MI
HEALTH

THE MIDLANDS HEALTH AND CARE INEQUALITIES POLICY COMMISSION

Tackling inequalities
in the Midlands

“Information is not presented in an accessible manner as the average reading age is 9 years old. So why is the information presented in an exclusionary way?” (Community Member)

“Disability, mental health and physical health holding the same weight would vastly decrease the inequalities” (Community Member)

“Not speaking English does not equate to a lack of intelligence” (Community Member)

*“Need a regional system that mirrors the approach needed at ICS level” (ICB Chair)**

“Stigma and discrimination feature heavily in inequalities and these things need to be discussed and addressed” (Community Member)

“We have plenty of data but often not enough staff (or funding) to look at long-term cooperative projects that have real meaning in our communities.” (Dr Leslie Borrill – Charnwood GP)

“Even if you are dying, they don’t care - that’s your problem not their problem” (Community Member)

*“Need to back-up well meaning words with a shift in resources, otherwise goodwill will fizzle away” (Primary care leader)**

“I’m registered blind- waited 7 months after arriving to the UK to get a referral to a specialist for my medications and be seen by a doctor.” (Community Member)

“Collaborative action is usually best where there is representation across the care system, as well as with community groups and patients themselves. Whilst this can be cumbersome to manage it tends to deliver a service or intervention that has higher impact on tackling the issue. Having sound data to back this up is also key, alongside monitoring progress and outcomes (where possible).” (Midlands GP)

“Intersectionality is a major problem in recognising people because they wonder whether people can have more than one problem or condition at a time” (Community Member)

*“I think if you if you took almost any kind of description of health inequality, you could probably find an organisation within the voluntary sector that’s trying to address it... particularly from a voluntary sector perspective, we still sometimes see a bit of a disparity between, for example, what the local authority is focusing on and what the NHS is focusing on” (Third sector leader)**

“Despite more information being available to people than ever in human history, people still do not see that their health choices have implications – this teaching would need to start very young.” (Midlands GP)

“Diabetes is seen in my community as inevitable with age” (Community Member)

“Awareness is only useful if it leads to change” (Community Member)

“Judgments are made about patients and their ability to use interventions (which in a way is natural for practitioners trying to provide appropriate care), but we need to learn to work around these challenges – not gate keep services that are known to create better outcomes.” (Simon Pizzey, Head of Strategy & Planning, University Hospitals of Leicester NHS Trust)

“Walk in centres make me sit for five hours and I am not assessed properly, given paracetamol, and sent home” (Community Member)

*Selected quotes collected by the King’s Fund

We dedicate this Policy Commission to:

The brave community members, leaders and representatives who were so kind and generous with their time, emotions and honesty in reliving particularly painful memories and discussing challenging topics.

The astonishing front-line workers and dedicated health and care professionals who spoke with us about difficult subjects and impossible pressures when they were already over-run doing their fantastic work every day.

We will not forget. You are heard. This is only the beginning.

For Rose

Rose Thompson was a talented radiographer, compassionate community leader and active equalities champion. As the Chief Executive of the charity B'ME Against Cancer (whose remit is to reduce cancer inequality, as well as health inequalities overall), she improved the lives of many during their most difficult days. Rose continued to fight for equitable and fair treatment for those most impacted by inequality until the very end, including working with the Commission to ensure it makes real and lasting change. She will be missed by so many.

In memory of Liz

Professor Dame Elizabeth Fradd DBE DL was an active champion of equitable health throughout her career, which included Honorary Professor at the University of Nottingham, High Sheriff of Nottinghamshire and Assistant Chief Nurse for England.

The focus of her working life and passion was the continuous improvement of Healthcare, particularly actions seeking to improve children's health and address mental health challenges, recognising the impact of the Pandemic in highlighting both hidden and previously known inequalities in health and social care.

Liz was a delight to work with and a driving force within this Commission. She will be dearly missed. Our thoughts are with her loved ones.

FOREWORDS

Lord Victor Adebowale CBE

Taking on a Commission that looks at health inequalities across a region is no easy task. I am grateful to the Commissioners for their patience when working with me and the team (I would particularly like to thank Alex Archibald for her stygian focus) to produce a piece of work I am proud of. This work is based on qualitative evidence (adequately supported with quantitative data), and I, personally, was struck by the stories of the people we engaged – particularly those who spoke of the racism and discrimination they experienced, which impacted on their health.

This report has set out the need for a regional approach to health and social care inequalities but, for me, the reason is simple: we cannot afford to stand behind silos, in an age of resource challenges. We need to collaborate, learn together and challenge each other. To confront often fundamental and systemic inequalities, organisations and the communities which they serve must come together more effectively and routinely. This is where the strength of the partnerships that already exist in the Midlands need to be leveraged further. Through the creation of more roles (including health champions and wellbeing guardians) that allow communities to be the driving force behind services, the region can not only learn from within but share expertise outwards. By coming together with a unified voice, these individuals, communities and partnerships can share success, avoid inefficiencies, and champion the brilliant work already being delivered. This report is the first step to achieving a regional approach in the Midlands.

As we strive to deliver effective, safe and patient-focused (including culturally appropriate) health and social care across the large and diverse population, it is vital that a representative workforce be supported, trained and directed to do so in a coordinated and evidence-based manner. To achieve this, staff must feel safe and respected by patients, colleagues and the wider community, and that they exist within a system that is proactively seeking to prevent current and future challenges. This cannot be addressed in silos and requires collaborative action across all organisations that are involved in public health interventions and medical training.

The necessary conversations to respond to the challenges raised by Midlands communities and the actions recommended should feel uncomfortable – this report does not aim to be an easy read for those with the power to create change. It is designed to leave us questioning ourselves and our organisations as we seek to improve our services and impacts. For it is at the edge of our comfort that our growth resides, and we must lean into that feeling. This extends through health and care delivery and into the 'traditional' ways of working within all organisations, funding silos and patterns of collaboration, where many restrictions and thus, opportunities, lie.

This Commission is the opening of a conversation. We seek to support and promote good practice. This report is extensive (we know) and not every action will be relevant to your organisation (see the chapter breakdowns). We hope, however, that you will see this as a means to create a regional conversation and to build on the great work you and your organisation are already doing to tackle health and care inequalities locally.

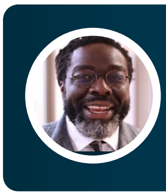
Professor Kamlesh Khunti CBE

Health inequalities are a major problem in the Midlands, where a significant proportion of the population suffer from ill health, often due to factors beyond their control, such as poverty and social exclusion. In this wide-ranging and comprehensive report involving community, healthcare and academic stakeholders, we recognise that health inequalities are complex, and outline a long-term strategy involving multiple partners across the region.

This Commission highlights that to effectively reduce health inequalities, we need to make research and, most importantly, clinical trials more accessible and open to people from all backgrounds, to ensure understanding of the health benefits for all. This will require work to better communicate the benefits across the region, and, in particular, for traditionally underserved groups such as ethnic minorities. When collecting and utilising any health-related data in academia or clinical practice, it is clear that there needs to be much greater emphasis on improving the capture and coding of data on ethnicity and associated social determinants of health to ensure we better understand the health needs of different ethnic groups. Such data is needed, for example, to monitor and address the academic attainment gap in the region, where the wealthiest students of African or Caribbean heritage do not perform as well as the poorest White students. By implementing these and the other key findings of this report, and by utilising the strong research community and diverse local population, we can make a real difference to the health of people in the Midlands.

COMMISSIONERS

The Commissioners were drawn from across the sector and represent a wide range of roles and stakeholder organisations, including the NHS, industry, academia, charities, Members of Parliament and local government.



Lord Victor Adebowale CBE

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Professor Dame Elizabeth Fradd DBE VL-L (1949–2024), Honorary Professor at the University of Nottingham

Jo Gideon MP – Former Conservative MP for Stoke-on-Trent Central

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Midlands Innovation Health (MIH) is a research and innovation partnership that coordinates and combines the collective excellence of seven Midlands universities to deliver improved health and regional growth. Driving disruptive translational interventions and influencing nationally, MIH draws together a critical mass of innovative regional stakeholders to impact national and global health challenges using local training strengths, expertise, networks, best practice and facilities. MIH also links the Midlands-based universities within a joint academic-NHS-industry innovation environment, to push forward research, collaboration and skills in the Midlands medical sector. MIH partners are the Universities of Aston, Birmingham, Keele, Leicester, Loughborough, Nottingham and Warwick. MIH acts as the Health branch of Midlands Innovation, a world-class multi-disciplinary collaboration that unites the power of university research with the unique strengths of Midlands industry to drive cutting-edge research, innovation and skills development

EXECUTIVE SUMMARY

The Midlands Health and Care Inequalities Policy Commission, with the support of Midlands Innovation Health, conducted an extensive programme of work from 2021 to 2024 to identify and address health and social care inequalities in the Midlands. The Commission found that people in the Midlands face extensive inequalities and poor health outcomes, which include the region having the highest infant mortality rate in the UK and one in twelve adults diagnosed with diabetes.

To summarise current policy that aims to improve these outcomes and to collect community and stakeholder insights, the Commission followed a three-phase process: review of existing recommendations, discussion within policy forums (community members and leaders) and stakeholder engagement. This allowed the identification of critical barriers and associated challenge areas by Midlands communities. These were:

Access: appointments, language, physical accessibility, and gatekeeping

Trust: racism and discrimination, cultural awareness, and empathy and understanding

Representation: health and care workforce, NHS culture, intersectionality, and clinical trials

Digital: digital literacy, systems and data sharing, and data collection and accuracy

Knowledge: health literacy and mental health

Practical actions that can be delivered by all Midlands organisations to help to overcome these barriers and to provide the environment and opportunities needed for a fair and equitable health and care service can be summarised by the following high-level themes:

- **Inclusion and representation within the workforce, leadership, policies, and practices**
- **Involvement, co-development, and awareness**
- **Education, skills, research and life-long training**
- **Accountability, oversight, and process**

In delivering this work, the Commission has highlighted examples of successful methods deployed locally to tackle health and care inequalities, identified areas where further work and research are needed, and provided actionable recommendations for where regional partners and the government should focus effort to uplift our health and social care system to become preventative, inclusive, and accessible for all. The Commission will continue to progress forwards, looking to motivate further action and galvanise collaboration to overcome the barriers identified.

It is the view of the Policy Commission that significant improvements can be made to address health inequalities, both in the short and long term, through the development of a clear regional strategy that addresses the following 10 priorities for change and includes delineation of the role and responsibilities of individual organisations across the Midlands:

1. Set tackling health inequalities as the priority.
2. Make people-powered health an essential.
3. Deliver whole system approaches.
4. Prioritise effective delivery and impact.
5. Develop and deliver a regional approach.
6. Capitalise on real community involvement.
7. Rebuild trust and respect.
8. Campaign for long-term investment.
9. Lead the way in data and digital done correctly.
10. Reflect local community need in policy and research.

Regional leaders should use this report as a reference to inspire and guide their efforts towards tackling health and care inequalities. By implementing the recommended priorities and using the report as a tool for review and monitoring, significant progress can be made in improving health outcomes for all in the Midlands.

For further information on any of the themes or priorities and to discuss collaborative opportunities, please contact: Alex Archibald (Project Manager) – Midlands Innovation Health (Alexandra.Archibald2@nottingham.ac.uk).

MIDLANDS EQUALITY IMPACT ASSESSMENT TOOL

CALL TO ACTION: What are you doing to tackle health and care inequalities?

We recommend that this checklist be completed by a variety of staff at different levels of responsibility and across different teams to indicate not only accuracy but also awareness across your organisation. Readers may also find it useful to review it both before reading the report (to set the scene) and after (to reflect any new awareness).

"Does your organisation and/or team have …"	**Tick for 'Yes'; leave blank for 'No'**
Leadership:	
1. "… a senior champion identified to lead health inequalities activity?"	☐
2. "… a detailed plan to enable it to truly act as an anchor organisation within the community?"	☐
Priorities, strategy and process:	
3. "… an ambitious equalities strategy (ideally with a health strand) setting tackling inequalities as a top priority?"	☐
4. "… routinely performed and detailed impact assessments (positive and negative) of the services provided?"	☐
5. "… a digital inclusion framework that sets out targets and measures to reduce this risk?"	☐
6. "… a collaborative data sharing policy that enables effective use for the local community?"	☐
7. "… a comprehensive feedback/complaints system (for staff and service users) that feeds into senior decision making?	☐
Inclusion and representation:	
8. "… a workforce inclusive and representative of your service users (at all levels, particular senior leadership)?"	☐
9. "… full understanding of the communities and groups present and served within the population?"	☐
10. "… activities underway to rebuild trust, increase involvement and invest in local communities?"	☐
11. "… mechanisms to tailor services to your local population, using community assets for delivery?"	☐
12. "… targets to actively improve communication with your local community, Voluntary Community and Social Enterprises, and service users?	☐
Optional open question – personal activity:	
Think about your role in helping the Midlands to overcome its health inequalities. Name one area that you could improve your activity and briefly summarise what you will require to achieve this.	

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Terminology Disclaimer:

Extensive discussion exists within policy and academic literature as to best terminology to refer to members of our society who do not identify as White British or White Other. Example terms include 'Black and Minority Ethnic' (BME), 'Black, Asian and Minority Ethnic' (BAME), and, with increasing international usage, 'the global majority'. In 2021, the NHS Race and Health Observatory[2] found that none of these terms were felt to be representative or universally accepted. This Policy Commission often discusses 'communities', as many challenges are wider than any one protected characteristic or excluded group (often called 'inclusion health groups'[3]). When referring to specific groups directly, however, 'ethnic minority'[4] has been used as it was identified as the least unpopular term by the NHS Race and Health Observatory and is in line with government guidance[5]. We do, however, recognise that this may not appeal to all and continue to seek feedback on this.

In addition, as raised by communities in the region and outlined within the report as an action for organisations involved in data collection and ethnicity coding, this Commission supports the removal of misleading and exclusionary assumptions of skin colour when referring to ethnicity e.g. Black African. It is, however, acknowledged that when working with and referencing data collected by a third party that it can be difficult to avoid – this report is no exception. Wherever possible we have avoided colour references for ethnic minority groups and have redesigned tables and diagrams (marked with *) to meet this ask from our communities. Where this may not have been achieved is within quotation marks to denote that it references third party data or is a means of self-expression.

CHAPTER 1. POLICY COMMISSION DEVELOPMENT

Purpose

The Midlands Health and Care Inequalities Policy Commission, supported by Midlands Innovation Health, is the core of a programme of activity to increase understanding of issues surrounding health and social care inequalities in the Midlands and the ability of the region to respond to them. In delivering this work, the Commission has highlighted exceptional examples of methods deployed locally for tackling health and care inequalities, raised awareness of further work and research required, set challenges for regional partners, and showcased where the government needs to focus its attention to uplift our health and social care system to become preventative, inclusive and accessible for all.

Scope

The Policy Commission acknowledges the NHS England definition of health inequalities and looks to apply this across both the health and care sector:

> *"Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing." (NHS England, 2022)*[6]

This definition incorporates two commonly, and often interchangeably, used terms – equality and equity. Equality refers to treating everyone the same and providing them with the same resource. Whereas equity means providing services relative to need and may require warranted variation in services for different groups[7]. The Commission team has been open to both approaches where appropriate and accepts them within this work.

The Policy Commission understands that there may be inequalities raised that step outside of the remit of health and social care but feels strongly that these wider determinants are still important and that participants deserved to be heard and recognised for all their views.

Methodology – A phased approach

By drawing on previously identified recommendations and working with practitioners and communities to explore the lived experience of efforts to tackle health and care inequalities, the Policy Commission aims to outline known good practice, identify barriers and set practical actions for overcoming them to accelerate change across the Midlands. This has resulted in a roadmap of actions to be taken by the Midlands anchor institutions (broken down by organisation type) to drive change across all or within parts of the Midlands.

Key Aims:

1. Determine the main health and care inequality challenges in the Midlands.
2. Summarise what existing action is already taking place and what is not, including current duties and requirements with respect to identifying and reducing inequalities.
3. Identify barriers and determine enablers with mechanisms for delivery across the Midlands.
4. Provide case studies of best practice and opportunities to learn from.
5. Propose priorities for change and guidance to support this.

To achieve these aims, the Policy Commission developed a three-phase approach for delivery designed to narrow down decades of research, policy work, and health interventions, and combine it with the latest community needs. Further details on this approach can be found in the Appendix.

- Phase 1: Extensive policy report collation, literature review, landscape assessment (Taskforce 1) and interviews.
- Phase 2: Policy forums (communities), individual interviews, testimonial collection, and collation of actions.
- Phase 3: Stakeholder engagement, change management, and post-report activities.

CHAPTER 2. WHY TACKLE HEALTH AND CARE INEQUALITIES IN THE MIDLANDS?

Population health challenge overview

In the Midlands, despite the best efforts of many (both professionals and volunteers) from across the health and care sector, our communities have a long history of facing complex challenges that directly and indirectly impact their health – many of which still persist today. While the region is by no means alone in facing health and care difficulties, with different communities across the UK struggling to live full, prosperous, and healthy lives, the Midlands does face its own distinct set of health concerns and should not be forgotten when tackling inequalities nationally or locally. These concerns include:

- The region has the UK's highest infant mortality rate (5.3 deaths per 1,000 live births), compared to 4.1 nationally[8].
- 1 in every 12 adults in the Midlands has received a diagnosis of diabetes, the highest prevalence of any region in England[9] [10], with 90% of those with type 2 diabetes[11]. There are particular hotspots in Sandwell (10.5%), Walsall (10.4%), and Leicester (10.3%). At a regional level, the West Midlands had the highest prevalence of diabetes at 8.6% nationally, with the East Midlands having the third highest at 8.1% and, of those diagnosed with type 2, 68.4% are of an ethnic minority background (the second highest in England)[12].
- Gaps in life expectancy of 6.2 years for males and 5 years for females exist between the most and least deprived areas[13]. Across the UK, the West Midlands has the second largest difference between males and females (4.1 years) while the East Midlands has the third smallest (3.8 years)[14], furthering inequalities locally. This inequality is also seen in healthy life expectancy, with the Midlands hosting both the area with the third lowest in the UK for females (North East Lincolnshire 54.3 years) and the one with the highest for males (Rutland 69.1 years)[15].
- At 15.9%, the East Midlands has the third highest hypertension rate in England (15.5% in the West Midlands).
- The Midlands hosts four of the six local authorities for the highest prevalence of year 6 aged children living with obesity in England. The West Midlands region has second highest prevalence in the UK[16].
- There are increasing mental health challenges: Leicester has the highest proportion of people subject to the Mental Health Act in England[17], and the East Midlands is the region where bipolar disorder is most common[18].
- The region hosts areas identified as particularly vulnerable to the impacts of the COVID-19 pandemic (Derbyshire, Nottinghamshire and West Midlands clusters, particularly around Birmingham)[19], implicating future resilience.
- Citizens in the Midlands are the most likely to report challenges in trying to book a GP appointment[20].
- There are also unknown challenges that drive significant variation in take-up of NHS Health Check invitations, with residents of the West Midlands being one of the worst in England (39.2%), in contrast to the East Midlands, which was the best (47.4%)[21].
- Details of other health indicators can be found in the Appendix.

