Publishing Approval Reference: PAR1779

Tackling inequalities in healthcare access, experience, and outcomes

Actionable Insights

This guide has been commissioned by The Health Foundation and NHS England and co-written by the Yorkshire and Humber Academic Health Science Network with an expert reference group.

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Actionable Insights

This document aims to support NHS systems in reducing healthcare inequalities and compliments the Healthcare Inequalities Improvement Dashboard and Actionable Insights tool.

When it comes to tackling inequalities in healthcare there is no ‘one size fits all.’ Rarely can one successful action or intervention be simply lifted and shifted to another place and what works well in one locality may not work in another. There are, however, common ingredients for success.

Based on analysis of 32 case study examples for tackling inequalities in healthcare, four themes emerged. These are proposed as necessary foundations for sustained service level action.

1. **Creating an enabling system context**
2. **Building clear and shared understanding**
3. **Maintaining a sense of urgency and commitment to act**
4. **Focusing on implementation, impact and evaluation**

1. Creating an enabling system context

Improving equality in access to, experience of, and outcomes from a single service or pathway of care will be dependent on the wider system context. There will need to be alignment in vision and priority at every level. Well-intentioned teams will struggle to have impact without this.

The following checklists set out the conditions needed to support sustained action for:

- System leaders in Integrated Care Boards (ICBs), Integrated Care Partnerships, provider collaboratives and within individual NHS bodies to consider whether they are creating the necessary conditions for improvement.
- Service teams to assess whether they are working within an enabling context.

1.1 Systems leadership

☐ Does the ICS have a shared vision and ambition for reducing healthcare inequalities?
☐ Is this ambition regularly communicated with leaders using every opportunity to reference the importance of reducing healthcare inequalities?
☐ Is there a dedicated and appointed health inequalities senior responsible officer?
☐ Do leaders recognise and reward efforts to reduce healthcare inequalities?
☐ Is there visible and active collaboration across all NHS organisations, voluntary sector partners and communities?
☐ Has leadership been sought at the development stage of the project?

1.2 Governance and resourcing

☐ Are the implications for healthcare inequalities considered across all policies, strategies, programmes of work and pathways?
☐ Are care pathways regularly reviewed to consider the extent to which they enable equitable access, experience, and outcomes?
☐ Are system resources allocated on the basis of 'proportionate universalism'? That is, universally, but with increased scale and intensity in line with levels of deprivation, disadvantage and existing healthcare inequality?
☐ In allocating resources are opportunities identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits?
☐ Are investment decisions delivering the maximum benefit to the local population rather than individual providers?

1.3 Data and intelligence

☐ Is data on patient ethnicity accurate and comprehensive?
☐ Is patient level data about potential risk factors complete in order to enable identification of individuals with the greatest need and risk stratification?
☐ Is the data available to create a shared systemwide understanding of the most significant healthcare inequalities and health outcome challenges facing the local and regional populations?
☐ Do information governance agreements enable effective data sharing and information exchange between partners. Are these being utilised?
☐ Are analytical capabilities fully utilised across business intelligence functions in local authority, public health, and voluntary sector?

Good practice example

The pilot Did Not Attend (DNA) Programme for respiratory services.

Serving a vibrant and diverse population, University Hospitals of Leicester NHS Trust (UHL) provides acute care and treatment for over a million people across Leicester, Leicestershire and Rutland (LLR), and the surrounding counties.

Many people living in Leicester and the broader LLR system live in areas of significant deprivation and poverty; there are high rates of smoking, obesity and harmful alcohol use, in addition to multiple chronic health problems. The population has a lower-than-average life expectancy and more years lived in poor health. They also currently face some of the longest waiting times for treatment in England; one in ten people in LLR are currently on a waiting list at UHL.

Understanding the population is fundamental to this and relies on having good quality, robust data available. In addition to local data, national tools such as the Healthcare inequalities improvement dashboard, bring together healthcare inequalities data in one place to provide actionable insights on which meaningful interventions can be based.

Chronic respiratory disease is one of five clinical areas requiring accelerated improvement within the national Core20PLUS5 approach and the programme has been designed to improve access to services and the efficiency of outpatient capacity use. Using local data, the trust identified that many of those not presenting at appointments (DNAs) belonged to deprived communities and/or were of ethnic minority backgrounds. To address this, a team of volunteers and colleagues proactively contacted patients from population groups identified as being more likely to DNA. This is in order to offer support with travel costs and car parking, as well as longer appointments where needed. Initial results have shown a significant difference in attendance for those contacted. DNA rates among this group were less than 1% compared to 50% for patients who were not contacted.

In 2021/22 there were over 4,000 DNAs in respiratory services alone at UHL: the majority affecting patients from the lowest indices of multiple deprivation. The economic case for improving equity and inclusion within our services is clear. However, the priority for UHL is improving the quality of our services for patients; enabling those in greatest need to access the services and clinicians which are most likely to benefit them.

The work of this pilot is easily transferrable to other services. UHL have now started to analyse waiting lists by deprivation and ethnicity, and are working on how they can improve access to elective care for patients with a learning disability

2. Building clear and shared understanding

Interventions for tackling healthcare inequalities need to be informed by understanding of how they are created and perpetuated. They also need to recognise that groups and communities are not homogenous, and their needs will differ.

The more precise the understanding of the inequalities in access, experience and outcomes for different groups, the more effective the response will be. This requires close working with local communities which will deliver solutions that are designed around their needs.

2.1 Start with the data

Good quality data is essential for providing insights that can drive improvements in tackling inequalities in healthcare. Careful analysis of data can expose systematic inequalities that are having a significant impact on certain communities.

- ☐ Are data sets are accurate, complete, and timely?
- ☐ Do data sets capture key characteristics (such as ethnicity or learning disability) so that those with the greatest need can be identified quickly?
- ☐ Have you looked beyond existing data sets to identify the local scientific and data community assets?
- ☐ Have you engaged with and built relationships with local informatics teams and data scientists to understand the meaning behind the data to identify any trends or patterns of systematic inequalities?

2.2 Test the data with lived experience

Healthcare inequalities are often complex and caused by many factors. The testing of data with people's lived experience enables a better understanding between what the data shows and reasons behind it e.g. societal, cultural etc.

- ☐ Have you brought together people who have experience of inequalities in the service areas you are reviewing?
- ☐ Have you used public and patient reference groups, engagement events, partnership boards opportunities for the public, programme board lay membership and/or your local Healthwatch and community champions?

Good practice example

Tackling inequalities in the diagnosis, service access and support for people with autism and neurodiversity

The Digitally Acting Together as one (DATA 1) project in Bradford created action on inequalities in the diagnosis, service access and support for people with autism and neurodiversity from deprived communities.

The project connected datasets from across health and social care to allow data scientists to analyse and learn more about patterns of vulnerabilities and how they intersect and interact.

