Turning the tide

The South East Response to the Covid-19 BAME Mortality and Morbidity Disparities, Health and workforce Inequalities.

Scott Durairaj

NHS England and NHS Improvement

Contents

Purpose.

1.1. The purpose of this paper is to agree a strategy for NHS England and Improvement (NHSEI) in the South East to address health and employment racial and wider inequalities. The Senior Leadership Team (SLT) are therefore asked to approve and endorse the paper which sets out the following:

1.1.1. Roles and responsibilities for the NHSEI SLT focussed on reducing racial and other workforce and health inequalities.

1.1.2. The Six ICS/STP's roles and responsibilities focussed on reducing health and workforce inequalities.

1.1.3. Agree a health and workforce inequality reduction assurance approach

1.1.4. Agree a way to make progress against the seven recommendations from the PHE report, Covid-19: understanding the impact on BAME communities

1.1.5. To develop a Health and workforce Inequality performance improvement scorecard

Context

1.2. By April 2020 Covid-19 had become a pandemic and at this stage the NHS and Social Care had yet to understand the wholescale loss of life that would follow. This loss of life was widespread across our communities and our own workforce. However in April the emerging knowledge that in the England and in other countries across the globe, data was suggesting people from Black Asian and Minority Ethnic (BAME) populations have a higher risk of developing life-threatening coronavirus (Covid-19) symptoms.

1.3. The Intensive Care National Audit and Research Centre (ICNARC), reports nearly a third of people who were critically ill with coronavirus were from BAME backgrounds. Now the initial global anecdotal evidence appears to be supported by the ICNARC report, which was based on data on all confirmed Covid-19 cases critical care units reported to the centre up to midday on April 3.

1.4. Of the 2,249 people analysed, 64.8 per cent were white compared to 13.8 per cent being Asian, 13.6 per cent recorded as black and 6.6 per cent described as other. Together the BAME groups represent 34 per cent, which is disproportionate compared to the population as a whole (2011 census 14%).

1.5. Furthermore, the report also investigated the backgrounds of those treated for non-Covid-19 viral pneumonia from 2017 to 2019 and there was no similar pattern. The BAME populations made up 10.4 per cent compared to the 88.8 per cent of white people recorded having had viral pneumonia – a percentage which sits closer to the UK's BAME population and shows no significant disparity.

1.6. Professor Khunti, Professor in Primary Care Diabetes and Vascular Medicine at the University of Leicester, and a trustee of the South Asian Health Foundation and leads the Centre for BME Health said at the time: "We have been concerned about this issue based on anecdotal reports and now this data is showing a signal regarding what we have been saying. This is a signal but at this stage, that's all it is. We now need more data, so we are therefore embarking on a mission to learn more through research."

1.7. The Intensive Care National Audit and Research Centre report came from data reported into the Case Mix Programme. This programme represents all NHS adult, general intensive care and combined intensive care, high dependency units in England, Wales and Northern Ireland, as well as some specialist and non-NHS critical care units. There was much discussion across research and the media as to what was underlying the disparities that became so stark over the month of April.

1.8. Now in June 2020, the solutions to the Covid-19 disparities are still critical and requires progress against, due to the fear of a second wave and the reality that the response to adequately safeguard BAME communities and NHS staff across the South East of England

cannot at this stage be adequately assured and we know the response is variable amongst organisations and systems alike.

1.9. Health and social inequalities are one of the key underlying factors in the disparities experienced by the BAME population. Health inequalities can be defined as the avoidable and unfair differences in people's health and care across different population groups within society. It can also mean differences and barriers in the access, quality and experience of care, and wider determinants of health, such as housing. Sir Michael Marmot, in the report Fairer Society, Healthy Lives[1], asserts that "inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work and age". In Health Equity in England: The Marmot Review 10 Years On[2], he asserted that outcomes are "even worse for minority ethnic population groups and people with disabilities". In light of the Covid-19 pandemic and the emerging impact on BAME staff and communities, inequalities are in clear focus.

1.10. The Public Health England (PHE) review confirms that the risk of dying among those diagnosed with Covid-19 is higher in BAME groups than in white ethnic groups. After accounting for the effect of sex, age, deprivation and region, it found that people of Bangladeshi ethnicity were at most risk, with around twice the risk of death than people of white British ethnicity. People of Chinese, Indian, Pakistani, other Asian, Caribbean and other black ethnicity had between 10% and 50% higher risk of death when compared to white British. The risk of mortality for people of Bangladeshi ethnicity was in line with other research, by the Office for National Statistics (ONS)[3] and Institute for Fiscal Studies (IFS)[4], but for other ethnicities mortality was generally lower than for those BAME populations highlighted at greater risk of mortality or morbidity due to Covid-19.

1.11. Diagnosis of Covid-19 among BAME people is also greater when adjusted for age. The highest diagnosis rates, which does not necessarily correlate with incidence, of Covid-19 were in people of Black ethnic groups (486 females and 649 males) and the lowest were in people of white ethnic groups (220 females and 224 males). All-cause mortality was almost four times higher than expected among black males for this period, almost three times higher in Asian males and almost two times higher in white males. Deaths were almost three times higher in this period in black, mixed and other females and 2.4 times higher in Asian females compared with 1.6 times in white females.

1.12. The review looked at other risk factors aside from ethnicity. The mortality rates from Covid-19 in the most deprived areas were found to be more than double the least deprived areas, for both males and females, similar to previous ONS findings. This was greater than the inequality seen in mortality rates in previous years, indicating coronavirus is exacerbating

[1] Marmot M, Goldblatt P, Allen J et al (2010), Fairer Society, Healthy Lives: The Marmot Review. The Institute of Health Equity accessed, April 2020.

[2] Marmot M, Goldblatt P, Allen J et al (2020), Health Equity in England: The Marmot Review 10 Years On. The Institute of Health Equity, accessed April 2020.

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020 Accessed 22 June 2020

[4] https://www.ifs.org.uk/publications/14879 accessed 22 June 2020

mortality inequality. In the comorbidities section, PHE says diabetes was mentioned on 21% of death certificates where Covid-19 was also mentioned, consistent with other studies[5]. This proportion was 43% in the Asian group, 45% in the black group and higher in all BAME groups than for the white British population. Diabetes was more likely to be mentioned on the death certificate in more deprived areas. The same ethnic disparities were seen for hypertensive disease.

1.13. Nursing auxiliaries and assistants, security guards and related occupations, and taxi and cab drivers and chauffeurs were found to have experienced a relative increase in deaths in 2020 significantly higher than the average of 1.5 among people of working age (20-64). The ONS has previously reported male bus and coach drivers, chefs, sales and retail assistants, lower-skilled workers in construction and processing plants, and both sexes working in social care as having significantly high rates of death from Covid-19.

1.14. An analysis of 10,841 Covid-19 cases in nurses, midwives and nursing associates found that those from Asian ethnic groups were overrepresented but the analysis did not look at the possible reasons behind these differences, which PHE said “may be driven by factors like geography or nature of individuals’ roles”.

1.15. The impact of health and social inequalities are clear and the NHS working together with partners across Integrated Care Systems holds the solutions for many of these challenges. They are not easy to eradicate due to their systemic nature and in the South East we agree as a region to support all our systems develop solutions as part of our long term plan commitment and our NHS England and Improvements roles of oversight, assurance and support.

1.16. This strategy rapidly addresses the disparities affecting BAME populations due to Covid-19 and was enacted by the end of April 2020. That strategy has three phases, with a timeline that will flex depending on the pandemic impact.

1.17. Phases of delivery

One Panel is divided into three distinct phases, with different roles and membership appropriate to proportional requirement.