These challenges, when combined with local socioeconomic factors, put the Midlands' population at a severe disadvantage compared to the rest of the UK. These factors include the region having:

- The Midlands contains areas with the least gross disposable household income (Leicester – the lowest in the UK, Sandwell, Nottingham, Stoke-on-Trent, Walsall and Birmingham)[22].
- 24.8% of our citizens live within the most deprived quintile in England and 13.2% are in the most deprived decile[23].
- 48 communities in the Midlands identified as "left behind" by Local Trust and Oxford Consultants for Social Inclusion, defined as severely deprived, disconnected from services, and with high levels of community need24.
- The Midlands contains some of worst constituencies in the UK for child poverty (2021/22) – 46.4% in Birmingham, 44.6% in Sandwell, 43.5% in Stoke-on-Trent and 41% in Nottingham. Across the sub-regions, 38% of the children in the West Midlands – the highest region and 33% in the East Midlands are living in poverty[25] [26] [27].
- The highest proportion of jobs and enterprises in the Midlands are in sectors identified as having been the most impacted by the COVID-19 pandemic (public sector and visitor economy)[28].

Living within this landscape is the UK's largest population, with the most diverse cultural heritage outside of London (2023 demographics data[29]):

- The Midlands population is over 10.6 million, an increase of 8.4% (+823,635) since 2011. This includes:
  - 5.4 million female residents, an increase of 8.5% (+418,984) since 2011.
  - 5.2 million males, an increase of 8.4% (+404,651) since 2011.

2021 Ethnicity Data	**% of England and Wales ethnic groups living in the Midlands[30]**			**% of population from each ethnic group[31]**		
	Midlands	**East Midlands**	**West Midlands**	**England and Wales**	**East Midlands**	**West Midlands**
Total: All usual residents	18.2%	8.2%	10.0%	100.0%	100.0%	100.0%
Asian, Asian British or Asian Welsh	21.5%	7.1%	14.4%	9.3%	8.0%	13.3%
Caribbean or African heritage*	16.6%	5.4%	11.2%	4.0%	2.7%	4.5%
Mixed or Multiple ethnic groups	17.2%	6.8%	10.4%	2.9%	2.4%	3.0%
White	18.0%	8.6%	9.4%	81.7%	85.7%	77.0%
Other ethnic group	14.8%	4.9%	9.9%	2.1%	1.3%	2.1%

However, while the Midlands has many multifaceted problems that it needs to address to prevent even greater inequalities, if tackled now, (with the long-term health of our citizens as a primary focus) the region has the potential to be a place of real opportunity to grow and learn. Utilising our entrepreneurial and community spirit, willingness to engage in research and ability to pilot interventions with globally representative populations, we can make a real impact upon the lives of many different communities. This report seeks to act as a roadmap to begin to achieve this change, starting with shaping fair and equitable health and care systems.

Wider determinants

Across the large and growing population of the Midlands, there are many interlaced factors that create and drive the aforementioned health and care inequalities, many of which do not exist only within the health and care remit. These non-health related inputs are often referred to as "wider determinants", have been found to influence 80% of health outcomes, and are associated with a larger burden of disease (examples include education, employment, income, housing, social position, cultural/personal preferences and access to green space)[32 33 34 35 36 37 38]. In addition to the previously highlighted socioeconomic challenges present, wider determinants in the Midlands include:

- An estimated 39,067 homeless people in the Midlands on a given night in 2024 (10,829 in the East Midlands and 28,238 in the West Midlands). 10,598 people were homeless in Birmingham making it the 4th worst place for homelessness in the UK[39].
- Significant social challenges, such as the West Midlands (outside of London) having the highest number of knife or sharp instrument offences per population in the UK – 6,639 recorded offences (109 per 100,000 population) (year ending September 2024[40]).
- Below average overall employment rates (75.5% East Midlands; 75.2% West Midlands; 75.7% national average)[41].
- 32% of Midlands local authorities in the quintile most likely to experience digital access exclusion[28].
- The Midlands has below the minimum recommended amount of green space available for its population, with 518,567 beyond a 10 minute walk of green space[42]. The East Midlands also has the lowest access to woodland in England (8.8%)[43].

Evidence has shown that by maintaining an equitable society, benefits are seen across the whole population, not just those living in the most deprived areas or currently experiencing the worst outcomes[7]. Understanding exactly in what way wider determinants interact and influence health outcomes is the focus of much debate and research.

How the region's population responded to the COVID-19 pandemic is a key example of the way in which these variables can link directly to health outcomes. Certain areas of the Midlands (which are often more deprived populations) have above-average vulnerability to the impacts of the COVID-19 pandemic. This is primarily due to the proportion of people aged 70 or older, those who have certain pre-existing health conditions (including certain ethnic minorities who may be more susceptible), and those who are in vulnerable family situations (resulting from school closures and reduced access for social care). These areas include: Derbyshire, Nottinghamshire, and clusters in the West Midlands, particularly around Birmingham19. This was further compounded by being the top 2 of the only 3 sub-regions to experience an increase of excess death unrelated to the virus during the pandemic (West Midlands (1,306 excess deaths, +1.0%), East Midlands (584 excess deaths, +0.6%) and South West (597 excess deaths, +0.5%)[44].

> *"The pandemic has increased awareness of pre-existing inequalities and the disproportionate effect on some groups, including disabled people, ethnic minority communities, care home residents, people in forms of insecure work and people experiencing homelessness. This awareness can open new debates about how to address inequalities and clear the way for employers, service providers, local communities, and governments to take more action to support these groups." (The Health Foundation, 2021)*[45]

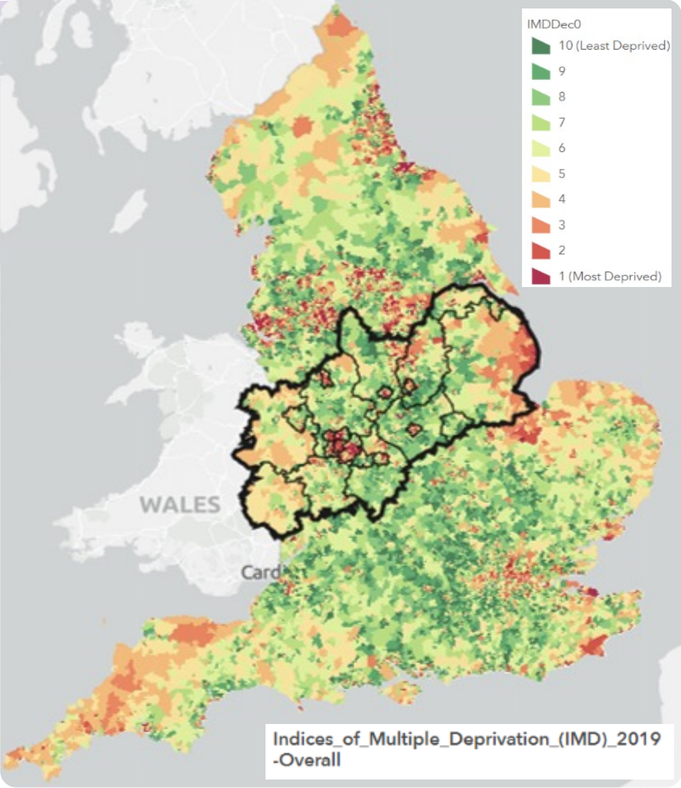
Below, we explore how these wider determinants, and the links between them, have and continue to impact the Midlands, preventing equitable health and care.

The link between deprivation, societal structure and health

Many of the wider determinants that impact health outcomes are interconnected, for example influencing the likelihood of exposure to certain risk and protective factors, such as smoking, food insecurity, diet, and physical activity[46,47]. Some links are not as clear, such as the inequalities in survival rates of cardiovascular disease that exist across gender (nationally, women are twice as likely to die[48]), which require deeper research to understand and dismantle. Perhaps the most pervasive determinant is deprivation, but there are also other variables that connect to this, including ethnicity and local environment.

DEPRIVATION:

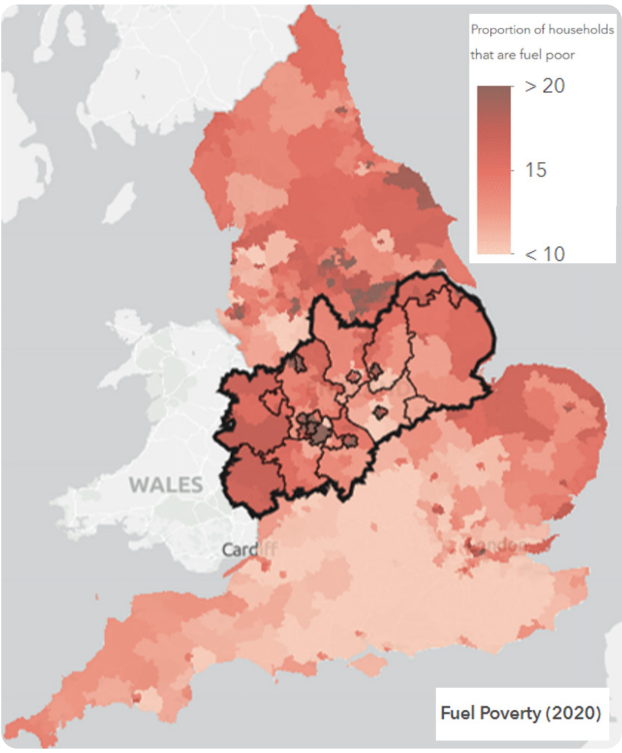
> *"In England, there is a systematic relationship between deprivation and life expectancy, sometimes known as the social gradient in health." (King's Fund, 2020)*[49] *"Health inequalities can be found along [this] social gradient, with those living in the most deprived areas having the worst outcomes." (Leicester Health and Wellbeing Board, 2021)*[7]



24.8% of the Midlands is classed as deprived (defined as being in the top 20% of the most deprived areas in England). The average deprivation gap across the Midlands (the difference between the lowest income score and the highest income score within a local authority) is 30.3%. The highest deprivation gap exists in Birmingham local authority district (54.5%), while the lowest is in Rutland local authority district (8.4%). Birmingham local authority district also has the highest income deprivation rate (proportion of the population in an area experiencing deprivation relating to low income) of 22.2%, with South Northamptonshire local authority district having the lowest (4.9%)[50].

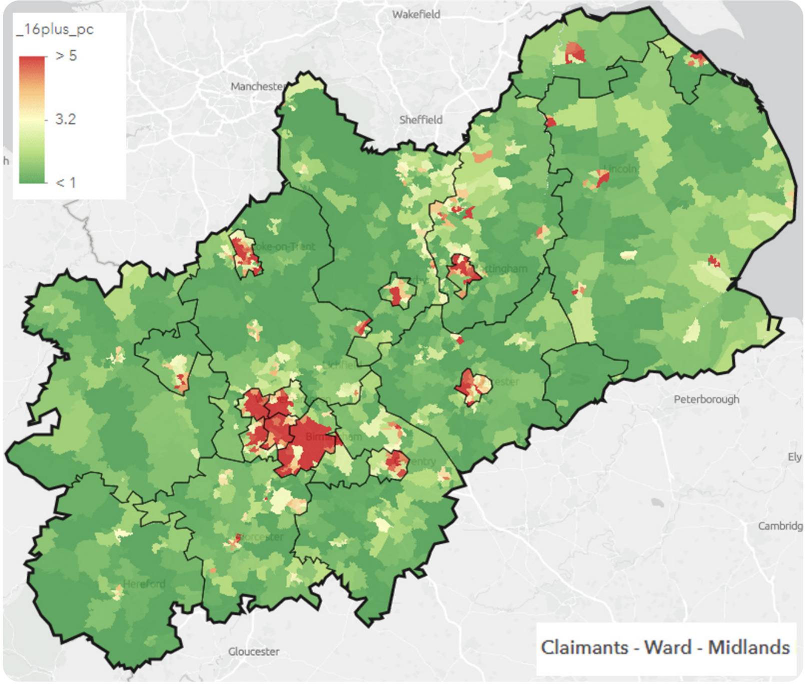
A related but separate[51] measure of resource availability within the population is fuel poverty – a factor that has become of particular concern of late. Nationally, a household is considered to be fuel poor if[52]:

- it is living in a property with an energy efficiency rating of band D, E, F or G; and
- its disposable income (income after housing costs and energy needs) would be below the poverty line.



In the Midlands, 17.7% (824,528) of households were fuel poor[53] compared to 13.1% England-wide in 2022 (the most recent data, which can be assumed to have worsened in recent years[54]). This has increased by 8.7% since 2021, with a 0.4% increase seen across England. At a local authority level, the region hosts 8 of the top 10 for proportion of fuel poor households in England:

- Stoke-on-Trent had the highest rates at 24.7%
- Birmingham (2nd, 24.0%)
- Wolverhampton (3rd, 23.0%)
- Coventry (4th, 22.2%)
- Sandwell (5th, 22.0%)
- Walsall (6th, 21.0%)
- Leicester (Joint 8th, 19.8%)
- County of Herefordshire (10th, 19.7%).



Even in the more affluent areas of the region, fuel poverty still exists in considerable proportions, such as in Rushcliffe (11.6%), Harborough (11.5%), and Blaby (10.9%) – the 3 lowest portions in the Midlands. This has resulted in levels of children living in fuel poverty of up to 42.2%, as seen in Birmingham.

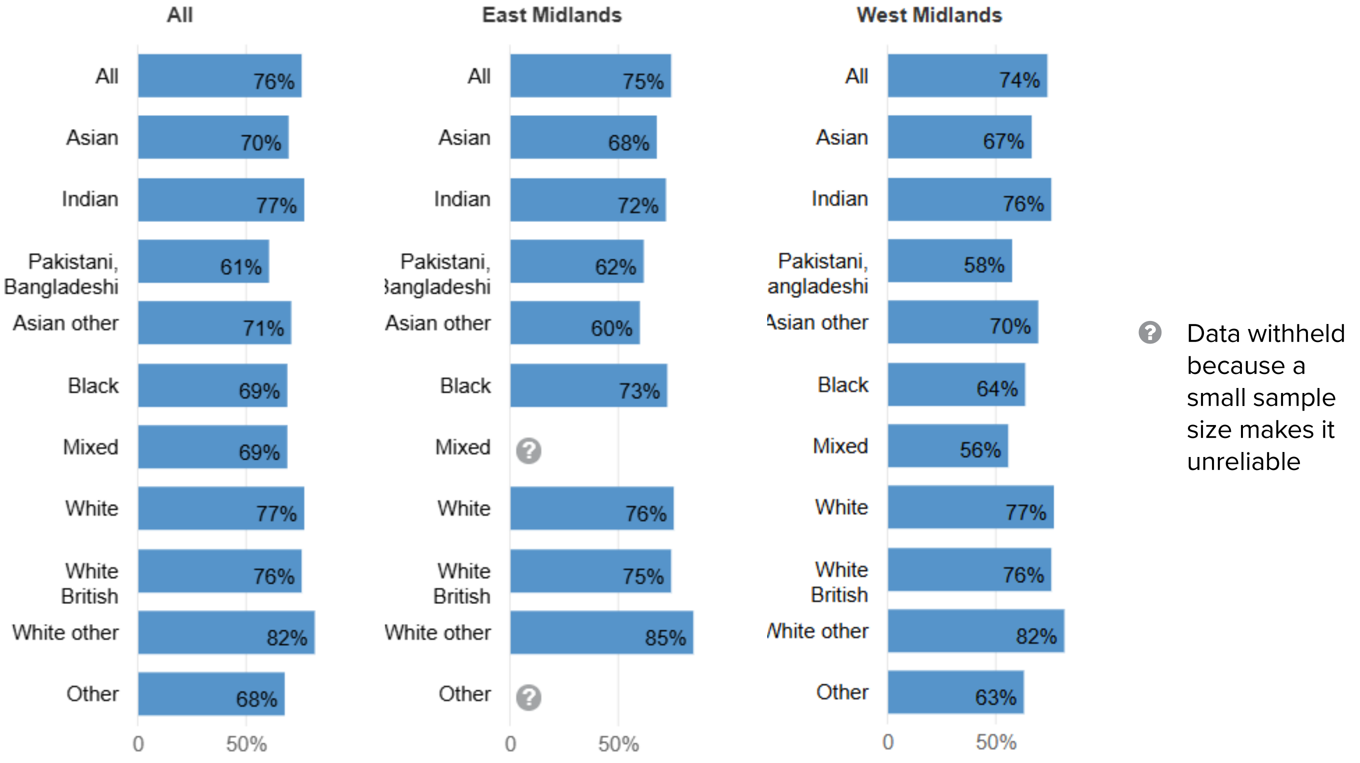
The final resource-related indicator explored here is the number of claimants (people claiming unemployment-related benefits) in the region. There are approximately 310,000 claimants aged 16 years and over in the Midlands (3.7% of residents, compared to 3.2% UK-wide – December 2024[55] [56]). However, as shown, there are considerable differences across the region. The wards with the highest number of claimants as a percentage of the population were based in Birmingham; Lozells at 21.4%. This is followed by Aston at 19.5% and Handsworth at 19.3%. This factor also highlights the considerable difference between rural and urban areas, which will be considered later.

In extreme cases, related factors (such as substance abuse, mental health issues and domestic violence) can compound existing deprivation and lead to homelessness. Homeless people's living arrangements, hygiene, exposure to violence and lack of access to healthcare supplies (complicated further by intersectionality) make them more susceptible to injury, disease, discrimination, mental illness, chronic/multiple health conditions and substance abuse[57] [58] [59]. As previously noted, this is a considerable concern for the region.

ETHNICITY:

> *"National and regional evidence suggests that increased risk among [ethnic minority] communities is due to a number of intersecting factors, including:*
>
> - *Increased prevalence of chronic disease*
> - *Reduced likelihood of using primary care services*
> - *Being more likely to work in sectors associated with increased risk, particularly in the health and care, hospitality and transport sectors*
> - *Failure to protect key workers and a lack of PPE in the early stages of the pandemic*
> - *Income inequality and deprivation, including household overcrowding*
> - *A system that is inadequately equipped to address the issue, including a lack of complete and high-quality ethnicity data and a lack of funding where it is most needed."*
>
> *(West Midlands Combined Authority, 2020)*[38]

The 2011 census showed that the Midlands region had the greatest disparity in England across ethnic groups in the likelihood of living in a deprived neighbourhood, with Bangladeshi communities being the most likely (over 50%) and White British communities being the least (9%)[60]. This significant gap is considerably lower in London and the South, indicating that deprivation-focused ethnic inequalities exist very much on a North-South divide. This is reinforced by variations in regional employment (16- to 64-year-olds) across different ethnicities, as shown below (2022)[61]:



Birmingham is home to the largest proportion of Bangladeshi people in the Midlands, with 48,232 citizens – accounting for 7.7% of the UK Bangladeshi population[62]. Demonstrating the link between ethnicity, deprivation, and health outcomes, evidence suggests that the Birmingham-based Bangladeshi community experiences[63]:

- Higher risks of maternal mortality and premature and/or low birth weight babies from mothers born in Bangladesh compared to women born in the UK.
- Higher prevalence of obesity among reception and year six children compared to other children.
- Highest prevalence rates of tobacco smoking and paan (chewing tobacco) use.
- Low levels of physical activity, particularly amongst women.
- Lower levels of awareness of the causes and management of disease.

