The Royal Society of Medicine

NHS England

Learnings from the Tackling Inequalities Conference 2023

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Contents

Background

On January 11th 2023, the Royal Society of Medicine (RSM), in partnership with the National Healthcare Inequalities Improvement Team at NHS England, hosted the 'Tackling Inequalities' conference, marking the launch of the RSM's multi-year programme addressing healthcare inequalities. The conference was centred on Core20PLUS5, NHS England's approach to inform action to reduce healthcare inequalities at both a national and system level. The conference was supported by experts in the field of healthcare inequalities, including key-note speeches from Professor Bola Owolabi (fig. 1), Director of the National Healthcare Inequalities Improvement Team and Professor Sir Michael Marmot, Professor of Epidemiology at University College London, Director of the UCL Institute of Health Equity, and Past President of the World Medical Association (fig. 2), as well as contributions from others including National Clinical Directors, leaders and managers from NHS England, RSM members and representatives from arms-length bodies (fig. 3). 231 delegates attended the live conference, of which 227 were from the UK and four from overseas (Australia, India and USA). Of those who attended, 141 were registered as doctors, 22 people were working for NHS England, 36 people were Core20PLUS5 Ambassadors, seven people represented a charity, 11 people were from the media and 22 people were sponsorship representatives. 22 people attended the conference on a bursary.

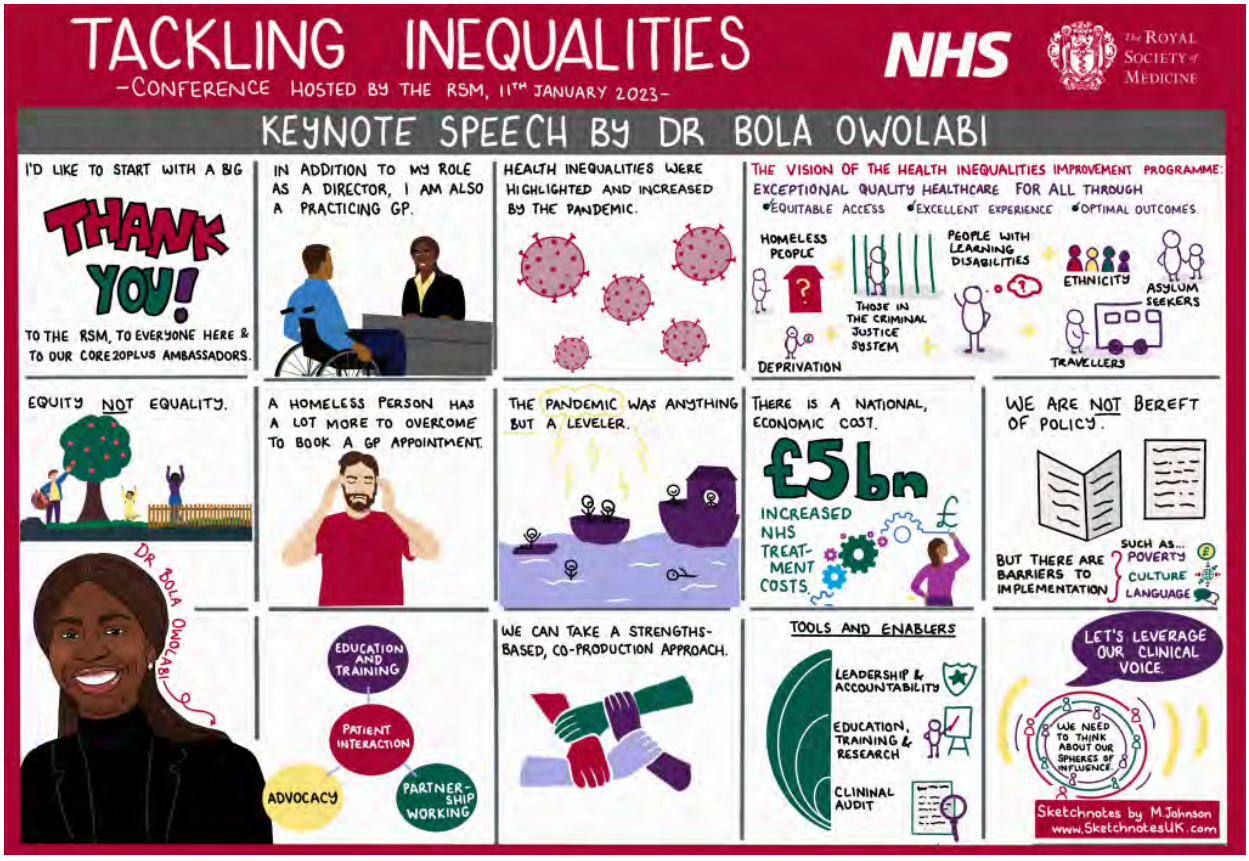

Fig 1: Sketch note summarising keynote speech delivered by Professor Bola Owolabi

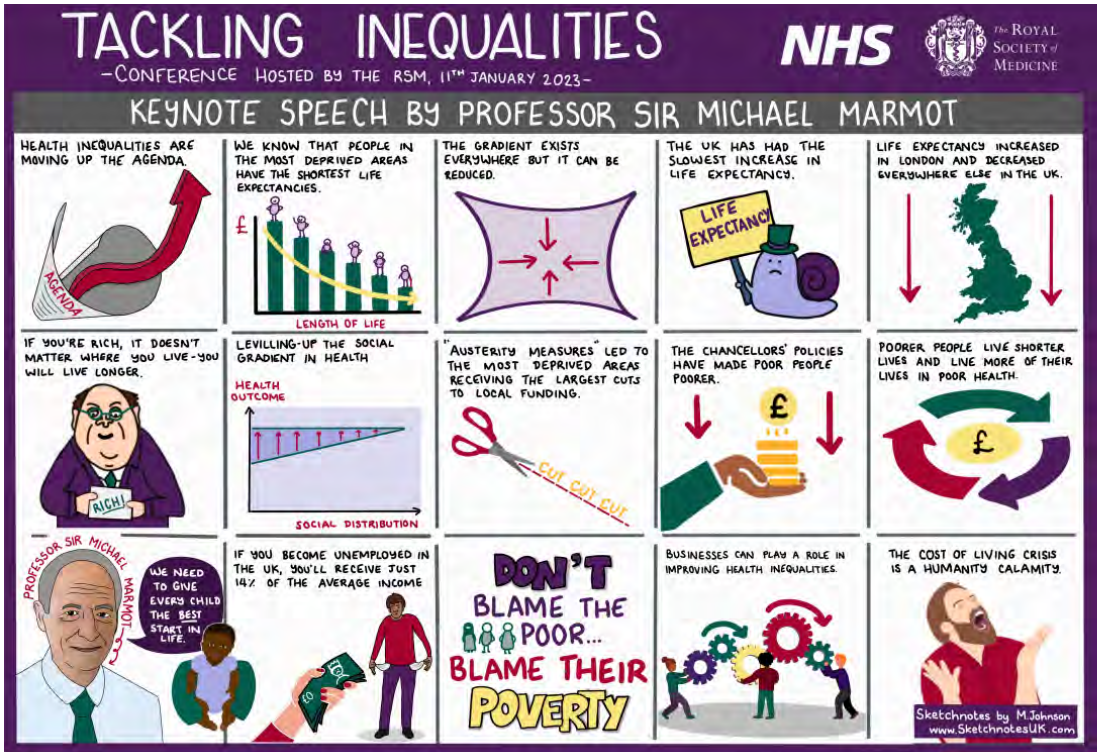

Fig 2: Sketch note summarising keynote speech delivered by Professor Sir Michael Marmot