	PHASE 1 – System Fix Covid-19 BAME Disparity Advisory Panel April 2020 – August 2020	Phase 2 – Regional Collaboration & oversight Covid-19 BAME Disparity Advisory Panel September 2020 – December 2020	Phase 3 – Regional Support Health Inequality Advisory Panel January 2021 – March 2022 (review)
Role	To support the system to better understand the impact COVID-19 is having on BAME population and workforce and support the system to rapidly respond.	To develop clear progress oversight between SE SLT, the 6 Systems and all Board for the delivery of the programme and help or support needed.	To Establish an expert advisory panel to deliver in depth system plan reviews to address health inequalities across the biggest challenge areas for the South East.
Features	✓ Providing strategic direction and support across systems at regional and local levels. ✓ Ensuring the key milestones are set and providing support to systems ✓ Overseeing progress against agreed deliverables ✓ Ensuring that an integrated and inclusive approach is taken ✓ To influence mainstream covid-19 work including restoration and recovery takes into consideration the disparities within the workforce and the population. ✓ Identifying and managing key risks, issues and dependencies and escalating as appropriate	✓ Providing assurance on the progress of the SE response to the BME Disparity issue due to COVID-19. ✓ Develop the chair model of the group ✓ Align and develop clarity of all NHSEI South East programmes, ownership and delivery methods relating to this area. ✓ Identify gaps, build resource and develop knowledge ✓ Influence and support nationally ✓ Continue to evaluate the impact on BAME populations and staff of covid-19 and the impact and spread of programme.	✓ Develop the membership via volunteers from systems for expertise across the deepest and most challenging health inequalities within the region. ✓ Develop a 12 month forward plan of monthly meetings involving systems in the design and long term plan detail requests ✓ Agree chair and co-chair for the year the co-chair will come from the community that faces the inequality ✓ Provide systems with a support or improvement recommendation package to enhance delivery ✓ Review with system and advisers in March 2022

[5] https://www.icnarc.org/About/Latest-News/2020/05/08/Report-On-9623-Patients-Critically-Ill-With-Covid-19

Health and Social Inequalities, a Brief Modern History

2.1. Before moving on to the phases of the delivery for the advisory panel it is critical for all members of the panel and the wider south east health and care system to develop a shared understanding into the recent history of health and social inequalities within the UK. This will help to connect to the social and political history and explain why the confidence in the delivery of recommendations is low within many BAME populations.

2.2. The Black Report[6] published 6 August 1980 was not the first or last public health publication where the description of problems is more impressive than the proposed solutions. The report made 37 recommendations for action many of which still remain outstanding or were institutionally failed to deliver the solution.

Inquiries shaping health inequalities policy

2.3. The UK's approach to tackling health inequalities is characterized by two inquiries: the Black Report and the Acheson Report, named after their respective chairs. As their impact upon policy is markedly different, they are crucial in understanding the relationship between evidence and policy (Oliver and Exworthy 2003).

a. The Black Report

The Black Report (1980) on health inequalities was commissioned by the Labour government in 1977. It identified four possible explanations of health inequalities: artefact, natural selection, cultural, and structural, but saw no role for health care in reducing health inequalities. The report was published just before a public holiday and only 260 copies were made available (Townsend, Davidson, and Whitehead 1988). The report was rejected by the Conservative government (then in power) because the proposals were too costly. Thus, the Black Report had little or no impact on policy for more than a decade (Berridge and Blume 2003; Davey-Smith, Bartley, and Blane 1990).

b. Independent Inquiry into Inequalities in Health.

The newly elected government commissioned an independent inquiry in 1997—the “second Black Report” (Exworthy 2003). The inquiry was asked to “moderate a review of the latest available information on inequalities in health” and “to identify priority areas for future policy development.” The Acheson Report (Acheson 1998a) concluded that the “weight of scientific evidence supports a socio-economic explanation of health inequalities.” It supported a model that was composed of different layers including individual lifestyles and the socioeconomic environment. Addressing social determinants, the report considered

[6] https://www.sochealth.co.uk/public-health-and-wellbeing/poverty-and-inequality/the-black-report-1980/

poverty, education, employment, housing, transport, nutrition, the life-course, ethnicity, gender, and health care. The report made 39 recommendations, three of which were claimed to be “crucial,” namely:

1. “All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities,”

2. “A high priority should be given to the health of families with children,” and

3. “Further steps should be taken to reduce income inequalities and improve the living standards of poor households” (p.xi).

The report made only three recommendations on health care, denoting its perceived contribution to tackling health inequalities.

The Acheson Report was “welcomed” by the government, noting that it was already implementing some of the report's recommendations. Academics and practitioners generally welcomed the report though this was not universal.

c. Macpherson report

In July 1997, more than four years after Stephen Lawrence was murdered by a group of white youths, the then home secretary Jack Straw announced the establishment of an inquiry into his death. A total of 70 recommendations designed to show “zero tolerance” for racism in society was made. They included measures not just to transform the attitude of the police towards race relations and improve accountability but also to get the civil service, NHS, judiciary and other public bodies to respond and change.

Some 67 of the report’s recommendations led to specific changes in practice or the law within two years of its publication. They included the introduction of detailed targets for the recruitment, retention and promotion of black and Asian officers, as well as the creation of the Independent Police Complaints Commission with the power to appoint its own investigators.

d. Marmot Review report – 'Fair Society, Healthy Lives

The Marmot Review into health inequalities in England was published on 11 February 2010. Although detailed in many areas it was absent on ethnic health inequalities. It drove a paradigm shift in the way people think about the causes of poor health, and played a huge role in establishing the political imperative for tackling inequalities. The government response was Healthy Lives, Healthy People. Subsequent there have been declines in health outcomes for some groups as reported in Health Equity in England: the Marmot Review 10 Years On.

e. The Race Disparity Audit,

Published by then Prime Minister Theresa May in 2017, the audit showed inequalities between ethnic groups in educational attainment, health, employment and treatment by police and the courts.

f. Lammy Review

Published in 2017, the review found evidence of bias and discrimination against people from ethnic minority backgrounds in the justice system in England and Wales.

g. The McGregor-Smith Review

This 2017 review of race in the workplace found people from black and minority ethnic backgrounds were still disadvantaged at work and faced lower employment rates than their white counterparts.

h. An independent review of the Windrush scandal,

This review was published in March 2020 and found the Home Office showed "institutional ignorance and thoughtlessness towards the issue of race"

i. Health Equity in England, The Marmot Review 10 Years On,

Published in February 2020, this follow-on report found that over the intervening period:

1. Health inequalities have widened.
2. Life expectancy has stalled and has actually declined for the poorest 10% of women.
3. The north-south health gap has opened up further still – with the largest decreases in life expectancy seen in the most deprived parts of the North East, and the largest increases seen in the least deprived parts of London.
4. The amount of time spent in poor health has increased.

The review also counters the theory that changes in life expectancy can be explained by increasingly severe winters and flu, showing that the substantial majority of these changes have their origin in wider determinants of health.

j. PHE Disparities in the risk and outcomes of Covid-19

Published on 2 June 2020, PHE's report provides more evidence that the impacts of Covid-19 are being disproportionately felt by some parts of the population, particularly those from BAME backgrounds. It has also impacted heavily on those in the later stages of their lives and those who live in deprived areas, and it is more of a risk to men than to women.

This is a compelling example of how Covid-19 is impacting pre-existing health inequalities at a time when action to close the gap was already urgently needed.

It is vital that this important report shapes our response to Covid-19. Both the public and health professionals will be expecting this Government to ensure the findings inform future policy decisions as we seek to reduce the risk to those most vulnerable. The report was heavily criticised for the absence of recommendations or records of the contribution from the population that had fed into the development process.

k. Covid-19: understanding the impact on BAME communities

The second part of PHE's review, published 16 June 2020 once again shows how Covid-19 has disproportionately impacted those from BAME communities and widened existing health inequalities even further. The delay in the publishing this part of the review socially angered and upset many BAME groups and populations, with some deciding to take legal action.