Data highlighted that large numbers of children were not being diagnosed until much later in their educational careers and structural inequalities were driving this. For instance, children born to mothers without educational qualifications were being diagnosed two years later than children born to educated mothers.

Further analysis assessed ‘key red’ flags to detect undiagnosed autism earlier. The data was then tested with key stakeholders including teachers, other services and the lived experiences of parents and pupils themselves.

Key stakeholder agencies and partners met to discover what the most effective response required. Activity then explored how the system needed to organise itself to respond effectively to the challenges discovered via the analysis. This led to the development of the ‘success project’ which demonstrated using those insights to deliver a faster and more efficient process for identifying children with undiagnosed autism in schools. Doing this in a school environment created an effective multi-agency whole system response involving teachers, wider services, parents and students.

Work with the data scientists to develop data infrastructure and tools to model patterns of vulnerability allowed:

- Front line practitioners to identify risk and intervene earlier
- Communication between practitioners enabled risks to be shared and activity coordinated
- Commissioners to better understand and respond to the needs of localities [using anonymised data].

Engagement at an early stage with local system senior leaders secured backing, sign up and commitment to help overcome organisational boundaries and identified available resource to support the project.

The project has been a success and is being picked up nationally with others seeking to model the same approach.

2.3 Co-design solutions with the communities the services are intended to benefit

The role of people and communities in creating health and wellbeing has increasingly been advocated in health and social care. Yet, never has this been realised more profoundly than during the arrival of COVID19. During the pandemic community influencers and connectors engaged as equal partners around a common concern. This sparked fresh conversations and actions based on lived experience and real-life cultural insights. From vaccination clinics in mosques and other faith settings to pop-up clinics and Covid outreach buses, there are many examples of how interventions can be made differently and better.

Systems leaders and service providers can build on the community partnerships developed during the pandemic to harness continuing insights into the adequacy of current service models. Use this checklist to co-design activity with your communities.

For example:

- ☐ Identify community assets - for example, faith settings - and draw on community adhesion.
- ☐ Take time to foster links, develop relationships, build trust and dialogue. Recognise how long it can take to engage and recruit people.
- ☐ Explore any sensitivities with the community and have frank, open discussions to determine barriers and understand what is important to people and what might be driving behaviour.
- ☐ Identify and work with community influencers, connectors, faith leaders, voluntary sector leaders, community activists who know the community well and are trusted members of the community you want to work with.
- ☐ Identify NHS staff who are from and have connections with the community, and involve them in the action or ask for their guidance and advice. Where possible, engage professionals who are in the same ethnic group to benefit from their community insights and lived experiences.
- ☐ Place genuine and meaningful decision making with local communities to identify new approaches that meet their needs. Effective partnership working can itself create greater agency among the most marginalised populations, enabling people to take steps to improve their own health and the health of their population.
- ☐ Where possible, visit the communities where people are from, rather than bringing them to unfamiliar, professional environments. Ensure when engaging with communities, groups and individuals, that the venues and the resources being used are safe and encouraging environments for people to share their stories.
- ☐ Enlist the help of a facilitator to effectively engage and ensure meaningful interactions and tangible action.
- ☐ Ensure that people and communities see that their input has been taken seriously and the tangible results.

2.4 Established community engagement models and further information

West Yorkshire Health and Care Partnership have a communications and engagement strategy which outlines how they engage with the public to inform the ambitions of their partnership. This infographic outlines their principles for patient and public engagement along with their communication and involvement objectives.

Yorkshire Ambulance Service NHS Trust outline in their Community and Engagement Strategy 2021 – 2024 which includes objectives, principles and their approach to engaging with communities including resources required and case studies from their community engagement pilot.

Solent NHS Trust developed their communications and engagement strategy in partnership with local people. The trust has identified four stands of work to drive their ambition which include building trusted relationships with the local population, bringing on board all Solent staff, effective data collection, analysis and reporting, and a comprehensive delivery plan.

Health matters: community centred approaches for health and wellbeing provides information on community centred approaches and how to create the conditions for community assets to thrive.

Good practice example

Harnessing the power of people and communities

In April 2020, in response to Covid, Barts Health and partners initiated an Interfaith and Community forum with faith and community stakeholders, the local authority, CCG and Barts Health colleagues.

The forum engaged with representatives and leaders from communities, rather than community members or service users. It took place via regular Zoom calls, with intervening action as needed. Discussions and actions covered several Covid topics, including vaccine research and the winter 2020 flu vaccinations. The weekly calls were mainly information sharing and insight gathering, to inform Barts Health, local authority, NHS partners and community Covid responders. Additional work agreed and undertaken by forum members outside of the weekly calls included the production of video information resources for community members.

An evaluation of the forum outlined the key impact and success factors:

- There was consensus that the forum ‘felt’ positively different than past engagement with Barts Health or previous experience of a faith forum.
- Users described an openness and ability to speak freely to identify important issues that mattered to the community and Barts, or other organisations
- It created an equal power dynamic and genuine sense of collaboration with communities to understand issues and seek solutions
- The forum generated momentum and action - not a tick box exercise.

While the Barts footprint provided a common point for people to come together, there has been a multiplier effect locally beyond the impact on Barts Health’s work.

The forum was instrumental across the North East London patch in sharing information and gaining insights into the response to Covid challenges from various organisations resulting in:

- The sharing of information to other stakeholders and communities
- The creation of high-quality resources
- Insights which have been of value to the work of many stakeholders across the wider NHS, local authorities, and community
- The forum work filled a gap in engagement, did not duplicate work other partners, such as CCG or Healthwatch and brought different perspectives and opportunities for reaching communities.

3. Maintaining a sense of urgency and commitment to act

Reducing healthcare inequalities takes time and commitment. While the task has to be everyone's responsibility, the case studies illustrate the importance of keeping the issues high on peoples' agenda. Strategies for doing this include:

3.1 Raise awareness

- Ask questions at forums, boards and meetings to raise awareness and the importance of an issue.
- Raise the issues underpinned by data and insights at the top level of the local system, organisation and/or department to ensure engagement, sign-up and commitment.
- Be clear about the level at which the issue needs to be raised depending on the size and nature of the issue and the level of response required. This may range from raising it at national forums, to ICS levels forums, to local place-based partnership boards to individual organisational boards or department heads.

3.2 Engage leadership on the issue

- Identify the 'leaders' across all the stakeholders' organisations and engage as early as possible with those with shared values and shared determination to improve the lives of those they serve – passion is as much an enabler and resource as funds.
- Identify any system barriers and escalate where appropriate – this will create attention and potentially resource backing for the response.
- In the case of a partnership response, seek endorsement at board level on the issue to help overcome organisational boundaries.

3.3 Engage hearts as well as minds

- Tap into people's sense of fairness. Emotional connections with the issues will help gain support and momentum for action.
- Tell the story through the lens of lived experience and the impact it is having.
- Describe the role everyone can play to ensure successful actions or interventions.
- Identify champions to push this work forward from the beginning and help maintain momentum.