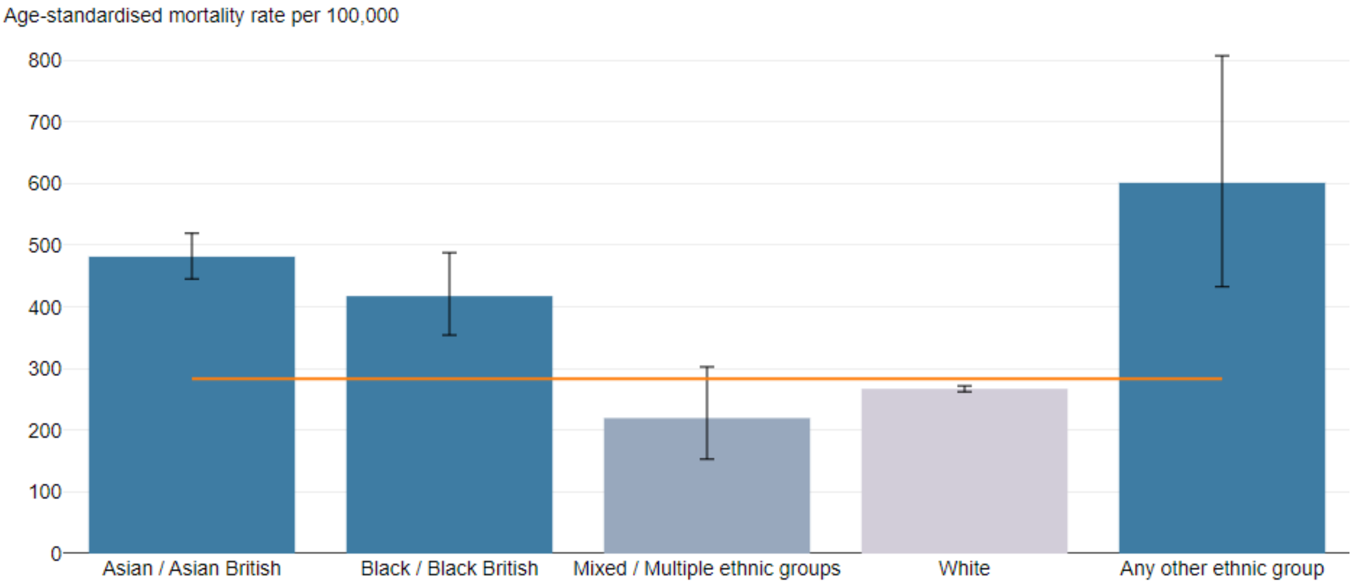
Discrimination and structural racism can also reinforce inequalities. For example: in housing, employment, healthcare, and the criminal justice system, which in turn can have a negative impact on physical and mental health[64].

These differences are compounded by disparities in local socioeconomic conditions across different geographic areas, such as those seen in public health funding changes in the West Midlands, where Sandwell, Wolverhampton, and Birmingham – the most ethnically diverse local authority areas in the region – have had significant cuts over the last five years (15%, 8%, and 9% respectively), well above the 5% national average[65,66]. While the East Midlands receives the lowest amount of public spending per person (across all sectors) of any region in the UK[67].

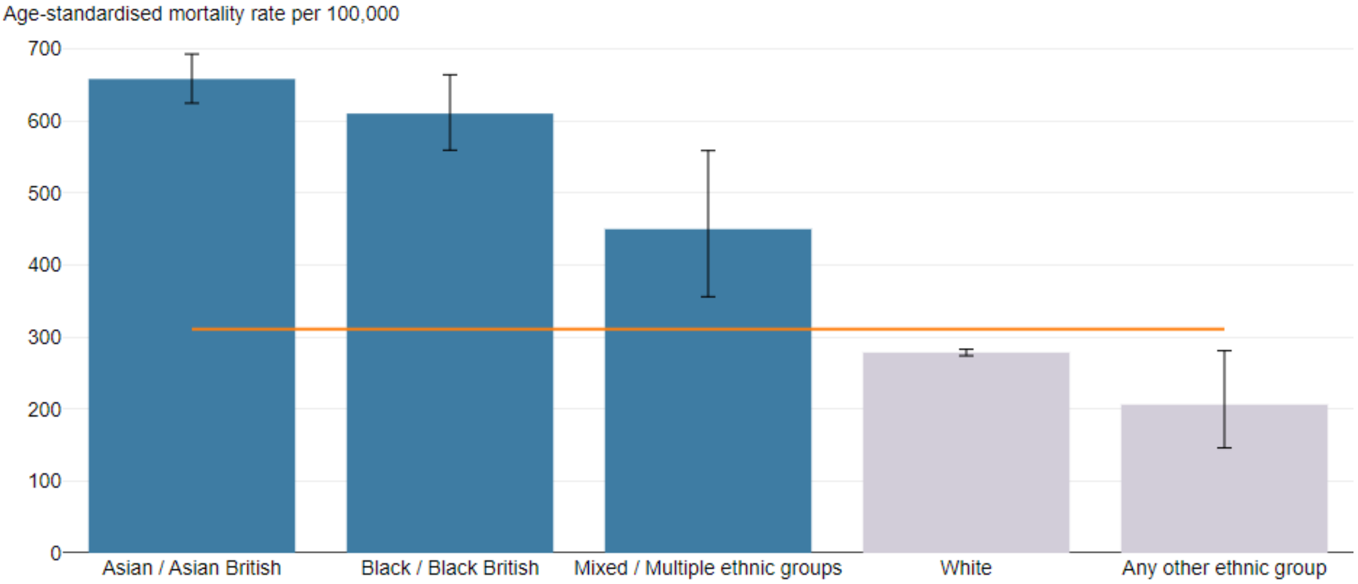
Inequality between ethnic groups is also seen across different disease areas and health outcomes. Nationally, it has been shown that certain ethnicities are more likely to suffer from certain diseases. For example: infant mortality, cardiovascular disease, and diabetes are higher amongst Caribbean or African heritage and South Asian ethnic groups, while mortality rates from cancer, dementia, and Alzheimer's disease are highest among White groups[64].

It is a combination of these factors (as well as variations in existing health conditions [including diabetes and obesity], living arrangement [including multigeneration households], job role, access to testing, impacts of lockdown measures, and the effectiveness of equipment across communities[68,69,70,71,72,73,74]), which led to the COVID-19 virus having a disproportionate impact on ethnic minority communities, who experienced higher infection and mortality rates than the White population[64,75]. In the Midlands, this translated into the following cumulative age-adjusted mortality rates across ethnicities[76,77]:

Cumulative age-standardised mortality rate from COVID-19, by ethnic group, East Midlands, March 2020 to December 2021



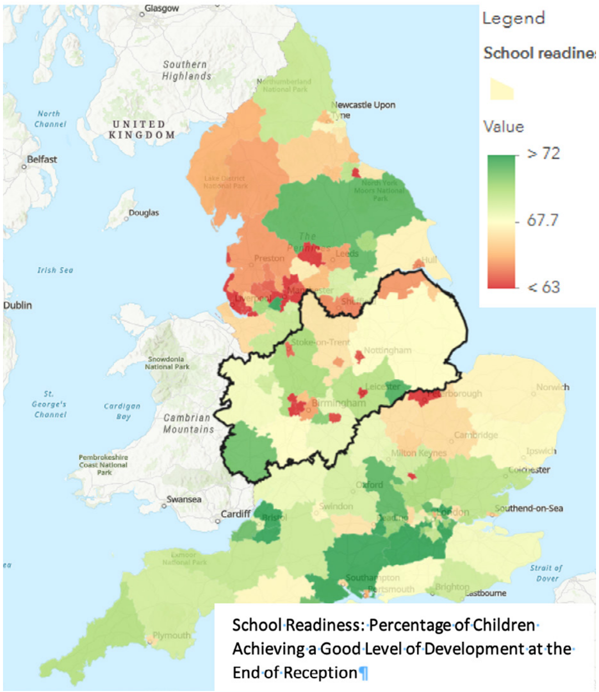
Cumulative age-standardised mortality rate from COVID-19, by ethnic group, West Midlands, March 2020 to December 2021



BEST START TO LIFE:

> *“The ‘first 1,000 days of life’ for lifetime health and wellbeing opportunities and outcomes is now recognised as critical.” (House of Commons: Health and Social Care Committee, 2019)[78] “To get the best possible start in life, a baby’s mother needs to be healthy before and during pregnancy and childbirth” (Kings Fund, 2013)[79]*

As already indicated in this chapter, there are a number of challenges that impact the lives and development of children and young people in the Midlands. Adversity and poor practices in childhood can determine the long-term wellbeing, mental health needs, and productivity of the adult population[80,81]. An example of this can be seen in the habits learnt in childhood with regards to physical activity. The East Midlands has the lowest percentage of children and young people that were reported as being physically active in England (just 47.5% – 2023/24)[82], while on 63.2% of adults are physically active. For the West Midlands, 49.4% of young people that were reported as being physically active and later in life, the region was lowest for physically active adults at 60.6%[83].



School Readiness: Percentage of Children Achieving a Good Level of Development at the End of Reception¶

Unpicking these behaviours is complex and requires whole family, if not entire neighbourhood, interventions. This also needs to be reinforced by systems and structures that enable good choices and increased knowledge, such as gyms, libraries, green spaces and public transport, combined with strong public health messaging.

Poverty and societal structure, as the dominant drivers of the social gradients[84], have the potential to limit many of the positive inputs that can influence life-long health, including nutrition, education and mental health.

Education is particularly important in the East Midlands, where early development lags behind the rest of the region and the South[85,86].

Finally, the mental health of children and young people in the Midlands is of particular concern given that the region has the lowest percentage of children and young people (aged 0-25) accessing mental health services in England. This has been attributed to the complexity of the processes that surround accessing mental health services, as well as inequalities in the experience and use of services across different abilities, support structures, cultures, and communities[80]. Despite this, demand has not lessened, as seen by the over 50% average increase in children’s mental health service demand observed by the West Midlands Mental Health Commission[87].

Challenges in urban, rural and coastal health

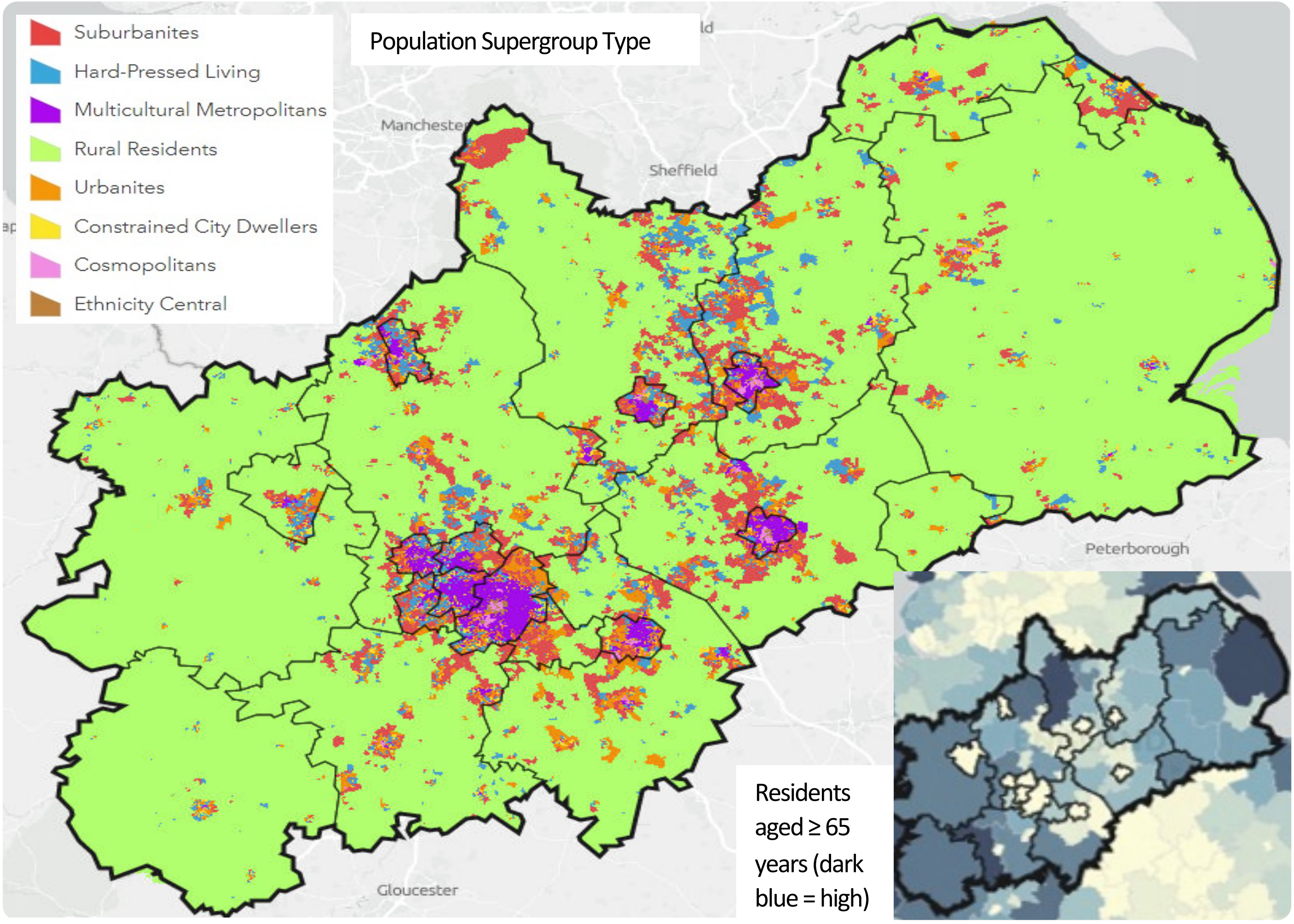
The interaction between wider determinants is clear to see when you consider the unwarranted variations in access, experience, and outcomes seen across different geographies – the key ones for the Midlands being urban, rural, and coastal communities.

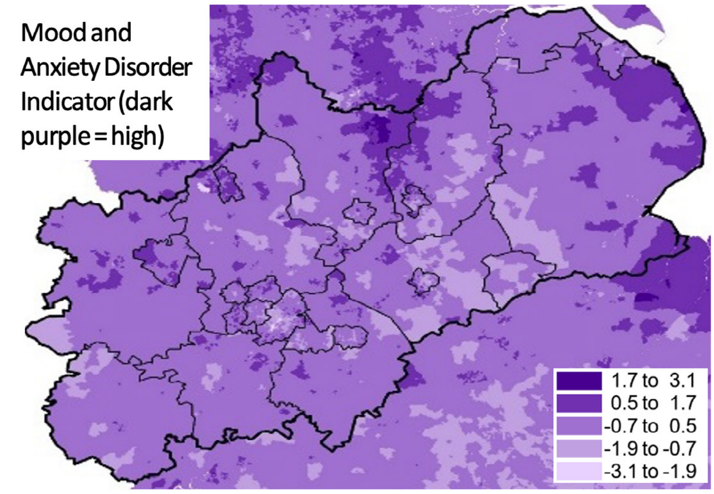
The Midlands encompasses a significant area, from Staffordshire in the west to Lincolnshire in the east, and reaching north to Derbyshire and south to Herefordshire – totalling 10,629 square miles, 65 local authorities, 50 miles of coastline and 2 sub-regions (East Midlands and West Midlands).

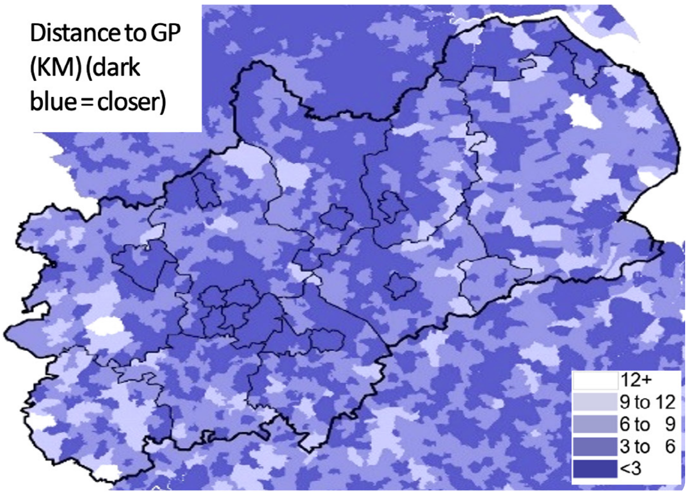
2021 distribution	Urban population		Rural population	
East Midlands[88]	3,322,894	73%	1,210,328	27%
West Midlands[89]	4,755,490	85%	846,357	15%

> *“Poor housing, lack of green spaces, pollution, unemployment, food and fuel poverty, violence and crime and inadequate education all contribute to worse health and inequalities.” (Birmingham City Council, 2022)90*

One would be forgiven for believing that rural and coastal communities[91], with their idyllic surroundings, are in some way immune to the impacts of negative factors (such as deprivation, over demand for services, pollution and lack of greenspace) seen in urban areas. This does, however, forget that cities are in themselves centres for economic and social activity and, therefore, have the potential to provide more opportunities than rural areas. In addition, the lack of opportunities for employment, social interactions, and facilities/services[92] can not only drive deprivation, but reduce wellbeing[92] and health outcomes. Compounding this is the age gradient[29] present, whereby the younger population tends to reside in cities, while the older population often retire to the country and the coast. Consequently, there is significant variation in the type and scale of health and care service demand across the region, resulting in inequalities.







> *"The availability of good medical care tends to vary inversely with the need for it in the population served" (Hart, 1971)*[93] *or in other words "those who most need medical care are least likely to receive it." (Kings Fund, 2001)*[94]

Issues of access, as seen during the pandemic, are complicated by certain facilities being made available digitally in some areas and not others, which are accessible to certain sections of society and not others, and are facilitated to differing degrees by varying types of support (from pamphlets to in-person training). Digital exclusion impacts directly on health outcomes[45] and is heavily dependent on both internet availability (which is subject to available infrastructure [see DERI map[95]] and household income) and digital literacy. An example of how this challenge sits in the Midlands was highlighted by the West Midlands Coalition for Digital Inclusion, which found that 45% of people in the West Midlands are either using the internet infrequently or not at all, while many are too proud to admit the impact digital exclusion has upon them and their families[96].

To address geographical variations in health inequalities, we must also address these wider determinants.

Why a regional approach?

As seen throughout this chapter, the poorer health outcomes that are present in the West Midlands are often not as severe in the East Midlands. As a result, one may wonder what need there is to work at a Midlands regional level, incorporating the East and West Midlands. Why not focus on the West Midlands only? There are two primary reasons:

Hidden inequalities

> *Inequalities can be found even within areas that might be regarded as affluent. Therefore, using a 'levelling up' approach will have an impact on the majority of the population." (Leicester Health and Wellbeing Board, 2021)*[7]

The East Midlands, far more so than the West Midlands, has greater proximity between the most and least deprived areas. This is seen by the East Midlands Moran's index score (extent to which neighbourhoods of the same income level are clustered together), which is the lowest in England i.e. closest to a uniform mix (least separation) of high and low deprivation neighbourhoods[97]. Consequently, when deprivation and other metrics are averaged, these differences are masked. We, therefore, cannot assume that communities in the East Midlands require no support.