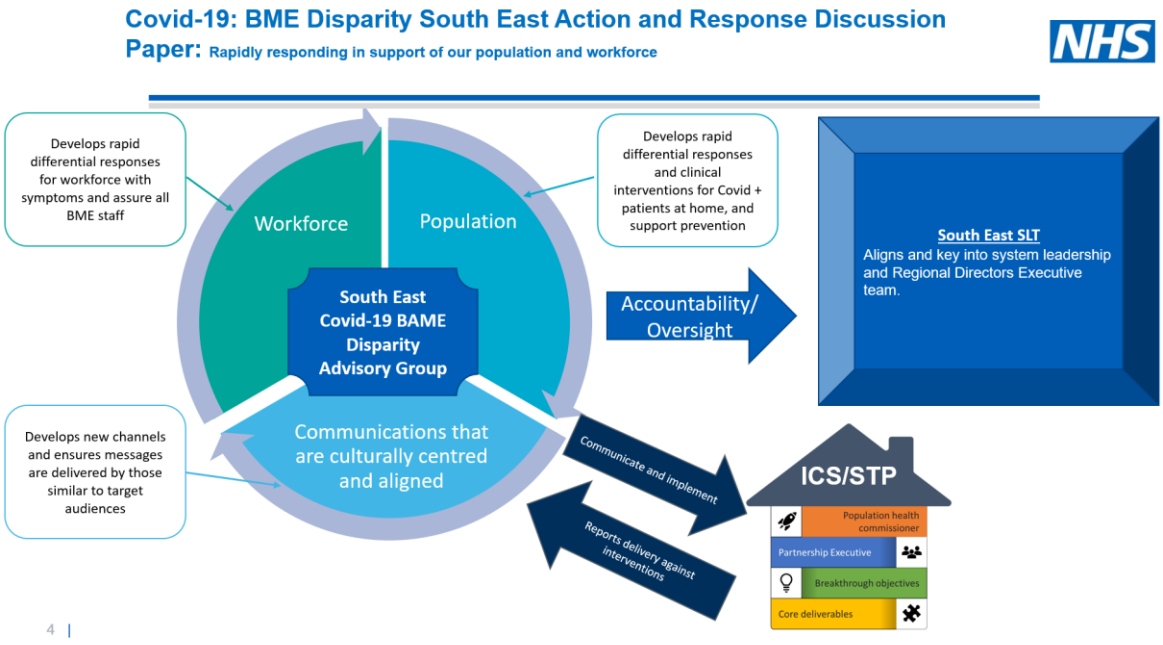
2.4. This section of the paper is designed to demonstrate just how many reviews, research and inquiries there have been, and this list is not exhaustive. It is concerning as to the lack of progress and delivery of the numerous recommendations over the years. This is an important sociological understanding and starting point to ensure what is planned in the South East must be delivered. There will need to be a concerted effort to ensure a focus on race and ethnicity with regard to both Health and workforce inequality as past evidence has shown once other important areas of inequality is included often action and focus on race is lost and this is in itself part of the structure of racism.

Current Position

Phase one

3.1. The South East BAME Disparity Advisory Group was established in response to the emerging evidence of the disproportionate impact of Covid-19 on BAME staff. The group is co-chaired by Anne Eden, Regional Director and Scott Durairaj, Director of ICS assurance. The group involves BAME leaders across the region to ensure its decisions are BAME led.

Figure 1



The group's purpose is to identify, develop and spread opportunities to act to minimise the disparity of impact of Covid-19 on the BAME workforce and communities across the region.

3.2. Delivery is led through five working groups and each meeting starts with a personal story to remind members about the urgency and importance of this work.

Working groups

Addressing population disparity

3.3. This work stream has piloted a variety of responses and clinical interventions in Slough and Sussex, and has influenced system wide responses across the South East designed to support prevention of Covid-19 in BAME communities. Working across systems with colleagues from primary care and Public Health England, the systems are exploring the introduction of contact tracing for targeted groups within BAME communities and working with BAME community leaders to co-design support for local communities.

Addressing workforce disparity

3.4. Building on national guidance, the group produced a ‘gold standard’ risk assessment to support organisations in the region undertake meaningful assessments. The tool was made available on mobile phones and was supported by guidance for managers which included a board checklist, health and wellbeing guide and advice for line managers on how to manage the risk assessment conversation. Metrics and a dashboard were also created to help executive teams readily understand and interrogate progress within their organisation.

Corporate NHS England / NHS Improvement BAME workforce

3.5. The group recognised that the needs of BAME staff employed within the regional team may be different to those with front line NHS facing roles. Senior leaders in the region established two-way communication to ensure that the disproportionate impact of Covid is openly discussed. Network leads have ensured that where organisations have a BAME staff network it is able to co-design solutions in partnership with HR and health and wellbeing teams.

Communications and engagement

3.6. The group’s purpose and determination to make a positive difference is at the heart of all communication helping to create a sense of shared endeavour among leaders in the region. Communication is informed by insight from a range of engagement networks across the South East to ensure they are meaningful and impactful.

Open and transparent communication is an important part of the BAME Advisory Group culture, with all meeting papers and action notes being made available to staff via a website.

System implementation and dissemination

3.7. An important aspect of the BAME disparity work is that decisions are co-led by the six systems in the region, whilst maintaining regional oversight of this work.

3.8. The Regional Director has engaged directly with systems leaders to ask each system to submit an action plan to respond to the community and workforce disparity during Covid-19. Plans have been reviewed, feedback and recommendations shared, and an example action plan developed to share good practice. (An example of a whole system approach at Sussex Health and Care Partnership ICS is attached at Appendix c.)

Phase one review

3.9. The advisory panel now need to pause and reflect on the delivery, impact of work to date whilst developing a clear strategy that considers the short term and long-range focus to ensure as a region, we learn lessons, we listen but most importantly we take action. The

publication of the PHE report *Beyond the data: Understanding the impact of Covid-19 on BAME groups* and its recommendations is embedded moving into phase two.

Next Steps

Phase 2

3.10. As we move through restoration and recovery the region needs to move from supplying support, advice and guidance towards working with our systems and organisations to ensure growth of deep and meaningful consciousness about BAME health inequalities and employment inequality with this being evidenced in robust plans to address inequalities monitored via assurance. We also expect to see all health inequalities that relate to the populations served, prioritised, addressed and considered in board and executive decisions across the region. However, there must remain a distinct clear focus on race and ethnicity to ensure the work is not diluted or lost.

3.11. We are currently working on what assurance will need to look like, taking the learning from the Covid-19 BAME disparities in mortality and morbidity.

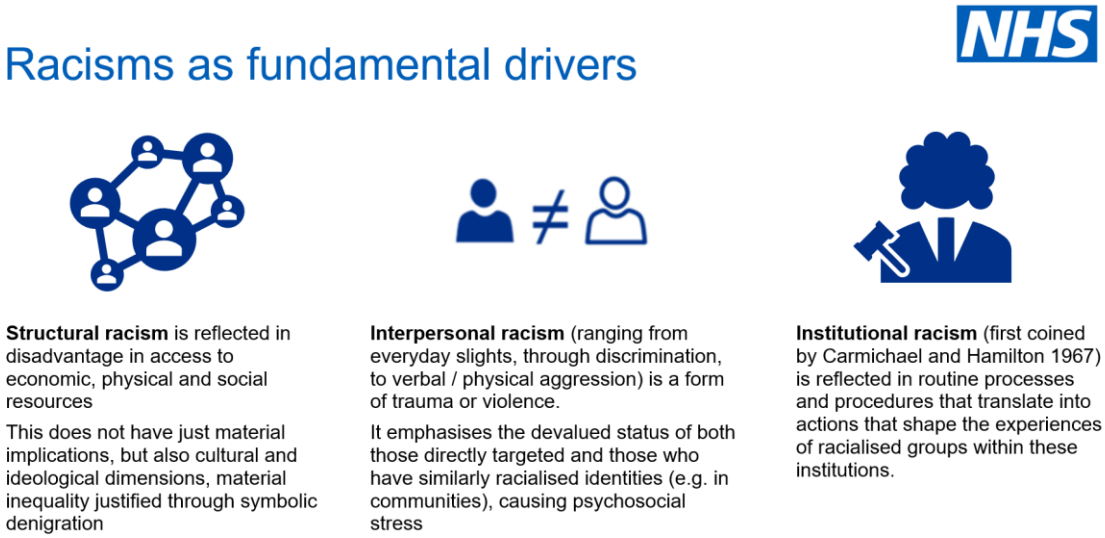
3.12. To understand and therefore address health inequalities that impact on BAME communities you first then need to examine the role of three inter-related dimensions of racism: structural; interpersonal and institutional. These dimensions can then later be applied to other intersecting social inequalities like sexism, hetero-sexism and ableism thus a useful model for considered action.

