EDC05 01/19

NHS Equality and Diversity Council January 2019

Embedding levers and accountability workstream: the way forward

1. Purpose of the workstream and work to date

The EDC commissioned this workstream to review the existing data and levers to make recommendations for action to reduce inequalities in care.

The scope of the work covers inequalities in access, experience and outcomes across Equality Act 2010 protected characteristics for people needing mental health and cancer care. We have also considered socio-economic status when looking at the evidence.

The workstream is considering how national accountabilities and levers should be reconfigured to create the best environment within which providers and commissioners can make progress on addressing these inequalities. The workstream is considering all levers for quality covered in the National Quality Board Shared Commitment to Quality and has an aim to ensure that cancer and mental health priorities in the long-term plan effectively reduce these inequalities.

The working group has met 3 times, most recently on 7th November 2018. The group has:

- collated the highest priority inequalities and examined coverage of equality and inequality in current levers (presented to EDC in October 2018)
- spent time on the "model of change" – concluding that levering improvement in inequality through national levers requires four elements of
    - setting expectations,
    - monitoring progress,
    - giving people the tools for the job and
    - ensuring consequences for good and bad performance (presented to EDC in October 2018)
- Fed these early findings into the relevant long-term plan workstreams
- Heard from a range of group members and others about the current overall challenges and successes in using existing levers to reduce inequalities (see "summary of current situation" section of this paper)
- Considered options for EDC to take this work forward (see "options appraisal" section of this paper)
- Discussed some overarching principles that will be required for any of the options to be successful (see Principles for any option section on this paper)
- The co-chairs have met with Ian Dalton to discuss options.

2. Summary of current situation

a) Whilst inequalities featured within some national accountabilities and associated levers, they are not that visible, high priority or coherent and neither are they as present in the levers with the most “bite”.
b) There are no national standards for measuring inequality which is perhaps the central issue in then using levers and accountabilities.
c) Tackling these inequalities will never be at the top of the agenda for boards and chief executives, unless they feature more prominently in accountabilities and levers *or* unless tackling them is seen as a way of meeting other targets and priorities (e.g. improving overall access performance by a focus on reducing variation in access due to inequality)
d) The Long Term Plan (LTP) states that the NHS will set out specific, measurable goals for narrowing inequalities, including those relating to poverty, through the service improvements set out in this Long Term Plan and that
    - all local health systems will be expected to set out during 2019 how they will specifically reduce health inequalities by 2023/24 and 2028/29.
    - CCGs benefiting from the health inequalities adjustment will also need to set out how they are targeting that funding to improve the equity of access and outcomes.
    - NHS England, working with PHE, the voluntary and community sector and local government, will develop and publish a ‘menu’ of evidence-based interventions that if adopted locally would contribute to narrowing inequalities.
    - CCGs must ensure that all screening and vaccination programmes are designed to support a narrowing of health inequalities.
e) Data quality is a limiting factor, especially in mental health. Though there are plans for improvement in data linked to inequality, time and resources are needed. While there are indicators of inequalities in mental health it has not yet been possible to establish clear indicators of unwarranted variation which can be used confidently to lever improvement without the risk of unintended consequences.
f) Sometimes, data does exist, but people can be uncertain how to act on this or acting on the data is not a priority, and these can also be limiting factors.
g) The Mental Health Act review has strong content on inequalities around ethnicity and for people with learning disability or autism which this work could also help to support.
h) Work in reduce inequalities in cancer is developing through both improving data and culture change to enable conversations and share best practice. There is a clear pathway from prevention to diagnosis to treatment in cancer. This makes inequalities relatively easy to measure and interventions to reduce inequalities relatively easy to identify – but there is still a long way to go to get these working in practice, including taking a targeted, whole systems

approach to cancer inequalities and getting better at translating the quality of data we do have into interventions in practice.

i) Beyond this health pathway there are broader issues in inequality in cancer care. These include tackling broader inequalities that have an impact on cancer prevalence. Another factor is the need to take a holistic view of inequalities post-diagnosis and treatment, such as welfare benefits, employment and housing – and the contribution that health makes to tackling these.