Current and future learning

> *"A fundamental shift is needed to refocus our shared efforts, requiring an emphasis on prevention and early detection, and informed by evidence of the most common risk factors driving ill-health." (Lincolnshire County Council, 2019)*[98]

Shared learning and effective championing are critical requirements for both the East and West Midlands to not only tackle their current challenges, but also to develop resilience and expert partnerships for the future. It is easy to look to the pandemic as a place where greater understanding of our population at a macro-level would have facilitated faster and better coordinated decisions, but there are also opportunities associated with delivery at scale for our large, diverse, and growing population that both sub-regions could benefit from.

As we move forward into a new, people-focused, community-driven way of working, there is power in bringing together a diverse range of people and geographies to build on existing strengths, deliver cost-effective interventions, and create an amplified, united voice.

Why now?

> *"Reducing health inequalities in the UK has been a policy priority for over 20 years, yet, despite efforts to create a more equal society, progress has been limited. Furthermore, some inequalities have widened and become more apparent, particularly during the COVID-19 pandemic." (Thomson et al, 2021)*[99]

> *"The measures taken to control the spread of the virus have wide-ranging implications for people's income, job security and social contacts. These factors will in turn have a powerful influence on people's ability to live healthy lives." (The Health Foundation, 2020)*[100]

As described previously, the composition of the Midlands population, geography, and infrastructure has a significant effect on how the region responds to healthcare challenges. The Midlands was (and continues to be) particularly susceptible to the impacts of the COVID-19 pandemic, which highlighted the already existing inequalities and initiated the development of this Policy Commission. It is, therefore, right that we reflect upon those impacts.

Across the Midlands, up to January 2023, there were almost 37,500 COVID-19 related deaths (16,414 in the East Midlands and 21,023 in the West Midlands[101]). In addition to the devastating social impact this loss of life has had, the virus led to increases in the risks associated with certain professions, unemployment rates, and the disruption to healthcare provision (including >8,000 lower new cancer patients across the Midlands) – all of which will have long-term health implications. The pandemic also changed the underlying epidemiological environment, including increasing the disparity in life expectancy between the most and least deprived areas by between 1.2 years and 1.5 years in the East Midlands and West Midlands respectively[36 76 77 102].

The mental health of the Midlands population has also been significantly impacted by COVID-19. Research in the East Midlands found people of younger age, male gender and South Asian, Caribbean, and African heritage are particularly vulnerable to acute mental health conditions during lockdown, and patients with acute cases of anxiety have increased[103]. This has also been felt within the healthcare workforce, with a West Midlands study finding that a third of hospital healthcare workers reported clinically significant symptoms of anxiety (34.3%) and depression (31.2%), while almost a quarter (24.5%) reported clinically significant post-traumatic stress disorder symptoms[104].

Despite these life-altering impacts, it is important to note that the region also experienced certain improvements during the pandemic. Although they appear to have been short-lived, their existence suggests that they can return if colleagues, systems and communities are willing to come together as they did during the pandemic:

1. Collaboration, innovation, speed, flexibility, and adoption within and between research, industry, local authorities, regulators, funders, and the health service. The pandemic saw greater use of new and collaborative data sources and rapid data and evidence collection, within a fast-paced regulatory environment, paired with the high-profile use of scientific and business expertise in making key policy decisions and developing/delivering interventions[45 105]. Maintaining this agility and openness, alongside a continued expansion of collaborative secure data sources, will build resilience to tackle future needs and defend against silo systems and processes.
2. Closer, real-time, place-focused, and meaningful engagement between all elements of the health and social care infrastructure (particularly the Voluntary Community and Social Enterprise [VCSE] sector), supported by the research community. This ranges from effective integration between GPs, hospitals, and care homes, to improved uptake of the vaccination programme and use of personal protective equipment (PPE, e.g. masks). This was achieved through clear local leadership and partnerships that were given the space and trust to work effectively within a clear national framework, supported by a common and empowering purpose for all health and care colleagues[65 106].
3. A considerable improvement in public trust at a local level (particularly local government and public health infrastructure), possibly at the expense of (or potentially because of) the reputation of national departments. One area that was particularly popular was the increase of data that should be made available to local Public Health Directors. Communities were more than happy for them to be given full access to household-level data (combined with any relevant characteristics, for example ethnicity data) to ensure they were able to react instantly to a rise in COVID-19 infections and would be happy to see this for any large future health challenge. The use of community champions linked to local health and social care infrastructure greatly reinforced this.
4. The development of policies and processes to learn and safeguard for the future, for example the routine use of stress tests and equalities impact assessments[65].

With the worsening impacts the pandemic has had across the region, there has never been a better time to focus and reignite this energy to tackle the inequalities across the Midlands health and care service.

CHAPTER 3. PHASE 1 AND 2 FINDINGS

Phase 1: Community and lived experience feedback

This substantial activity looked to champion the voice of communities. To deliver this the Policy Commission team engaged community members, representatives, charities, local authorities, and NHS staff from a wide range of backgrounds and locations to gather insights into the barriers of equal health and potential solutions to the issues raised (including those outside of health and care, where they relate to health outcomes). Some of the topics discussed were specific to a small number of community groups, but most were common across many and only varied in the severity of their impact. The table below summarises these discussions. Further details can be found in the Appendix.

What are the barriers to fair and equitable healthcare for all?	What are the potential solutions to these challenges?
ACCESS	
Access to GP appointments and services	Recruit more staff with wide and varied skills
Communication – both in terms of spoken/written languages and the use of technical jargon	Provide Community Liaisons Officers, Social Prescribing Link Workers and Health Champions (particularly in GPs)
Physical accessibility and distance to services	Support place-based community services e.g. volunteer transport schemes for those with mobility issues
Gatekeeping of services	
TRUST	
› Racism and discrimination via unfair and avoidable actions or protocols › A lack of cultural awareness within the health and care workforce › Low levels of empathy and understanding when under pressure › Mistrust within communities	› Use networked, bottom-up community involvement › Involve faith/community leaders in healthcare settings › Deliver mandatory long-term, planned, ever-developing cultural competency programmes › Develop long-term and inclusive planning models › Improve community relationships with services by engaging directly with the people they target most via dedicated staff
REPRESENTATION	
Lack of healthcare workforce diversity in senior roles	Further develop employment policies to recruit based on values not qualifications
Acceptance of micro-aggressions, bullying and low staff wellbeing within NHS culture (added to patient incident)	Oversight and process to address health inequalities
Poor understanding and response to intersectionality	Workforce development
Low representation in clinical trial participants	Diverse clinical trials
DIGITAL	
Assumed digital literacy and connectivity Fragmented systems and poor data sharing Poor data collection and accuracy, particularly regarding carers, ethnicity, sexuality/gender, and medication	Creation of digital inclusion awareness training and champions Ensure appropriate data sharing regarding vulnerable people Provision of non-digital alternatives e.g. online/in-person appointments/prescriptions and sign-in pods/reception
KNOWLEDGE	
Assumed health literacy and prioritising	People-powered health
Poor understanding of complex mental health issues and a lack of parity with physical conditions	Addressing/understanding wider determinants

Phase 2 Findings: Actions to tackle health and care inequalities

[Look out for the Summary panels to guide you through this section, marked with ➔ blue arrows such as the one below]

➔ The following chapter (pages 26-93) provides a roadmap for different organisations across the Midlands as they look to tackle the aforementioned health and care inequalities. It details specific actions that can be taken to address specific challenges that are creating/contributing to inequalities and provides case studies of good practice where this has been achieved in the Midlands region. The chapter is broken down by lead organisation (the health service [pages 26-55], local authorities [pages 57-63], educators/researchers [pages 64-76] and where actions need to be delivered collaboratively from the very start [pages 77-93]) and then by focus area. There are two sections within each area of focus: feedback from communities, and policy recommendations (supported where appropriate by additional information from healthcare workers and discussions with the Midlands Integrated Care Systems [ICSs]).

Summary of the actions identified

Below is a summary of actions that can be delivered by all organisations to provide the environment and opportunities needed for a fair and equitable health and care service across the Midlands:

Action Themes:

1. Inclusion and representation
   - Guarantee representation within organisations at all levels – particularly in senior roles.
   - Monitor delivery of inclusive policies and practices – with a focus on recruitment and promotion.
2. Involvement, co-development, and awareness
   - Work with the VCSE sector, communities, and businesses to utilise place-based assets, for example by procuring locally.
   - Raise preventative/self-care awareness to encourage people-powered health – linking to all public-facing services and utilising linked workers and social prescribing.
   - Deliver with and within communities to generate trust and tackle negative perceptions, including working with faith and community leaders.
   - Maintain a standard of care for all, which is patient-focused and with equitable access and outcomes.
   - Integrate vulnerable, marginalised, and underserved groups into policy development and delivery.
3. Education, skills, and life-long training
   - Create community-based health champions to educate both staff and communities.
   - Recruit more staff with varied skills and backgrounds.
   - Deliver advanced cultural competency training, tailored to local needs, as part of career development at all levels.
   - Ensure availability of and create an uplift in experienced staff trained to engage specific communities and groups (community liaison officers).
   - Promote digital inclusion awareness, training, and champions.
   - Focus on future workforce education, skills, understanding, and wellbeing.
   - Share learnings across the region, as well as nationally to support further growth.
4. Accountability, oversight, and process
   - Deliver long-term planning/funding that builds and protects services.
   - Agree accountability and monitor metrics, for example those relating to health inequalities, workforce, and complaints.

- Consider social determinants and early life implications in planning, policies, and processes.
- Provide seamless services and the data sharing/resources/infrastructure needed to support this.
- Make tackling health inequalities part of all processes – particularly impact monitoring.
- Generate accurate data collection, which includes more detailed ethnicity coding.
- Ensure that workplace practices protect and promote wellbeing.

Current legislative and regulatory responsibilities

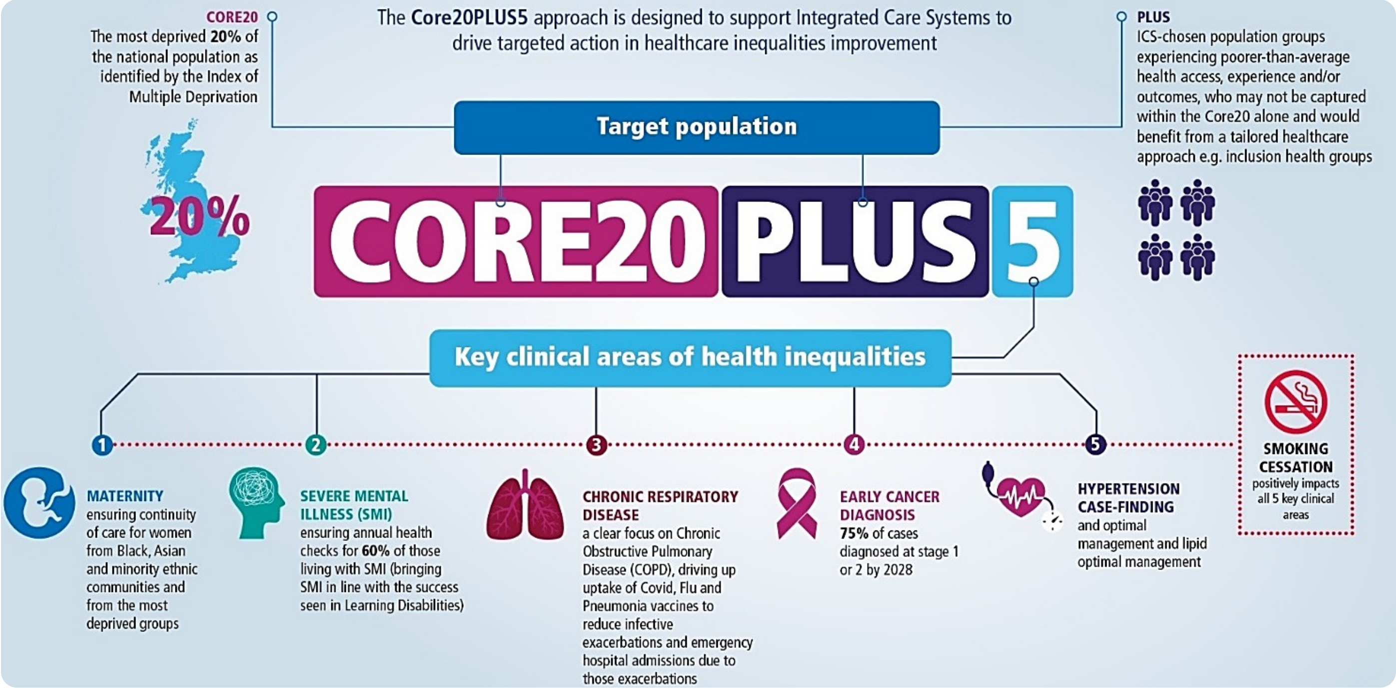
The health service has a specific role in addressing healthcare inequalities, contributing to the wider government ambition to improve life expectancy and health life expectancy by 5 years by 2035[107]. The following section summarises those responsibilities:

NHS Priority themes and Core20PLUS5

NHS England has set out a clear focus on preventing ill-health and tackling health inequalities by redoubling efforts on the 5 strategic priority areas that underpin the National Healthcare Inequalities Improvement Programme, as well as the Core20PLUS5 approach[108], which provide a framework for action to address healthcare inequalities.

> *“COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan. To help achieve this, NHS England and NHS Improvement issued guidance as part of its ‘phase 3’ response to the COVID-19 pandemic, setting out eight urgent actions for tackling health inequalities. Systems are now asked to focus on five priority areas in the first half of 2021/22, distilled from the eight actions:*
>
> - *Restore NHS services inclusively*
> - *Mitigate against digital exclusion*
> - *Ensure datasets are complete and timely*
> - *Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes*
> - *Strengthen leadership and accountability” (NHS England, 2021)*[109]

Action against these 5 priorities can be supported by and measured against NHS England’s Core20PLUS5 framework. This framework seeks to address health inequalities by focusing improvement work on the 20% most deprived of the population (Core20), other locally determined at-risk groups – such as those with learning disabilities – (PLUS), and 5 key clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer detection, and hypertension case-finding, plus smoking cessation across all clinical areas.



A Core20PLUS5 approach for children and young people[110] has also been developed, with a focus on asthma, diabetes, epilepsy, oral health and mental health.

NHSE has developed specific roles in the system to take forward delivery and spread improvement using the Core20PLUS5 approach:

- Core20PLUS ambassadors are healthcare professionals who can help to spread best practice and innovation to drive targeted action on health inequalities. Over 100 Core20PLUS ambassadors were recruited in the first cohort.
- Core20PLUS connectors are people from those communities who experience health inequalities that are recruited to help change services for the better, through co-production and co-design, and health promotion in culturally competent approaches. Over 400 connectors were recruited by April 2023, in partnership with 48 Healthwatch or voluntary sector partners.

Delivery of the 5 priorities and Core20PLUS5 approach remains a focus in the NHS priorities, and operational planning guidance[109] [111] and systems have been asked to consider health inequalities in their Joint Forward Plans. The ICSs have been tasked with implementing the Core20PLUS5 approach across their geographies.

The Health and Care Act 2022 formally established ICSs as legal entities with statutory powers and responsibilities to plan services, improve health (including promoting better health and wellbeing) and reduce inequalities across geographical areas. It also sets out the role of Integrated Care Boards (ICBs: statutory bodies responsible for planning and funding most NHS services) and Integrated Care Partnerships (ICPs: statutory multi-partner committees which develop local health and care strategies)[112]. Tackling inequalities in outcomes, experience and access is one of the 4 aims of ICSs[113]. The Act also includes specific obligations and new data provisions on inequalities for ICBs, Trusts, and Foundation Trusts, including the “triple aim” (which requires these bodies to consider the effects of their decisions) and the duty to cooperate between NHS bodies and local authorities. Finally, the Act requires that NHSE and ICBs seek to integrate services where they consider this would reduce inequalities of access or outcome.

This activity builds upon the Equality Act 2010 which, through the public sector equality duty, places a responsibility on NHS England to drive systemic and demonstrable improvement in equality considering the protected characteristics set out in the Equality Act 2010[114].

In addition to these responsibilities, NHS providers are expected to adhere to the National Institute for Health and Care Excellence guidelines, which cover an extensive set of conditions, treatments, and communities, including those experiencing homelessness115, disabled children and young people with severe complex needs[116], and adult carers[117].

Local authorities’ statutory public health responsibilities

> *“Local authorities have, since 1 April 2013, been responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse… Local authority social services have existing duties to provide welfare services such as residential accommodation for those who are in need of care, because of age, illness or disability, which they cannot otherwise obtain.” (House of Commons Library, 2014)*[118]

Local authorities’ statutory responsibilities for public health services are set out in the Health and Social Care Act 2012. The Act conferred new duties on local authorities to improve public health. It abolished primary care trusts and transferred much of their responsibility for public health to local authorities from 1 April 2013 (including most sexual health services and services to address drug or alcohol misuse)[118] [119].

In addition, the Care Act 2014 provides the legislative framework for the provision of social care, situating ‘wellbeing’ at the centre of assessment of needs and outlining a number of duties in relation to the commissioning of health and social care provision[120]. It requires local authorities to ensure prompt delivery of services that prevent deterioration of health, access to information and advice, provision of a range of high-quality, appropriate services, and choice of how care is organised[121]. The Act also requires consideration of how processes are undertaken and the implications of the public sector equality duty.

Health and wellbeing boards (HWBs) were also established under the Act to allow political, clinical, professional, and community leaders from the local health and care system to collaborate to improve the health and wellbeing of their local population[122]. HWBs are responsible for assessing the health and wellbeing needs of their population, publishing joint strategic needs assessments and joint local health and wellbeing strategies, and for informing the development of joint commissioning arrangements. With the creation of the ICSs, HWBs continue to play a vital statutory role instilling mechanisms and setting strategic direction for joint working locally.

ACTIONS FOR THE HEALTH SERVICE

This Policy Commission recognises the potentially insurmountable challenge that the health service (primary, secondary, tertiary, and community healthcare, as well as infrastructure, such as the ICSs) faces when trying to maintain an equitable and healthy population. Especially when delivering this action in response to upstream influences, with its primary tools focused on downstream interventions. The long-term solution proposed by this Policy Commission is collaboration to tackle wider determinants and to deliver interventions earlier, however, there are some activities that can be delivered now to begin to create that change.

This section (pages 26 to 55) outlines actions that can be taken to achieve:

- The commission and delivery of exceptional healthcare for all, ensuring equitable access, excellent experience and optimal outcomes.
- A fully integrated, accountable, responsive, and understanding NHS infrastructure across all areas.
- Regional impacts on deprivation-related outcomes in line with the health service's role as a key employer.
- Increased trust and engagement within communities that are often marginalised and not often heard.
- Forward-thinking resource allocation that understands local community need and mitigates against the risks (such as non-attendance for appointments).
- A happy, trained, experienced, and supported workforce that has the necessary resources and safeguards to deliver the care they joined the health service to be a part of.