3.13. The structural, institutional and interpersonal racism/discrimination disadvantages the population and accumulate across a life course, are important drivers of ethnic inequalities in health outcomes.

3.14. We need to recognise how to identify in our data, policies, behaviours and practice, how our health and care outcomes are established. Figure two shows an example of how race inequalities are established. To addressed meaningfully, we require partnerships with local authority and VCSE colleagues to address upstream. Interpersonal discrimination is usually identifiable from staff surveys, WRES data and good workforce engagement. This interlinks with institutional discrimination which again can be evidenced by some of the WRES metrics and the organisations that lack ethnic diversity in senior levels.

3.15. Racism has its origins in ongoing historically determined **systems of domination** that serve to marginalise groups on the base of phenotypic, cultural or symbolic characteristics, thereby generating a racialised social order.

Figure 2



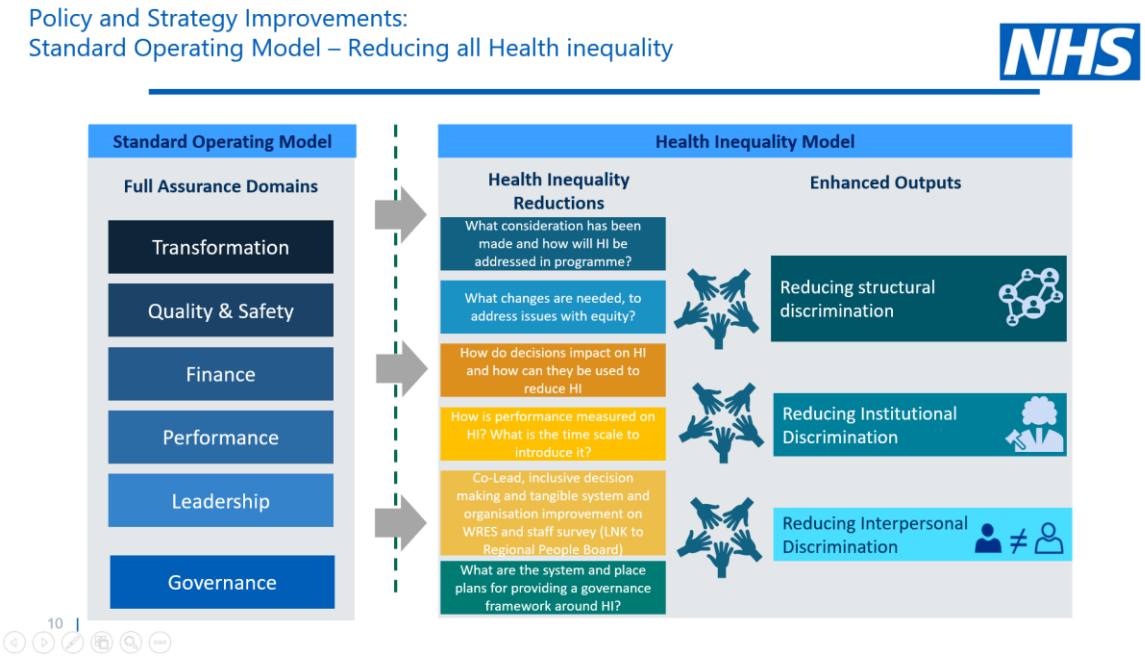
3.16. Once we understand the way BAME health inequalities are driven, we need to consider how our daily decisions and considerations either reaffirm and strengthen the elements that will lead to more inequality in health and societally or we actively and consciously look to dismantle these through how we deliver our core functions.

3.17. Figure 3 broadens this understanding to other areas of social disadvantage and adapts the standard NHSEI Assurance elements to reduce the impacts of these three drivers of inequalities.

3.18. Assurance on inequalities can be thought of by triangulating the data and considering it in the same way that we might look at a healthcare performance issue. If an acute trust is not achieving the 4 or 12 hour A&E performance standard we know what data to look for, establish a cause and effect and look to ensure the remedies are focussed on the performance challenge. However, with both health and workforce inequality we often get stuck on issues of training rather than considering what is the broader structural or institutional challenge we really need to address.

3.19. Figure 3 helps to join the links between what we do and our outcomes and prompt considerations about how these impacts can be reduced. By utilising our existing assurance framework and adding the understanding of how health inequalities are driven: structural, institutional and interpersonal, help define the correct response or range of responses needed. Using social science as a backdrop for the change model will help ensure the solution is correct for the challenge.

Figure 3



During phase 2 NHSEI South East region will look to recruit volunteers from across the system, supported by the ICS and STP connections including those in local authority or VCSE organisation who have specific expertise and proven knowledge, skill or lived experience of health and care in one or more of the health inequality target areas. This wider and diverse group will come together during 2021 to review system plans; their delivery and approach to reducing health inequalities for those specific areas and the panel will provide feedback to each system.

A pivotal element of success will ensure the future strategy develops ownership at senior level from System to region in a way that provides clarity of accountability and oversight.

Phase 3

3.20. The success factors of real delivery in the reduction of health inequalities will need a regional and system wide consideration which is locally owned and Board level driven.

3.21. In figure 3 the remit of the advisory board is expected to broaden to include all health inequalities and workforce inequality. It will **still maintain a focus on BAME health and workforce inequalities** but will examine all other target areas in addition. The co-chair of the group will be a member of the regional NHSE Senior Leadership Team, being joined by a co-chair who will rotate to ensure that the meeting reflects the priority health inequality being examined.

3.22. It is expected that the work streams that were developed to support the Covid-19 BAME disparity response should remain but also expand their focus or consider other models of delivery to ensure a BAME focus will require consideration and regional discussion.

3.23. **Covid-19 South East BAME Mortality Disparity Workforce sub group** will look to identify examples of good practice linked to work arising from Covid-19 and the increased awareness of the need to tackle workplace race discrimination. To build a network of HR and OD leads who are committed to innovative work to help this work develop. To use existing and new networks (especially at ICS level) to help identify good practice and learning. Emphasise repository of good practice on risk assessments and linked to EDI – regional awards to encourage this. To use webinars and invited training events to identify and share good practice and learning around Covid-19 and HR/OD practice that develops from such events and from wider national initiatives. To propose updates to workforce guidance on Covid-19 as required. To support EDI initiatives as appropriate (there will be crossover with the EDI networks). To liaise with relevant Regional officers and support staff and the Regional People Board (and the regional SPF) but to act as a micro social movement with no direct and immediate accountability. To have access to limited resources to pump prime the initiative to be reviewed on regular basis. To Act as advisors to regional Health and Workforce Inequality Disparity Advisory Panel to ensure organisations are delivering on this agenda. The region will need to consider how disability, LGBT and other workforce equality programmes should be considered. It is recognised as highlighted throughout this document amalgamating these functions has historical led to a loss of focus and progress on race.