3.4 Commitment of resource

- Identify and confirm resource requirements (people, expertise and financial) from the outset otherwise there is the risk of burn-out as people struggle to make the changes needed.
- Identify any training needs.
- Make a clear and compelling case for resource, its impact, any return on investment and savings to the system.
- When presenting a case for a healthcare equity issue, ensure it covers the statutory and legal responsibility case, the financial case and the moral case. This will strengthen the rationale and increase the chance to resonate with different stakeholders and their interests.

Good practice example

Launch of a Health Inequalities Academy

West Yorkshire Health and Care Partnership launched a Health Inequalities Academy to equip staff with the skills needed to understand and address inequalities, spark curiosity, and inspire action. The Academy also aims to equip all staff with an understanding of the individual and collective action that can be taken to create a more equitable health and care system. A particular focus is reducing inequalities related to ethnicity, deprivation, mental health and learning disability status and inequalities by health inclusion groups. The Academy covers all clinical priority areas.

The Academy was launched with a system wide three-day event to over 500 delegates in March 2021. This was an initial opportunity to learn from national and local good practice.

It then established multiple different channels for learning and development including:

- Sector and population specific communities of practice e.g., acute trusts, mental health.
- Learning events – Trauma, Adversity and Resilience, Health Inequalities Grant Funding Showcase, Kings Fund Leadership Development session.
- Health Equity Fellowship Programme – 30 fellows to undertake a nine-month development programme with protected time to work on a health equity project alongside a training programme run by Health Education England and University of Leeds.
- Website – repository of information and access to training resources.
- Bespoke learning modules – developed in partnership with Fairhealth for PCN Health Inequality leads and Acute Trust colleagues.
- Population specific training resources – co-produced with community members for transgender and gypsy and traveller populations.

4. Focusing on implementation, impact and evaluation

The case studies highlighted high levels of commitment to reducing health inequalities. However, many teams find it harder to point to impact. Maintaining senior level commitment to the agenda will depend on being able to show results. The ability to do so will be increased by:

4.1 Using a logic model

- Develop a logic model to help make the connection between short-term actions and longer-term impacts.
- The logic model can support the sustainability of your initiative by helping to create more manageable steps that can contribute to the overarching aim over time and help you to always keep the bigger picture in mind.

4.2 Have an orientation towards action

- Establish a project team to drive the project or action forward including good communications and engagement support alongside subject matter experts and administrative support.
- Start small then build up, using successes to bring additional partners on-board.
- Utilise quality improvement expertise within the organisation including tools and techniques.
- Adapt existing resources and tailor to your needs.
- Identify others who have done something similar or are tackling a similar issue and learn from and with them.

4.3 Action, test and learn

- Establish a framework for monitoring the success of interventions in improving equity in healthcare against specified metrics.
- Try out new and different innovative approaches and if they fail (which they might) do not feel discouraged, try something else.
- For a new action or intervention try soft launches to ease staff into their new roles. This may include low key events with no publicity.
- Insights generated will be of value to the work of many stakeholders across the wider NHS, local authorities, and community so please share.

4.5 Keep communicating, promoting, and sharing

- Develop a communications plan from the outset – this is key to be able to engage the target population, but also to make it known further afield. Press releases, social media, campaigns are all powerful tools.
- Engaging with communities and identifying the heart of the problem may be tough, but the work and journey can be fulfilling, enjoyable and inspiring - so energise people positively and enjoy ‘small’ successes.
- Establish a recognised brand (or use an existing campaign which is trusted and known by the community).
- Ensure you have the right people communicating the right message to the right cohort.

Section Four - Case Studies

The following criteria was used to assess the suitability of case studies for the purposes of this publication.

Criteria	Detail
Scope	The action or intervention must be within the scope of the NHS system. The case study may be from outside of the NHS but can be replicable in the NHS.
Implementation	The action or intervention must have been implemented. Concepts and ideas that have not been implemented or tested were not considered.
Actionable insights	The action or intervention needs to have clear instructive guidance and actionable, practical insights that others can adapt and apply to their local context.
Target population	The action or intervention can target the 20% most deprived population and (PLUS) other identified health groups e.g. ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveler communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.
Priority actions	The action or intervention can relate to the five priority action areas **1.** Restore NHS services inclusively **2.** Mitigate against digital exclusion **3.** Ensure that datasets are complete and timely **4.** Accelerate preventative programmes **5.** Strengthen leadership and accountability
Clinical areas	The action or intervention can contribute to one or more of the five clinical areas of focus: Maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis, hypertension case-finding
Impact and outcomes	The action or intervention must demonstrate evidence of impact

Following a review by a group of national experts, the following six case studies were agreed for inclusion:

Case study	Geography	Target population	Healthcare Equity Issue	Clinical area	Actionable Insights
Case study 1: Increasing vaccine uptake	Keighley, West Yorkshire	Bottom 10% IMD scoring LSOAs	Vaccination uptake for ethnically diverse communities and population groups	Respiratory	**1 and 4**
Case study 2: Population Health Management Programme – Heart Attack	Bristol, North Somerset and South Gloucestershire	People living in the highest deprived quintile	Improve the health and well-being of a group of people who were at higher risk of developing heart failure	Cardiovascular disease	**1, 2, 3 and 4**
Case study 3: Physical Health Checks for people with Severe Mental Illness (SMI)	Coventry and Warwickshire	People with Severe Mental Illness (SMI)	Physical outcomes of those with Severe Mental Illness (SMI)	Mental Health	**2 and 4**
Case study 4: Nudge the Odds	South Yorkshire and Bassetlaw	South Asian and Romanian population groups	Uptake in cancer screening from areas of deprivation and underrepresented communities	Cancer	**1, 2, 3 and 4**
Case study 5: Health Equity Assessment Tool (HEAT)	North West Coast	Groups identified via health equality assessment	Various healthcare inequalities	Patient Safety – Multiple Clinical Areas	**1, 2, 3 and 4**
Case study 6: Reducing inequalities in Covid-19 vaccinations in North East London	North East London	Different ethnic groups/deprivation quintiles	Vaccination uptake amongst ethnically diverse groups	Respiratory	**1, 2 and 4**

Case Study 1: Increasing Vaccine Uptake

Increasing vaccine uptake for ethnically diverse communities and population groups across the Airedale area that live in some of the most socio economically diverse wards in the country.

Geography	Target Population	Healthcare Equity Issue	Clinical Area
Keighley, West Yorkshire	Bottom 10% IMD scoring LSOAs.	Vaccination Uptake	Respiratory

Target population

Central Keighley communities with significant levels of deprivation with a large ethnic minority population, mainly Pakistani and Bangladeshi residents. Eastern European communities as well as a significant population of white working-class communities living in poverty (old and young).