Focus Area 1: ICS partnerships, connected services and coordinated commissioning

> *"The involvement of [ICSs with local government] and place-based partnerships can bring 3 key benefits:*
>
> - *join up health and social care at all levels in the system, creating better outcomes and a less fragmented experience for patients and users.*
> - *improve population health and wellbeing and tackle inequalities through the leadership...to address wider determinants of health, such as housing, local planning and education.*
> - *enhance transparency and accountability through supporting engagement with local communities and providing local democratic oversight." (The King's Fund, 2022)*[123]

The Midlands has 11 ICSs – the highest number of any region in England. Built upon the previous sustainability and transformation plans/partnerships (STPs), this complexity perhaps reflects our large population, an already overly intricate health service, significant local variation in population patterns and infrastructure and/or a reluctance to expand existing partnerships. This has resulted in a unique opportunity, if correctly delivered. The Midlands ICS infrastructure has the potential to deliver large-scale, strategic decision making with full awareness of local demand and challenges. This does, however, require the ability and willingness to look sideways and engage outside of the primary focus area. Given the significant workload and pressure upon the ICSs, this is asking a lot from a small workforce, but the need for effective collaboration has never been stronger. ICSs, and the NHS organisations within them, need to collaborate as anchor institutions and systems to leverage their procurement, estates, employment and investments in order to address health outcomes and wider determinants.

Community Feedback:

a. Set the standard for **long-term planning** and move away from reactionary short-term funding that damages trust.

b. Review where changes in local **policy and providers** of NHS services could have impacted health inequalities:

  i. ACTION ✓: Examine the impacts of recent changes in policy (made in light of COVID-19) on local communities.

  ii. ACTION ✓: Ensure providers of NHS services are working to address inequalities in access, experience and outcomes, particularly where new providers have been set up.

c. **Senior leadership** to set examples and send positive messages to the communities:

  i. ACTION ✓: Midlands ICSs to state who the stakeholders and senior management are and ensure they have a fair representation from ethnic groups.

  ii. ACTION ✓: Midlands ICSs to engage directly with communities, with VCSEs that represent them.

d. Coordinate **digital** interventions:

    i. ACTION: Working closely with the local Health Innovation Networks and NHS Research and Innovation teams to identify opportunities for rapid scale-up.

Policy Recommendations:

e. ICSs, and the NHS organisations within them, to collaborate as anchor institutions and systems to leverage procurement, estates, employment strategies, and investments to address the wider determinants of health. **Share metrics and processes** within and between ICSs across the Midlands to support learning and identify best practice/ areas for improvement in addressing health inequalities:

    i. ACTION ✓: Create an obligatory line of enquiry in quarterly performance monitoring conversations with organisations and systems, supported by a well-developed health inequalities accountability framework. A lack of progress should trigger appropriate support interventions and sanctions that are used to respond to other critical system issues.[124,125,126]

    i. ACTION ✓: Consider the evidence-based ethnicity differences in outcome measures when establishing processes (for example BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood, and influence on lifetime physical health).[90,127]

    ii. ACTION ✓: Ensure Equality Impact Assessments are aligned with Core20Plus5 tools and guidelines, and internal activity associated with the Equality Act 2010 and risk registers, through tailored measurement, mitigation, and monitoring processes designed to dismantle barriers and ongoing sources of exclusion, while continually involving local communities and utilising the voluntary sector in the collection of impact measures.[128,129]

f. Change local delivery models to provide a **seamless service** – from upstream interventions through to specialist interventions (including rehabilitation) – that is more inclusive in development and delivery. This is in line with the NHS Long Term Plan to make care more population-tailored, to boost ‘out-of-hospital’ care and to dissolve historic divides between primary and community health services:[130,131]

    i. ACTION ✓: Go above and beyond the requirements of the Health and Care Act 2022 by commissioning jointly across NHS and public health, between community and acute services, and the wider health landscape.[46]

    ii. ACTION ✓: Identify possible service level challenges, particularly in inner city, rural and coastal communities, such as GP/service availability in inner cities and ageing coastal communities, and equitable outcomes costing more in rural areas for a variety of reasons relating to remoteness and limited economies of scale.[132,133]

    iii. ACTION ✓: Improve crisis support and follow-up care to a robust review of mental health support capacity across the region, particularly for those with complex mental health needs.[131]

    iv. ACTION ✓: Rethink the delivery model of mental health services to involve the VCSE sector, service users and GPs. This collaborative model should provide a regional clinical view on managing the dual support and treatment needs of those with complex needs, such as children and young people with neurodevelopmental conditions. Community mental health transformation programmes were flagged by healthcare workers as particularly effective initiatives for tackling health inequalities.[80,134]

    v. ACTION ✓: Investigate joint opportunities, working with regional partners, to improve health across the Midlands through service-led interventions such as: [135,136]

        » Reviewing variation in access, uptake of screening services, and hospital admissions relating to chronic disease indicators (such as retinal, hypoglycaemia and foot for diabetes).

        » Interrogating data jointly through the Health Informatics Collaborative[137] to identify trends.

        » Using data to identify unmet patient need (e.g. in dental services), and test innovations in education, training and the workforce to tackle complex challenges (such as eliminating dentist deserts).

    vi. ACTION ✓: Promote a proportionate universalism approach (actions or interventions that are implemented for the whole [local] population, but with a scale and intensity proportionate to need[138]) using an agreed framework, to deliver services such as the NHS Health Check. This would provide an opportunity to target several protected characteristic groups, including: age, ethnicity, sexual orientation, and disability.[46,138,139]

    vii. ACTION ✓: Create bespoke care interventions based on need, such as out-of-hospital integrated care models for homeless people (including hospital discharge schemes and intermediate care), and consistent care plans for frequent attenders to the emergency department e.g. via a High Intensity Use service.[46,140,141]

g. Develop and deliver against **Core20PLUS5**[108] (for adults and children):

    i. ACTION ✓: Compare ICS health inequalities strategies to identify collaboration and shared learning.[142]

CASE STUDY: Coventry and Warwickshire Integrated Care System – Physical health checks for people with severe mental illness (SMI)

Nationally, SMI patients experience premature mortality in adults compared with the general population, whilst at a Trust-level, they are four times more likely to access emergency care. To improve physical outcomes of those with SMI conditions, healthcare assistants were recruited to support Primary Care Networks.

The HCAs facilitated the delivery of annual physical health checks and provided a pro-active outreach service into communities, initially within Coventry, with Point of Care Testing machines purchased to support this activity. The programme also aimed 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.

Working with Coventry Warwickshire Partnership Trust, this programme delivered a pro-active approach which makes people feel cared for and not forgotten by the system. It also ensured that SMI health checks coverage in Coventry rebounded faster after the pandemic than other areas. Originally limited to Coventry, as a result of this success, the initiative is now in place across the whole of Coventry and Warwickshire.

The full case study can be found here: www.england.nhs.uk/wp-content/uploads/2022/07/B1779-Actionable-Insights-Tackling-inequalities-in-healthcare-access-experience-and-outcomes-guidance-July-202.pdf

CASE STUDY: Leicestershire County Council's Public Health Team – Cancer screening

To inform pilot interventions combating low engagement with cancer screening programmes across Charnwood, insights were collected from groups with poor screening uptake in Beacon and Carillon using targeted focus groups (Bangladeshi, Polish, homeless, carers, Gypsy, Traveller and Roma, and sex workers), surveys (public, carers and healthcare professionals) and an uptake variation study.

RESULTS:

Barriers – Health literacy, misinformation, language, technology, GP access, transparency, intimate nature of screening, cultural issues (e.g. stigma within Bangladeshi community), fear/fatalism (e.g. among homeless communities), and wider issues (e.g. mental health and carer commitments).

Enablers – Family history, reminders, access options, good experiences, targeted information and trust.

RECOMMENDATIONS:

- Build trust through co-production, representation and sensitivity.
- Improve access (e.g. alternative appointment times) and community provision (e.g. mobile clinics).
- Utilise tools and staff to overcome translation and filtering challenges.
- Use a 'Making Every Contact Count' (MECC) approach, active engagement and transparency.
- Share information using trusted sources (e.g. GPs and local health champions), effective communication and appropriate materials.
- Upskill healthcare staff on NICE Guideline NG12.
- Emphasise the importance of prioritising a person's own health.

ACTIONS:

- Beacon and Carillon Primary Care Networks: Offering Saturday cervical screening appointments, building understanding regarding declined bowel cancer screenings and applying a MECC approach.
- Charnwood GP Federation: Extending acute appointment access.
- Extended Access Service: Successfully reengaging bowel and cervical screening patients (258 screenings booked June-August 2022).
- Public Health and Integrated Care Board colleagues: Developing training on embedding a population health management approach to tackling inequalities within the population.

The benefits of investing in rehabilitation to improve recovery and return to work

Professor Mark Lewis, University Academic Lead for Strategic Partnerships[143], Loughborough University

Professor Pip Logan, Professor of Rehabilitation Research, University of Nottingham[144]

There are significant gaps in current rehabilitation services. These include a large shortfall in the number of neuro-rehabilitation beds, little focus on vocational rehabilitation and return-to-work, no coordinated rehabilitation for patients with multiple injuries, very little post-discharge psychological support in the region, and little ongoing support in the community (for patients as well as community providers). Nationally, capacity within inpatient specialised rehabilitation services caters for about 950 patients per year – approximately 5% of the total number of adults admitted to major trauma centres. Limited rehabilitation options hinder patient progression, both physically and mentally. Patient outcomes through rehabilitation services benchmark poorly in England when compared to Europe, the USA, and the Defence sector. This is shown clearly in return-to-work rates, with 50–60% of people returning to work six months after a major injury in Europe and the USA, while in the UK the figure is just 34% (Trauma and Research Network). In addition, twice the number of UK military patients return to duty compared to NHS patients returning to work. This indicates that there is an opportunity to dramatically improve outcomes for patients, including return-to-work rates. The COVID-19 pandemic serves to highlight that the need for specialist rehabilitation pathways is greater than ever to support patients with complex rehabilitation needs.

The key strategic goal for the soon to be completed National Rehabilitation Centre (NRC) – located just outside of Loughborough – is to provide support for those who need it, whatever their health conditions. The NRC aims to improve and integrate rehabilitation services across the welfare system, the workplace and the healthcare system, building on the expertise and outcomes achieved in the military. It is vital to improving rehabilitation services not only in the Midlands, but also nationally. Without the NRC, these gaps in service will remain, with rehabilitation services continuing to be disjointed and varying in quality dependent on region. In developing a new clinical pathway, the NRC will see patients earlier in their rehabilitation journey to provide better physical and mental outcomes. It will also provide a saving to the health and social care system, and wider economy, through reducing waits for acute beds and reducing overall length of inpatient stay. The delivery of better outcomes reduces the need for ongoing health and social case costs, returns more people to work, increases contributions into the economy and reduces burden on family members. Through embedding research and innovation alongside education and training, and the development of best practice and new standards, the NRC provides the opportunity to become a new model of rehabilitation that can be replicated elsewhere in the country. The NRC is a chance to transform rehabilitation and become an international centre of excellence in joined-up rehabilitative care, through world-leading clinical, research and education activities.”

The role of anchor institutions in tackling health inequalities

Dr Mubasshir Ajaz, Head of Health and Communities, West Midlands Combined Authority

The NHS is a symbol of national pride, a fact never more apparent than during the pandemic. However, it is in need of support if it is to continue to tackle not only the newsworthy stories – waiting times for A&E and ambulances, backlogs, service shortages, discrimination and staff retainment – but also the complex, systemic and often over-looked challenges that underpin the headlines. This support may not be seen as additional budget, which makes its primary source even more vital – collaborative, place-based action.

It may seem like a paradox, asking NHS organisations to do "more" through place-based action, when they are already struggling, but by fulfilling its role as an anchor institution, one rooted in the local community and positively contributing to local areas in ways beyond providing healthcare, it can support those communities and help itself come out of a multitude of financial and resource issues.

As has been discussed already in this Policy Commission, wider determinants (from where you live and work, to the air you breathe and the people/services/spaces you can access) can account for up to 80% of the causes from which health concerns originate. When we start to consider the whole picture, we see that the only way to move forward is to build on our existing strengths and work towards delivery that reaches both across and outside of the health and care service. This is where anchor institutions, such as local authorities, mayoral combined authorities, ICSs, universities, and voluntary sector organisations must play a critical role. Their leadership, shared language, strong and active community partnerships, and flexibility in pooling and utilising all available resources can both enable positive actions and drive sustainable change.

Covering a considerably wider agenda and with the ability to focus locally to improve not only health, but the economy, infrastructure and levels of education, anchor institutions are the key component for effectively implementing policy and for tackling inequality. The West Midlands Combined Authority (WMCA), for example, successfully completed a three year programme of work funded by the Health Foundation to develop and accelerate actions and boost partnership working (including the three ICSs within its geography: Birmingham and Solihull ICS, Black Country and West Birmingham ICS, and Coventry and Warwickshire ICS) to tackle health inequalities through an inclusive growth approach. This has led to a further programme being funded (March 2023) to investigate how to use systemic actions and change to further the impact the combined authority can have nationally.

Anchor institutions are often leading employers for their local communities, but they are also drivers of change within them. Traditional activity has been through public health campaigns, outreach programmes to support local services, and charity sponsorship, but, moving forward, these activities also need to do more to deliver long-term interventions. By assuming this responsibility, comes the necessity to work collaboratively with other anchor institutions and, critically, communities themselves. This has never been more opportune than now, with the introduction of the ICSs.

The West Midlands ICSs are taking this responsibility seriously and WMCA, as a fellow West Midlands-based anchor institution, welcome the opportunity to work with them and others in partnership to deliver change. The next step is to work with other place-based partnerships across the Midlands to create real and lasting impact, based on shared experience and expertise, for the whole of the region."

Focus Area 2: Workforce challenges within the healthcare service

> *"4 in 10 junior doctors (40%) are actively planning to leave the NHS as soon as they can find another job….Many of those doctors wanting to quit the NHS plan to work as doctors abroad. According to the survey, a third of junior doctors (33%) are planning to work as doctors in another country in the next 12 months." (British Medical Association, 2022)*[145]

> *"The last year's data (June 2021-June 2022) saw a 25% increase in the number of NHS nurses leaving their role, with an additional 7,000 leaving compared to the previous year…There are now 46,000 vacant nursing posts, a record high." (The Kings Fund, 2022)*[146]

The crisis in NHS workforce availability is a primary focus nationally, and is a severe challenge to the Midlands as well. However, there are additional and substantial concerns that also need to be addressed such as skills and wellbeing and representation (regionally 23% of staff are from an ethnic minority yet only 10% are at Board level [2020])[147]. It is important, therefore, that we look to tackle the root causes of these problems in a coordinated way as a region.

Community Feedback:

a. Ensure the workforce is **representative** of the communities, cultures and experiences within the population to build trust and improve health outcomes:
    i. ACTION ✓: Equal opportunities to be given to people from ethnic minorities to increase their career prospects and provide fair chances for everyone, through new recruitment, training and apprenticeships.
    ii. ACTION ✓: Make sure those from minority and, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and other (LGBTQIA+) backgrounds are encouraged to go for promotions and that there is fair representation at the interview panel.
    iii. ACTION ✓: Create a network of established paid community-based health champions (policy note: this should expand the Public Health England (PHE) community-centred approaches[148] and learn from the Core20PLUS Connectors[149]).
    iv. ACTION ✓: Develop monitoring mechanism to ensure this takes place.

b. Address the burden on current healthcare staff by recruiting a more diverse workforce, with **broader skillsets** and cultural understanding, across all levels:
    i. ACTION ✓: Compulsory, interactive and up-to-date equality, diversity and inclusion (EDI) training similar to continuing professional development (CPD). This is to include awareness of different languages and cultural differences such as grieving processes, symptoms, required diagnostic techniques, and appropriate care (for example skin and hair maintenance amongst communities with African or Caribbean heritage).
    ii. ACTION ✓: Invest in people with the skills and understanding to specifically work with certain communities.
    iii. ACTION ✓: Staff from ethnic minority backgrounds need to be encouraged towards CPD, mentoring and other progression opportunities to ensure diversity in senior positions.

c. Demonstrably prioritise the **wellbeing** of all staff, so that this sector (primarily made up of compassionate individuals) feels valued and supported:
    i. ACTION ✓: Ensure that all staff members, not just management, feel like they have a voice, through wider consultation policies on decision making.
    ii. ACTION ✓: Review workload and flexible working patterns policies, linking to actions regarding cultural competency, empathy and understanding, to ensure equity of opportunity.
    iii. ACTION ✓: Review complaints and disciplinary policies to break the blame and bullying culture within NHS staff and management.
    iv. ACTION ✓: Reconsider the target-focused approach that staff work towards, to prioritise the health and wellbeing inequalities of both colleagues, patients and families/carers.

Policy Recommendations:

d. Set reducing inequalities as a priority for **accountability, recruitment, performance and system improvement**:
    i. ACTION ✓: The reduction of health inequalities to be given equal weight alongside other key priorities, such as targets for waiting times and financial balance (while also ensuring that addressing inequalities is a key measure of success for these other priority areas). This includes evaluating testimonial evidence with the same consideration as statistical evidence.[124,150]
    ii. ACTION ✓: Strengthen ICS ability to hold providers and commissioners to account for actions taken, e.g. in response to Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data. Internal accountability should also be reviewed, with all NHS leaders and managers (not only wellbeing guardians[151]) held accountable for their role in addressing inequalities in access, experience and outcomes.[124,127,130,136]
    iii. ACTION ✓: Ensure recruitment policies and leadership development programmes address the need to diversify the healthcare system's senior leadership, to make it more representative of the diverse communities it serves, and to include more inclusive qualification requirements across all levels. This also includes being open in recruitment processes, for example by advertising job opportunities in the Starting Out careers guide as demonstrated by Health Education England.[90,142,152,153,154]
    iv. ACTION ✓: Implement a strategic commitment to achieving culture change in the experience of ethnic minority and LGBTQIA+ staff, focused on creating diverse and inclusive environments at all levels of the system.[124,130]
    v. ACTION ✓: Where complaints are made against ethnic minority staff, they should be supported by advocates in whom staff have confidence to ensure fairness.[65,155]

e. Develop a skills base supported by inclusive training:
    i. ACTION ✓: The health and care system to work alongside the NHS WRES team to ensure provision of an agreed standard of cross-cultural training for managers and staff.[65,156]

f. Position respect, equality and diversity at the heart of health and care delivery while developing the proposed culture change that includes ensuring **equal and fair pay** across the system:
    i. ACTION ✓: Review mechanisms to reduce the gender pay gap, gender, and equity pay gap to ensure all NHS staff receive a national living wage and deliver a liveable NHS bursary for medical students.[130,157]

g. Actively monitor and tackle **burnout and stress** within the workforce, particularly in light of the pandemic, to improve staff wellbeing and retention:
    i. ACTION ✓: Build a baseline health and wellbeing assessment for local staff that thinks innovatively about data collection and is conscious of survey fatigue and data protection.[158,159,160]
    ii. ACTION ✓: Ensure that management training and timetabling approaches are supportive and understanding of staff needs. This is of considerable concern to regional healthcare staff, with examples including a lack of flexibility and support around maternity, sickness and mental health requirements.[161]
    iii. ACTION ✓: Build staff wellbeing into provider contracts, including psychological support and adjustments.[162]
    iv. ACTION ✓: Develop staff management approaches that maintain the improved collaboration across health and social care (particularly within teams) seen during the pandemic. This should include a supportive framework for integrated care, extension of successful interventions across health and care, removal of legislative barriers between partners (e.g. VCSE and local authorities) and enabling of innovative approaches.[163,164,165]
    v. ACTION ✓: Effectively manage the backlog of health issues (mental and physical) to ensure that they are not more difficult to resolve in the long term and do not cause bottlenecks. This will require funding and resource, and will cover early intervention, prevention and rehabilitation as well.[45,161,166]

h. Release staff from the **pressures of resource constraints, lack of support, and bullying, racist and discriminatory behaviours** amongst staff and patients to allow them to showcase the compassion that drew them the sector:

> *"Prejudice [and discrimination] exist within the NHS staff [workforce]:*
>
> - *Black and minority ethnic staff were 1.16 times more likely to enter the formal disciplinary process compared to White staff.*
> - *30.3% of Black and minority ethnic staff, and 27.9% of White staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public.*
> - *Just 40.7% of Black and minority ethnic staff believe that their organisation provides equal opportunities for career progression or promotion compared to 88.3% for White staff." (National Health Service, 2021)*[167]
> - *"LGBTQ+ staff in the NHS are more likely to face physical violence, bullying and harassment in their workplace than other staff." (NHS Confederation, 2022)*[168]
> - *"17.5% of Midlands staff from minority ethnic backgrounds said that they have experienced discrimination from other staff (6.7% of white staff) – the third highest in the UK." (NHS Workforce Race Equality Standard, 2022)*[169]

i. ACTION ✓: Build a support system for staff and patients so that concerns are managed and dealt with before health outcomes are impacted upon or complaints are filed. This system should be based on empathy and understanding rather than blame, and be empowered to make changes to prevent further challenges.[130, 154, 170]

ii. ACTION ✓: Update policies to adhere to NHS Midlands recommendations that all management and HR personnel consider involving an independent person (i.e. cultural ambassador) before opening a formal investigation into staff from ethnic minorities and use the National Patient Safety "a just culture guide" as a framework when staff are involved in a patient safety incident to help eliminate any potential bias. [154, 170]

iii. ACTION ✓: Tackle resourcing and behavioural issues that lead to challenges such as discrimination and reduced patient attention, e.g. reports of a lack of feeding, fresh clothing and washing on hospital wards. This activity should include training and support to actively encourage anti-racist behaviours (those that proactively tackle all forms of racism) as detailed in the Midlands workforce, race, equality and inclusion strategy.[147]

CASE STUDY: University Hospitals Birmingham (UHB) NHS Foundation Trust – Menopause Passport

Nationally, women are leaving their jobs, reducing hours or passing up promotions due to menopause symptoms. In 2022, UHB launched the Menopause Passport – a first of its kind within the NHS – recognising the importance of staff health and wellbeing. Accessible to 18,000 female staff, the Passport aims to help staff of any age, feel comfortable and supported as they approach and experience the menopause, thereby reducing workplace impacts.