3.24. The regional people board will TBC

3.25. **The Corporate Workforce Inequality Work Stream,** will be informed and advised by the system workforce inequality work stream and membership should have alignment, however this function will sit within the regional people board be advised on race by Covid-19 South East BAME Mortality Disparity Workforce sub group, led by Shahana Ramsden

3.26. **The Health Inequality Mortality and Morbidity Reduction Board-** will be established from the current Covid-19 BAME Mortality Reduction Board, looking to expand its membership. As it is envisaged that Health Inequality ownership will be required at NHS board level we should also look to replicate this within the region. This should be located as part of the Medical Directorate but will continue to need partners from PHE, HEE, Primary Care and Specialised Commissioning and pull the system leadership and action together. a concerted focus on BAME health inequalities must remain. Executive led by Dr Shahed Ahmed. The original group had three main aims:

3.26.1. To minimise the likelihood of BAME populations becoming infected by the virus

3.26.2. This will be enabled by high quality culturally competent social marketing and communications, readily available and convenient access to culturally competent testing, and rapid culturally competent contact tracing. Isolation will need to be appropriately supported socioeconomically, emotionally and physically.

3.26.3. To minimise the risk factors for poor clinical outcomes in BAME communities

3.26.4. Objective 2 will require weight management support to be provided to high risk BAME individuals and communities as well as clinical management of diabetes and high blood pressure. As well as individual support, organisations will support communities and ensure culturally competent social marketing for risk factor management.

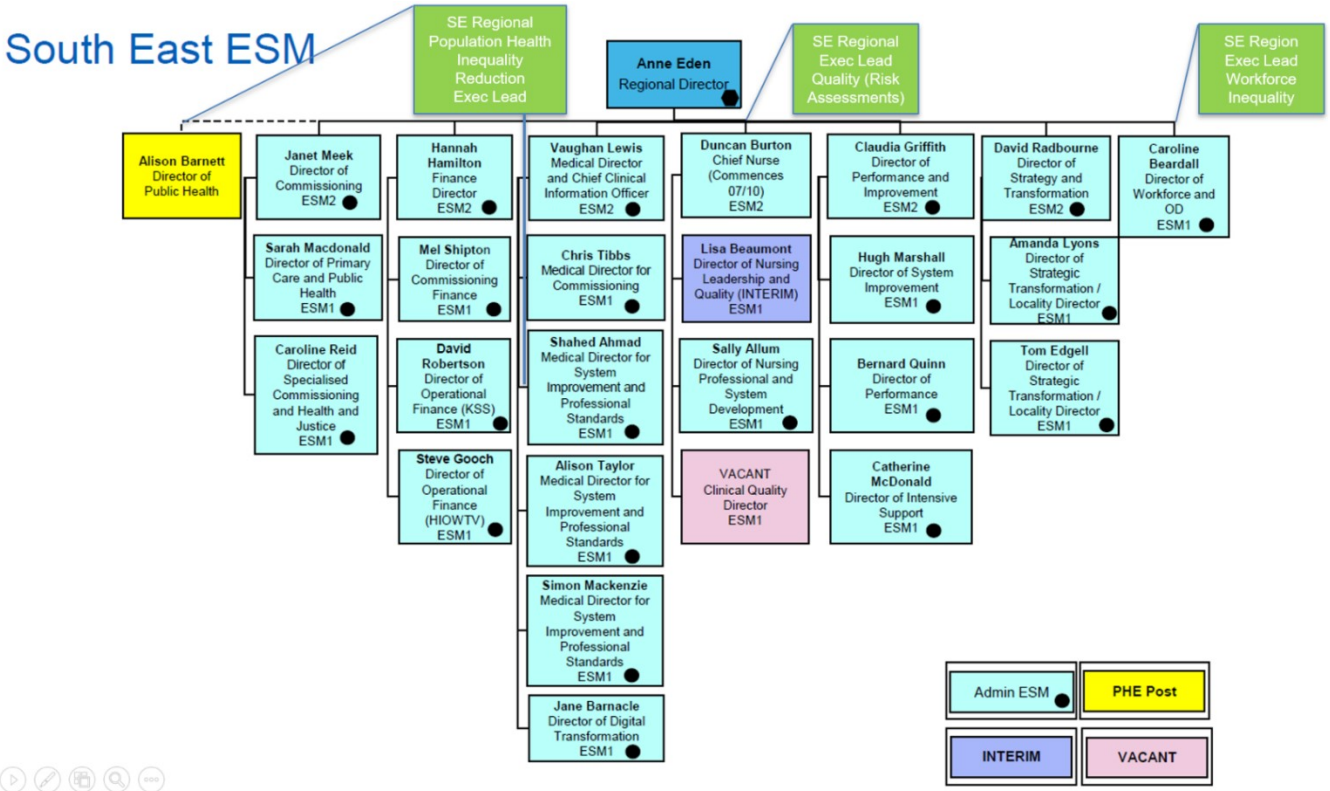
3.26.5. To minimise the poor clinical outcomes by ensuring BAME communities have access to the very best clinical monitoring and treatment as early as possible in their illness

3.26.6. Objective 3 will require high quality early pre-hospital pathways for BAME individuals, and appropriate in-hospital care pathways.

3.27. These objectives are underpinned by a need for access to high quality evidence and research and high high-quality data available to GPs, local authorities, NHS organisations, the six ICS / STPs, local resilience fora (LRF) and at South East regional level.

3.28. **The South East Regional SLT** will have an oversight and assurance of health and workforce inequalities and be provided information by standard assurance metrics and process, enhanced to correctly focus on health and workforce inequalities. There is no desire to increase the reporting functions; instead the change in culture and practice should be the focus. The South East Region will look to have executive leads for the region that will mirror and support that from within the six systems. They are as follows:

Figure 4



Population: NHSEI Dr Shahed Ahmed in partnership with Alison Barnett for PHE (TBC)

Quality and Safety: Chief Nurse for the SE of England (Duncan Barton) (TBC)

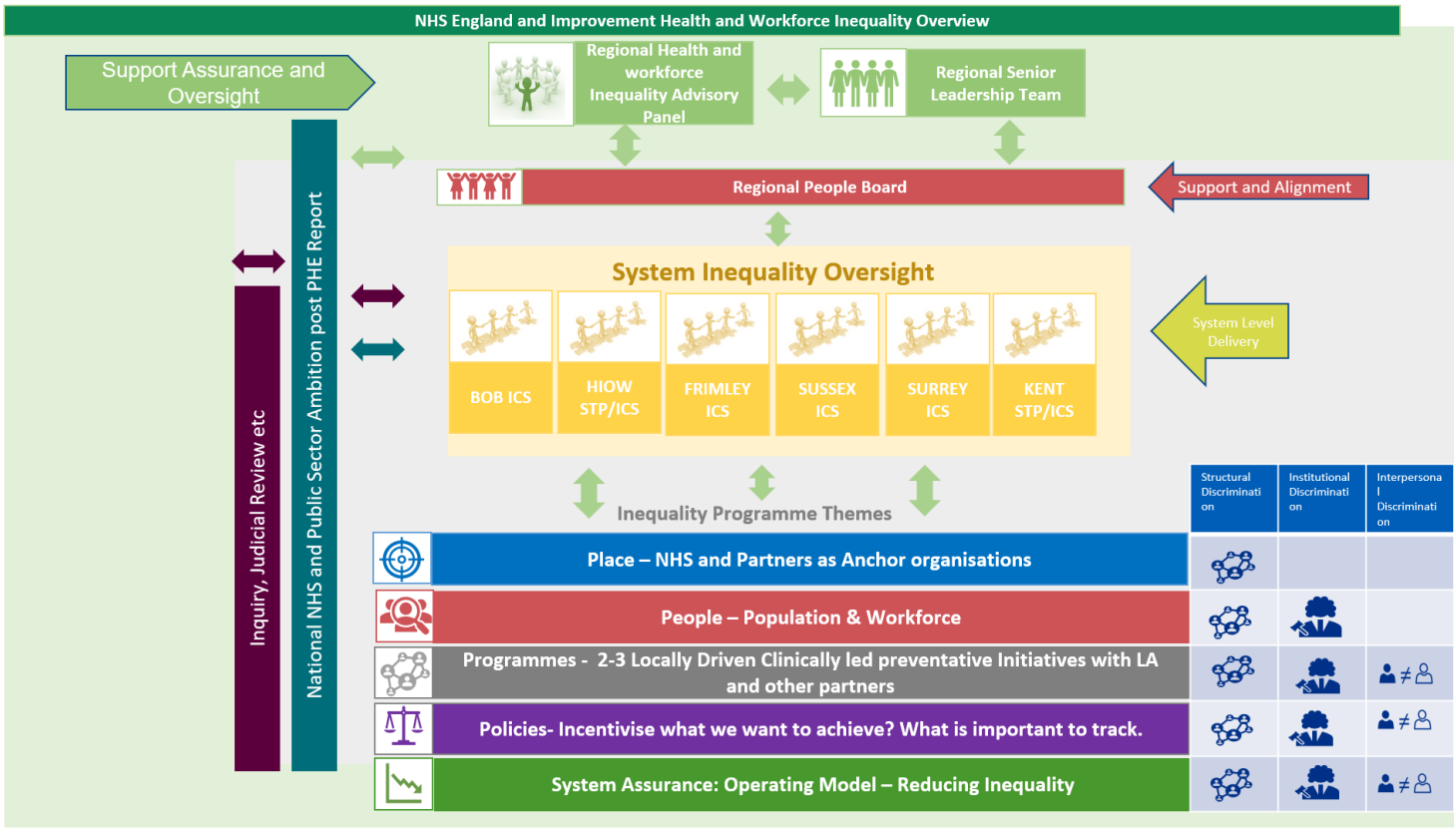
Workforce inequality: executive lead Caroline Beardall (TBC) in partnership with the Covid-19 South East BAME Mortality Disparity Workforce sub group.

