NHS Equality and Diversity Council: Embedding levers and accountability workstream options paper

1. The task

Inequalities are stubborn, persistent and difficult to change. They are caused by a range of social and environmental issues as well as issues within service provision which mean that people do not always receive equity in healthcare. Experience has told us of the importance of integrating work to reduce inequality into the mainstream of service delivery.

The EDC commissioned this workstream to review the existing data and levers and make recommendations for action. These will focus on reducing inequalities in access, experience and outcomes for people using health services. The focus is initially on mental health and cancer care, considering all levers for quality covered in the National Quality Board Shared Commitment to Quality.

Through looking at levers, we are working on the "why and what" for reducing inequalities – as well as the "how" at a national level in terms of a co-ordinated approach to using levers. The "how" at a local level, in terms of changes needed to achieve a reduction in inequalities, is the responsibility of all the people working in the NHS. This is out of scope of the working group, although it should be noted that establishing the range of interventions that will most improve outcomes is work that needs to be undertaken either at a national level, or locally with the ability to spread across the system.

Since the confirmation of priorities in the NHS Long Term Plan, this workstream also has an aim to help ensure that cancer and mental health priorities in the plan effectively reduce these inequalities.

2. Work to date on this workstream

Since the last EDC meeting in April 2018, the working group has been established and two meetings have been held. The focus has been on

- Continuing to gather evidence of inequality in access or outcome across all protected characteristics. Then using this work to decide on key priorities where levers may need to be checked for impact and/or amended. Levers clearly need to be aligned so they are all pulling in the same direction – which means setting policy goals first for reducing inequalities, hence the working group attention on identifying key issues. (see appendix A)
- Understanding what existing work we need to take account of and build upon.
- Agreeing a model for how levers can reduce inequalities and potential options for this – see below
- Engaging more widely to understand current work in this area better and to maximise expertise available to the working group – mainly through informal routes.

3. Link with NHS long term plan

This work is critically linked to the development of the NHS Long Term Plan over the past couple of months – as cancer care and mental health care are plan priorities and there is a cross-cutting priority to reduce health inequalities. The working group has been linking in to the process for developing the Long Term Plan, through the NHS England Equality and Health Inequalities team and more recently the cancer and mental health programmes, to ensure alignment of thinking, for example around the role of levers in changing health inequalities.

The current Mental Health Act review may also impact on the best approaches to using levers to improve equality, as there is some focus in the review around inequality in application of the Act and the impact on people with mental health conditions, e.g. in relation to ethnicity.

4. Links with other current work

We are not starting from a blank canvas in looking at how levers can reduce inequalities in mental health care and cancer care. There are a number of initiatives underway that the workstream aims to add value to, rather than replace. The current work underway includes:

- NHS England mental health and cancer care programmes both have existing equality related deliverables, for example in Improving Access to Psychological Therapies and the BME equality programme within the cancer care patient experience programme. There is also a wide programme of work to reduce health inequalities faced by people with serious mental illness, which is a different aspect of equality in relation to mental health.
- Public Health England work on mental health and cancer care (including the new PHE screening inequalities strategy)
- Third sector cancer and mental health organisations also have programmes of work to reduce inequality, for example Macmillan, the Mental Health Foundation Equalities Commission as well as equality focused organisations having programmes of work on cancer care and mental health care, to give just two examples - Young People's Health Partnership and Race Equality Foundation
- Equality and Human Rights Commission have a mental health priority in Is Britain Fairer?.
- "Owners" of some of the national levers are already undertaking some work to help reduce inequality in access, experience and outcomes – see Appendix B

We need to consider how the EDC work can add value to existing work. From our work to date, we believe this workstream has a role in ensuring that levers are co-ordinated to tackle the most pressing inequalities in mental health care and cancer care. From the quick review of the coverage of inequality issues in the main levers in appendix B, we see that this is not currently the case, with different topics prioritised within different levers without an obviously clear rationale.

5. High level change model and key questions

We need to be aware that levers are part of the solution – and sit in a wider model of change. The task and finish group is using a 4 step model to think through how levers contribute to change – this model aligns with other equality change programmes such as the Workforce Race Equality Standard.