As well as signposting help and advice, the passport can be used to request adjustments to working environments, such as wearing lighter uniforms or changing working patterns. The Trust has also established a menopause support group, a network of menopause champions and Q&A sessions with its menopause expert. The passport was the idea of UHB nurse Wendy Madden, who has worked for the Trust for 20 years.

Already the Passport is making a real impact, both within and outside of the NHS (including industry). This includes reducing stigma, ensuring staff feel valued, allowing open and honest conversation with managers, and helping staff to share their experiences. When used throughout their journey, colleagues can benefit from a positive, open environment and flexible adaption of support as symptoms change or if they move roles.

www.uhb.nhs.uk/news-and-events/news/first-menopause-passport-launched-at-nhs-trust-which-employs-over-18000-women/623385?from=2022;13

The barriers in general practice to addressing health inequalities and the wider determinants of health.

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Partner, Willowbrook Medical Practice; Chair, Nottinghamshire Local Medical Committee; National Council Member, Royal College of General Practitioners; GP Council Member, Governance & Nominations Committee of the Royal College of General Practitioners.

It is a sad fact of reality that the environment in which we are born, raised and work can impact our health and even our life expectancy. Coming from a socially and financially deprived background myself, I know the stark realities only too well.

I chose to work as a GP in an area of high deprivation and this daily exposure crystallises my unique insight into how health inequalities affect the most underprivileged groups within our society. Practicing on the front line provides me with an opportunity to be able to tackle these unfair and avoidable differences by trying to positively influence the wider determinants of health for the patients I serve.

However, in recent years the overwhelming demand for healthcare has far outstripped the capacity of provision. Creating internal competition within different parts of the NHS in an attempt to make efficiency savings can create a counterproductive 'race to the bottom' in which there are only losers and no winners.

The chronic underfunding of general practice operating within the constraints of perverse contracting systems in a resource-limited and rationed system has contributed to a workforce and workload crisis. Reams of red tape, overbearing regulation, medico-legal litigation, punitive pension/taxation regulations, and inadequate IT/premises infrastructure have eroded GP morale and numbers. Many GPs have no option but to firefight and provide reactionary 'sick care' rather than the panacea of proactive 'health care' that everyone aspires to deliver.

Despite having 1900 fewer GPs compared to 2015, GPs deliver approximately 1.4 million consultations per day which equates to 90% of the total activity of the NHS for only 8% of the overall funding. From a fiscal perspective, GPs provide an unparalleled return on investment on every taxpayer's pound.

GPs have never worked so hard to right systemic wrongs not of their own making, yet feel so persecuted for their efforts by the negative demonising political and media rhetoric.

Frustratingly, we as GPs are unable to achieve our true potential in challenging the inverse care law until the problems that fetter our profession are addressed. Fortunately, solving these problems is relatively simple and politically agnostic, but addressing the institutional inertia and achieving the strategic paradigm shift required to implement the solutions may be a challenge. Now is the time to move from analysis to action; policy to practice. Doing nothing is not an option if we truly value the jewel in the crown of the NHS that is general practice."

Focus Area 3: Improving communication with patients and communities across the health sector

> *“Being able to understand health information, (and make subsequent decisions based on this understanding), and engage with health care structures and systems, are important determinants of health and wellbeing…In England, 43% of adults (18-65) do not have adequate literacy skills to routinely understand health information.” (Health Education England, 2022)*[171]

> *“We do not know the full extent of waste generated through poor communications but this report argues that it is in excess of £1 billion. This waste is evident in poor adherence to medication regimes, repeat visits to clinics, disputes and, ultimately, litigation.” (Marie Curie, 2016)*[172]

It will take time and resources to improve communications across the range of approaches to how health information is generated, stored and shared, and to correct the negative impacts that this complex challenge has had in the past, but this will have far-reaching benefits, including improving trust, health literacy and health outcomes.

Community Feedback:

a. Increase **engagement and connection with communities** to tackle detachment, poor communication and lack of trust. Many feel that they have been let down by health services, so they are less likely to seek help, leading to long-term and more serious health issues:
   i. ACTION ✓: Deliver more population-tailored, face-to-face health services with increased promotion and visibility within target communities.
   ii. ACTION ✓: Healthcare workers to go to communities rather than having communities come to them. This can help them to better understand the communities’ challenges.
   iii. ACTION ✓: Public Health communications to be more population-tailored, targeting communities and including, for example, sharing stories.
   iv. ACTION ✓: Work closely with community engagement programmes to encourage service consistency, engagement and access.
   v. ACTION ✓: Improve the use of appropriate or chosen names in letters and within clinical settings to remove, for example, the use of dead names of trans+ patients when accessing health services.

b. Develop mechanisms to increase **trust within communities** that have historically experienced discrimination from, and been disadvantaged by, authorities. This would also tackle the fear within certain communities that the health services might get the wrong impression and patients may be seen as a burden on the system. These feelings of exclusion not only impact physical health but mental health as well:
   i. ACTION ✓: Convert and build upon COVID-19 Champions to create a network of community-based health champions, who are more likely to be trusted by their community. This overcomes concerns regarding anticipated stigma and misunderstanding of how other people perceive certain groups e.g. for their clothing, hygiene, accent or education. This action was repeatedly highlighted as an effective approach by health professionals, particularly GPs, but requires adequate long-term resources to become a sustainable approach.

CASE STUDY: Birmingham City Council – Bolder Healthier Champions

The Bolder Healthier Champions programme originates from the similar COVID-19 Champions, who were essential in assisting Birmingham City Council with tackling the many challenges that were posed by the coronavirus pandemic. Bolder Healthier Champions go beyond COVID-19 to help disseminate reliable and trustworthy information on health and wellbeing topics and also provide feedback and intelligence about what is needed by local citizens. The Bolder Healthier Champions has four strands: Community Champions, Workplace Champions, Youth Champions and Champions Plus for public sector professionals, social prescribers and voluntary and community sector staff who have completed ‘Making Every Contact Count’ training. The Champions come from all walks of life and the Council is actively recruiting to increase the programme’s depth and breadth of reach. The Youth Champions programme is a joint initiative between the Public Health division and Youth Services in the Council. The Champions are supported by monthly webinars tailored for their specific strand – these are a combination of recorded and live sessions and shared via the Council’s YouTube channel, a monthly newsletter and regular feedback sessions to help shape the programme.

www.birmingham.gov.uk/info/50267/public_health_campaigns/2425/bolder_healthier_champions
www.youtube.com/@healthybrum-birminghampubl2686

CASE STUDY: University Hospitals of Leicester NHS Trust – United Against Prostate Cancer

This project aims to improve the prostate cancer pathway and support available for patients. It will tackle disparities and provide equitable access to prostate services. Led by the University Hospitals of Leicester NHS Trust's 'United Against Prostate Cancer' project team, it includes representatives from a number of local and national clinical, scientific and community stakeholder groups, including the UoL Centre for Ethnic Health Research (CEHR).

This work is part of a national pilot project which focuses on establishing genetic testing of prostate tumour tissue samples to help identify the causes of this disease in patients. This could be useful in planning their treatment or determining if their relatives could also be at an increased risk of breast, ovarian or prostate cancer.

CEHR has built on previous work, engaging communities with African and Caribbean heritage to discuss prostate cancer over a game of dominos in the highly successful Play Domino: Talk Prostate campaign. Following this success, the team have supported the development of a model of peer-patient champions from the community, including the development and delivery of a training package. The aim of this role is to help raise awareness and understanding of the increased rates of prostate cancer in this community and encourage peers to take part in genetic testing within their communities.

https://ethnichealthresearch.org.uk/play-domino-talk-prostate-2

    ii. ACTION ✓: Increase the presence of faith leader and community champions in hospitals to overcome issues of language, trust and understanding of medical terminology.
    iii. ACTION ✓: Help family members to support care in hospital wards, particularly for terminal patients, by providing basic care such as help with meals.
    iv. ACTION ✓: Investigate issues with the way the NHS deals with complaints (PALS), specifically confidentiality of personal information of complainants and informed action taken to prevent further incident.
    v. ACTION ✓: Deliver a campaign to raise awareness of the NHS infrastructure and how best to access specific services. This would help tackle confusion, gatekeeping and the perception of impenetrability.
    vi. ACTION ✓: Work with the General Pharmaceutical Council to ensure consistency and quality of service across community pharmacies, and then communicate findings with communities to tackle any negative perceptions.

c. Improve care and enable communication between medical professionals with family members and carers despite difficulties with **confidentiality** issues:
    i. ACTION ✓: Review data sharing, service access and confidentiality policies for vulnerable people. Maintaining up-to-date carer information through linked systems would help to address trust and communication challenges.
    ii. ACTION ✓: Upgrade policies to support families in having honest conversations with healthcare professionals about their concerns without fear of repercussions for the patient.

d. Tackle **language** barriers which result in increased demand for appointments (for example from confusion with changing medication and packaging), reduced health outcomes (such as misunderstanding of symptoms, diagnosis or treatment) and low levels of trust:
    i. ACTION ✓: Support healthcare teams to learn a few short phrases in the primary languages spoken by the population in their area. Links to the need for community champions and advocates.
    ii. ACTION ✓: Invest in more interpreters and translators (which have become difficult to arrange due to funding cuts) in hospitals to support communication and exchange of medical information (policy note: this is in line with Healthcare Safety Investigation Branch safety recommendations e.g. for booking systems failures[173]).
    iii. Tackle medical jargon both during appointments/consultations and on medical letters (linking to the Plain English Campaign[174]). This links to medical advocates, but also cultural awareness training, workforce representation, education and data.

Policy Recommendations:

e. The NHS, Care Quality Commission, General Pharmaceutical Council and social care organisations must ensure they are operating to the highest levels of **cultural competence and awareness**:

   i. ACTION ✓: Cultural competency must be updated to go deeper than just generic equality training. It must help professionals understand the differences between, and challenges faced by, different communities, to understand that even specific communities are not just one homogeneous group and that there can be additional compounding issues that impact health (for example during pregnancy/maternity, multiple long-term conditions [MLTC], cultural attitudes and expectations around care and diet). It should also be a mandatory part of continuing professional development.[65, 136, 154, 175]

   ii. ACTION ✓: Linking this with upstream interventions to ensure that targeted activities (such as those tackling obesity, diet, exercise and smoking) are culturally competent and geographically aware (for example, regarding challenges for coastal communities).[124, 132, 156]

CASE STUDY: Birmingham cultural immersion for nursing students

Flourish is a newly formed organisation that brings together different voluntary sector-based organisations that are working in West Birmingham, which encompasses Ladywood and Perry Barr wards. These areas of Birmingham are amongst the most deprived. Some of the members are co-designing, with NHS Ladywood and Perry Barr Locality Partnership (LPBLP) and Birmingham City Council's Public Health Division, a programme of community and cultural immersion for trainee nurses and midwives studying at Birmingham City University. The pilot started in January 2023, combining school placements and cultural immersion experiences. These placements will teach active listening and cultural humility; provide immersion within non-White cultural groups through Flourish's community partners; allow students to learn about local schools' health priorities and to contribute to addressing these; and encourage professional partnerships with community organisations to create better health outcomes for global majority families.

- Ensure availability of, and create an uplift in, experienced staff trained to engage specific communities and groups (Community Liaison Officers).
- Promote digital inclusion awareness, training and champions.
- Focus on future workforce education, skills, understanding and wellbeing.

   iii. ACTION ✓: Assess the availability of culturally aware mental health services, evaluate current services to determine how they meet the needs of specific communities, build on these services to address gaps, and work with those communities to co-produce awareness campaigns. Mental health workers to also actively acknowledge personal histories of racism and recognise this as trauma to enable effective intervention.[90]

   iv. ACTION ✓: Deliver local population-focused training to raise awareness of cultural, community, and mental health challenges, including specialised training for key engagement points, for example GP reception staff and those working with people sleeping rough. This should include techniques for open conversation such as reflective practice, the Three Conversations model and Family Group Conferencing.[176, 177, 178]

   v. ACTION ✓: Offer the Opening Doors' Pride in Care programme to NHS staff and the Pride in Practice programme to GP practices, dental surgeries, pharmacies, and optometrists, to ensure that all lesbian, gay, bisexual and trans+ people have access to inclusive healthcare that understands and meets their needs.[136, 179]

   vi. ACTION ✓: Ensure that planning for language support takes account of the impact that conditions such as dementia have on language capabilities.[136, 156]

f. Standardise, train, and allocate accountability for the effective sharing of medical Information:

   i. ACTION ✓: Challenge the widely criticised approach of sending detailed technical letters regarding appointments or diagnosis. This links to the need for the use of clear language, as well as more detail on patient's spoken/written languages.[180, 181]

   ii. ACTION ✓: Review the framework for communicating with patient's families to ensure they are treated with maximum compassion and are proactively kept up-to-date with information about their loved ones.[65]

   iii. ACTION ✓: Work with communities to define a set of communication gold standards across a range of different scenarios that ensure written and verbal health messages are clear and concise[181], with written information not relied upon as an alternative for verbal communication where spoken language is a barrier[182]. This should then be communicated publicly via a charter for patients' families and friends.[65,181,183]

   iv. ACTION ✓: Develop further opportunities to demonstrate instructions, such as measuring dosages and counting pills, and providing practical advice for cooking and exercise. These strategies are more effective than providing written materials or reading out instructions, and can help to challenge language barriers and low health literacy. This should include having the patient repeat back the information (teach-back technique, i.e. "We discussed a lot today, can you tell me what you found the most important?"), presenting information in segments ('chunk and check'), and routinely offering help with forms. [171,181,184]

g. Develop, improve, and communicate **standards of care** for all:
   i. ACTION ✓: Define a patient charter of 'patient promises' to support staff to deliver patient-focused care and to allow patients to hold staff to account. It should be noted that patients felt that standards would only impact trust when backed by appropriate and immediate action. To that end, Health Service leaders should be held accountable for this and the aforementioned communications charter through select committees.[65,185]
   ii. ACTION ✓: Create champions across the healthcare system actively advocating for, and engaging with, groups that experience reduced health outcomes, for example within discharge teams working with hospital ward staff on behalf of different community groups (including Gypsy, Roma and Traveller), LGBTQIA+, rough sleepers and those who have experienced mental health challenges or domestic abuse. It is important that champions not only have lived experience of local challenges, but are also supported with appropriate training.[186,187]
   iii. ACTION ✓: Dedicated support for people with complex and co-occurring mental health needs, drug and alcohol dependency, such as dual diagnosis workers, formal protocols for referral, and joint clinics.[154,176,188]
   iv. ACTION ✓: Provide peer advocates/educators or social prescribing link workers commissioned to help people navigate the system and access support.[176,184]
   v. ACTION ✓: Further work with partners across government to improve the wellbeing of people in prison, reduce inequalities, increase continuity of care and address health-related drivers of offending behaviours.[130,135]

CASE STUDY: Keele University – Virtual Patients

A team from the Keele University School of Pharmacy and Bioengineering have been developing educational simulations in collaboration with the Personalised Care Institute (PCI). These simulations are aimed at all healthcare professionals in the NHS to enable them to practice key elements of shared decision making (SDM). At present, SDM does not happen in practice to the extent that it ought to; it is imperative that all healthcare professionals have appropriate training in how to engage patients in SDM.

The simulations created are "virtual patients" – an animation of a patient with whom the learner can communicate by selecting what they would like to say or do. The animation then responds and the consultation progresses. Learners can use these simulations for free, at a time convenient to them and receive automated, tailored feedback to support their development. Learners are encouraged to repeat the consultation based on the feedback they receive, to hone their SDM skills. www.personalisedcareinstitute.org.uk/virtual-patients

h. Take an active role in improving the **perception** of the health service:
   i. ACTION ✓: Invest in strategic, ongoing programmes of engagement that build sustained, trusting relationships with minority and disadvantaged communities, as well as working in partnership with communities to develop, deliver, evaluate, and improve services, upstream interventions, and health promotion activities.[136,189,190]
   ii. ACTION ✓: NHS England must change perceptions about its involvement in commissioning so that it is seen as an active and engaged partner191. This is a vital component for ICS delivery.

CASE STUDY: University of Leicester – Health communication and inequalities in primary care access during the COVID-19 pandemic among ethnic minorities: Lived experiences and recommendations

Case Study: Health communication is critical in the context of public health, and this was highlighted during the COVID-19 pandemic. Ethnic minority groups were significantly impacted during the pandemic; however, communication and information available to them were reported to be insufficient. A multi-disciplinary team at the University of Leicester explored the health information communication amongst ethnic communities in relation to their experiences with primary health care services during the COVID-19 pandemic. The research used qualitative methodology with six focus groups and semi-structured interviews with 42 community members and leaders from three ethnic minority communities (African-Caribbean, Somali, and South Asian) in Leicester.