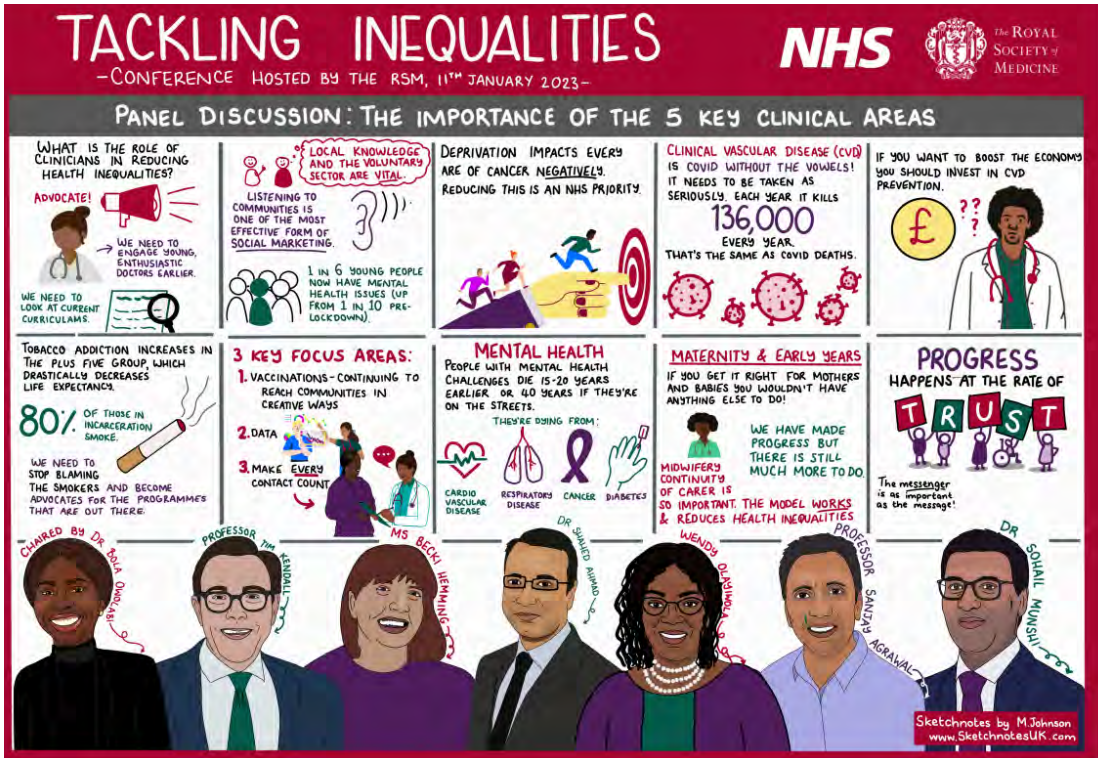

Fig 3: Main messages from Panel Discussion exploring the importance of the 5 key clinical areas of the Core20PLUS5 approach.

The conference provided the opportunity to delve into the Core20PLUS5 approach, exploring the five key clinical areas of focus that require accelerated improvement as a priority to tackle healthcare inequalities: maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis and hypertension and hyperlipaemia case-finding and optimal management, as well as an additional sixth key area: prevention, with a specific focus on smoking cessation (fig. 4).

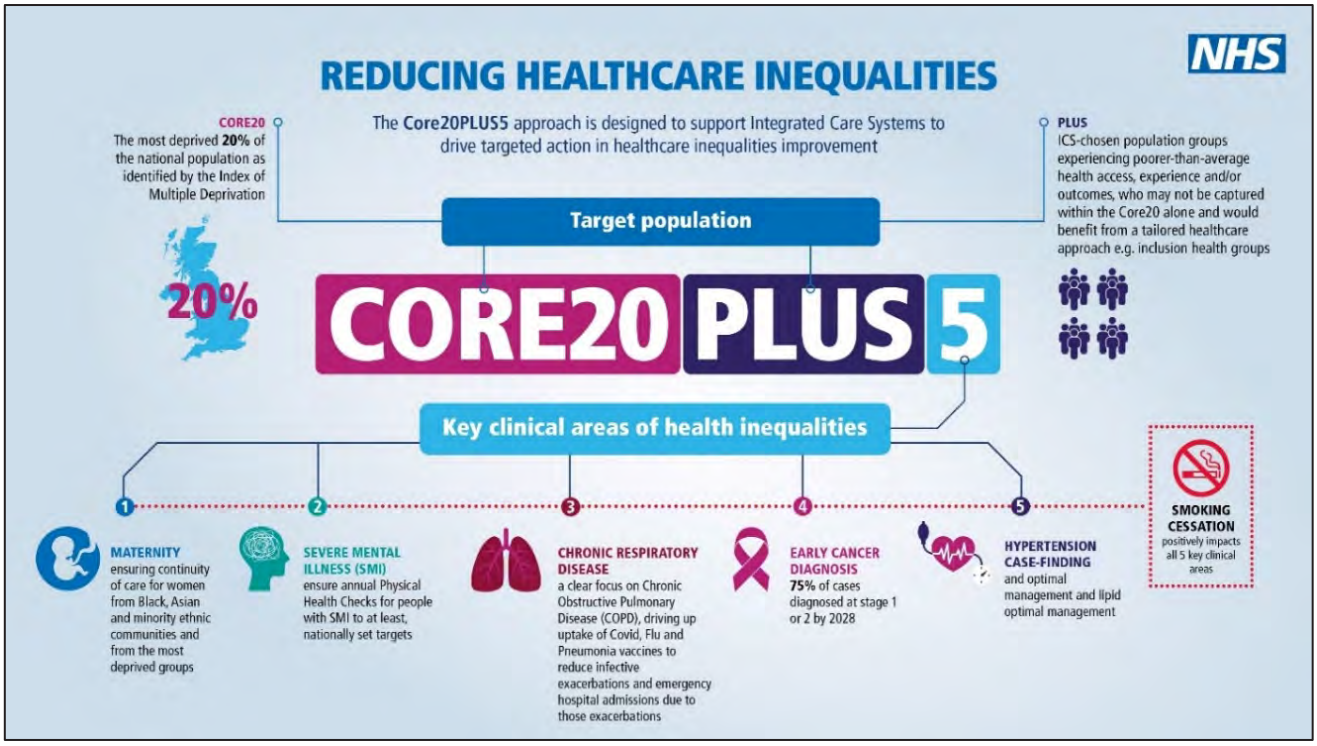

Fig 4: Core20PLUS5 Infographic

Data-driven improvement and a strengths-based approach are two key quality improvement methodologies that form the foundation of the Core20PLUS5 approach. Both of these methodologies were incorporated into the conference content, to provide delegates with tools and resources, such as data, links to key pieces of evidence and exemplar cases, that would assist delegates in instigating change to tackle inequalities in their spheres of influence.