	Step	Key questions
1	**Setting the right expectations**	• Who should set the expectations? (National programme leads, local areas, EDC?) • Should expectations be set nationally and/ or locally? • If nationally, what are the key issues/metrics that need to shift and how should these issues be set out? (e.g. through bringing in patient equality standards or via national "goals") • If locally, should there be a framework of expectations/ metrics to help local goal setting? (e.g. through EDS2 work) • Who should be responsible for progressing the expectations – provider organisations, commissioners or local areas? (e.g. STP, ICS, LA in relation to public health functions)
2	**Effective monitoring**	• What data would be required to monitor progress in line with the decisions about setting the right expectations? (some levers require really robust data sets, especially payment levers) • Where are the national gaps in monitoring and is it possible to address these? • Could existing data sets be used better (e.g. work on enabling tracking of people with a learning disability through mental health or cancer care pathways) • Are there local solutions to improved monitoring? • Are there ways of raising ambition without requiring more data collection? (e.g. greater regulatory focus on equality improvement initiatives, or using "deep dive" qualitative reports which have been used successfully in national suicide prevention work)
3	**Providing tools and support to meet goals**	• What national support is in place already that could be harnessed to meet the goals? (e.g. through NHS England workstreams) • Where are there gaps in national support that would need to be addressed? • What local support is in place that could be harnessed to meet goals? Are there gaps? (e.g. Cancer Alliances etc) • What is the relationship with the refreshed EDS2?
4	**Rewards for progress/ Consequences for lack of progress**	• Which levers would be most effective to get these inequalities up the agenda – contractual/ commissioning, payment tariffs, regulatory, other? (strongly linked to question about responsibility) • What is the capacity of each lever to change?

Traditionally amending “levers” may be more concerned with step 1: setting expectations and step 4: consequences, but the working group believes that consideration of all 4 steps are necessary in order to maximise the effectiveness of levers in reducing inequalities. Another key question is whether the same approach would work for different for different programmes, e.g. cancer care and mental health care – or whether there are at least the same principles applied. Would this then work for other long term plan priorities?

6. Initial observations from working group

Discussions and analysis have led to the following early observations:

a) Whilst reducing inequalities has significant priority and visibility within the NHS Long Term Plan, it does not yet have much priority or visibility in national levers.

b) It is also difficult to answer the question of “who is accountable” for this agenda other than “everyone”.

c) This lack of priority in national levers and lack of sharp accountabilities combine to represent a material risk to the delivery of the Long Term Plan.

d) Many of the organisations that “own” levers have attempted to include aspects of reducing inequalities in their approaches, but there is no overall coherence or alignment across organisations in how this agenda is tackled. Indeed, the awareness of what other organisations are working on is mixed.

e) What levers there are for encouraging greater progress on reducing inequalities tend to focus on “setting expectations” and “monitoring progress” and less on the “providing support” and “ensuring consequences”. Consequently, inequalities feature less in the levers that typically have the most “bite” – e.g., payment regimes; special measures regime.

f) Unlike in other areas such as urgent care, there are no national standards or targets for reducing inequalities, making is difficult to use existing provider and commissioner accountabilities and levers effectively.

g) A focus on addressing access inequalities (e.g., in screening or early intervention) is likely to have higher impact in some disease areas and can largely be within NHS control; a focus on the prevention agenda (e.g., differences in smoking prevalence) is likely to be more important in other disease areas, but requires a coordinated NHS and local authority approach.

h) Data quality is poor in mental health, which is a limiting factor to using some types of levers, especially financial levers, and therefore holding to account.

i) The effort to address levers and accountabilities across the NHS system must have credible, dedicated resource able to work across the national

bodies involved if it is to resolve these challenges.

j) Changing levers and sharpening accountabilities on their own cannot "solve" inequality; the role of this effort should be to set a national framework where there is greater incentive and the best environment for providers and commissioners to reduce inequalities.

7. Options for developing the work

1. EDC to be **responsive to each programme in developing the Long Term Plan:** the working group to act as a sounding board for health inequality recommendations coming from Long Term Plan programme directors with no specific model in mind – but ensuring all 4 steps above have been considered. This would be a relatively short term intervention for the task and finish group and would need to be agreed with the SROs leading the development of the plan.
    - **Pros:** responsive to different approaches to tackling inequalities for different long term plan priorities, this may test different approaches which there can then be learning from and may enable some better co-ordination of work on inequality between plan priorities, where this makes sense.
    - **Cons:** it may be difficult to galvanise local areas or providers around a number of different approaches to tackling inequality for different conditions, especially for plan priorities likely to be delivered by the same provider organisations, e.g. acute trusts.

2. **EDC to provide a co-ordinating role which enables existing "lever owners" to co-ordinate work** to improve levers to reduce inequalities where this makes sense, aligning with the outcomes of the NHS long term plan.
    - **Pros –** builds on existing work, in discussions so far this has been popular with programme leads and others. There appears to be a lack of co-ordination at the moment that this could address.
    - **Cons –** this is an incremental approach, not a "new approach" so is less easily conveyed to provider organisations, This means it would not provide an overall impetus to a greater focus on reducing inequality beyond that achieved by incremental improvement to individual levers. Would need to ensure that there were clear outcomes from this work to justify setting up a new cross-organisation structure to do this.