Significant challenges to accessibility, communication and primary care service were language barriers and poor access/use of digital technology, with these factors mostly affecting the elderly. In addition, delay, a lack of clarity, and inconsistency in health information limited the trust of communities in the Government and health providers, making ethnic minorities vulnerable to mis-/disinformation. Therefore, in order to improve future health communication strategies in primary health care and other health services, experiences from the pandemic should be reflected upon, and positive initiatives such as the use of community-tailored communication and health access support should be infused into the population and private healthcare strategies, especially for ethnic minorities. https://pubmed.ncbi.nlm.nih.gov/36429886/

Action on health inequalities: Slowing down to speed up

Dr Ruw Abeyratne, Director of Health Equality and Inclusion, University Hospitals of Leicester

Today, in its 75th year, the NHS continues to deliver on its founding principle: universal healthcare free at the point of delivery. However, in 2023, we know that this does not mean the same care for all. Since 2011, improvements in life expectancy have slowed and eventually reversed for some in the aftermath of the COVID-19 pandemic. Concerningly, healthy life expectancy or the proportion of years lived in good health shows a similar pattern. This final conclusion is just the tip of the iceberg. Below that lies a myriad of accumulated inequalities that are driving avoidable disparate experiences and outcomes for underserved groups whilst straining a healthcare system that is already at its limits.

We live in a time of crisis: we are recovering from a global health crisis, we face a daily cost-of-living crisis, and the NHS faces workforce and funding crisis that make it increasingly hard to deliver excellent care. Health inequalities cost the NHS an estimated £4.8bn a year in hospital episodes alone. The broader economic cost is several multiples greater. The financial case for action is compelling; tackling health inequalities is critical to the stewardship and sustainability of the NHS. Utilising local data to highlight disparities, for example in waiting lists, and inform targeted interventions to address these leads to objective and iterative improvements in productivity and financial efficiency, whilst enabling improved access to care for the most underserved. These 'quick wins' are essential for providing context, mandate for continued action, and an essential sense of urgency about the challenge. But they will not solve the problem at its core.

The solutions to many health inequalities can be found within the communities we care for. True engagement with communities requires a two-way relationship founded in trust. Unfortunately, communities consistently report that their trust in healthcare has been eroded; a combination of damning statistics and systemic inaction cultivating disempowered populations over generations. Demonstrating action driven by surface-level community insights in small but impactful ways helps. However, developing a deeper understanding of communities, their heritage, and their historic relationship with healthcare through combined research and community engagement, takes time. The pace of change is necessarily slow but will lay solid foundations for lasting and meaningful co-designed improvement.

The wider determinants of health describe the complex combination of environmental and social circumstances that impact inequalities. Acute care providers often see patients in crisis but the role they must play in delivering preventative, equitable healthcare to tackle inequalities is significant. Collaboration across whole ICSs is necessary to ensure a shared vision for tackling inequalities as well as shared resource and expertise to the advantage of the local population. Recognising the individual, but synergistic, roles that different providers play within pathways will ensure that the now recurrent health inequalities adjustments in ICS budgets are utilised for maximum impact. Furthermore, as anchor institutions, healthcare providers have the power to influence the wider local economy across a number of wider determinants through employment, collaboration with local education, approaches to environmental sustainability, and other areas.

Healthcare organisations belong to the communities that they serve; colleagues will often have personal experiences of the healthcare that they help to provide. To treat workforce and patient populations as discrete entities limits perspective. Consistent data tells us that colleagues across the NHS experience discrimination in their daily work and career progression. If it is happening to colleagues, it is happening to patients. Uniting colleagues in a shared ambition to address health inequality demands difficult but vital conversations about systemic discrimination in our workplaces. More importantly, working to address health inequality requires meaningful action to dismantle these barriers.

Tackling health inequality is hard and will take considerable resolve. Recognising the urgency of the problem and the need for action is vital. But change takes time, demanding trust and collaboration. Balancing the competing pace of crisis management with the need for developing deep understanding and relationships that enable action will be key to reforming how we deliver healthcare. Once achieved, this balance will enable us to realign ourselves with the NHS vision and mission, and provide a truly universal and sustainable healthcare service for all."

Focus Area 4: Digital and data-driven initiatives

> *"The need now is for the health and care sector to adopt digital tools, urgently and consistently, to address both our long term health improvement goals and the immediate tasks of recovering from the pandemic." (NHS England, 2022)*[192]

While many datasets and digital interventions in the healthcare and wider sector should be delivered collaboratively, the Health Service has (understandably) a need to protect and restrict access to a considerable number and variety of data, and thus cannot share it openly. There is a broad range of opportunities for this data to be utilised to tackle societal problems safely (some of which are explored later), but there is also a range of actions that can be delivered within the health service to improve both the quality and efficiency of its care.

Community Feedback:

a. Review the **collection, structure, and sharing** of medical data. The way systems are currently set up create health inequalities for many groups (e.g. elderly, disabled, those with literacy or language issues, mental health issues):

   i. ACTION ✓: Ensure completeness and accuracy of medical data. As MLTC and intersectionality have increasing impacts on the population's health outcomes, it is vital that medical records are correct and comparable (particularly for research purposes). This links to correct and inclusive ethnicity data.

   ii. ACTION ✓: Investigate the sharing and coordination of medical data linking to actions to support communication with patients and careers. This relates particularly to information sharing only with those identifying as next of kin to the exclusion of carers.

   iii. ACTION ✓: Consider who has access to medical records within the Public Health infrastructure. Respondents supported the Directors of Public Health being given access to household level data during a crisis event such as a pandemic.

b. Provide **consistent services and targeted support** with links to opportunities for training:

   i. ACTION ✓: Coordinate and deliver consistency across digital services. Concerns were raised regarding the variation in provision of and access to services including digital appointments and online prescriptions.

   ii. ACTION ✓: Remove reliance on assumed digital literacy that compounds health inequalities by providing access to paper/in-person options (for example online/in-person appointments, sign-in pods/reception, online/in-person prescriptions) alongside digital champions inside GPs and emergency departments.

   iii. ACTION ✓: Link any initiatives to existing digital training/support organisation to make it relevant to health, providing practical examples, such as how to request prescriptions online.

Policy Recommendations:

c. Implement mechanisms that can **take advantage of the latest digital expertise, capabilities, and infrastructure**:

   i. ACTION ✓: Review the impact of terminology and ethnicity coding on medical forms and records. This includes removing colour from ethnicity groupings (for example Black African) to be more inclusive to self-identity within different communities. This action should be delivered alongside comprehensive and standardised ethnicity data collection across the NHS and social care, supported with effective training.[90 124 157 193]

   ii. ACTION ✓: Investigate and share learnings on successful application of methodologies and techniques to connect datasets within and across the healthcare infrastructure, including information governance procedures for secondary use of data (such as ethnicity) between GPs and hospitals for example. This links to necessary joint activity to improve information sharing across the wider health and care community.[194]

   iii. ACTION ✓: Examine the opportunities available from the UK's first multi-city 5G test-bed and Vodafone Centre for Health with Deloitte (both based in the Midlands) to lead the way in user-centric disruptive mobile solutions.[154 195]

   iv. ACTION ✓: Ensure digitally-enabled primary and outpatient care go mainstream across the NHS as detailed in the NHS 10 Year Plan.[130]

   v. ACTION ✓: Utilise data analytics to provide insight into locations and demographics of target groups, for example:[46 156 154]

      - Addressing out of hospital cardiac arrest by analysing data to find out where they occur and targeting training in these areas.

- Better understand lifestyle drivers of cardiovascular disease and diabetes through better data linkage.
- Identifying underlying determinants behind variations in screening uptake.
- Improving staff knowledge of issues affecting ethnic minority groups through improved use of demographic data.
- Using local research capabilities and infrastructure to identify not only where public health issues are, but also where they may occur in the future.

CASE STUDY: Birmingham City Council Public Health division – Community Health Profiles

Birmingham community health profiles are desk-based needs analysis for specific communities of identity and experience, which bring together data and published evidence to provide a basic understanding of communities. The communities covered so far in the profiles include: Bangladeshi, Caribbean, Indian, Kenyan, Muslim, Nigerian, Pacific Islands, Pakistani, Sikh, Somali, deaf and hearing loss, sight loss, lesbian and trans. Each report includes an infographic and there is an accompanying webinar, and, if appropriate, a version translated into the primary language of the community. The profiles are then supported by a commissioned embedding partner, who works for 12 months with the local community to raise understanding of the evidence and co-create solutions with some small pump prime funding.

https://www.birmingham.gov.uk/info/50305/community_health_profiles

vi. ACTION ✓: Better integrate digital services, whilst enabling robust evaluation of digital programmes with a strong focus on user experience, to ensure all innovations are effective.[45]

d. Introduce policies to enable better uptake of digital services in communities previously excluded by them, including implementing a **digital inclusion in health and care policy**:[46]

i. ACTION ✓: Continue to integrate digital services, whilst enabling robust evaluation of digital programmes with a strong focus on user experience and increased accessibility, to ensure all innovations are effective.[45]

ii. ACTION ✓: Connect with organisations that engage directly with deprived communities to provide access and digital skills support.[136]

iii. ACTION ✓: Train staff to be digital health champions who can support patients directly with using digital tools and can connect with local communities and organisations.[196]

iv. ACTION ✓: Update data held on patients to include spoken/written languages. Healthcare professionals are currently unaware if letters being sent (for example, regarding appointments) can be read by recipients (or even if they have someone who can read it to them). This links to the need for more detailed patient data that goes beyond their health to support care, such as mobility information.[197]

v. ACTION ✓: Ensure that there are offline and face-to-face alternatives for those who are digitally excluded due to poor digital infrastructure (especially in rural communities), precarious internet access, a lack of digital skills and/or unwillingness, for example the elderly, people in insecure housing, and those who are dependent on dongles and low data packages.[136, 187, 198, 199]

e. Improve **data quality related to ethnicity (and other protected characteristics) and health**, such as the coding of ethnicity in health datasets, including:[200]

i. ACTION ✓: Develop an ethnicity information standard for the NHS, including new guidance that specifies how ethnicity data should be collected and recorded, and the ethnicity classifications used, ensuring coherence of the standard with any new Government Statistical Service harmonised ethnicity standard.[136]

ii. ACTION ✓: Implement a sexual orientation and trans status monitoring information standard as detailed in the LGBT Foundation's "Pride in Practice" programme.[136, 179]

iii. ACTION ✓: Deliver an ongoing assessment of data linkage between, for example, GP records, hospital records, or NHS England's central records. Considering data access and sharing, metadata for research, and aggregated statistical data.[127]

iv. ACTION ✓: Carry out a review of language and terminology around ethnicity to understand how to target messaging without stigmatising any particular group.[185]

TASKFORCE 2 SUMMARY: An early warning system for preventing ill health and wellbeing

We need to be proactive rather than reactive

Addressing health inequalities requires an approach that is proactive rather than reactive. We need to identify and address the causes of ill health and wellbeing before they manifest in disparities across groups. The systems aiming to address disparities should intervene early rather than reacting to problems once they arise.

We should seek to prevent, reduce, or delay problems like multiple disadvantage, whereby someone experiences a combination of homelessness, substance misuse, mental health issues, domestic abuse, and contact with the criminal justice system. Often, it is easier to intervene before problems like these arise.

We need an effective early warning system

We should start using screening systems that act as an early warning system for later problems with health and inequalities. People and groups scoring poorly on certain indicators should be referred to local community and voluntary services that can intervene. Ideally, data should come from already existing official sources, such as the Annual Population Survey, although we need these data to be disaggregated by group (age, ethnicity, etc.) at local authority or lower geographic levels for effective targeting.

What should go into the early warning system? We can look at local levels of personal wellbeing in the UK to understand where to target in this region. A social needs screener could be useful, but it would need to be brief and ideally not require new data collection. Could we forecast which areas need more assisted care buildings? Predict cardiovascular disease or Alzheimer's from local activity levels? Researchers can help by identifying the best predictors.

The full taskforce report can be found in the Appendix.

Focus Area 5: Appointments, referrals and services

> *"The combination of ongoing pressure on services, the backlog of care and chronic workforce shortages means waiting times have increased to record highs." (British Medical Association, 2023)*[201]

Despite an increase in GP appointment availability (4% increase nationally[202]), 40-50% of Midlands appointments being delivered on the same day of booking[203], 70% face-to-face[203], and an almost elimination of over 2-year waiting times[204] across the region's health service, there is still considerable work to do to reduce waiting times, particularly for 18 weeks to 1.5 year wait times[205]. The challenges faced by patients booking appointments are perfectly outlined by the NHS England guide to 'Reducing inequalities in access to general practice services'[206] and some general solutions are provided. More can be done, however, to reduce the difficulty of booking, attending, and delivering appointments, referrals, and services across all areas of the NHS.

The implications of these wait times go beyond the immediate (and substantial) health concerns of those already within the healthcare system, with many not attempting to – or being able to – access care soon enough and increasingly people turning to private care (and the long-term financial consequences of this). Addressing the root causes and upstream factors is vital, for example staff availability and retention in GP surgeries, non-attendance across the health service, and closer links to adult social care, where there are challenges with discharge rates. This work is particularly important in areas of the Midlands that are tackling the impacts of more extended lockdown periods.

Community Feedback:

a. In partnership with the Primary Care Networks and Care Quality Commission, i**ncrease the consistency, quality, and accessibility of GP services**:
    i. ACTION ✓: Implement a system-wide review of digital-by-default deployment, taking into account inclusivity requirements and a clear demand for a return to face-to-face appointments. Alongside concerns over service equity, digital literacy, and data privacy, this was seen as a way to improve connection, trust, and understanding, which in turn leads to improved outcomes. Digital exclusion not only impacts demand, it also impacts upon which staff members can work remotely based on their ability to pay for broadband/mobile data.
    ii. ACTION ✓: Identify mechanisms through which GP surgery registration policies can be challenged and standardise. These have become a barrier through complex and lengthy processes involving evidence (including utility bills and photo ID) and health questionnaires within a certain period of time.
    iii. ACTION ✓: Combine the development of models of best practice with inclusive training to ease the burden of booking appointments, including the ability to book during the day, with the same GP, facilitated by additional triage and cultural awareness training for reception teams.
    iv. ACTION ✓: Review the impact of the 10-minute or single concern appointment approach, which often creates the need for further appointments. This should be connected to community engagement, linked workers, and health champions to reduce unnecessary appointments and increase communication during them.
    v. ACTION ✓: Investigate how data can be collected systematically on patients who are not registered or have been removed from GP registers. This data is not recorded but may identify significant inequalities.
    vi. ACTION ✓: Review the location and patient number of GP services to better understand the burden of individual surgeries and neighbourhoods.
    vii. ACTION ✓: Develop and enforce standards and measurable outcomes for maintaining a continuous and consistent approach for appointment booking and queries. The number and quality of engagement for patients who do not manage to reach the doctor are not recorded, but there needs to be oversight to ensure standards of care. This should also encourage an increase in staffing to facilitate demand.

b. Improve and focus **service delivery** to support patient needs:
    i. ACTION ✓: Deliver more 'patient-centred' approaches across the healthcare system, focused on outcomes vs short-term cost saving, such as maintaining prescription brands to prevent unnecessary GP queries.
    ii. ACTION ✓: Support the development and delivery of mechanisms to support patient travel, including working with the voluntary sector. It is automatically assumed that patients will have someone to drive and accompany them to appointments, however, there isn't any system alternative offered to accommodate patients who don't.
    iii. ACTION ✓: Convene a regional group of key stakeholders to determine where actions can be taken locally and in collaboration to tackle GP appointment and referral waiting lists, ambulance response times and A&E waiting times. This may involve preventative measures or supporting volunteer groups.

   iv. ACTION ✓: Identify a safe space adjacent to emergency departments that can be made available for patients who experience mental health challenges, developmental disabilities or other difficulties that make being in a loud crowded place a problem.

Policy Recommendations:

c. Work with Primary Care Networks, GPs and pharmacies to consider **patient-centred processes and practices**:[175]
   i. ACTION ✓: Further increase flexibility for home visits and working within community settings; two areas that healthcare workers flagged as positive policies for increasing health outcomes.[37 133 207]
   ii. ACTION ✓: Implement mechanisms to reduce missed appointments (e.g. SMS reminders, booking windows opened 24-hours before the appointment, GP letters for non-responders, and the ability to switch between face-to-face and remote consulting). These must be balanced with mechanisms to manage demand.[135 208]
   iii. ACTION ✓: Identify individuals at risk earlier (be that of mental health challenges, detrimental activity – such as smoking, addiction, or rough sleeping – or chronic disease) and develop models of care that enable them to engage with interventions proven to either prevent or improve outcomes for early onset chronic disease.[209]
   iv. ACTION ✓: Create GP-led, in-hospital management of target groups and focus on increasing GP registrations.[46]
   v. ACTION ✓: In line with the Pharmacy First scheme, promote the role of community pharmacists, particularly for signposting and medicine review, to further their positive impact on access to certain health services.[133]
   vi. ACTION ✓: Provide effective, trauma-informed care for women and link to programmes such as the Mental Health Foundation's 'Engaging with complexity'.[46 210]
   vii. ACTION ✓: Deliver targeted communications and support, with referral to the My Planned Care platform, to support patients on the waiting list (and their carers) to maintain their health and access the latest information on their local hospitals and treatment.[211 212]

The vital role of social prescribing link workers

Christiana Melam, Chief Executive, National Association of Link Workers

Social prescribing link workers (SPLW) are leading a ground-breaking innovation that allows the NHS to deliver whole-person care to meet the needs of the local population, whether it be a reduction in health inequalities, an improvement in mental health and quality of life, an increase in the NHS workforce capacity, or joined-up care.

SPLWs are not an optional addition; they are an integral part of the multi-disciplinary team (MDT), delivering holistic service to patients, bringing the community closer to the NHS, and enabling a move to a more social model of health (we need to de-medicalise social issues in healthcare). They act as the glue between community, health, and social care, joining it all together.

Owing to the ever-increasing NHS workforce pressures, increased public demand for whole-person care, health inequalities, and mental health crises, all stakeholders need to understand the absolute necessity of the role of SPLW in reducing health inequalities, improving health outcomes, and sustaining the NHS. We must move from a deficit- to an asset-based model to address health inequalities; this is far more sustainable and cost-effective than short-term token measures.

SPLW are new members of the NHS workforce, defined in some quarters as "connecting people to wider community support that can help improve their health and wellbeing." However, this definition is too narrow in scope and only defines the community connecting aspect. It does not reflect the full scope of their role and their impact in practice.

SPLW are frontline non-clinical healthcare professionals working at an individual-, community-, and systems-level as part of the MDT to deliver personalised care and enable communities to take control of their health and wellbeing. They make observations of how to improve an individual's physical and mental health, looking at it from the social, cultural, economic, and environmental circumstances in which they live. Looking at the wider and social determinants of health, SPLWs seek to address what matters to the person holistically through "time to talk" and shared decision-making. They empower people to create a personalised action plan to achieve the goals they have set for themselves without feeling overwhelmed and enable them to achieve them. The collaborative approach, which underpins SPLW's interactions, naturally empowers people and fosters independence and resilience.

The SPLW intervention is a "cure" – it helps to remove barriers preventing people from taking control of their health and wellbeing. SPLWs have access to patients for longer, which means their knowledge can inform intelligence and service provision nationally and locally, providing a complete picture of what is going on and what is needed. We must empower SPLWs with the resources they need to drive systems change, recruit more across the entire health and social care landscape, and deliver all-door access to SPLWs.