Place as Anchor institutions: Adam Doyle SRO Sussex Health and Care Partnership ICS (TBC)

Policies - Commissioning Levers and incentives: led by TBC

3.29. The system wide focus is critical for delivery by the six ICS systems in the region, with an expectation of a clear line of sight for both ownership and delivery of health and workforce inequality reduction. It must not be a tick-box exercise; it must move beyond the intellectual buy-in to the emotional buy-in and deliver improvements and transformation with full consciousness and priority to reduce inequalities.

Figure 5

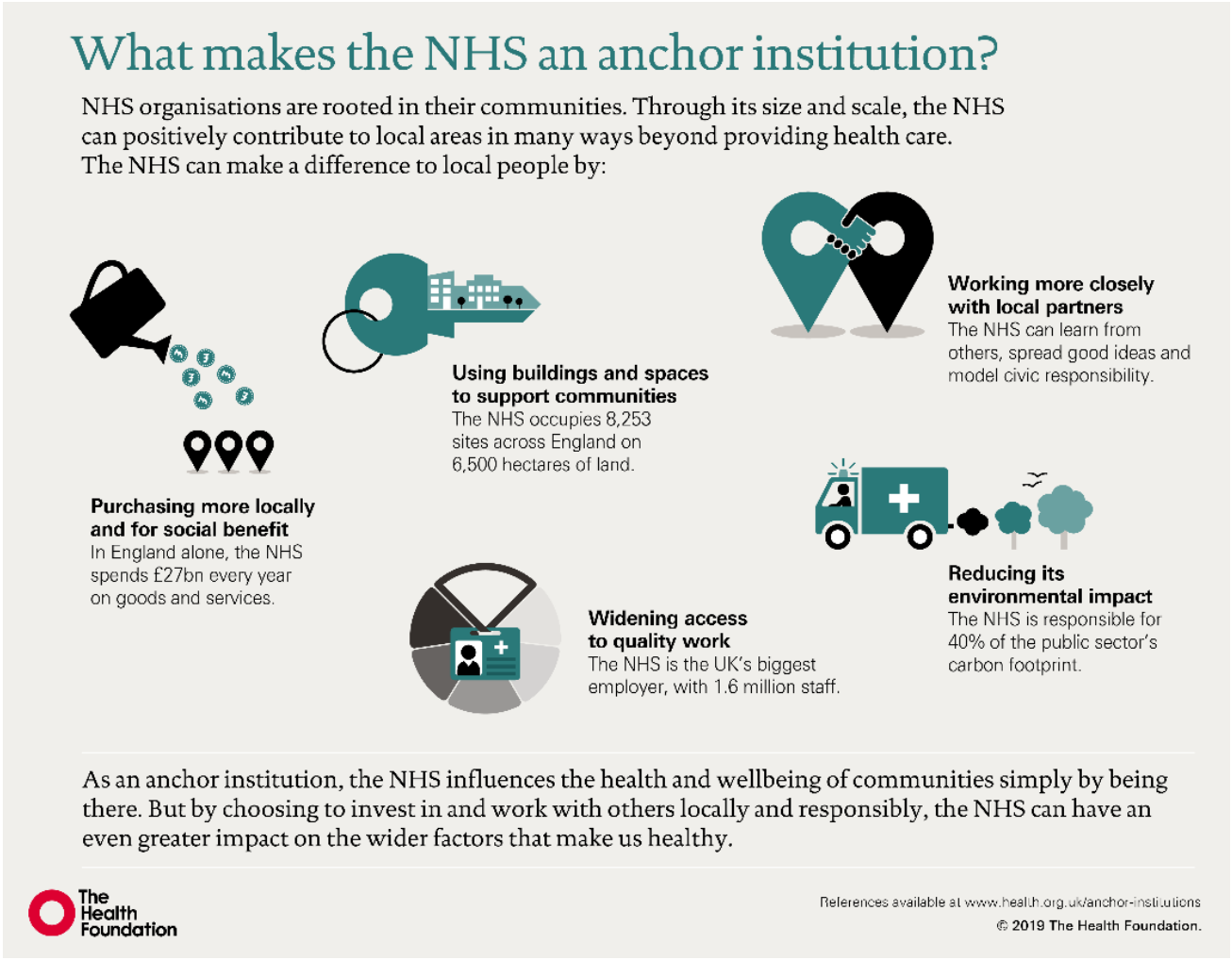


3.30. The term anchor institution refers to large, typically non-profit organisations like hospitals, local councils, and universities whose long-term sustainability is tied to the wellbeing of the populations they serve.

3.31. Anchors get their name because they are unlikely to move, given their connection to the local population, and have a significant influence on the health and wellbeing of a local

community. The South East aims to support the six ICS/STP systems to understand how place and NHS organisations act as anchor institutions in their local communities and can positively influence the social, economic and environmental conditions in an area to support healthy and prosperous people and communities. NHSEI in the South East also has its part to play as an Anchor organisation and this will be achieved by working with our systems.

3.32. During the past 15-20 years the Social Determinants of Health (SDoH) framework has become the main approach to understand health inequalities. As an anchor institution, the NHS, local authorities and the VCS can do more to help people stay well. Beyond our role as providers of care and preventative health programmes, NHS organisations have an opportunity to improve people's health through the way we interact with our community and our economy –as large employers, as civic partners, as landowners and tenants, and as organisations that spend large amounts of public money.



Regional Commitments

4.1. There will be regional delivery and oversight against the seven national PHE recommendations listed below, taken from the report 'Beyond the data: Understanding the impact of Covid-19 on BAME groups'

I. "Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of Covid-19 on BAME communities".

4.1.1. Led regionally by the population work stream - The Health Inequality Mortality and Morbidity Reduction Board

4.1.2. NHS organisations must review the consistency and accuracy of patient ethnicity data and ensure 100% coverage by an agreed regional deadline for completion. All new patient registrations must include a standardised ethnicity code recorded. Patients presenting who have 'Not Stated' recorded for their ethnicity on their record, or who have a blank code or a non-compliant code, must be asked the question by culturally competent staff. GP practices should proactively review patient lists and add ethnicity by a date agreed by the region, in time to avoid unequal access for BAME groups ahead of winter, and in preparation for any future Covid-19 vaccination prioritisation. Data about potential risk factors should be systematically recorded and updated for all individuals, so that as risk prediction and stratification tools are refined, those at greatest risk can be quickly and correctly identified. Data for learning disabilities and people who are homeless, as well as other at-risk patient populations should be part of the data improvement work.