What is the health equity issue being tackled?

Vaccine uptake amongst ethnically diverse communities and population groups.

What informed the decision to tackle this issue?

Due to significant diversity in ethnicity, culture and the very high levels of socio-economic deprivation, we anticipated significant inequities in vaccination access and uptake. Locally we understood the scale of vaccine hesitancy, and that it would require a concerted, collaborative, proactive and innovative effort to reach out to the most vulnerable. Data showed the stark variation in vaccination uptake from between our most deprived communities and the more affluent areas locally.

What was the approach or intervention?

Our immediate action was to be proactive and innovative in how to improve access and reach out to our most vulnerable communities to overcome the anti-vaccination myths and campaign that was impacting vaccination uptake. Our trusted relationships and Voluntary and Community Sector (VCS) networks were strong due to our previous work and investment in communities. We invested in a dedicated community engagement / innovation role to enhance these.

We promoted vaccine uptake through social networks and local community organisations. We sought to understand the concerns underlying vaccine rejection. We seconded and onboarded 28 staff from the local VCS into our Modality Primary Care Network (PCN) to bring those skills and relationships in-house and strengthen our approach. We partly funded these additional health coach roles (from a variety of local charitable or community organisations) using PCN underspend monies. Each week, health coaches are given a list of patients who have declined the vaccine, need help accessing vaccine centres, or who have not been contactable when invitations were made. Health coaches also promoted vaccination in their communities and worked with community leaders to dispel vaccination myths.

We worked with community partners and VCS health coaches to deliver 30 pop-up vaccination clinics across a range of community and faith settings including:

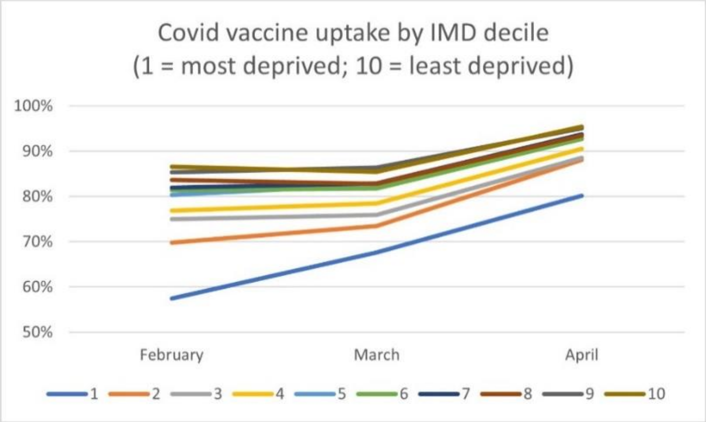
- Two large mosques and a Muslim faith-based community centre
- The local Bangladeshi Community Centre
- An Asian Women centre where we delivered the countries first female only vaccination event, using a diverse female staff team with cultural competence
- Local College, shopping centre and church

- A range of community settings serving some of the most deprived communities.

Impact, outcomes and key successes

Health coaches have had 800 conversations with patients. In February 2021 we launched our first vaccination clinic in a mosque that was attended by 160 people. We then ran another pop-up clinic at the mosque which served a further 500 people. We set up a further two clinics all of which demonstrated the importance and success of having a community-based clinic. In June 2021 we switched the mosque site from being a pop-up clinic to become our Keighley central vaccination centre. At the time of writing, we have vaccinated over 50,000 people mostly from the most deprived and diverse communities.

Despite our overall vaccination uptake being lower than the most affluent areas locally, the graph below evidences the significant gains and increase in vaccinations because of our concerted and proactive efforts.



The table below demonstrates the significant progress we have made locally when compared to the vaccination uptake rates of practices working in similarly deprived communities across the district. To date vaccination and booster update data for the target IMD area compared with similar IMD areas across Bradford shows a significant uplift.

IMD area MSOA	Vaccination 1	Vaccination 2	Booster
Keighley central	67.4%	58.6%	33,6%
Manningham & Lister Park	59%	50.7%	17.6%
Girlington	57.3%	48.5%	17.2%
Brown Royd	54.1%	46.0%	15.7%
Central Bradford	56.5%	47.7%	18.1%

Dates and figures for the above table are accurate to 5th January 2022

As well as the successes in increasing vaccinations we:

- Optimised community assets and harnessed these for other healthcare priorities.
- Used these strong links and relationships to improve work around health checks, identifying and supporting people living with hypertension, supporting digital consultations, increasing volunteering opportunities and utilising local community networks to promote health messaging and opportunities.
- Continued to devolve power and allow communities to lead where appropriate.
- Used our communities and community leaders and advocates to send strong messages that counter the anti-vaccination messages and dispel myths.
- Learned and continue to ensure our services continually improve in cultural awareness, sensitivity - using insights into lived experience to improve our services and reduce the inequalities in service access, experience, and outcomes.

- Invested in our communities and continue to work with local community assets.

What have been the key challenges?

- Continuous Anti Vaccination messaging
- Can’t be bothered attitude
- Resource
- Engaging the younger population

Contact for further information

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Case Study 2: Population Health Management Programme – Heart Attack

Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System took part in the national 22-week Population Health Management Development Programme to help find and support groups at higher risk of developing heart failure and significant health inequalities.

Geography	Target Population	Healthcare Equity Issue	Clinical Area
Bristol, North Somerset and South Gloucestershire	People living in the highest deprivation quintile	To improve the health and well-being of a group of people who were at higher risk of developing heart failure	Cardiovascular Disease

Who is the target population?

People living in the highest deprivation quintile, based on local data. People who live in the more deprived areas of BNSSG are more likely to die 7.5 years earlier for men and 6.7 years for women. Overall, people living in those areas are not only on average, more likely to die earlier but also have 10 fewer years of good health than others living elsewhere in the region. The data showed that the people in this group were more likely to die or develop more serious health problems as well as being more likely to need high-cost care and resources in the future. 47% of the group are from a Black, Asian and Ethnic Minority background.

What is the health equity issue being tackled?

Detection and supports for groups at risk of developing heart failure and significant health inequalities.

What informed the decision to tackle this issue?

A linked data set was interrogated using a Population Health Management (PHM) approach to produce a report specifically identifying drivers of emergency admissions by clinical risk, multimorbidity and matrix segmentation for the Primary Care Networks (PCNs). The data used linked from general practice, acute, community, wider determinant and mental health services. It showed that the key attributes of people to focus on were:

- people within the highest deprivation quintile
- obese with BMI =/>35
- hypertensive
- coded with depression and anxiety
- aged between 40—69

A cohort of 102 people with these combined attributes that the data showed as being at higher risk of developing heart failure were selected.

What was the approach and intervention?

The programme included action learning sets helping health and care professionals to:

- link local data
- build the capability to find rising risk groups of patients

- learn about predictive modelling using costed segmentation
- design and explore how to deliver new models of care for identified patients
- track and monitor the impact of interventions.