3. EDC to work with others to test the development of **a set of national expectations about reducing inequality** for **each programme with national indicators**– which should be monitored and reported on locally. This could be characterised as patient equality standards (an approach like the WRES). These equality standards could be set at an area level or a provider level and levers can be aligned to these. They could cover either one or more equality characteristics. For example, there could be a mental health patient equality standard that covered a "basket of equality metrics" based on current policy priorities such as reducing over-representation of BME people as detained patients under the Mental Health Act, access to IAPT for BME people and older people, improved monitoring of sexual orientation and reducing over use of anti-psychotic medication for people with a learning disability. Some work on scoping a patient race equality standard in mental health is underway.
    a. **Pros:** clarity in expectations and easy to align levers with metrics. If right metrics were selected, they could work at different 'levels' e.g. a range of organisations in a local system can contribute to the reduction in detention of BME people. Enables national work to measure progress on key issues

and to identify and share good practice based on areas or organisations where metrics have improved.

b. **Cons:** May be unintended consequences for inequality issues that are not selected as key issues or metrics. Needs larger resources to develop as will need consultation, piloting and engagement with patients to get detailed indicators right. Lack of local flexibility to set priorities. In discussions about this approach, there were a range of views about whether metrics could be used where effective improvement approaches are not yet known – some people believing that these metrics could encourage quality improvement and innovation whereas others believing that the focus should be where organisations can immediately apply well-evidenced interventions to improve. There may also need to be an assessment of the costs in sustaining this type of approach.

4. EDC to work with NHS Long Term Plan leads and others to agree **national priority topics but expectations are set locally**, this could be seen as a similar approach to current version of EDS2, or could have added requirements to ensure a tighter focus on specific issues. This would need to align with the development of EDS3 as it goes through consultation.
    - **Pros:** Local flexibility within national priorities enables local areas to focus on the most important inequalities issues for their local populations. If this included a "basket of metrics" that different areas/ providers can then select from this would add greater ability to benchmark progress nationally and share good practice. (Similar to CQUINs)
    - **Cons:** Difficult to apply some levers where there is no consistency in goals. Variable public sector equality duty/ EDS2 reporting means that not all areas or providers are able to carry out good assessments of priorities - may mean that some of the greatest inequalities are not addressed locally. Requires additional work to identify local priorities and report these - so that there is clarity amongst local partners, including people who use services, about which priorities and metrics have been selected. More difficult to measure progress nationally where there are not common goals. Will this drive enough change compared to the current system, which, it could be argued, has not produced enough change to date?

8. Resource requirements

Developing this work to date has relied largely upon a couple of staff in the CQC taking this on as an additional project, supported by others giving their expertise on an ad hoc basis. In order to move the work onto the next stage and depending on the option chosen, it may be necessary to have more resource. There are 2 options for this:

- To ask the NHS England programme directors covering the NHS Long Term Plan and/or the National Directors for mental health and cancer to lead the development of this work, with the EDC task and finish group providing acting as an advisory group. However, from conversations with these teams, resources in these teams may be a limiting factor for taking on new work.
- To ask other EDC members to contribute project management, policy, engagement and analysis expertise to this workstream for the next stage of the development – up to obtaining an agreed proposal which can then be implemented by EDC partner organisations. To do this , the workstream needs a minimum of
    a. 1 FTE project manager
    b. 1 FTE policy/ engagement manager
    c. 1 FTE analyst

9. Summary recommendations/ EDC decisions

1. **EDC to decide which option(s) above the working group should take forward to develop in detail**
2. **EDC to agree on resourcing this work**

Group membership

Dominic Dodd, Royal Free NHS FT, co-chair
Adam Sewell-Jones, NHSI, co-chair
Kevin Holton, Head of Experience of Care and Equality and Health Inequalities NHS England
Rob Webster, Chief Executive, South West Yorkshire NHS Trust
Sean Duffy, NHS E National clinical director for cancer
Emma Rigby, Young People's Health Partnership
Max Edelstyn, Programme Principal, Health, Equality and Human Rights Commission
Campbell McNeill and Claire Laurent, NHS E Cancer programme
Ruth Davies and Jonno McCutcheon, NHS E Acute Adult Care mental health programme
Lily Makurah, Lucy Elliss-Brooks and Donna Glover, Public Health England
Lucy Wilkinson, CQC – secretariat and Fran Tinsley – CQC analyst

Others involved to date

Preeti Kathrecha, EHRC; Sara Munro, Chief Executive Leeds and York Partnership NHS Trust; CQC cancer advisory group; NHS England Acute Mental Health team; Macmillan Cancer Care; Richard Murray, Kings Fund and UCL partners

Appendix A: Summary of key inequalities from working group meeting 1

(note that this covers access and outcomes, rather than experience of care)