Data-driven Improvement

Data-driven improvement involves creating virtuous circles of data which reveal insight that drives interventions to bring about improvement, generating intelligence about what works. epistemicAI is a research intelligence platform that provides a multidisciplinary approach to information gathering that unites artificial intelligence with a comprehensive alternative to search engines and allows users to connect the dots across billions of biomedical concepts, documents and entities. The epistemicAI team support the Core20PLUS5 approach and sponsored the conference through generating extensive knowledge maps via the research platform. The knowledge maps generated virtuous circles of data and summarised key pieces of evidence that support the Core20PLUS5

approach. These maps were shared with both speakers and delegates prior to attending the conference.

Strengths-based Approach

A strengths-based approach embraces identifying exemplar work and building on the strengths that have been developed from that work. For each of the five clinical areas of the Core20PLUS5 approach, an interactive breakout session was held, which provided the opportunity for conference delegates to share their own ideas and work being undertaken to tackle healthcare inequalities. The following three questions were addressed in these sessions:

1. What work are you doing to address healthcare inequalities improvement in this clinical area?
2. What ideas do you have to address healthcare inequalities in this clinical area?
3. What tools or interventions can help to address healthcare inequalities improvement in this clinical area?

There was also a sixth breakout session to explore prevention, in particular smoking cessation. The questions for the prevention breakout room were:

1. Does the framing of the overall national approach of Prevention and Core20PLUS5 make sense?
2. Are there any missed opportunities?
3. What tools or interventions can help?

A post conference survey evidenced that 96% of responders agreed that what they learnt at the conference had inspired them to take increased action on tackling health inequalities. However, we would like the learnings from the conference to be shared more widely than the delegates who attended. Therefore, we have created this report, which is divided into six chapters, one for each of the breakout sessions. Each chapter provides a summary of the epistemicAI knowledge map literature for that clinical area, supported by additional hand-searching of other literature. It also highlights the key themes identified from summarising the conference delegates' responses to the three questions asked in each of the breakout sessions. Each chapter concludes with example pledges made by delegates at the end of the conference.

Maternity

The Knowledge Map Evidence

The World Health Organisation defines maternal health as the health of women during pregnancy, childbirth and the postnatal period (Shimizu 2023). In England, Women make up 51% of England's population and, of these, more than three quarters at any one time want to either prevent or achieve pregnancy (Public Health England 2018a). According to the Office of National Statistics in England, there are more live births to mothers resident in the 10% most deprived areas of the country (12.8%), in comparison to the 10% least deprived areas (7.2%) (Bradford 2022).

In the United Kingdom, maternal health outcomes vary between different groups of women. However black and minority ethnic women tend to have worse maternal health outcomes compared with white British women (Aquino, Edge et al. 2015). Black Caribbean and black African mothers have a higher absolute risk of early preterm birth than white British mothers (Puthussery, Li et al. 2019). Post partum haemorrhage is a greater risk for women from all ethnic minority groups, with the greatest risk seen in black women (Jardine, Jennifer, Gurol-Urganci et al. 2022). Black women were more than twice as likely to be admitted to intensive care in pregnancy or during the postnatal period to six weeks after birth, compared with women from other ethnic groups, even after accounting for demographic, health, lifestyle, pregnancy and birth factors (Jardine, J., Gurol-Urganci et al. 2022).

Socioeconomic deprivation and minority ethnic background are considered risk factors for an adverse pregnancy outcome, with these risks being responsible for a substantial proportion of stillbirths, preterm births and births with Fetal Growth Restriction (Jardine, Jennifer, Walker et al. 2021). Babies born in the most deprived areas have 47-129% greater risk of adverse birth outcomes (neonatal death, infant death and preterm birth) than those in the least deprived areas and minority ethnic babies have 48-138% greater risk of adverse birth outcomes compared with white British babies (Opondo, Gray et al. 2019).

A study from 2013 explored maternity service use and perceptions of care in ethnic minority women from different ethnic groups compare to white women and showed that women in all ethnic minority groups had a poorer experience of maternity services (Henderson, Gao et al. 2013). The study found that women from ethnic minority groups compared to white women were more likely to be younger, single and multiparous, tended to gain access to antenatal care later in pregnancy, and had fewer antenatal checks, fewer ultrasound scans and less screening. They were less likely to receive analgesia during labour and more likely to deliver via emergency caesarean section, in particular black African women. Post natal, they had longer lengths of hospital stay and fewer home visits from midwives.

A further study from 2015 explored midwives' experience of providing care for black and other ethnic minority women through conducting interviews with qualified midwives in one NHS Trust in the Northwest of England (Aquino, Edge et al. 2015). Three main themes of experience were identified –

1. Language difficulties – difficulty engaging with women whose English language was limited.
2. Expectations of maternity care – a mismatch between the expectation of midwives and women of the maternity care service.
3. Complex needs extending beyond maternity care – a need to look after women holistically, working with internal agency to support needs that may be beyond the scope of maternity care.

Continuity of care is important in all aspects of healthcare, contributing to healthcare inequalities in experience and outcome. Research undertaken in a General Practice setting showed that ethnic minority identity and socioeconomic deprivation are associated with lower continuity of care (Stafford, Bécares et al. 2023). A synthesis of studies found that discriminatory practices and communication failures in NHS maternity services are failing ethnic minority women and that women-centred midwifery care is positive for all women but often experienced as an exception by ethnic minority women (MacLellan, Collins et al. 2022). Midwifery-led continuity models provide the same midwife or team of midwives during the pregnancy, birth and the early parenting period. Midwifery-led continuity models have been shown to improve maternal health outcomes including reduced chance of an epidural, fewer women requiring episiotomies or instrumental births, increased chance of a spontaneous vaginal birth, less likelihood of a preterm birth and lower risk of neonatal mortality (Sandall, Soltani et al. 2016).

Strengths-based Approaches

The following section outlines the themes derived from the conference delegates' answers to the three questions posed to them during the breakout session exploring health inequalities and maternity.

What work are you doing to address health inequalities improvement in this clinical area?

Theme	Examples
Addressing smoking in pregnancy.	– Convening key stakeholders, including Action on Smoking and Health (ASH), National Childbirth Trust (NCTs), Royal Colleges, and charities, to specifically address smoking

	cessation during pregnancy and its impact on health inequalities.
Co-designing services, policy and guidance, particular with seldom-heard groups.	– Conducting focus groups with seldom-heard communities to involve them in the design and improvement of maternity services, ensuring their specific needs and experiences are considered. – Collaborating with groups that experience differential outcomes to co-produce NICE guidance, aiming to understand the underlying causes of health inequalities and develop appropriate actions to address them.
Family nurse partnership.	– Implementing the Family Nurse Partnership programme, which focuses on early intervention, education, and empowerment of families, particularly those facing health inequalities in maternity.
Breastfeeding promotion.	– Recognising the importance of breastfeeding and emphasising its promotion among midwives, which can contribute to improved health outcomes and reduce inequalities in infant feeding.
Highlighting birth rights.	– Within the Scottish National Maternity Network, prioritising the reduction of inequalities and raising awareness of birth rights and reports such as "FIVEXMORE" and "Invisible Women" that shed light on specific issues faced by marginalised groups.
Maternal continuity of care and personalised approaches.	– Undertaking projects aimed at improving maternal continuity of care, particularly for minority ethnic individuals. – Emphasising personalised care approaches to address health inequalities during the six-week postnatal check.