Using a PHM approach, we have improved the health and well-being of a high-risk group of patients identified by our linked datasets as needing more support. This has enabled us to offer patients a menu of local support including:

- an appointment with a social prescriber to discuss their personal needs including onward referral to other services including weight management and exercise programmes
- medication reviews and annual health checks
- links to peer support
- a Healthy Heart Group consultation.

Based on the data, a strengths-based approach was developed to create short, medium and long-term deliverables:

- Short - Structured medication reviews, improved patient understanding of heart failure, improved self-reported levels of exercise and improved participation with existing services
- Medium - Improved wellbeing scores, improved health literacy, reduction in emergency admissions, increased physical activity, lower blood pressure, reduced smoking rates, improved mental health, improved understanding of nutrition and diet
- Long - Reduction in admissions for those with heart failure, fewer appointments in GP surgery, reduced cost to NHS and social care, sustained improved wellbeing score, increase social support networks, patients have positive experience, wider determinants addressed.

Outcomes and Impact:

- Strong relationships with social prescribers, the wider PCN team, the VCSE and peer networks which we will continue to build on
- This systematic approach to identify and address inequalities and their causes is becoming embedded into the emerging culture of the PCN supporting an emerging model of proactive care and collaborative working at place level
- Patients flagged on the system and being proactively followed up for their key statistics during their annual health check for weight and blood pressure.

What have been the key successes?

We carried out Patient Activation Measures on first contacts with the patients, often with the social prescriber. These will be repeated at 3, 6 and 12 months. This has brought them to the point they are at in terms of the outcomes.

Key challenges and potential solutions

- The pandemic has reduced capacity and has limited interventions.
- No clear revenue streams for creating and implementing the intervention especially at the practice level.
- Data sharing within the PCN- an identified person with EMIS log in for all PCN practices could be a potential solution for this.
- Unclear how follow up of metrics in the longer term will be done e.g. repeating Wellbeing questionnaire scores – future data collection could be embedded within a job description for someone working in the PCN.

Contact for further information

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Case Study 3: Physical Health Checks for people with Severe Mental Illness (SMI)

Recruitment of Health Care Assistants, (HCAs) to support PCN Networks to deliver annual physical health checks and to provide a pro-active outreach service into communities, initially within Coventry.

Geography	Target Population	Health Equity Issue	Clinical Area
Coventry and Warwickshire	People with Severe Mental Illness (SMI)	Physical outcomes of those with Severe Mental Illness (SMI)	Mental Health

Target population

People with SMI needs in accessing healthcare.

What is the health equity issue being tackled?

Improve physical outcomes of those with SMI conditions through annual physical health checks and follow-up support, including engagement with health promoting activities provided by the voluntary and community sector. The programme also aims to raise awareness amongst people with SMI and professionals about the additional physical health needs of people with SMI to reduce the risk of diagnostic over-shadowing and to ensure holistic needs are met when accessing healthcare support.

What informed the decision to tackle this issue?

- Premature mortality in adults with SMI conditions, in comparison with the general population and national benchmarking.
- Trust level admission data – SMI patients are four times more likely to access emergency care than the general populations.
- Among those with SMI, local data showed those from the most deprived communities were three times more likely to have an emergency hospital admission than those with SMI living in the least deprived areas of Warwickshire.

What was the approach and intervention?

We recruited HCAs to support PCNs to deliver annual physical health checks and to provide a pro-active outreach service into communities, initially within Coventry. Point of Care Testing machines were purchased to support delivery.

We then collaborated with Coventry Warwickshire Partnership Trust (specialist mental health provider) for supervision of the HCAs and improve the co-ordination of care.

Next steps was collaboration with the VCSE to increase engagement with health checks and follow-up support. Grapevine is a local charity that specialises in helping people experiencing isolation, poverty, and disadvantage. Grapevine were commissioned to work with individuals with SMI to understand the barriers and facilitators to accessing care. Mind was commissioned to contact those on the SMI register to inform people of their eligibility for health checks, as well as flu and coronavirus vaccinations. Warwickshire Wildlife Trust was commissioned to provide “The Environment and Me” (TEaM) initiatives to encourage people with SMI to engage with the natural environment and increase physical activity levels. Mind were commissioned to provide the “Get Set to Go” initiative in Warwickshire, which provides activity taster sessions and support for people with mental ill-health. Adaptation of the local healthy lifestyle service offer was made to ensure people with SMI were eligible and could access appropriate support.

Outcomes and Impact:

- Feedback following awareness raising calls from Mind has highlighted how this pro-active approach makes people feel cared for and not forgotten by the system; feedback following delivery of health checks suggest people value them and will engage again next year.
- Whilst coverage of health checks dropped in all areas of Coventry and Warwickshire during the pandemic, there was less of a reduction in SMI health checks coverage in Coventry and has re-bounded faster than other areas. Originally rolled out in Coventry as this was identified as the area of highest deprivation, the project is now being rolled out across other areas.
- Appreciation of the pro-active support from VCSE partners – increased uptake.
- Better joined up working with the mental health trust, primary care and community partners.

What have been the key successes?

- Co-production workshop sessions with key clinical stakeholders and patient engagement groups.
- Maintaining relationships is important, particularly during system pressures.
- Development of a logic model helped to develop plans and ensure connections made between specific activities and longer-term outcomes.

What have been the key challenges?

- High level of demand on healthcare professionals.
- Cultural challenge – some clinicians were sceptical that the approach of working with community and VCSE partners would work.
- Initially limited funding hampered progress.

Contact for further information

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Case Study 4: Nudge the Odds

Targeted behaviour science approach using nudge interventions and messaging to individuals in areas where attendance at cancer screening programmes was low.

Geography	Target Population	Healthcare Equity Issue	Clinical Area
South Yorkshire and Bassetlaw	South Asian and Romanian population groups	Uptake in cancer screening from areas of deprivation and underrepresented communities	Cancer

Target population

South Asian and Romanian populations including translated materials in Urdu, Bengali, Polish, Romanian, and Slovak. Further work is planned with large Gypsy and Traveller communities to tailor messaging and interventions to meet specific needs as Doncaster.

What is the health equity issue being tackled?

Levelling up to reduce variance and narrow the gap between areas with high cancer screening coverage compared to areas of low coverage within areas of deprivation and in underrepresented communities to encourage the offer of screening. The aim was to create optimum outcomes based on a human factor approach with the application of Behavioural Science concepts and service transformation to enable equitable access for all population groups across South Yorkshire and Bassetlaw (SYB) through various nudge interventions that meet the needs of individual communities and population groups to reduce health inequalities and achieve positive outcomes in cancer screening and cancer early diagnosis.

What informed the decision to tackle this issue?