3. Principles for any option:

The working group proposes that the following principles are necessary for any option to work:

1. It must be **co-produced** with people who use services and other stakeholders. This will require resource.
2. There must be visible **leadership** on this agenda – sustained and ambitious action is required to address these long-standing inequalities. There also needs to be a more cohesive and nationally agreed approach. Perhaps a national champion or "tsar" is required. They will also need resource to ensure effective support and implementation, e.g. a small team.
3. Any option should "make it **as easy as possible for people to do the right thing**". And the work will be most successful if NHS staff *want to* engage with it, rather than *have to* engage with it. This means that we need to look at behaviour change as part of the solution.
4. A link must be made between **reducing inequality and improving overall performance.**
5. The intervention must align with the **change model**: setting expectations, monitoring progress, giving people the tools for the job and consequences for good or poor performance
6. The intervention should build on current successful work in this area rather than replace it, in particular the work needs a strong link to the **Long Term Plan** teams leading on mental health and cancer care and an avoidance of duplication of work. In order to deliver the Long Term Plan broad commitments to tackling inequality, there needs to be development of more detailed commitments to tackling inequality within some areas of mental health and cancer care, which this proposal could support. It also needs to align with broad LTP commitments about narrowing inequalities.
7. There must be a strong link made with developing **person-centred care** as one of the "tools for the job", rather than focussing only on finding solutions for groups of people with protected characteristics.

4. Option appraisal:

There are several specific interventions that the EDC could take forward;

a) **Do nothing**: Let the different parts of the system carry on as they were

b) For the working group to become an **advisory group** which shares work underway and provides advice to other programmes of work, e.g. long-term plan priorities

c) A WRES or model hospital type approach, where a **set of markers for monitoring progress** in addressing inequalities are developed and deployed and are then used in national levers.

d) An EDS-type approach of helping NHS organisations to reflect on current performance and **providing access to good practice and tools**, helping organisations to improve aggregate performance through a route of reducing inequalities.

e) To have an access-target type approach where **national standards and targets for reducing inequalities** are developed and linked into the national accountabilities and levers system.

Discussions in the working group have led to the conclusion that these are not "stand alone" options. **A combination of these is necessary to meet all 4 steps in our change model. The main issue is the sequencing of interventions over time.**

The seven options

Combining the interventions gives us seven possible options. These are summarised below, with their main advantages and disadvantages. The appendix gives a fuller options appraisal, in the form of a decision matrix.

	Option Name	Sequence of interventions over time	Main advantages and disadvantages
1	**Working group to become advisory group**	Working group advise "lever owners" to assist in alignment and provide "critical friend" around effectiveness	Low resources required Quick to establish
			Will this provide level of change required?
2	**Do nothing**	None	No resources required
			No change EDC reputational risk
3	**"Reporting to targets" for providers**	Develop markers>embed into tools or develop new tools> introduce standards/targets and link to levers and accountabilities	Tested approach e.g. WRES and model hospital take similar approach Relatively easily understood as additional information that can drive change in willing organisations
			Will this create enough impetus for change?

			What about inequalities where clear markers are hard to define currently? (e.g. mental health) Not aligned with LTP approach of local systems setting goals for narrowing health inequalities Is this in providers control – e.g. commissioning impacts on detention rates
4	**"Reporting to targets" for local areas**	Develop markers>embed into tools or develop new tools> introduce standards/targets and link to levers and accountabilities	Tested approach e.g. WRES and model hospital take similar approach Covers commissioning, integration and provision In line with LTP approach to local health systems setting local goals for narrowing health inequalities
			Will this create enough impetus for change? What about inequalities where clear markers are hard to define currently? (e.g. mental health) Getting ownership at area level
5	**"Targets with tools" for providers**	Pilot national standards where data currently available>embed into tools, levers and accountabilities> expand range of standards over time	Creates greatest impetus because consequences appear earlier in sequence
			What about inequalities where clear markers are hard to define currently? (e.g. mental health) – either risk of unintended consequences or some important issues get missed from scheme Is this in providers control – e.g. commissioning impacts on detention rates
6	**"Support to targets" for providers**	including key inequalities in tools > developing markers>moving to targets	Support first – better buy in? Allows time to develop markers and targets required
			Unless commitment to whole sequence, may not add anything new as will be like EDS3 and other improvement initiatives Does not address commissioning and integration potential for improvement
7	**"Support to targets" model for local areas**	including key inequalities in tools > developing markers>moving to targets	Allows time to develop markers and targets required Allows time to establish how local area could be held to account Could align with LTP approach
			Will this create enough impetus for change as takes time to get to consequences? Getting ownership at area level

Note that there is no "targets to tools" option for local areas listed. It would be difficult to hold local areas to account and create consequences for good and bad performance at an area level as a first intervention with the current financial and area-level working arrangements in the NHS. It is also not aligned with the approach outlined in the LTP of local goal setting.