What ideas do you have to address this clinical area?

Theme	Examples
Education and training.	– Addressing unconscious bias among midwives and healthcare professionals.

	– Improving knowledge through comprehensive foundation training for doctors, midwives and nurses, including increased knowledge and awareness of race, prejudice, and cultural competence in health.
Accessibility and equity.	– Improving health literacy within minority communities, including addressing language barriers. – Removing barriers to healthcare access, such as eliminating NHS charges for asylum seeker women. – Empowering individuals with education on self-advocacy and recognizing healthcare concerns.
Communication and engagement.	– Listening to and acknowledging concerns of women to reduce stress and its impact. – Involving communities and advocating for change at all levels of power.
Workforce barriers.	– Cultural competence training for healthcare professionals with ongoing assessment and updates. – Increasing diversity in the maternity workforce. – Focusing on mental health and wellbeing of staff to improve maternal care, and enhance staff retention and morale.
Collaboration and research.	– Adopting a joined-up approach to research involving academia, public health, NHS, regulatory bodies, and the Care Quality Commission (CQC). – Increasing the amount of research into the causes of differential outcomes for maternal health.

What tools or interventions can help?

Theme	Examples
Data.	– Analysing the link between clinical negligence claims and healthcare inequality and address it through NHS resolution and the Getting It Right First Time (GIRFT) initiative. – Improving local data collection and utilisation to understand contributing factors and risks.

	– Utilising the NHS patient survey programme and local partnerships to gather data on the experiences of ethnic minorities and deprived populations.
Community engagement, outreach, and collaboration.	– Establishing sustainable relationships with communities through community outreach programmes led by trusted individuals from the same community. – Identifying female community leaders and involving them in local approaches and decision-making processes. – Collaborating with the voluntary and community sector (VCSE) to ensure diverse representation and participation.
Communication.	– Improving communication and coordination between primary and secondary care providers. – Promoting empathy, sympathy, and prompt contact with patients/clients to enhance patient experiences and outcomes.
Cultural competence and personalised care.	– Ensuring personalised care is targeted to specific groups and individuals. – Offering midwife-led advice on early infant development and breastfeeding support during each visit.
Systemic changes and support.	– Advocating for changes in pay structures, training support, and respect for healthcare professionals. – Establishing children's centres that cater to maternity and neonatal care.

Pledges

"Improving the education system for midwives in order that they care for women in a more professional and knowledgeable manner and that this does not get misrepresented as racist by the BME population."

"It's clear that the inequalities gap will continue to widen. It is important to ensure that any action we take does not widen this gap further and I will ensure that addressing inequalities is an underpinning theme in all programmes of work I undertake."

"Continue to educate colleagues, family and friends on the inequalities faced by some people within our society and communities."

Severe mental illness (SMI)

The Knowledge Map Evidence

Severe mental illness (SMI) refers to people with psychological problems that are debilitating enough that the person's ability to engage in functional and occupational activities is severely impaired. It includes schizophrenia, schizoaffective disorders and bipolar affective disorders (Public Health England 2018b). People with an SMI often experience poor physical health as well as their poor mental health, developing chronic physical health conditions at a younger age, including obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), stroke, heart failure and liver failure (Office for Health Improvement and Disparities 2023). Adults with SMI are five times more likely to die prematurely (before the age of 75) than adults who do not have an SMI; this premature mortality is higher in men compared to women and in more socioeconomic deprived areas compared to less socioeconomic deprived areas (Office for Health Improvement and Disparities 2023). It is estimated that two out of three deaths in people with SMI are from a physical illness that could have been prevented (NHS England 2016). Research has shown that excess mortality seen in people with an SMI relative to the general population is irrespective of ethnicity, with the causes of mortality including suicides, non-suicide unnatural causes, respiratory disease, cardiovascular disease and cancers (Das-Munshi, Chang et al. 2017). Improving the physical health of people with an SMI is therefore critically important.

According to the Five Year Forward View for Mental Health, in 2016 there were over 490,000 people with an SMI registered with a GP, with the proportion receiving an annual health check ranging from 62-82% (NHS England 2016). An observational study performed between 2013 and 2017 showed that people with an SMI or on a long term anti-depressant were 5-10% more likely to access NHS Health Checks than people without these conditions and those with an SMI or on a long term anti-depressant treatment who attended NHS Health Checks had a higher rate of diagnosis of chronic kidney disease, type 2 diabetes, mellitus and other co-morbidities (Garriga, Robson et al. 2020). Annual health checks for people with SMI would therefore support the early diagnosis of physical health conditions and help to improve access to evidence-based physical care, assessment and intervention.

Strengths-based Approaches

The following section outlines the main themes derived from the conference delegates' answers to the three questions posed to them during the breakout session exploring health inequalities and severe mental illness.

What work are you doing to address health inequalities improvement in this clinical area?

Theme	Examples
Symptom differentiation.	– Making more effort to differentiate between symptoms that are related to SMI and those that may be indicative of a physical disorder which is crucial for accurate diagnosis and appropriate treatment.
Identification of those with an SMI.	– Utilising electronic registers to identify individuals with SMI, enabling targeted interventions to improve their overall health.
Person-centred approach.	– Focusing on adopting a person-centred approach when addressing health inequalities in SMI, avoiding assumptions about individuals' needs and actively engaging with them to understand their specific requirements and preferences.
Encouraging engagement with General Practitioners (GPs).	– Encouraging individuals with SMI to seek support from GPs and engage in regular healthcare check-ups, with the aim to ensure that their physical health needs are adequately addressed and monitored.
Community collaboration and service development.	– Collaborating on projects to work with communities and services to support the physical health needs of individuals with SMI.

What ideas do you have to address this clinical area?

Theme	Examples
Research.	– Further research is required around physical health outcomes for people with an SMI, to explore and establish appropriate thresholds to improve treatment outcomes.
Support for employment and iAPTs.	– Providing support for individuals with SMI to access employment opportunities.

	– Collaborating with Improving Access to Psychological Therapies (iAPTs) as a potential avenue for support for employment.
Myth busting.	– Dispelling myths surrounding SMI and physical health, in particular smoking and addressing the misconceptions that is it not possible nor safe for people with a mental illness to quit smoking.
Social prescribing.	– Linking people with an SMI to non-medical sources of support and activities to improve their overall physical and mental well-being.
Involving service users in evaluation.	– Improving involvement of service users in the evaluation of services to gain insight into their experiences and outcomes.
Outreaching physical health checks.	– Conducting health checks in different community settings, such as religious venues, supermarkets, car parks and mobile vans, to increase accessibility and ensure that individuals with SMI receive regular health assessments.
Buddies and mentor schemes.	– Setting up buddies or mentor schemes to provide support during health checks. – Creating circles of support as a means of facilitating long-term health management with psychological support.
Promotion of success.	– Publicising success stories, such as smoking cessation and weight loss achievements. – Sharing positive experiences can serve as motivation and inspiration for others with an SMI.
IT support and data management.	– Using IT support to manage data related to health checks and feedback to healthcare professionals.

What tools or interventions can help?