The project initially began looking at variance in cancer screening coverage across SYB. The cancer screening coverage data from GP practices enabled us to identify which practices in which PCN meets target, are below local standard and below the national average. This identified that initial focus was required in the more deprived, low education, low-income areas. Working with a company called CAJA the commissioned Behavioural Science experts and practices in those areas, a suite of nudge interventions and communication assets were developed to encourage individuals to attend cervical screening. Again, working with and through primary care in areas with low coverage underrepresented population groups were identified and a programme of work commenced using a Capabilities, Opportunities, Motivation, Behaviour (COM-B) method to understand the needs of those communities to tailor the Behavioural Science nudge interventions and messages to encourage those populations to attend cervical screening.

What was the approach or intervention?

SYB Cancer Alliance established a project to roll out a targeted Behaviour Science approach using nudge interventions and messaging to individuals in areas where attendance at cancer screening programmes was lower than other areas in SYB, areas of high deprivation and within underrepresented population groups such as those from an Asian, Romanian, Gypsy and Traveller community to encourage individuals to attend cancer screening programmes. Initially aimed at cervical screening the learning is now being applied to Bowel and Breast cancer screening programmes.

The learning has also been extended to support recovery in other cancer pathways and services with Phase 2. Phase 2 includes working with voluntary and charity organisations to encourage individuals with worrying cancer signs and symptoms to contact their GP practice - the “push” element. The second element is working with primary care settings in specific areas to identify individuals that might be at higher risk of cancer and encourage them to contact their GP surgery if worried about any changes to their bodies, - the “pull” element to the programme, and finally the “stick with” element to encourage those individuals referred to diagnostic services to attend hospital appointments as planned, to rule out cancer or complete treatments for the best outcome for themselves.

Phase 3 is looking at creating a Behavioural Science Academy aimed at bringing the nudge theory and messaging to wider health areas other than cancer through a PHM approach to embed appropriate communication channels, with salient messages targeted to the right areas and population groups through the right connectors be those voluntary and charity organisations, GPs, nurses, pharmacists, community faith leaders etc.

Based around nudge theory, the interventions have been co-designed with the right connectors in the communities for example the voluntary and charity organisations, translators, public health workers, screening and immunisations team and the clinicians themselves. The nudge interventions and assets are trialled initially and adapted where required. For example, a Covid safe message was introduced to encourage people to attend the practice. The interventions were reviewed to understand proof of concept before being shared to other settings and areas with similar demographics and challenges following an adopt and adapt model to support roll out across SYB. Working in targeted areas has led supporting organisations to apply nudge techniques to other areas, for example, COVID vaccination invite letters.

Outcomes and Impact:

- Increase in patients who have taken up the routine offer of screening in the practices that have adopted the nudge interventions.
- Early evidence that the nudge interventions encouraged attendance in primary care and early cancer detected in one of the trial areas.
- Positive relationships developed through good engagement with community organisations and through community leaders.
- Ease of proof of concept realised though monitoring and review of interventions in trial sites, approach used to support other services such as the COVID vaccination programme.
- Cultural and behavioural change in practice realised though feedback from trial sites with voluntary organisations and primary care working together focused on a common goal using the nudge assets as a multiagency approach to tackling cervical cancer screening health inequalities.
- Creation and delivery of a Behavioural Science Introduction training programme where SYB stakeholders and partners across voluntary organisations and within primary and secondary care services have engaged. This has built confidence and competency in behavioural science theory and teams have applied it to their daily practice.
- Linked up working between voluntary organisations, primary, and secondary care to implement the approach across the whole cancer pathway.

What have been the key successes?

- Co-design of the nudges has led to a collaborative approach as everybody feels they have contributed which aided joint ownership to drive forward the nudge interventions and use of the assets in areas of greatest challenge in cancer screening or cancer pathway recovery from Covid impact.
- The nature of the project enabled us to adapt with the changing needs of the population and services, so it is very responsive to current situations and challenges.
- Engaging key stakeholders from the outset – CRUK, and Screening and Imms as programme partners to build sustainability in the understanding of Behavioural Science and its application and to support scale up and roll out of phase 1 across primary care settings. Engaging community organisations and primary, and secondary care services in targeted areas when extended to phase 2.

- Driving forward change and improvements from grassroots.
- Set up of Behavioural Science Academy to progress the work within a PHM approach.
- Use people's lived experience as they have a wealth of intelligence and understanding of the local area and population and the needs of the population and patients, do not just assume, enable collaboration, codesign and ownership for a common purpose and goal.
- Developed robust governance and escalation processes linking the behavioural science experts across the wider system to embed learning and build sustainability to drive forward developments and improvements.
- Developed a community of practice to share learning and experiences in an honest and open approach through the working group and train the trainer approach which has helped the continued development and roll out of the programme.

What have been the key challenges?

- Due to the nature of the project, there is no blueprint. We are always learning, developing and testing which is exciting, but also has its pitfalls as things may move at a slower pace than anticipated while winning hearts and minds.
- Due to the success, it could quickly become unmanageable due to the small team running the project. However, the strong governance in place allows us to manage expectations and be realistic in the delivery.
- Workforce fatigue due to the pandemic, also competing demands on services and individuals in the current climate is a challenge, however through the local place operational groups opportunities are often identified and progressed.
- Narrowing the scope for an evaluation has been difficult as well as deciding the metrics as the purpose of the programme is to be subtle; evaluating effectiveness is a challenge that requires qualitative expertise.
- Timely roll out as the needs of each area are considered before resources can be developed. However now we have a bank of nudge interventions and assets it is getting quicker and easier.
- Initial engagement to secure the proof of concept was difficult given the novel approach.

Contact for further information

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Case Study 5: Health Equity Assessment Tool (HEAT)

Development and application of a health equity process using Public Health England's Health Equity Assessment Tool (HEAT)

Geography	Target Population	Healthcare Equity Issue	Clinical Area
Northwest Coast	Groups identified via health equality assessment	Various health inequalities	Patient Safety – multiple clinical areas

Who is the target population?

The project has a clear focus on identifying and supporting targeted population groups.

What is the health equity issue being tackled?

Various aspects of health inequalities across a range of communities and target groups.

What informed the decision to tackle this issue?

It was identified as necessary at board level to include health inequalities across all activity due to diverse population groups in the area. Many areas say they need to target health inequality, but do not know how or use it as a tick box exercise whereas this offers support to tackle health inequalities across the board. Some areas also target populations that are the easiest to deal with to achieve targets. This approach creates a level playing field where we consider those with the most need in everything we do and as standard project documentation. Once the HEAT has been completed, we then ensure next steps are taken to address this in the project. Data and intelligence are formulated from the following data sources:

- PHE Data
- Fingertips
- Local Authority Data
- Trust Level Data
- Tertiary Sector Trust data
- Use of unpublished data to try and get a timely feel for issues
- Qualitative interviews and conversations with the communities that they support.

What was the approach or intervention?

