NHS England and NHS Improvement Board meetings held in common

Paper Title:	Tackling Inequalities in NHS care
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Summary and action for the Boards:

The pandemic has shone a stark light on inequalities in health and healthcare. The twin challenges of recovering NHS services in an inclusive way, and realising our Long Term Plan ambitions, require focus and drive at every level in the NHS.

This paper outlines (i) the starting position and context, (ii) progress to date against our 2020 priorities and future plans, for the Boards to note and discuss.

Context

1. People in more deprived areas spend more of their shorter lives in ill health than those in the least deprived areas.

2. And during the pandemic we have seen disproportionate deaths from COVID-19 between those living in the most deprived areas and those living in the least deprived areas. These mirror higher mortality due to other causes, in line with social gradient.

3. We have also seen significant disparities in relation to COVID-19 mortality by ethnicity. People of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

3. Chronic Respiratory Disease is a major cause of the life-expectancy gap between the most and least deprived deciles. Recurrent hospital admissions (for acute exacerbations of chronic respiratory disease) are more prevalent in more deprived neighbourhoods. This is reflected by the steep and widening gradient in readmissions for chronic respiratory disease.

The NHS role

4. Most of the fundamental factors driving *inequalities in health* and lie outwith the responsibility of the health care system. E.g. our educational system; economic

and community development in our most deprived neighbourhoods; employment levels pay and conditions; and availability and quality of housing.

5. The NHS nonetheless contributes to tackling inequalities in health in three distinct ways:

   (i) by influencing multi-agency action to address these social determinants. The role of ICSs working with local authorities and local communities is particularly critical here. Nationally NHS England will continue to work alongside Government, and once it is established, the Office for Health Promotion. We can also forge new international partnerships such as that announced earlier this month between the NHS Race and Health Observatory and the US Centre for Disease Control;

   (ii) the NHS is a significant economic actor in its own right. The choices we make as an employer, a purchaser and a local 'anchor institution' can help moderate inequalities. With the inclusion of social value as a criterion for procurement decisions, the proposed new NHS Provider Selection Regime can also help;

   (iii) through tackling *inequalities in healthcare provision*. This is our direct responsibility and must be the prime focus of our action. The enduring mission of the NHS is high quality care for all. That means tackling the relative disparities in access to services, patient experience and healthcare outcomes. International studies such as Commonwealth Fund surveys continue to show the NHS is one of the most equitable health care systems in the world. But at the same time, minimising inequalities in NHS provision is a hugely challenging ambition.

6. In this context, the Long Term Plan placed tackling health inequalities at the heart of NHS goals for this decade. The big population health improvement goals can only be met through far better engagement with those least likely to present at NHS services now: the increase in early cancer diagnosis at stage 1 and 2 to 75%, the detection of the estimated 4.5 million people in England with unmanaged hypertension, and reducing the life expectancy gap for people with learning disabilities and severe mental illness.

7. The COVID pandemic reinforced the need for action. A task and finish group developed *Eight Urgent Actions*. Published in July 2020, as part of the third system letter, this mandated immediate steps for the NHS to take. Our focus was on practical actions that could be achieved quickly, to build momentum and confidence, and establish stronger foundations for medium term progress:

Progress and future plans

8. Overall our assessment of progress is threefold:
   (i) right now, the NHS is more focused and galvanised to tackle health inequalities that at any previous point
   (ii) rapid progress has been made in some targeted priority areas;

(iii) the scale of the challenge will only become fully apparent and addressable through better data and public reporting.

13. On wider determinants of inequalities, momentum on the NHS serving as an anchor institution is building, supported by the launch of the Health Anchors Learning Network in February 2021 with the Health Foundation. With the Kings Fund we have reviewed how the NHS could reduce the causes or impact of living in poverty and are working with two regions to test approaches to increasing youth employment.

14. In summer 2020 all systems developed comprehensive plans to implement the eight urgent actions, and the 2021/22 planning framework placed health inequalities centre stage.

15. Clear progress has been made in strengthening leadership at all levels:

(i) all ICSs and providers have now identified named executive leads for tackling inequalities in care
(ii) all provider executive leads have received health inequalities training using the CQC 'Well-Led Framework, and plans are underway to develop a Health Inequalities Leadership Framework, informed by insights research conducted by the Kings Fund
(iii) in general practice the RCGP has now developed a Health Inequalities training programme, including a leadership module, and work has been undertaken to define the role of Health Inequalities leads for Primary Care Networks
(iv) lead directors have been confirmed in all regions
(v) the NHS Race and Health Observatory is up and running
(vi) NHSE has established a new dedicated NHS Inequalities Improvement Team, led by our first dedicated NHS Health Inequalities Director, Dr Bola Owolabi, as SRO within the Primary Care, Community Services and Strategy Directorate. Ian Dodge is the lead accountable Board Executive sponsor, responsible for supporting Bola and her team. Within NHSE, the inequalities team is now supporting action across all our national programmes and our data and analytics functions through the Health Inequalities Improvement Board.
(vii) a national Health Inequalities Oversight Group of external stakeholders is providing insight and challenge

16. The most important intense and successful work on tackling inequalities has been the COVID vaccination programme. Working with local community and faith leaders, we have been able to increase the rate of COVID-19 vaccination uptake amongst more hesitant groups, for example the vaccination rate has increased from 38% in January 2021 to 70% in May 2021 for people from a Black African ethnic background. The opportunity is to apply the learning to other national programmes. Real time national data tools have been the single most important advance, backed by a panoply of different approaches such as using places of worship and pop-up centres, sharing best practice in community engagement, and culturally competent communications.