Theme	Examples
Collaborative working.	– Partnership working and avoiding siloed approaches within Integrated Care Systems (ICS).
Community hubs.	– Creating community hubs to act as one-stop shops that provide comprehensive services for individuals with SMI. – Including home visits to overcome barriers to accessing healthcare services.
Training and education.	– Providing training for mental health staff immunisations for patients with SMI. – Providing training for cancer screening to address the specific needs of individuals with SMI.
Population health and screening.	– Promoting and signposting to screening and immunisations during physical health checks for individuals with SMI. – Employing population health approaches to address health inequalities and improve outcomes for this population. – Using SMI registers to identify individuals who may benefit from targeted interventions including screening.
Data management.	– Encouraging data collection, such as height and weight, at GP practices to inform care planning and interventions. – Maintaining longitudinal records to ensure continuity of care and comprehensive understanding of patient needs. – Sharing data across and between all professionals dealing with patients with mental health issues. – Data sharing from secondary care to avoid duplication of health checks.

Pledges

"I am fully invested in reversing health inequalities amongst people with mental illness (priority smoking cessation) autistic people (priority access) and people with learning disabilities (priorities equitable access and experience and outcomes). I will align our physical health strategies for these groups with Core 20 plus 5 and use the data shared to shine a light on our blind spots and ensure they are addressed."

"Supporting the service users struggling with alcohol and drug misuse remains my personal pledge and the information gained at the conference is invaluable."

"I will do what I can to raise the awareness of the inequalities that exist and help raise awareness with relevant people to address such issues."

"I will share CORE20PLUS5 CYP and adults and check that people understand their focus."

Chronic respiratory disease

The Knowledge Map Evidence

Respiratory disease is one of the three most common causes of mortality in the UK, with one in five people in the UK diagnosed with lung disease during their lifetime, and it continues to be a major driver of health inequalities – the 20% most deprived population groups are two-and-a-half times more likely to be diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and almost twice as likely to develop lung cancer compared to those from the least deprived population groups (British Lung Foundation). Despite knowing this, health outcomes for respiratory disease have not improved over the last 10 years to the same extent as other disease areas, including cardiovascular disease and cancer, and England has amongst some of the highest mortality rates from respiratory disease in Europe (Public Health England 2022).

Socioeconomic deprivation in patients with COPD is associated with increased emergency care use, including emergency hospitalisation, length of hospital stay, secondary healthcare costs and mortality, and inversely related to participation in exercise rehabilitation and secondary care appointments (Collins, Stratton et al. 2018). The multifactorial causes of these health inequalities between socio-economic groups include greater exposure to risk factors such as smoking tobacco, air pollution, poor housing and occupational hazards, and variation in healthcare quality and access, including vaccination programmes (Public Health England 2022). Whilst exposure to risk factors is largely outside of the influence of the NHS, variation in healthcare quality and access are not.

Immunisation is one of the most cost-effective public health interventions and equality in immunisation is an important way to address health inequalities, ensuring that there is not only high overall coverage but also high uptake of vaccines within underserved communities (Public Health England 2021). For adults, the NHS currently offer three respiratory vaccinations: anti-influenza (flu), anti-pneumococcal and anti-COVID-19 (NHS England 2023b).

There has been a gradual decline in uptake of the universal influenza vaccine programme for those aged 65 years since 2005 and there still remains a substantial disease burden on the population from influenza (Pebody, Warburton et al. 2018). Acute respiratory infections, especially influenza, are frequently the cause of exacerbations of COPD, with vaccination being the main preventative measure against influenza and its complications (Ji, Jareño-Esteban et al. 2022). Influenza vaccination has been shown to have a moderate effect in preventing confirmed influenza in people with COPD (Martínez-Baz, Casado et al. 2022) and reduces exacerbations in COPD patients (Poole, Chacko et al. 2006).

The pneumococcal vaccine is offered to adults aged 65 years or over and those with certain long-term health conditions to protect against bacterial infection from Streptococcus pneumoniae (NHS England 2023c). Patients with COPD are at increased risk of pneumococcal disease including

community-acquired pneumonia and acute exacerbations of COPD. Studies have shown that the pneumococcal vaccine provides significant protection against community-acquired pneumonia and reduces the likelihood of a COPD exacerbation, with moderate-quality evidence suggesting the benefit of pneumococcal vaccination in people with COPD (Walters, Tang et al. 2017).

Patients with COPD are at increased risk of COVID-19 infection, as well as having a worse prognosis, with higher risk of hospitalisation, severe disease and mortality (Ji, Jareño-Esteban et al. 2022). For this reason, COPD is considered a priority condition for vaccine administration. However, COVID-19 vaccine uptake is lower amongst minority ethnic groups compared to white British group in England, despite the higher COVID-19 mortality rates seen in minority ethnic people (Gaughan, Razieh et al. 2022). Ethnic inequalities in COVID-19 vaccine uptake exceeded those for influenza vaccine uptake (Watkinson, Williams et al. 2022).

The volume of respiratory disease places a huge burden on the NHS, accounting for over 700,000 hospital admissions and more than six million hospital bed days in the UK each year (British Lung Foundation). This costs the UK more than £11 billion per year, of which £9.9 billion is from NHS costs and £1.2 billion from wider economy costs through working days lost (Public Health England 2022). Respiratory disease has therefore been highlighted as a priority area for strategic clinical networks in England, to integrate care better and reduce lung health inequalities (British Lung Foundation).

Strengths-based Approaches

The following section outlines the main themes derived from the conference delegates' answers to the three questions posed to them during the breakout session exploring health inequalities and chronic respiratory disease.

What work are you doing to address health inequalities improvement in this clinical area?

Theme	Examples
Funding for innovation and research.	– Investing in respiratory research. – Providing funding for innovative projects that can be undertaken to address respiratory health inequalities.
Outreach services into underserved areas.	– Targeting COPD cases in the most deprived areas - the Mid and South Essex Respiratory Van is an example of outreach services that are being used to deliver prevention, referrals and vaccines to underserved areas.

Treating tobacco dependency.	– Focusing on treatment in acute settings, including automatic smoking cessation referrals for inpatients and maternity out-patients.
Targeting certain populations for vaccination.	– Targeting populations that are at high risk for respiratory diseases and providing vaccinations.
Respiratory and spirometry hubs.	– Improving access to respiratory healthcare services through implementation of respiratory and spirometry hubs that can provide specialised care and testing to improve respiratory health outcomes. – Training and upskilling of clinicians to perform and interpret spirometry.

What ideas do you have to address this clinical area?

Theme	Examples
Bottom-up approach.	– Applying a 'bottom-up' approach, including engaging with local communities to understand their specific unmet needs in relation to respiratory health. – Using MECC (Making Every Contact Count) principle. – Working with VCSE (Voluntary, Community and Social Enterprise) to provide targeted support.
Improving funding for equipment.	– Improving funding for spirometry, which is a key diagnostic tool for respiratory diseases, resulting in barriers to accurate diagnosis and treatment for respiratory conditions and potential to exacerbate health inequalities.
Maternity incentive scheme for smoking cessation.	– By providing incentives for pregnant women to stop smoking, respiratory health outcomes for both mother and baby could be improved.
GP involvement in smoking cessation.	– Increasing the availability of primary care settings to address tobacco dependence.
Challenging normalisation of symptoms.	– Challenging the normalisation of certain respiratory symptoms, such as the "smoker's cough" to encourage patients to seek help for these symptoms and improve their respiratory health outcomes.