AHSN Diversity Pledges have identified the requirement for AHSNs to deliver health equity assessments across the full programme and project portfolio, as part of the wider Equality Diversity & Inclusion (EDI) agenda. The Innovation Agency (IA) have pledged to commit to undertaking health equity assessments on all programmes of work by March 2022. PHE's HEAT was therefore identified in early 2021 as a practical framework which can be systematically applied to programmes or projects to identify and support local action. The tool allows a focus on all health inequalities in all communities, but also includes individuals that may fall outside of inequality characteristics such as sex workers and prisoners.

The Patient Safety and Care Improvement (PSCI) team piloted a retrospective assessment of a project and provided feedback to the Board on the practical elements of applying HEAT. In May 2021, we coordinated PHE training sessions offered to IA staff, utilising three PSCI projects as live examples, with feedback gained from colleagues on the equity process. A Health Equity working group was set up in August 2021 to collaborate with IA colleagues and design a process for equity assessments across the organisation and develop guidelines to incorporate health equity assessments when working with SMEs on health innovations.

The process, which is currently being piloted (as of November 2021), includes:

- Stage 1: Training session to assist colleagues with identifying appropriate health inequalities data, and supporting initiation of the HEAT process
- Stage 2: HEAT refined with assistance from an internal panel to ensure a collaborative document includes reflective feedback from colleagues with a wide variety of experiences and backgrounds
- Stage 3: HEAT refined further with assistance from a North West Coast (NWC) community panel, providing reflective feedback on whether the process is equitable for NWC communities
- Stage 4: An assurance framework to capture insights and learnings from the HEAT – ensuring that best practice methodology is used, including measuring success and identifying barriers in implementation of the HEAT in practice.

Project Methodology:

- Quality Improvement Approach
- Continuous testing
- QI Capability
- Stakeholder Engagement – ensuring all the key stakeholders are embedded in the decision-making process on what is best for them.

Outcomes and Impact:

The IA is currently piloting and refining the health equity process. By November 2022 six projects will have gone through stages 1-3 of the health equity process. NHSE Respiratory Networks have expressed interest in the health equity work delivered to date and have requested further information in relation to HEAT applied to our programmes.

Specific health equity actions which have been identified as part of the HEAT process are beginning to shape the work programme in the PSCI team:

- COPD and asthma discharge care bundles - the commission now includes a health inequalities focus specifically referring to tailoring bundles to patients' individual needs, which in turn will enable reduction in hospital readmissions and reduce health inequalities in vulnerable populations.
- Development of Cheshire and Merseyside respiratory website for patients, carers and clinicians, which includes accessibility widgets, translation options and broad-reaching launch activity to include marginalised communities.
- Paediatric Early Warning Score (PEWS) – quarterly collaborative meetings across the NWC paediatrics health and social care network. IA staff to join regional children and young people forums to be aware of current issues, challenges and ideas generated for that community. Collaborate with patient engagement leads to support Patient Reported Experience Measures from clinical settings. There will be a focus on the parental concern element of the PEWS charts used, allowing families and carers to have their voice heard. An aim to then evaluate this across all healthcare settings involved.
- Unconscious bias training to all staff members.
- Systematic approach to addressing health inequalities.
- Ability to use population data and apply this to different projects to identify what is important and what is not.
- As a result of this work, it has been shared with clinical specialities who are now rewriting their policies to encompass protected characteristics that were previously not in the policy – Sex workers, prisoners, LGBTQ+ etc.

What have been the key successes?

- Use of patient safety networks – ensuring health inequalities is always on the agenda.
- Through projects like the proactive care partnerships – it was identified that it is possible to do protective characteristic searches, and this was then overlayed into other projects when identifying other health issues such as asthma and COPD.
- Support from the board really moved the process along at scale and pace.
- Building on relationships and harnessing these to move the work forward.
- Data sharing and ability to analyse the data to do target focussed work.

What have been the key challenges?

- Time and conflicting priorities.
- Culture change and culture shift requires time.
- Access to timely data is a slow process and data sharing agreements have been problematic.
- There is no one size fits all approach.
- Longevity - important to ensure that this doesn't become just another tick box exercise.

Contact for further information

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Case Study 6: Reducing inequalities in Covid-19 vaccinations in North East London

Action to reduce the inequalities in vaccinations between different ethnic groups, deprivation quintiles, and among people with additional barriers to vaccinations including homeless populations and people with learning disabilities or physical or mental ill health.

Geography	Target Population	Healthcare Equity Issue	Clinical Area
North East London	Different ethnic groups/deprivation quintiles	Vaccination uptake	Vaccinations

Who is the target population?

- Black, Asian and Minority Ethnic groups
- People with no recourse to public funds
- Homeless populations
- Housebound patients
- People with serious mental illness
- People with learning disabilities
- Deprived populations.

What is the health equity issue being tackled?

Significant health inequalities exposed and exacerbated by Covid-19, evidenced in disproportionate mortality rates from the disease and reflected in lower vaccination rates. We sought to reduce the inequalities in vaccinations between different ethnic groups, deprivation quintiles, and among people with additional barriers to vaccinations including homeless populations and people with learning disabilities or physical or mental ill health.

What informed the decision to tackle this issue?

An evidence review and early local community insights identified that there were a range of reasons why some groups were less likely to be vaccinated than others. We were aware that Covid-19 was disproportionately affecting some groups more than others, and that there had been particularly high mortality rates in the younger populations of some of our more deprived boroughs. We had a health inequalities recovery workstream and ICS priority to address inequalities across our work as we recover from the pandemic.

What was the approach or intervention?

Following the evidence review and sharing of initial local insights around the vaccination programme in January 2021, we established a NEL Vaccination Equalities Group with a wide, multi-sectoral membership of people involved in the vaccination programme.

We developed a fully interactive vaccination inequalities dashboard which included data on vaccinations by ethnicity, deprivation, cohort and ward to enable local areas to drill down into the groups with lower vaccination rates. Data from the Clinical Effectiveness Group at Queen Mary's University London was used to understand vaccinations in underserved populations including people with SMI, housebound and homeless populations.

These and other sources of data were presented to the group and discussed alongside local insights. Meetings included regular local system updates to share local measures and challenges to vaccination uptake. We discussed emerging new interventions (e.g. door knocking, one-off largescale vaccination events) and how well they were addressing inequalities. We included feedback from London and national meetings and reports (e.g. London Vax Hax workshops) and invited topic specific speakers (e.g. Doctors of the World).