II. "Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of Covid-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes".

4.1.3. Led regionally by TBC

III. “Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users”.

4.1.4. Led by 6 ICS / STP SRO’s (will link with primary, specialist and health and justice commissioning)

4.1.5. As per figure four, the South East NHSE/I regional SLT will identify leads for population and workforce inequalities. All six systems will have an identified executive Board-level lead for tackling inequalities. Each system will by an agreed date have coordinated all NHS organisations to have an identified executive Board-level lead for tackling inequalities, and for each Primary Care Network to have identified an agreed inequalities champion.

4.1.6. All six systems will have an identified executive Board-level lead for tackling workforce inequalities and understand their local challenges. Within the NHS South East region, ICS / STP reporting will include Workforce Race and Disability Standards data, pay gaps, severance pay, turnover, exit interviews, and absenteeism rates disaggregated by demographic characteristic and by place, site, occupation, and service to further refine analysis of local socio-economic or discriminatory barriers and workplace inequality and to develop workforce plans to address these underlying causes of workforce inequality.

4.1.7. By an agreed date all six ICS / STP’s should set out to their population and to the region how they plan to reduce inequalities in the restoration of critical NHS services to take account of the actions contained in this strategy, as well as local priorities. This should be part of the place-based assurance or for STP’s the system assurance processes. As the ICS / STP’s develop their plans for 2021/22, they must build on the collaboration with local government and system partners seen during Covid-19, including delivery through Primary Care Networks and through those NHS organisations serving as ‘anchor’ institutions through the NHSE/Health Foundation Network to shift the paradigm and tackle these systemic issues. Longer-term this will be built on to develop community plans to address the underlying causes of health inequality.

4.1.8. The six systems need to ensure when signing off plans, that Board members are satisfied they can demonstrate how they reduce population health inequality and workforce inequality. Members need assurance and scrutiny of how plans address the structural, institutional and interpersonal elements of racism and other forms of

discrimination and exclusion, and how the implementation of the change is informed by evidence.

4.1.9. Plans on addressing health inequality or discrimination must not focus primarily on formal policies and diversity training. Research shows bias reduction through diversity training and diversity evaluations are some of the least effective interventions to increase the proportion of women in management. The effects of unconscious bias training to improve cognitive understanding last only in the short-term and have limited impact on decision-making[7]. These interventions will not change institutional discrimination any more than they change interpersonal discrimination (bullying)[8].

4.1.10. The six systems should use research and data, including lived experience, to drive interventions, inserting accountability at every level. Systems and places will set clear, measurable, time-limited health inequality reduction and workforce equality goals, building this into individual objective setting and appraisals and not leaving it to those subjected to poor experiences or outcomes to challenge them. For example, managers must be held to account for patterns of apparent discrimination in appointments and development. If there is no credible explanation, then individual performance outcomes must reflect this and managers must be supported to achieve them.

4.1.11. The boards of NHS organisations within each system must understand that whilst improved BAME representation is crucial they must also prioritise developing inclusive leadership behaviours (e.g. growing consciousness, privilege and decolonising, allyship and cultural intelligence, collaboration, courageous honesty, perspective-taking, empowerment, social activism, and fairness). Boards must also prioritise developing culturally safe psychological safety, so that that members and workers welcome the differences that BAME people and other people from marginalised, disadvantaged or under-represented groups bring, recognising that when people are really included and valued, and able to bring their whole selves to work, there are benefits for all[9].

[7] Kalev A, Dobbin F, Kelly E. (2006) Best practices or best Guesses? assessing the efficacy of corporate affirmative action and diversity policies. Am Sociol Rev 2006;**71**:589–617 doi:10.1177/000312240607100404

[8] Atewologun D, Cornish T, Tresh F. Equality and human rights Commission research report 113 unconscious bias training: an assessment of the evidence for effectiveness. EHRC, 2018. https://warwick.ac.uk/services/ldc/researchers/resource_bank/unconscious_bias/ub_an_assessment_of_evidence_for_effectiveness.pdf

[9] Justine Evesson, Sarah Oxenbridge, David G Taylor. (2015). Seeking better solutions: tackling bullying and ill-treatment in Britain's workplaces ACAS

4.1.12. Systems and NHS organisations must ensure equality, diversity and inclusion are drivers of service improvement. Positive visions for equality and health inequality reduction, linked to quality and safety must be led at board level.

The expertise of Equality Diversity and Inclusion Leads, WRES champions and Staff networks should be consulted but ownership and responsibility should not be delegated.

IV. "Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of Covid-19, especially for key workers working with a large cross section of the general public or in contact with those infected with Covid-19".

4.1.13. Led by regional Chief Nurse (TBC).

V. "Fund, develop and implement culturally competent Covid-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability".

4.1.14. Led by population work stream - The Health Inequality Mortality and Morbidity Reduction Board

4.1.15. **Protecting people at greatest clinical risk of COVID.** All six of the ICS / STP's must coordinate each of their place-based plans to minimise poor access and outcomes for people at greatest clinical risk from Covid-19, utilising data and insight to respond to local need. These plans must include arrangements for how information about risk and how to avoid infection will be made available and communicated effectively to everyone, including those at risk of exclusion, such as people with learning disabilities, those whose first language in not English and people who are homeless. The systems must ensure that NHS providers are proactively reviewing the care needs of people who may be clinically vulnerable or who are choosing to shield themselves at home in line with NHS guidance.

VI. “Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma”.

4.1.16. Led by population work stream - The Health Inequality Mortality and Morbidity Reduction Board

4.1.17. **Proactive engagement on prevention**. Each of the six ICS / STP’s must address specific local needs and continue to make progress reducing health inequalities by improving preventative services, social prescribing, maternity services and services for children and young people, in collaboration with partners in local government and other system partners. At the same time, we expect consistent regional progress on the following four areas:

- **Uptake of the flu vaccination for those at risk**. Eliminate the performance gaps within the national eligibility categories for people living in the most deprived 20% of communities and for Black and Asian groups across the South East region. The six ICS/STP’s must ensure there is high-quality engagement with local communities, employers and religion and belief groups

- **Delivering annual physical health checks for people with learning disabilities,** using the comprehensive evidence-based tool in general practice, and improving the quality of local learning disability registers. The NHS Long Term Plan set out an ambition for general practice to improve performance to 75%, and this is now backed by a £140/head item of service fee, a new Primary Care Network incentive that goes live from October, and a QOF Quality Improvement Module developed by the RCGP and NICE. By March 2021 general practice should aim to return to a level of checks necessary to achieve the 75% annual target, with progress monitored through monthly performance data from an agreed date

- General practice, working with commissioners and wider system partners, including social care and voluntary sector organisations, should develop **priority lists for preventative support and long-term condition management**, including reflecting how health needs and care may have been exacerbated during the COVID-19 pandemic. Priority groups for programmes such as smoking cessation, obesity management, cardiovascular and respiratory condition management, should be engaged proactively, recognising the extra barriers to engagement which COVID-19 has brought. For example, places should focus referrals into the NHS

Diabetes Prevention Programme on individuals of South Asian and Black African ethnicity and those from the most deprived communities

- **Enhanced model of maternity care,** offering continuity of carer to women to at least 35% of women by March 2021. The six ICS / STP's in the region will develop and deliver plans to eliminate performance gaps for those living in the most deprived 20% communities, and for BAME women living in the south east region.