Patient-initiated follow-up.	– Developing patient initiated follow up in COPD case finding to empower patients to take control of their respiratory health.

What tools or interventions can help?

Theme	Examples
Community engagement and education.	– Improve patient engagement and education through television, media, and public health messaging.
Bring together diagnostic tools.	– Incorporating early and accurate asthma diagnosis into the Total Lung Health Check (TLHC) programme. – Combining investigations so that patients do not have to incur costs for multiple hospital attendances.
Staff upskilling and embedding MECC.	– Upskilling staff to perform and interpret spirometry. – Embedding Make Every Contact Count (MECC) as normal practice in clinical encounters.
Innovative approaches.	– Exploring giving combination vaccines to drive uptake. – AI-driven approaches. – Maximising technology to share knowledge and useful data.
Community-led services.	– Increasing referrals to community services and into @Point of Care services to improve accessibility.

Pledges

"I will make sure I continue to shout out about Core20PLUS5 in the areas that I work in (NHS screening and immunisation services)."

"I will feed my knowledge of health inequalities into all the immunisations work I do now whilst working in NHSE and in the future when we move to ICB's."

"I will commit to addressing and improving inequalities of access to all the routine immunisation programmes."

"I will continue to ensure that deprived individuals who come under my care get the best treatment possible."

Early cancer diagnosis

The Knowledge Map Evidence

The diagnosis of any cancer at an early stage of the disease (stages 1 and 2) is associated with improved outcomes, including increased survival chances (Nuffield Trust 2023). The NHS Long-Term Plan 2019 set out the ambition that, by 2028, the proportion of cancer diagnosed at stages 1 and 2 will rise from around 50% to 75% of cancer patients (NHS England 2019).

Cancer is one of the greatest contributors to inequalities in life expectancy for people from the most socio-economically deprived areas, due to:

- Higher prevalence of smoking rates, with smoking being the largest cause of cancer in the UK, responsible for 3 out of 20 cases
- Higher prevalence of obesity, with around 23,000 cases of cancer in the UK each year caused by excess weight
- Reduced rates of screening uptake
- Lower recognition of the signs and symptoms of cancer
- More reported barriers to seeking help
- Higher probability of being diagnosed with cancer following an emergency presentation with one out of five cancers in England diagnosed through this route and diagnosed with at a later stage of disease
- Cancer patients receiving different treatment at the same stage of diagnosis compared to those from the least deprived areas (Cancer Research 2020).

Socioeconomic variations in cancer incidence vary by cancer type, region and age. A study conducted in 2008 showed that lung and ovarian cancer incidence was highest for the most deprived patients whilst the opposite was seen for malignant melanoma and breast cancer (Shack, Jordan et al. 2008). The study also highlighted regional differences in socioeconomic gradients, with the widest gap seen for lung and cervical cancer in the North and for malignant melanoma in the East and South West. Awareness of these trends are vital for public health prevention policies and delivery of cancer services.

A study looking at survival gains by eliminating inequalities in stage at diagnosis showed that reducing socioeconomic and sex inequalities in stage at diagnosis would result in substantial reductions in deaths within five years for patients diagnosed with malignant melanoma (Rutherford, Ironmonger et al. 2015). For breast cancer, the number of deaths in women in England with breast cancer that could be avoided within five years of diagnosis if socioeconomic differences in stage at diagnosis has been eliminated, has been estimated at approximately 450 women (Rutherford, Hinchliffe et al. 2013). A further study evidenced that eliminating socio-

demographic inequalities would result in 61% of patients with the 10 studied solid tumour cancers included in the study being diagnosed at an early stage (1 and 2), thus reducing the gap from the national target of 75% of cancers diagnosed at early stage from 18% to 14% (Barclay, Abel et al. 2021).

Strengths-based Approaches

The following section outlines the main themes derived from the conference delegates' answers to the three questions posed to them during the breakout session exploring health inequalities and early cancer diagnosis.

What work are you doing to address health inequalities improvement in this clinical area?

Theme	Examples
Improving access to cancer screening.	– Improving access to cancer screening through various methods, including developing system-level groups to work collaboratively to increase uptake of cancer screening, commissioning screening liaison nurses for people with learning disabilities, and Targeted Lung Health Checks (TLHC) in specific populations. – Offering incentives to engage with screening for certain population groups, including those experiencing homelessness – Reducing 'Did Not Attend' (DNA) rates with targeted communication and reminders to the populations most at risk.
Education and training.	– Increasing awareness and knowledge among patient-facing staff and healthcare workers of signs and symptoms of cancer, including the development of e-learning resources and organising medical updates for psychiatrists. – Training staff on communication skills and confidence to talk about cancer.
Co-production and engagement with underserved communities.	– Involving patients from underserved communities in the development and delivery of cancer care services. Examples include reaching out to trusted groups like the British Islamic Medical Association to promote cancer screening. – Need to avoid duplication of efforts in communities.

Technology, innovation, and data.	– Maximising the use of technology and data to improve cancer care services, including developing digital health equity, linking records across Integrated Care Systems, and building databases of people locally most at risk of cancer. – Identifying initiatives aimed at making interventions cheaper, more successful, and with simpler patient journeys. – Better understanding the link between early diagnosis, comorbidities and cancer outcomes, including raising awareness of biomarker tests.
Health research and policy.	– Ensuring health research is informed by diverse communities, involves and recruits diverse participants, and is used to inform policy decisions. – Understanding and reporting patient experiences. – Ensuring that research data is disaggregated by ethnicity and deprivation in specific cancer types.
Make Every Contact Count.	– In particular, asking all patients about smoking and weight.
Workforce.	– Understanding how the workforce can better support health and wellbeing of NHS staff in terms of their own health and wellbeing.

What ideas do you have to address this clinical area?

Theme	Examples
Targeted outreach and engagement.	– Outreach services to improve access to screening for at-risk populations with low uptake. These strategies include community involvement, working with community groups, working in different places like sport centres, utilising community leads, VCSE, access to experts with lived experience in the community and using culturally appropriate communication methods. – Involving people and communities in designing the content of messages to encourage people to access screening, early

	education, and increasing trust in those who deliver healthcare.
Improving access to screening.	– Providing asymptomatic screening/testing, targeted cervical screening, self-testing kits and virtual clinics to increase screening uptake. – Using digital reminders for screening and immunisations when people become eligible, via NHS app – Making every contact count non-clinicians and clinicians to signpost screening and have conversations about cancer diagnosis and prevention, for example at dentists or vaccine appointments.
Coordinated effort.	– Coordinating efforts to improve cancer screening and diagnosis, involving a system-level approach. – Involving the community in the multidisciplinary team (MDT).
Empowerment and training.	– Empowering and training healthcare staff to have conversations around screening, prevention and cancer diagnosis. – Looking after NHS staff, including their health and wellbeing, such as via cancer screening and one-to-one conversations.

What tools or interventions can help?

Theme	Examples
Behavioural change/insights training.	– Training for programme managers and front-line clinicians to improve their understanding of behavioural insights and to facilitate behaviour change in patients.
Community engagement initiatives.	– Co-designing, engaging, educating, and using innovation to improve access to cancer care within the community, as well as engaging community and faith groups.
Rapid results.	– Providing rapid results to address patient worry and concerns and improve communication with patients.