We collated good practice case studies, for example:

- Newham participated in a multigenerational housing pilot which sought to persuade whole households to present for vaccination. Survey results indicated that people who have received multiple previous contacts (which has not led to attendance) are encouraged to attend due to the ability to have their household vaccinated at the same time – and that more informal access methods (e.g. walk-in) provides a considerable draw to certain communities.
- Broadway theatre Making Every Contact Count (MECC). The vaccination centre targeted people attending for vaccination to ask about general wellbeing, and offer social prescribing link workers, care coordinators and other targeted interventions (e.g. NHS Health Checks). The site also delivered specialist clinics, such as for people with LD or SMI, older people and homeless populations, which included bringing in relevant VCSE organisations and targeted interventions. They participated in a NHSE London pilot in June.
- Outreach to homeless and asylum seeker hostels and street homeless across boroughs. Work to support ‘Safer Surgeries’ to ensure GP registration is possible for all including undocumented migrants. Undocumented residents' clinics.
- Covid-19 vaccination helplines/ call centres in many boroughs to encourage and arrange vaccinations– including peer supporters for nervous or concerned patients in Newham, and call handlers who can speak community languages in Tower Hamlets.
- City & Hackney small grants programme offering funding to VCSE organisations to engage with and deliver the vaccination to their local communities.
- Vaccination bus in Waltham Forest, delivering vaccinations to faith settings (mosques, churches) and substance misuse services.

We mapped local vaccination outreach, engagement and ‘pop up’ clinics, including:

- Community African Network CAN and Support Where It Matters SWIM were commissioned to increase vaccine confidence in Black African/Caribbean/British communities. They delivered two pop-up clinics including a pre-clinic and on-the-day engagement. 124 people were vaccinated. 51 of which identified as Black African/Caribbean/British (72 identified as BME). 28 were undocumented migrants. VCSE partners have also focused on increasing vaccine confidence and uptake via LVS, pharmacies mass vaccination sites.
- We empowered individuals in communities to discuss the vaccine with those who are unsure through vaccine ambassador training by delivering a two-hour training session providing key information about the vaccines and conversational skills and a resource pack in Havering.
- Around 100 people have attended training and confidence in having conversations about the vaccine rose from 62% pre-training to 96% post-training. Successfully engaged with local groups most affected by Covid-19 and/or with low vaccination uptake, including adult social care and HMO/Hostel residents and staff and House of Polish and Eastern Communities.
- Work with faith settings to provide vaccinations at convenient location. On identifying low vaccine uptake among Muslim communities in Havering, the local authority facilitated contact with the Havering Islamic Centre. The CCG worked with the centre manager to arrange a pop-up clinic after Friday prayers. The clinical lead was a member of the Muslim community.
- Vaccine outreach workstream established in Waltham Forest ran a series of vaccine pop-ups in mosques, libraries, churches and primary schools (16 clinics and over 800 vaccines), supported by locally targeted communications and engagement through council, health and community organisations. Many receiving the vaccine at these locations have not felt

comfortable travelling to larger centres. Increasingly faith organisations are offering support. Increased uptake in south of borough (targeted) and Muslim community. Handed over control of booking systems and communications to community/faith groups.

- We co-developed a logic model and outcomes framework to support NEL-wide and local monitoring and evaluation. The logic model identifies the impacts we want to see from our work on reducing inequalities and works back to identify the outcomes and activities/outputs (interventions) that we are or can consider developing. The outcomes were aligned to the WHO Increasing Vaccinations Model to show how the outcomes are expected to move people along the process towards vaccination. The outcomes framework identifies priority outcomes and a set of indicators for each which can be used to measure the extent to which the outcome has been achieved.

Outcomes and Impact:

The local interventions implemented across NEL to improve vaccine equity have improved knowledge, confidence, access and vaccination rates among those groups initially showing low rates of vaccination.

Data on the change in trends in vaccination uptake by ethnic group compared to the White British group provided by NHS London colleagues suggests that the inequalities in uptake have narrowed for uptake in Black ethnic groups (both Black African and Black Caribbean), Bangladeshi and Pakistani groups over 2021. However, the gap in uptake between other White groups and White British population has not closed, requiring further targeted interventions. One of the difficulties in closing the gap for this group is identifying which communities within this group are experiencing barriers.

The data shows that for some ethnic groups, later cohorts did not reach a peak difference from the White British population as large as earlier cohorts. For example, the peak difference for the Black African population for cohorts 1-4 was 42%, whereas this was 24% and 28% for cohorts 5-9 and cohorts 10-12 respectively. This implies that the interventions that were put in place to increase vaccinations in these communities had an impact across the cohorts. There was a similar pattern for the Bangladeshi, Indian and Pakistani communities.

City and Hackney evaluated their vaccination work. Data from community events show that over 90% of respondents reported that they had had a satisfactory or very satisfactory experience. Further, a relatively high proportion of these attendees were not registered with a GP which suggests a target population was reached. In the case of events with the Chinese community, this delivering of messages on vaccine benefits and clinics was done solely via the Community Champions, demonstrating the value of community outreach and the Champions as supporting the delivery of messages into different communities.

What have been the key successes?

- Convening people from across the ICS working on vaccinations to work together on improving equity of Covid-19 vaccinations has been a great example of collaborative, multisector working. It has built and strengthened local relationships with communities and the VCSE. It has developed a wider understanding of the need to take a hyperlocal approach that is co-developed with and suitable for our diverse communities to address health equity. This is true for vaccination programmes, including flu and childhood immunisations, but also for the provision of wider health services.

What have been the key challenges?

- The speed and scale of the Covid-19 vaccination rollout meant that the programme needed to focus on numbers of vaccines given. Improving access and vaccine confidence among those groups experiencing health inequalities takes time and may not be a ‘quick win.’ The programme required a two-pronged approach –enabling large numbers to get vaccinated and work with communities to enable all to have equal access, experience and outcomes.

- Convening the right people to spread learning and good practice across the system – partners who had often not worked together before.
- Developing data and analysis that supports local action and enables partners to identify inequalities and monitor the success of their interventions.

Contact for further information

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Literature and resources

https://www.kingsfund.org.uk/publications/what-are-health-inequalities

Tudor Hart, J. (1971). "The Inverse Care Law". The Lancet. 297: 405–412

https://www.rcpjournals.org/content/futurehosp/8/2/e204

https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities

Do multiple community-based interventions on health promotion tackle health inequalities?

Guest blog: ‘Culturally appropriate’ care - the solution to health inequalities? | therichmondgroup.co.uk (richmondgroupofcharities.org.uk)

Understanding lay perspectives on socioeconomic health inequalities in Britain: a meta-ethnography

https://www.england.nhs.uk/about/equality/equality-hub/resources/

http://www.health.org.uk/sites/default/files/What-makes-us-healthy-quick-guide.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833959/IoD2019_Infographic.pdf

https://www.bma.org.uk/what-we-do/population-health/addressing-social-determinants-that-influence-health/reducing-health-inequalities-in-your-local-area-a-toolkit-for-clinicians

http://www.healthscotland.scot/media/1223/health-inequalities-action-framework_june13_english.pdf

https://www.hiat.org.uk/resources/14941_HIAT_long_v8_web.pdf

Inclusion Health Tool for Primary Care Networks - Friends, Families & Travellers (inclusion-health.org)