VII. "Ensure that Covid-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised".

4.1.18. Led by population work stream - The Health Inequality Mortality and Morbidity Reduction Board

4.1.19. A good model of **inclusive restoration** of NHS services will prioritise those in greatest need. Within the NHS South East region, ICS / STP reporting will include performance in relation to patients from the 20% most deprived communities (using the Index of Multiple Deprivation); patient ethnicity, with disaggregated data on Black and Asian groups; and patient disability. For example, we could set a regional ambition to have this in place by October 2020, linked to better data recording. Monitoring will initially compare service use and outcomes before and after COVID-19. Performance indicators should include emergency, outpatient and elective waiting times and activity, cancer screening diagnosis and treatment. Key metrics will need to be developed on the equity and quality of end of life care, mental health, children's health services, primary and community services. This will go alongside each ICS / STP using the enhanced measurement of health inequality indicators as set out in the NHS Long Term Plan to further refine analysis of local socio-economic disadvantage and health inequality.

4.1.20. **Mental ill-health** is a significant contributor to overall health inequalities. Many of the measures set out in this strategy will therefore need to particularly support those with a mental, as well as physical, health condition. To prepare for the potential increase in demand on mental health services, the six ICS / STPs should continue to deliver the mental health transformation and expansion programme as set out in the Long Term Plan, delivering improved access, experience and outcomes for BAME communities, LGBTQIA+ communities, older people and other marginalised groups across all mental health care pathways. The ICS / STPs must also work collaboratively, across primary and secondary care, to ensure 60% of people on the GP SMI register receive a comprehensive physical health-check and appropriate follow-up interventions.

4.1.21. **Digital inclusion**. To reduce exacerbating health inequalities through the implementation of digital solutions, new care pathways will be tested for impact on health inequalities, starting with four: 111 First; total triage in general practice; digital mental health; and virtual outpatients. The six ICS / STPs will assess how the blend of different 'channels' of engagement (face to face, telephone, digital) has affected different population groups, including those who may find any particular channel more difficult to access, and put in place mitigations to address likely issues. Each ICS / STP will conduct a review on all four, with agreed actions, published by 31 March 2021.

4.2. Structural, institutional and interpersonal discrimination should be understood by every board executive and non-executive to address and improve the outcomes for our diverse population and staff. The expectation will be every member of every NHS Board will be able to confidently explain to staff and managers (and interview panels) why tackling racism is important for the NHS and demonstrate what they are doing personally to achieve this. It is an obligatory and binding expectation. To gain the insight required to act requires difficult face-to-face discussion, reading, and listening and acting on lived experience. Recognising how this may cause leaders racial stress and they will be supported to develop their awareness and regulation both individually and socially.

Conclusion

5.1. A renewed narrative should focus on the population regularity[10] that health inequalities represent. While we cannot say which individuals will fall ill or die at younger ages, we can observe clear inequalities in health and mortality between social groups. We can also observe that the accumulation of risks and resilience across the life course will typically play out differently for people in different social positions. There are also clearly defined processes through which the social and economic conditions that people live in can enter the body and generate inequalities in health out of inequalities in conditions and opportunities. The health impact of conditions and opportunities across all social determinants of health arise through three main processes, identified by Diderichsen and colleagues[11]. These include: (a) inequalities in risks for illness and disease; (b) inequalities in vulnerability to these health risks; and (c) inequalities in the consequences of poor health. As stated above, these processes involve the more 'traditional' factors behind disease, such as accidents, bacteria and risk factors for non-communicable diseases.

5.2. We need to be very clear about the fact that being less educated, or having a low income, or being a migrant does not *determine* you to poorer health and premature mortality. Rather, what we see are clear social regularities in which people in certain groups or places are having on average worse conditions and opportunities, and therefore on average worse health and higher mortality. However, these social regularities cannot be translated into individual predictions. The reason for this is that there are large individual variations within social groups, although it is also important to note that the size of the variation around the means also follows a social gradient. Groups higher up on the social ladder have on average better health and lower mortality, but they are also more concentrated around that mean. Groups further down have lower means, but also a wider distribution.

5.3. Two matters need to be addressed. First, social structures are not distant from people; rather it is the case that people are embedded in social structures. This may sound very theoretical, but a good starting point for a more practical approach is that social structures (such as organisations, legislation, institutions, norms) are all created by humans, are constantly upheld and recreated by humans, and can also be torn down by humans. We all live in direct connection with all those structures, at home, at work, in the community. To illustrate with a health policy example, we can use increased tobacco taxation versus individual smoking cessation counselling as two ways to reduce smoking rates. The former is a structural change, the latter a form of (preventive) individual treatment. However, the effect of tobacco taxation on smoking rates is realised only when the higher prices affect individual purchasing decisions, in other words when people buy fewer cigarettes because of the higher price. In fact, behavioural change is at the heart of many structural policies,

[10] Goldthorpe, JH. Sociology as a population science. Cambridge: Cambridge University Press, 2016. Google Scholar | Crossref

[11] Diderichsen, F, Andersen, I, Manuel, C. The Working Group of the Danish Review on Social Determinants of Health. Health inequality – determinants and policies. Scand J Public Health 2012;40:12–105. Google Scholar | SAGE Journals | ISI

although the method is quite different from individual counselling. The main point, however, is that people's lives are intertwined with social structures, and that the arguments for going 'upstream' rather than 'downstream' completely miss this fact. Rather, we need to understand inequalities as a result of structural conditions and the individual responses to those. When proposing policies we also need to address both levels, because we cannot afford to refrain from one or the other.

5.4. There are challenges that everyone needs to handle across the life course, and these challenges are much the same in different groups and societies. However, the means and resources to handle them differ a lot both across and within social groups. Inequalities between groups therefore arise from a combination of unequal conditions, unequal opportunities and unequal scope for action, with lower social strata having on average poorer conditions, poorer opportunities and smaller scope for action.

5.5. It is important to stress, again, that the inequalities that we can observe as social regularities are driven by probabilistic processes. Inequalities between social classes or educational groups in living conditions, opportunities and health does not mean that every member of a particular group enjoys the same living conditions or the same health status. On the contrary, there are large variations within social groups, and as discussed above, these variations are also systematically different between groups. Inequalities between groups are driven by the fact that a larger share of members of the lower strata lives in poor circumstances, has poor health status and dies at a young age, not by all members being poor and dying young.

5.6. This distinction is crucial both for understanding the processes involved and for policy design, and policy design needs to consider variations within groups. While it may be easy to conclude that we need tailored policies directed to the groups most exposed or in the most vulnerable positions, this will in most cases be erroneous. If only 15% of women with short education are smokers, it will not be very meaningful to target the whole group. Instead, everyone should be treated and supported according to his or her needs. Children with reading difficulties should receive adequate help and support irrespective of their gender, race or their parents' education. Given the social inequalities in living conditions and opportunities that exist there will certainly be more children with less educated parents who will be in need of extra support to develop their reading abilities, but such support should be offered to all children in need and not conditioned on parents' educational level (an approach often referred to as 'proportionate universalism'[12].

5.7. The system has to use its size, partnership and leadership skill that has seen much improvement in the areas of quality, safety, performance, financial sustainability and innovation to address and reduce inequalities for the NHS, our staff and our population and

[12] Marmot, M, Allen, J, Goldblatt, P, et al. Fair Society, Healthy Lives: The Marmot Review. London: Strategic Review of Health Inequalities in England post- 2010, 2010.
Google Scholar

for the future generations that will receive better care and achieve better health than they do currently.

5.8. Finally, we need as a region and partnership of 6 systems to agree a set of Health and Workforce Inequality performance and improvement metrics to ensure we deliver success for our workforce and population and not to follow in the failures to address these challenges that the past has taught us.

The region is serious about reducing health and workforce inequalities, and we will take accountability and be transparent to those we serve as well as those we employ, in either our successes or our failures. We have the power and the responsibility to prevent any more lost generations, or neighbourhoods left behind or oppressed groups from facing structural and institutional barriers to health. We need to consider the individual and how structural, institutional and interpersonal racism and wider discrimination has impacted on them. We need to use new approaches in addressing policy, focus and the combined power of the region as an anchor partnership to succeed.