Cancer care	• Improving access to cancer care for people with a learning disability • Reducing late/ emergency presentations of cancer for people from some BME communities • Improving outcomes in cancer care for people from some BME communities • Improving monitoring of cancer access and outcomes on the basis of sexual orientation and transgender status • Reducing inequalities in access based on socio-economic status (to be further defined from data)
Mental health	• Access to IAPT for BME and older people – building on pilot • Improved access to other "preventative services" for BME people, to shift over-representation of BME people detained under the Mental Health Act • Improved access to preventative services for disabled people and LGBT people • Use of voluntary sector as "bridge" into statutory services (as a tool rather than an outcome?) • Reducing inequalities in access based on socio-economic status (to be further defined from data) • Intersectionality – eg older LGBT people, younger BME people needing CAMHS

Appendix B: summary map of key levers

Lever	Acts on	Cancer/ mental health	Current inequality coverage	Capacity to change?	Notes
1. NHS Standard contract	All health care other than primary care	both	Equity in access, equality and non discrimination is a "service condition"	? deadline for 2019 contract	Service condition covers both legal requirements under equality act and NHS specific requirements e.g. EDS2 and WRES. Is the issue more about contract enforcement?
2. CQUIN	Acute and MH trusts	both	No specific – though some may have an positive impact e.g. restraint reduction	Set to 2019	
3. Quality premium	CCGs	both	Recovery rate of people accessing IAPT services identified as Black, Asian and minority ethnic (BAME); Proportion of people accessing IAPT services aged 65+; improved access to MH services for children and young people. No equality specific in cancer	**?**	Early access to cancer included – could be extended to cover inequality measures about early access
4. National tariff	NHS trusts	cancer	None	**?**	Not amenable to change to consider inequality issues?

Lever	Acts on	Cancer/ mental health	Current inequality coverage	Capacity to change?	Notes
5. Best practice tariff	NHS trusts	cancer	None	**?**	Not amenable to change to consider inequality issues?
6. QOF	GP practices	both	QOF indicators for serious mental health conditions, depression, cancer, palliative care. Only specific equality content is a measure of % women with severe mental illness who have had cervical screening	Currently under review with a proposal to change to fewer indicators, add some quality improvement indicators and encourage a more person centred approach . Possibility to influence?	Analysis of current QOF suggests it could be driving inequalities in care – as GP practices in more deprived areas are less likely to meet QOF targets but some evidence is contradictory re improvement of these practices
7. CQC assessment framework	NHS trusts, GP practices, local systems of requested by Secretary of state	both	Equality in access and experience covered in responsive key question – not cancer or mental health specific	Difficult to change framework but possible to change supporting information that inspectors consider (e.g. new metrics)	Nationally agreed metrics could be added to CQC "Insight" – monitoring tool for NHS trusts and GP practices and followed through in inspection
8. NHSI single oversight frameworks	NHS trusts	both	A few metrics in quality of care theme are equality related, though not cancer or MH specific – eg mixed sex accom. breaches in acute – others could have positive equality impacts e.g. access standards for people with first episode of psychosis	? Last updated November 2017	There are IAPT metrics but these do not include the equality metrics used in CQUIN

Lever	Acts on	Cancer/ mental health	Current inequality coverage	Capacity to change?	Notes
9. Quality accounts	Providers of NHS healthcare including independent (not primary care)	Both	None specific; though new learning from deaths reporting requirement may help reduce inequalities. Also required to report on 3 areas that the organisation will improve – could include reduction in inequality	Low – prescribed set of indicators set through regulations? Possibility that improvement areas could include reducing inequality?	Available to public through NHS Choices.
10. NICE quality standards and guidance	Dependent on guidance and standards	Both	38 Mental health standards include specific standards on (a) promoting health and preventing premature mortality in BME communities [QS167] covers mental health but not cancer – new this year and (b) preventing assessing and managing mental health issues in people with a learning disability [NG54] and [QS142]including tailored talking therapy and reducing anti psychotic medication) Hundreds of cancer topics -		? for some equality issues in mental health, the need might be more about aligning other levers with existing NICE quality standards covering equality (see left) Less equality content in cancer
11. Other Quality frame works	Dependent on framework	Depend ent on frame-work	Dependent on frame-work. Eg implementation of NHSI Learning Disability Improvement Standards would improve equality in NHS cancer and mental health services	Dependent on framework	Several other improvement frameworks that might be aligned with priorities eg NHSI Patient experience improvement frame-work

Lever	Acts on	Cancer/ mental health	Current inequality coverage	Capacity to change?	Notes
12. Behavioural levers	Individual staff or people using services	Both	N/A – Patients; some work by behavioural Insights team on improving uptake of cancer screening by identifying sub groups of non-attenders and targeting material Staff: Most BI work on equality has been carried out around workforce equality rather than equality for patients (eg clinical decision making) though EHRC has commissioned some work on BI and IAPT referrals. Some other types of learning around equality or "cultural awareness" training do aim to change staff behaviours	New work – would need commission-ing	Would need to partner with other organisations to test effective equality-led behavioural change interventions