Test at home options.	– Offering test-at-home options to increase accessibility and reduce fear of healthcare professionals.
Accurate data.	– Collecting accurate data on deprivation, demographics and protected characteristics, to identify and address inequalities.
Trusted messengers.	– Using champions, community leaders, faith leaders and trusted voices to build trust with individuals and communities and provide support to engage them in cancer care.
Multi-speciality approach.	– Establishing multi-speciality clinics to provide comprehensive care and reduce inequalities in access to cancer care.
Advance diagnostic and intervention technology.	– Using advance diagnostic and intervention technology to improve accuracy, efficiency and accessibility.
Personalised care approach.	– Implementing a personalised care approach to better meet individual needs and reduce inequalities.

Pledges

"Work with the barber to raise awareness around inequality issues in our service e.g., prostate cancer."

"I will take opportunities to share the evidence about health inequalities (especially from Sir Michael Marmot) and will "refuse to collude with despair"."

"I will continue to hold ICS account to measurably make progress on narrowing health inequalities."

"Continue to work in my AHSN with the health and care system to focus on Core20 population groups, match innovation to priorities with effective co-production and robust evaluation."

Hypertension and hyperlipidaemia case-finding & optimal management

The Knowledge Map Evidence

Cardiovascular disease (CVD) is the leading cause of premature mortality and a major contributor to health inequalities in England, with people from lower socioeconomic groups and ethnic minorities dying younger due to preventable CVD associated with lifestyle choices, compounded by their reduced likelihood of being served by CVD prevention services (Woringer, Cecil et al. 2017). The NHS 2019 Long Term Plan (LTP) acknowledged that early detection and treatment of CVD can help people live longer and healthier lives, yet there are too many people living with undetected, high risk conditions such as high blood pressure, high cholesterol and atrial fibrillation. Therefore, over the next 10 years from 2019, the NHS are working to prevent up to 150,000 heart attacks, strokes and dementia cases, the consequence of CVD risk factors (NHS England 2019).

To help deliver this objective the NHS has launched the national CVDPREVENT audit for primary care, which aims to support professionally-led quality improvement in primary care for the prevention of CVD in England, through helping organisations to identify variations, trends and opportunities in the prevention and management of CVD conditions. The CVDPREVENT audit incorporates age, sex, ethnicity and deprivation data, giving users the ability to assess the gaps between different groups, thus assisting to address health inequalities. In addition to this, the LTP pledges to work with local authorities and government bodies to improve the effectiveness of approaches such as the NHS Health Check, rapidly identifying and treating those with high-risk CVD conditions.

Hypertension (high blood pressure) is one of the most important risk factors for CVD, with around one third of the UK population having high blood pressure (NHS England 2023a). Hyperlipidaemia (high cholesterol) is another major risk factor for CVD, resulting in coronary and peripheral artery disease. Risk assessment and management programmes for hypertension and hyperlipidaemia are proven to be successful, as demonstrated by the NHS Health Check.

The NHS Health Check programme was introduced in 2009 in England with the aim of systematically assessing adults from age 40-74 years for cardiovascular risk factors. It involves cardiovascular risk stratification at five-year intervals and offering treatment to those at high risk. A study completed in 2013 showed that the NHS Health Check resulted in significant but modest reductions in mean cardiovascular risk score, diastolic blood pressure, and total cholesterol and

lipid ratios after one year in patients registered with general practices in a deprived, culturally diverse setting in England (Artac, Dalton et al. 2013).

However, whilst research has shown that the NHS Health Check contributes to improvements in health, there is mixed opinion on whether it improves or perpetuates health inequalities. A microsimulation study from 2018 estimated that the NHS Health Check programme at the time was preventing approximately 300 premature deaths (before 80 years) and resulting in an additional 1,000 people at age 80 years being free of cardiovascular diseases, dementia and lung cancer each year in England, with the benefits being greatest for people living in more deprived areas, therefore reducing health inequalities (Mytton, Jackson et al. 2018). Alternatively, a retrospective database study in 2015 highlighted that the coverage of NHS Health Checks was low in high risk individuals; coverage was similar in deprived and affluent groups but lower in some ethnic minority groups, which could widen inequalities (Chang, Kiara Chu-Mei, Soljak et al. 2015). A difference-in-difference matching analysis conducted between 2009-2013 showed that the NHS Health Check had low attendance and that age, sex and socioeconomic subgroups appeared to have derived similar level of benefits, therefore not addressing health inequalities (Chang, Kiara C. -M, Vamos et al. 2019). A further study exploring the cost-effectiveness and equity of the NHS Health Check showed that, in Liverpool, implementation of the health check was neither equitable nor cost-effective and that structural policies targeting cardiovascular risk factors could substantially improve equity and cost savings (Kypridemos, Collins et al. 2018).

One reported methodology to reduce these reported inequalities is through the delivery of the NHS Health Check in the community setting, with outreach events providing evidence of how local health partnerships and community assets, including informal networks, can improve the delivery of outreach NHS health checks and in promoting the health of targeted communities (Riley, Coghill et al. 2015). Ultimately, reaching the communities that require CVD risk stratification and management will require initiatives that are tailored to the groups and personalised by individuals.

Strengths-based Approaches

The following section outlines the main themes derived from the conference delegates' answers to the three questions posed to them during the breakout session exploring health inequalities and hypertension and hyperlipidaemia case-finding and optimal management.

What work are you doing to address health inequalities improvement in this clinical area?

Theme	Examples
Screening and risk stratification.	– Screening patients on admission to hospital to identify patients at risk of CVD.

Medication management and monitoring.	– Medication prescribing, administering, and reviewing, along with blood pressure monitoring to manage hypertension.
Social prescribing.	– Using social prescribing interventions for cardiovascular prevention. – Guiding Primary Care Networks on how to deliver social prescribing.
Community engagement initiatives.	– Offering physical health checks to hard-to-reach populations in various different settings. – Outreach work, including workshops and education for ethnic minority groups. – Hosting events in mosques and food banks.
Making every contact count.	– Offering regular blood pressure checks for in-patients with learning disabilities and mental health service users.
Education and training.	– Education and training of primary care staff, care co-ordinators and community champions about hypertension and cardiovascular prevention. – Producing public awareness campaigns on hypertension and its links with other diseases.
Collaborative working.	– Working with patients with hypertension to find ways to address hypertension and health inequalities.
Strengths-based approach.	– Working on quality improvement projects to help primary care manage hypertension, including sharing best practices for case finding with non-clinical primary care staff.
Research.	– Working on research projects and data analysis to identify populations at risk from CVD, factors that drive inequalities, and evidence-based interventions that can benefit hypertension.

What ideas do you have to address this clinical area?

Theme	Examples
Community-based interventions.	– Reaching out to deprived communities, involving family and friends, and working with local communities and partners to understand population groups and engage community stakeholders. – Developing proactive community events to reach people where they are, including schools, mosques, food banks and football clubs. – Using the Make Every Contact Count approach. – Recognising that it is necessary to involve community leaders and primary care providers in these efforts.
Data collection and analysis.	– Finding alternative sources of data that can be utilised to estimate the rates of hypertension in different population groups. – Ensuring that data on ethnicity is collected as it is essential for reliable analysis when exploring health inequalities.
Communication.	– Providing accredited training for trusted community messengers, health and wellbeing coaches, and various health professionals to deliver the right message at the right time.
Leadership and partnerships.	– Taking a partnership approach with primary care providers, community leaders, healthcare authorities and voluntary, community, and social enterprise (VCSE) organisations to tackle hypertension and hyperlipdaemia.

