer 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, peer-to-peer support opportunities, and the dissemination of case studies.

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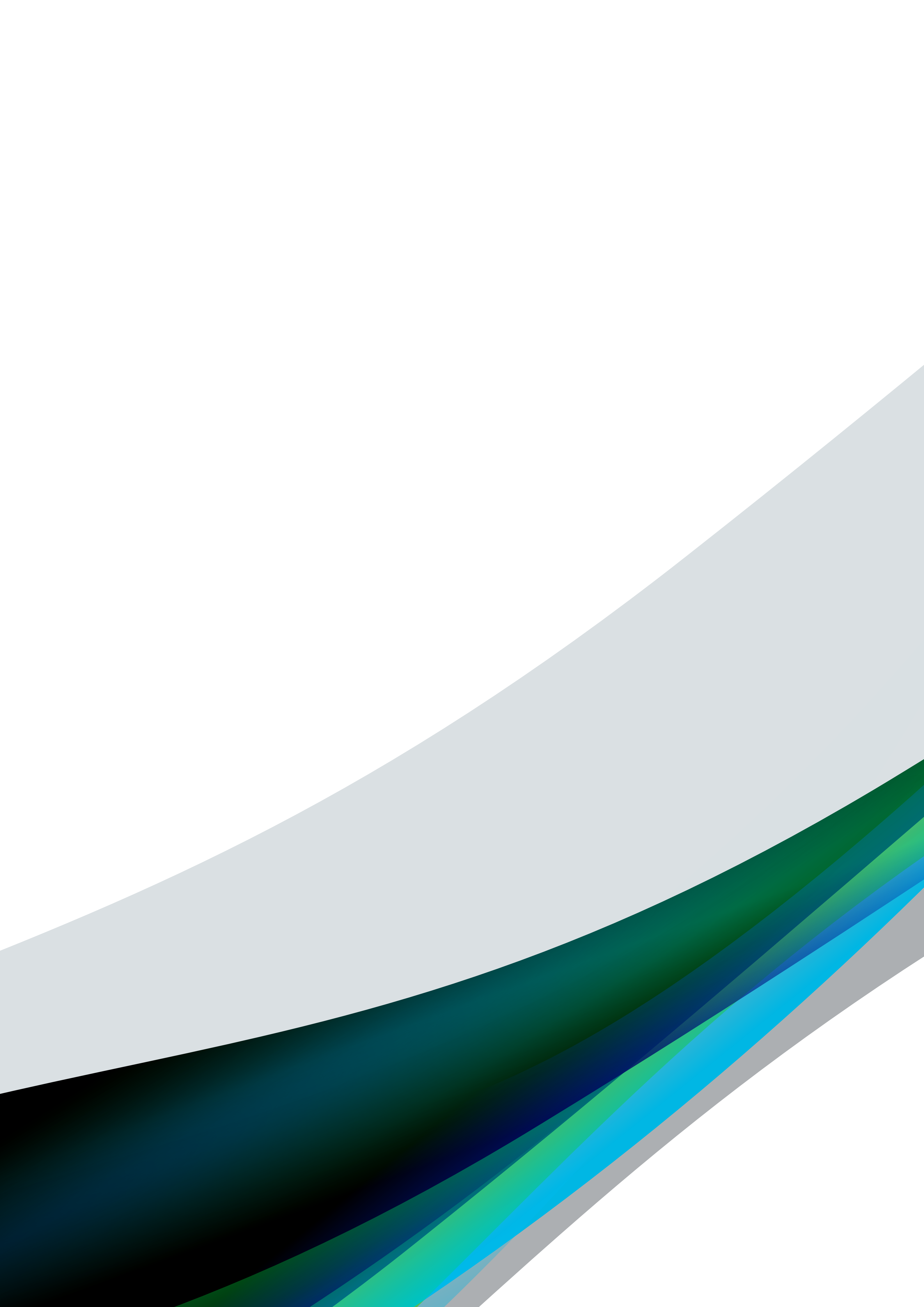
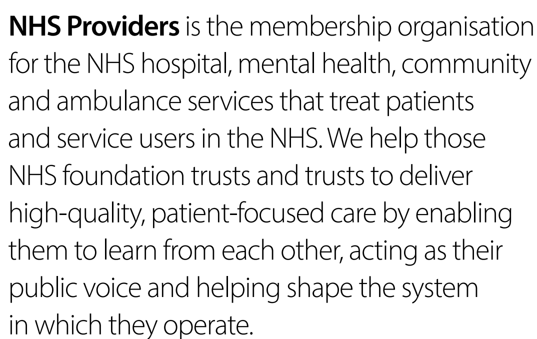
Interactive version

This report is also available in a digitally interactive format via:
www.nhsproviders.org/united-against-health-inequalities-moving-in-the-right-direction





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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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