17. Primary Care Networks significantly exceeded our expectations in providing health checks for all over 14s with a learning disability. The Long Term Plan set a goal to increase this from just over 50% to 75% by 2024. Last July we challenged PCNs to go faster, and achieve at least 67% by the end of March 2021, aided by a variety of reinforcing actions incentives and support. National performance came in at 73.5%. We are now expecting the NHS to deliver the 75% target in 2021/22, two year earlier than planned, with a focus on implementing the follow-up health action plans.

18. Attention now turns to the goal of increasing physical health checks in primary care for people with a Severe Mental Illness in 2021/22. Given current performance, achieving the 60% target will be very challenging. It is supported by the agreement reached in January with the BMA GPC that all six elements are now included in the QOF from April 2021. Systems have been given additional funding for outreach work to improve uptake of health checks and vaccines amongst people with SMI and we plan to offer additional training for nurse associates to deliver the health checks.

19. Regional mental health teams have been working to identify opportunities to mitigate against inequalities in access, experience and outcome for each mental health pathway. Systems have now validated plans to develop the mental health transformation and expansion programme in an inclusive way, This will be aided by better data, with new data quality KPIs developed and put in place for the Mental Health Services Dataset (MHSDS).

20. Significant further progress is required in 2021/22 to deliver against the 35% continuity of maternity target set out in the Long Term Plan. There are 214 ‘carer continuity’ teams in areas of deprivation, and 165 teams in areas with large black or ethnic minority populations. Health Education England have funded virtual training up to May 2021. However, an October 2020 survey showed that only 15.9% of eligible women were on a ‘carer continuity’ pathway. This survey is being repeated to obtain updated information. The inequalities improvement team will be working with the maternity team to develop a dedicated improvement plan on continuity of carer.

21. Nationally we have mapped out work on digital inclusion across four different service areas (mental health, primary care, NHS 111, and outpatients) and reviewed the emerging evidence base on the potential impact of the adoption of remote consultations on patient access, and on health inequalities. All 42 ICSs have reported back to NHSE on plans to mitigate against digital exclusion. We have assessed these reports to identify:

    - current capacity at ICS level to implement remote consultations inclusively across different service areas, and to evaluate the acceleration of remote care during the pandemic on different patient cohorts
    - examples of good practice, which could be spread more widely
    - how NHSE/I might further support local systems to mitigate against digital exclusion

22. We have seen significant improvement in the completeness of health inequalities datasets. We are now tracking elective services and 2-week cancer referrals and first treatment by patient ethnicity and deprivation quintile. This has been aided by a new tool that displays missing invalid and not stated categories for ethnicity. Similar indicators are being developed for diagnostic activity, mental health, specialised services and children's health services. Actions are in place to improve data collection on ethnicity across primary care, outpatients, A&E, mental health, community services and specialised commissioning. Work is underway with NHS Digital to continue to improve the coverage of disability data.

23. Whilst we saw disparities in access to NHS care by ethnicity and deprivation after the first wave of the pandemic, for many services this recovered. Our work on Long Covid also includes dedicated analysis and focus on tackling inequalities.

24. As part of this year's NHS Operational Planning, the Eight Urgent Actions in the Phase 3 letter have been distilled and focused into Five Key Actions that systems are progressing.

25. A key focus of the Health Inequalities Improvement Team will be to continue to drive forward delivery of these five priorities at a system level. This includes specific projects and convening ICS and Provider Health Inequalities Leads through the Health Inequalities Forum, which the Team has established and oversee.

26. This will be achieved by affecting the wider health eco-system, including payments, incentives and performance levers, to deliver improvements in health inequalities. For example, health inequalities criteria are included in the Elective Recovery Fund Gateway. Alongside mobilising professional networks in the system, we are seeking to create a positive health inequalities improvement culture, and the capacity and competence for change.

27. Paramount to driving long-term change and a quality improvement approach is having sufficient, high-quality granular data to measure performance on health inequalities across services. Building on the success of the COVID-19 Vaccine dashboard we are developing a similar tool to provide actionable intelligence for region and systems to drive forward improvements in health inequalities. The development of the Health Inequalities Improvement Dashboard (HIID) is a key deliverable of the overall Health Inequalities Improvement Programme and will help to drive and support the delivery of the five key priorities outlined in the 2021/22 NHS Planning Guidance. The initial focus of the Health Inequalities Improvement Dashboard will be on key metrics related to the priorities in the 21/22 Planning Guidance.

28. In addition to the actions undertaken during the last year and currently underway, moving beyond the pandemic and the immediate NHS recovery, we want to redouble our efforts to see sustained progress in reducing health inequalities in five key clinical areas detailed in the NHS LTP, including cancer early diagnosis, hypertension detection, and respiratory disease management.

29. During 2021-22 we will launch the ‘Core20PLUS5’ initiative to drive targeted health inequalities improvements in the following areas:

Core 20 – Most deprived 20% of our population

PLUS – Other population groups as identified by local population health data e.g. ethnic minority communities

5 – Targeting five key clinical areas of health inequalities:

1) Early Cancer diagnosis (screening & early referral),
2) Hypertension case finding,
3) Chronic Respiratory disease (driving Covid & Flu vaccination uptake),
4) Annual health checks for people with Serious Mental Illness,
5) Continuity of maternity carer plans

Conclusion

30. The Boards are invited to note progress and plans.