What tools or interventions can help?

Theme	Examples
Prevention and outreach programmes.	– Establishing preventative programmes that focus on lifestyle modification to reduce poor health, such as obesity, tobacco, alcohol, and promoting physical activity.

Community-based approach.	– Building relationships and trust with communities to improve healthcare access and outcomes – Having social prescribing champions and local community ambassadors.
Communication.	– Ensuring there is tailored advice available for specific communities, such as culturally sensitive diet and exercise advice. – Improving interfaces between primary, secondary and tertiary care as well as social prescribing.
Data collection and evidence-based approaches.	– Using reliable data collection strategies to evaluate interventions and balancing evidence-based approaches with local needs and resources.

Pledges

"I think that as a working GP who understands the limitations in Primary care, I can be a voice for what GPs in general can and cannot do."

"As a public health professional my entire work is dedicated to the concept of proportionate universalism; distributing resources according to where there is most need and working tirelessly to address the avoidable and unfair differences in health. I would like to see more collaboration across the system, including an understanding of our role and expertise from clinical colleagues. I hope the newly formed ICSs can provide the opportunity to do this."

"I will engage with the leaders where I work and interrogate the outcome measures, they use to reduce inequalities."

"I make a personal pledge to share what I have learned with my circles of influence."

Prevention: smoking cessation

The Knowledge Map Evidence

Smoking tobacco is the single biggest preventable cause of morbidity and mortality and is the single largest driver of health inequalities in England, with higher prevalence of smoking in those from low socioeconomic areas and marginalised groups, including people with mental health conditions, unemployed, in contact with the justice system, experiencing homelessness, lone parents, looked-after children and LGBTQ+ (ash 2019).

Smoking tobacco impacts on all areas of the Core20PLUS5 approach:

Core20: Smoking rates are higher amongst low-income groups (ash c). In 2016, people living in the most socioeconomic deprived areas of England were more than four times more likely to smoke than those living in the least socioeconomic deprived areas (ONS 2018a). A person's likelihood of smoking increases in line with the level of deprivation in their neighbourhood (ONS 2018b).

PLUS: Smoking rates amongst ethnic minority groups are lower than the general population, except for those of mixed or multiple ethnicities where the rates are the highest (ash a).

5:

Maternity: Smoking in pregnancy results in significant harm to both mother and baby, including low birth weight, stillbirth, miscarriage, preterm birth, heart defects and sudden infant death, therefore is the single most important modifiable risk factor during pregnancy (ash e). Studies have shown that pregnant women who successfully quit smoking in early pregnancy can reduce the risk of poor maternal outcomes (McCowan, Dekker et al. 2009).

SMI: People with a mental health problem are approximately twice as likely to smoke compared with the general population, often smoking more cigarettes and find it harder to quit (ash d).

Chronic respiratory disease: Smoking accounts for 86% of COPD-related deaths (ash b).

Cancer: 54% of deaths from cancer (that can be caused by smoking) were estimated to be attributable to smoking (NHS Digital 2019).

Hypertension and hyperlipidaemia: A recent systematic review examined the impact of smoking on cardiovascular disease, including hypertension and hyperlipidaemia. The study found that the risk of cardiovascular mortality in older adults who were current smokers is double that of non-smokers and that, in people aged 60 years and older, smoking strongly contributes to acute coronary events, stroke and cardiovascular deaths (Mons, Müezzinler et al. 2015).

Strengths-based Approaches

The following section outlines the main themes derived from the conference delegates' answers to the three questions posed to them during the breakout session exploring health inequalities and smoking cessation.

Does the framing of the overall national approach of Prevention and Core20PLUS5 make sense?

Theme	Examples
Positive	
Collaboration and co-operation.	– The approach recognises the importance of wider social co-operation and co-production to tackle healthcare inequalities. – Emphasis on the role of the NHS in advocating for patients and working with other systems and services to redesign the healthcare system.
Cultural considerations.	– Cultural issues were recognised as essential in implementing the approach effectively. – Training on cultural awareness and culturally competent language to address health inequalities and engage diverse communities is needed.
Social determinants of health.	– A focus on social determinants of health is crucial to prevent ill health and health inequalities. – The NHS has a key role in utilising its resources as an employer and anchor institution to address health inequalities locally.
Communication and engagement.	– Effective communication of the short-, medium- and long-term benefits of prevention is needed.

	– Using positive motivational approaches, social marketing, and engaging trusted voices and organisations to reach different communities.
Workforce wellbeing.	– The importance of addressing NHS workforce health and wellbeing to ensure a workforce capable of addressing health inequalities.
Areas of improvement	
Improved clarity.	– Requirement for more detailed information and clear definitions, including more explanation and expansion regarding Core20PLUS5 and prevention. – A desire for local and personalised approaches that focus on tangible areas of improvement and prompt a mindset change.
Collaboration and engagement.	– Improved collaboration with VCSE partners and public engagement.
Specific health focus.	– Following the New Zealand approach to ban tobacco. – Addressing oral care for adults and difficulties accessing NHS dentists. – Working with food providers to promote healthy eating.

Are there any missed opportunities?

Theme	Examples
Community engagement and collaboration.	– Strengthening community support and partnerships, integrating social prescribing, and involving stakeholders and volunteer sectors.
Social determinants of health.	– Addressing social determinants of health. – Focusing on poverty-related factors - prioritise local recruitment and encourage real living wage.
Education.	– Providing training in motivational interviewing and cultural competence. – Embedding prevention in professional training.

Specific health focus.	– Targeting weight management and obesity prevention. – Addressing oral health and access to dental care. – Improving childhood nutrition and activity levels.
Data sharing and analysis.	– Utilising data analysis, cross-referencing with GP records, and sharing data for informed decision-making.

What tools or interventions can help?

Theme	Examples
Enhanced screening programmes.	– A bigger push and funding needed for screening programmes.
Patient-centred approach.	– Understanding the patient/public perspective and offering personalised solutions. – Customised and co-created approaches with communities.
Health education and literacy.	– Increased health education efforts and promotion of health literacy.
Cultural considerations.	– Cultural representation to support understanding and engagement. – Identifying what works in different communities.
Strengths-based approach.	– Building on existing services rather than creating new ones. – Adopting a whole system approach involving multiple sectors.

Pledges

"Supporting the service users struggling with alcohol and drug misuse remains my personal pledge and the information gained at the conference is invaluable."

"I work in a tertiary service and lack some of the primary/community-based care experience which can target so many. Thinking about targeting poorer communities for health advice promotion using food banks, maybe with the help of local running clubs as many support them with club donations.... Also to liaise with colleagues in my own service and DGH's in deprived area to gauge if any local initiatives ongoing or worth developing."

"I plan to promote MECC in my organisation, starting in my clinical areas."

"I pledge to actively explore patients' wider determinants of health to ensure they are receiving the best care and a more personalised approach to their care."

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