The decision matrix in the Appendix weights the relative importance of criteria for success and then scores each option on each of the criteria. Doing this, the options are ranked in the following order of preference:

1. **"Reporting to targets" for providers (option 3) joint top with**
2. **"Reporting to targets" for areas (option 4)**
3. "Targets with tools" for providers (option 5)
4. "Support to targets" for providers (option 6)
5. "Support to targets" for areas (option 7)
6. Turning the working group into an advisory group (option 1)
7. Doing nothing (option 2)

However, continuing the working group as an advisory group may be useful, regardless of the other options considered – for example to provide a more cohesive approach to using levers to improve equality in access, experience and outcomes and to support a 'national champion' for this work.

5. Conclusion and recommendation

From this analysis, we conclude that the best option is for the NHS to progress the development of a reporting system of "markers" of health inequalities, where possible aligned to national targets around overall performance (e.g. referral to treatment times etc). This can be supported by tools and then the markers can be embedded into levers or developed into targets with greater "bite" if necessary. This also supports the approach in the LTP of national and local setting of goals for narrowing health inequalities.

Developing the "Reporting to targets" option at a provider level may be easier than at an area level, because of greater development of measures and clearer accountabilities at a provider level. However, the LTP commits to local areas developing their own goals for narrowing health inequalities. Many inequalities in access need addressing through joint working or commissioning attention. Therefore, there are likely to be longer term advantages of developing this at an area level. depending on the development of integration in local health economies. We would therefore propose trying to establish this approach at an area level, possibly with specific organisations taking responsibility for markers, where that makes sense to do so.

This may need to be an iterative process to some extent. For example, as data and our understanding of the issues in mental health improves we are likely to also evolve the indicators that are used.

This should align with the development of implementation plans following the publication of the Long Term Plan. For example, the mental health teams will be consulting with the system and stakeholders extensively to establish how we achieve the ambitions set out in the long-term plan. It will be vital that duplication of work is avoided.

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Appendix: decision matrix on 7 options

Option		1	2	3	4	5	6	7		1	2	3	4	5	6	7
		Advisory group	Do nothing	Reporting to targets: providers	Reporting to targets: areas	Targets with tools :providers	Support to targets: providers	Support to targets: areas		Advisory group	Do nothing	Reporting to targets: providers	Reporting to targets: areas	Targets with tools :providers	Support to targets: providers	Support to targets: areas
Factor	**Factor weighting 1-3**		**Score -3 to +3 compared to Option 1 (advisory group only)**							**Weighted scores**						
1. Potential to drive level of change required to tackle inequalities for people using services	3	0	-3	2	2	3	1	1		0	-9	6	6	9	3	3
2. Possible to establish first intervention within 12 months from current position	1	0	0	-2	-3	-3	-1	-2		0	0	-2	-3	-3	-1	-2
3. Enables all 4 elements of the model for change	3	0	0	3	3	3	3	3		0	0	9	9	9	9	9
4. Minimises unintended consequences where there are not yet clear indicators of unwarranted variation	2	0	3	-2	-2	-3	0	0		0	6	-4	-4	-6	0	0
5. Makes it easy for people to do the right thing: efficient deployment of resources locally, e.g. does not un-necessarily add to data collection burden but assists local action	3	0	-3	2	3	1	2	1		0	-9	6	9	3	6	3
6. Makes it easy for people to "do the right thing": potential to link reducing inequality	2	0	-3	3	2	3	0	0		0	-6	6	4	6	0	0

with other national targets															
								TOTAL	**0**	**-18**	**21**	**21**	**18**	**17**	**13**