If social prescribing is designed and implemented correctly and co-productively, it can:

- *Support mainstream joined-up care across the health, social, and community care system.*
- *Provide services that truly meet local people's needs.*
- *Reduce the workload for GPs.*
- *Reduce overmedication.*
- *Improve health and wellbeing.*
- *Reduce unnecessary visits to hospital services.*
- *Strengthen multi-disciplinary and multi-sectoral working.*
- *Contribute to reducing health inequalities and social injustice.*
- *Build patient and community resilience.*
- *Empower populations, individuals, providers of care, and the system.*

www.nalw.org.uk

Focus Area 6: Long-term conditions, care, and management

> *"Long-term conditions are a major cause of poor quality of life in England. People in lower socio-economic groups are more likely to have long-term health conditions, and these conditions tend to be more severe than those experienced by people in higher socio-economic groups." (The King's Fund, 2022)*[49]

> *"People living in poorer areas also have greater levels of multiple diagnosed illness (multimorbidity). Large inequalities in the burden of disease are concentrated within a few diagnosed conditions, including chronic pain, diabetes, COPD, anxiety and depression, alcohol problems and cardiovascular disease." (The Health Foundation, 2022)*[213]

The NHS Long Term Plan aims to reform community care for long-term conditions, with the intention of delivering better care and reducing the pressure on emergency hospital services[214]. Actions taken as a result of this strategy must recognise and address the inequalities present in the care and management of long-term conditions if fair and equitable healthcare is to be achieved. If the UK is to meet its health life expectancy targets for an ever-ageing population (with long-term conditions being more prevalent in older people[215]), it is vital that the health and care system coordinate effectively to protect our vulnerable citizens.

Community Feedback:

a. Respondents raised concerns that marginalised communities and isolated individuals sometimes have little self-care knowledge sitting alongside increased health-related issues relating to cardiovascular disease, diabetes, and lifestyle illness.

    i. ACTION ✓: Involve health professionals when working with marginalised communities (e.g. Gypsy, Roma and Traveller) and ethnic minorities so that they can gain a better understanding of their health (including dental) needs and respond accordingly.

    ii. ACTION ✓: Provide clear support for those unable to accurately maintain and monitor their prescriptions, such as the elderly, those with mental health issues, and friends/family members looking to support loved ones, including guidance and signposting to pharmacies for questions regarding medication and the local Healthwatch for queries regarding services.

Policy Recommendations:

b. Focus the drive for joined-up activity on long-term health conditions to tackle geographic and socioeconomic inequalities in access including:

    i. ACTION ✓: End under-diagnosis by increasing community awareness of symptoms and lifestyle influences (in a way that is specific and culturally appropriate), as well as maximising referrals to the NHS Diabetes Prevention Programme.[130]

    ii. ACTION ✓: In line with the Taking Control campaign, improve access to and uptake of diabetes structured education, via a menu of options, so that they have the skills and confidence to manage their condition.[46 216]

    iii. ACTION ✓: Close the gaps in long-term condition care and management using strong quality improvement work in clinical commissioning groups and NHSE as identified in the Quality and Outcomes Framework.[65]

    iv. ACTION ✓: Review sickle cell disease services against the national clinical quality standard to check any shortfalls in quality and resourcing of services.[65]

    v. ACTION ✓: Strengthen preventive measures for key disease areas within at-risk groups and improve early detection, diagnosis, and timely, evidence-based care. This activity should link to actions which improve the determinants of health and subsequent investments in urban renewal programmes, education, and job creation:

        - Providing Flash Glucose Monitors for people with type 1 diabetes and Continuous Glucose Monitoring for pregnant women.[46 217]
        - Providing pulmonary rehabilitation for respiratory disease.[46]
        - Join up pathways of care for people living with type 2 diabetes and obesity, including by integrating weight management services with other aspects of treatment and care, like mental health support.[10 218]

- Raising awareness amongst women (twice as likely to die of coronary heart disease as breast cancer in the UK due to misdiagnosis, alongside a lack of symptom awareness, care seeking, and care provided) by signposting the Heart Age Tool and long-term health guidance.[219 220 221 222]
- Deploying interventions for the prevention and treatment of musculoskeletal conditions, which impact a large proportion of the population and can lead to other health conditions.[46]
- Investigate the underlying factors that result in women of Caribbean and African heritage being more likely to be diagnosed with more advanced breast cancers and breast cancers that have fewer treatment options (such as triple negative breast cancer). 25% of African women and 22% of Caribbean women are diagnosed with stage 3 or stage 4 breast cancer at diagnosis in England, compared with 13% of White women.[223]

CASE STUDY: Cities Changing Diabetes – Learnings from Leicester on addressing the prevalence of type 2 diabetes

9.6% of Leicester's population aged over 17 are recorded as living with a diabetes diagnosis, which is significantly higher than across England (7.1%). Type 2 diabetes represents 90% of all cases of diabetes, with obesity thought to be responsible for 85% of the risk of developing the condition.

To address this prevalence and to improve the health and wellbeing of the local population, partners across Leicester (including Leicester's health service, the city council, sports clubs, faith communities and others) have come together through the Leicester Cities Changing Diabetes programme. This joint-working project, funded and developed between Leicester Diabetes Centre and Novo Nordisk, raises awareness, educates, and trains communities to deliver prevention and lifestyle education in Leicester city.

As part of the Cities Changing initiative, a "diabetes pledge" was signed by Leicester's professional sports clubs and Leicester City Council demonstrating their commitment to partnership working in driving down type 2 diabetes in Leicester.

The diabetes pledge has led to the creation of a number of health-promotion programmes, including Walking Cricket, Healthy Goals and United Leicester. All of the sports clubs join together and host sport festivals within Leicester, giving communities the opportunity to try a new sport or a slower-paced version of a sport they love, with walking sports.

www.leicesterchangingdiabetes.com

CASE STUDY: Centre for Ethnic Health Research, University of Leicester – Beliefs and traditions behind use of natural remedies for diabetes in South Asian communities

One of the key aspects of engaging with patients and carers from ethnic minority backgrounds, such as South Asians, is being able to understand and relate to cultural and traditional practices. A commonly held practice is the use of natural remedies, particularly in the context of managing diabetes.

Although there is little conclusive scientific evidence on the use of certain natural remedies for the management of diabetes, this is a popular method adopted by South Asian patients, one that is often preferred over prescription medication and which may replace it for some people. In order to engage with this community and understand why medication adherence is often so low, it is important to understand the motivation behind the use of these natural remedies and how it affects their decision-making process when it relates to management of their diabetes.

Workshops with this population were held within local community centres with a researcher and an artist. Stories were shared about their beliefs and the traditions behind the use of natural remedies. Listening to these stories, the artist will be creating a mural illustrating these beliefs, which can be shared to raise awareness of the importance of understanding culture in diabetes management.

Focus Area 7: Maternity care and infant health

> *"Women with low socioeconomic status and social risk factors are at a disproportionate risk of poor birth outcomes and experiences of maternity care. Specialist models of maternity care that offer continuity are known to improve outcomes but underlying mechanisms are not well understood." (Rayment-Jones et al, 2022)*[224]
> *"Strong local leadership is vital to an effective cross agency approach to improving maternity and early years services and reducing infant mortality". (Department of Health, 2010)*[225]

The need to address these inequalities in health outcomes is highlighted by the stark reality that British women from African and Caribbean heritage are more than five times more likely to die in pregnancy or childbirth than White women, mixed ethnicity women are two times higher and Asian women almost twice as high, while British-born babies of African and Caribbean ethnicity have more than twice the risk of still birth than those of White British ethnicity[90 226 227]. Added to this, women with a learning disability experience poorer maternal wellbeing and pregnancy outcomes compared to the general population, including preterm and low-birthweight babies[228].

Community Feedback:

a. Significant variations in maternal and infant health outcomes exist across the region and the UK. Areas requiring further work, as raised by communities were:
    i. ACTION ✓: Provide **continuity of care with midwives**.
    ii. ACTION ✓: Provide **dietary information** for those that choose not to breastfeed and, critically, provide a safe space for conversations about this. It is possible to promote breastfeeding without demonising other choices and isolating those individuals and their families.
    iii. ACTION ✓: **Share learning, support, and training** between hospitals so that underperforming facilities in the region meet and maintain the expected staffing requirements, standards of care and practices.

Policy Recommendations:

b. **Improve and standardised maternity care and support services**, as the way in which parents are supported during pregnancy can affect not only the early years of a child's growth, but also their prospects into adulthood:
    i. ACTION ✓: Facilitate better understanding of the role and responsibilities of different agencies and staff to promote greater effectiveness and improved service delivery. This needs to be linked to strong local leadership and a drive to tackle challenges.[138]
    ii. ACTION ✓: Deliver targeted, educational, and enhanced midwifery-led continuity of care, as women who receive this are less likely to lose their baby, experience pre-term birth or report reduced experience of care across a range of measures. Pre-term birth is a key risk factor for neonatal mortality. This action should align with the NHS commitment to ensure continuity of midwifery care for Black, Asian and minority ethnic women during and after pregnancy, where staffing levels mean that this is safe to do so.[8 130 229]
    iii. ACTION ✓: Remove silos of care and treat women who may become pregnant, are pregnant, or who have recently been pregnant the same as a non-pregnant person (unless it is a clear reason not to do so), this allows maternity care to be linked to other activities to improve health and reduce inequality, such as:[230]

        - Link activities to reduce maternal death with those to reduce death in women from cardiovascular disease, as cardiac disease is the largest single cause of maternal deaths.[98]
        - Develop a mechanism to ensure all venous thromboembolism risk assessment tools used for pregnant and postpartum women are consistent with national guidance, tackling the leading cause of direct maternal death during or up to 6 weeks after the end of pregnancy.[231 232]
        - Ensure that there are clear and explicit pathways into specialist perinatal mental health care and recognise that post-pregnancy counselling is as important as pre-pregnancy counselling to address maternal suicide, the leading cause of direct deaths occurring within a year after the end of pregnancy.
        - In addition, GPs should inform maternity services of any past psychiatric history, and maternity services should ensure that the GP is made aware of a woman's pregnancy and enquire of the GP about past psychiatric history.[233]

c. Deliver significant improvements in **information access suitable across different cultures, abilities, and ages**:

   i. ACTION ✓: Enhance delivery of critical public health messages relating to maternal and infant health, ensuring these are targeted to those most at-risk, and are multilingual, accessible, and designed to be educational (including visual aids).[8] [228]

CASE STUDY: Small Steps Big Changes – Inclusive communications

Small Steps Big Changes (SSBC) is funded through the National Lottery Community Fund's A Better Start Programme (2015-2025), which is focused on promoting good early childhood development. The SSBC programme supports the improvement of social and emotional development, communication and language, and nutrition outcomes amongst 0–4-year-olds in 4 ethnically diverse council wards in Nottingham City. SSBC uses inclusive communication strategies aimed at maximising the engagement of local families with its programme of activities.

- The SSBC website has been developed to be translated from English into the top 5 languages spoken in the SSBC wards. This makes basic public health information available to more families. The website design also supports the direction of written language for right-to-left scripts such as Arabic.
- Based on a survey that explored access to and experiences of healthcare for non-English speaking families in one of Nottingham's Primary Care Networks[234], online migrant health patient resources[235] were developed in multiple languages. These languages were identified by the Children's Public Health 0–19 Nursing Service as the most common languages needing a translator. The co-produced resources provide information around the available services, the importance of vaccinations, and self-care advice and guidance on when to seek medical attention for common childhood illnesses.
- SSBC commissioned a social marketing firm to develop a breastfeeding public health campaign for Nottingham: Feed Your Way[236]. The campaign features 6 families' stories about their breastfeeding experiences. These families reflect the wider community, including ethnic minority and LGBTQIA+ families.

www.smallstepsbigchanges.org.uk/

www.tnlcommunityfund.org.uk/funding/strategic-investments/a-better-start

CASE STUDY: Leicester City Council and Centre for Fun and Families – 1,001 critical days building communication skills

Two new services are being delivered in Leicester to support communication skills during the first 1,001 critical days, with a particular focus on 2 groups: women on the perinatal mental health pathway; and families where English is an additional language (EAL). The services are commissioned by Leicester City Council, and delivered by the Centre for Fun and Families, a local charitable organisation who have worked extensively with Leicester families.

Wellbeing in Pregnancy: This is a 4-week group aimed at pregnant people who are experiencing mental health issues (and their partner/supporter) with a focus on bonding and early communication, managing stress, worry and anxiety in pregnancy and as a new parent, and preparing for parenthood.

There have been challenges during service mobilisation in embedding the programme within existing referral pathways, largely due to capacity demands across the services which are most appropriate to identify and refer to this service. This is being addressed by using networks across healthcare service, local authority, and other VCSE organisations to share service information and encourage referral, and by exploring feasibility of utilising other existing referral pathways which do not place additional demand on system capacity. Geographical spread of pregnant women is a potential barrier to accessing a single location within the city, so there is an option to use different venues to deliver the service, and for free transport to be provided to enable attendance.

EAL: This is a baby and toddler group, held weekly, for families with children from birth–2 years and whose first language is not English. The aim of the group is to empower families, build their confidence, and provide opportunities for them to support their children's communication, language development, and bonding.

To minimise barriers to attending, the group is delivered on a rolling 8-week basis, allowing participants to attend sessions as and when they are able. Transport is also provided, if needed, to ensure families do not miss out on being able to attend due to external factors, such as distance from venue and the cost of travel.

Early feedback indicates that participants have found the group really beneficial, reporting greater confidence and understanding how they can support their baby/toddler with communication and language development, such as extending the vocabulary they use with their child, consciously allowing their child time to respond, following their interests, using books and singing, and increasing play opportunities.

ii. ACTION ✓: Collate recommendations from relevant guidelines into a single definitive source of guidance, particularly for target groups, such as the care of older women in pregnancy.[230]

CASE STUDY: Birmingham schools portal to support "Best Start in Life"

NHS Ladywood and Perry Barr Locality Partnership and Birmingham City Council's Public Health Division are developing a health education resource portal to support their approach to the "Best Start in Life". To keep these up-to-date, secure, and readily accessible, both the Young Peoples Education Community and its delivery professionals are developing a health education resources portal. This multi-functional portal will have a library of resources, including:

- pre-event contextual material
- activities
- pre- and post-event surveys, etc.
- lesson plans
- videos
- worksheets

The online surveys are essential for capturing learning and knowledge and for evaluating the Best Start in Life Health Hack programme. To ensure the programme is achieving required outcomes and can be adapted and updated when required, the portal will also include dashboards with real-time data analysis for education professionals and key stakeholders within the city and the NHS.

CASE STUDY: Small Steps Big Changes and Nottingham Trent University – New Fathers Information Pack

A consultation with new fathers commissioned by Small Steps Big Changes (SSBC), a National Lottery Community Funded 'A Better Start' Site, showed that fathers didn't know where to find information to support their parenting role. To address this need, SSBC developed a 'New Fathers Information Pack'. The aim of the pack was to prepare fathers for when their baby was born by providing information and advice about what to expect as a new father.

An evaluation of the pack was carried out, aiming to understand the impact that it had and to explore fathers' and professionals' opinions of it. The pack was described positively by fathers and professionals. Fathers considered the pack a useful source of reference, as well as a tool to share with others. Professionals said that the pack had the potential to find 'hard to reach' fathers. Overall, it was considered a valuable source of information which fathers said they would like to see offered nationally.

www.smallstepsbigchanges.org.uk/knowledge-hub/Downloads/Fathers_consultation_summary.pdf

www.smallstepsbigchanges.org.uk/knowledge-hub/learning-hub/ssbc-annual-report-2022

CASE STUDY: The Centre for Ethnic Health Research (CEHR) – Inequalities and healthcare access for those who have experienced baby loss

CEHR was one of 15 organisations who have been awarded £1,000 from the East Midlands Health Innovation Network's Patient and Public Involvement and Engagement (PPIE) Fund to involve more patients and citizens in research and healthcare. The funding is enabling the Centre and the Black and Asian Baby Loss Patient and Public Involvement (PPI) and Research Collaboration to look at and address the inequalities in healthcare access for this community. This is being achieved by establishing a PPI network to gather evidence on how to tackle ethnicity-related perinatal mortality, run focus groups and produce culturally appropriate resources.

"The Centre is delighted to have received this funding to explore how we can improve outcomes for women and babies in this area. The project is shining a light on novel evidence on racial inequality and its impact on maternal and infant mortality. We value working in partnership with local women from Black and Asian backgrounds alongside the national charity, Sands, which provides support to anyone affected by the death of a baby." Barbara Czyznikowska, CEHR Community Engagement Officer

Further information about the Fund, as well as the other successful applicants:

https://healthinnovation-em.org.uk/our-work/patient-and-public-involvement/public-involvement-fund

iii. ACTION ✓: Identify infants at greater risk of dietary-related health issues to enable targeted upstream interventions through health professionals, which is critical for obesity prevention and management.[237]

CASE STUDY: University of Nottingham – Babies at Greater Risk of Overweight (BabyGRO)

High birthweight and rapid weight gain in the first year of life are early predictors of later child overweight[238]. However, there are currently no UK guidelines for the routine identification of overweight infants meaning that valuable opportunities for early intervention are lost. The research undertaken by the team developed the Infant Risk of Overweight Checklist (IROC): an evidence-based algorithm to help health professionals easily identify infants with risk factors for child overweight[239 240]. This, together with a systematic review of interventions to prevent early childhood obesity, led to guidelines for the early identification and management of infant risk of bring overweight[241].

Subsequent research explored ways of implementing these guidelines, culminating in the Babies at Greater Risk of Overweight (BabyGRO) training programme for health professionals. BabyGRO comprises 2 online learning resources (Reusable Learning Objects) to help health professionals target parents of infants with risk factors for child overweight with support to help them manage their infant's growth.

BabyGRO1 includes an interactive version of the Infant Risk of Overweight Checklist to enable easy assessment of infant risk of overweight. Features such as annotated centile charts, parent and staff quotes from previous research and media clips, help to build health professionals' confidence to raise the issue of healthy growth with parents. BabyGRO2 is designed to support the selection and implementation of appropriate, evidence-based intervention strategies (e.g. responsive feeding, reduction of sedentary behaviour).

The BabyGRO programme has been accredited by the Institute of Health Visiting (iHV) and can be found here:

1. BabyGRO1 Identifying infants at greater risk of being overweight

   www.nottingham.ac.uk/helmopen/rlos/practice-learning/communities/babygro/risk/index.html

2. BabyGRO2 Supporting parents whose infants are at greater risk of childhood being overweight

   www.nottingham.ac.uk/helmopen/rlos/practice-learning/communities/babygro/supporting-parents/index.html

iv. ACTION ✓: Provide supportive infant feeding advice regardless of how a family choose to feed their infant.[218 237]

CASE STUDY: Aston University – The Psychology of Eating in Adults and Children (PEACh)

Aston University's PEACh group are investigating the psychology behind human eating behaviour from the earliest stages of life, through childhood and adolescence, and into adulthood. Their research examines biopsychological, affective, psychopharmacological, cognitive, and social influences on eating behaviour and adiposity. Projects exploit a wide range of methods, including experimental studies of responses to food stimuli and manipulations of eating behaviour, longitudinal designs, observational methods, and intervention design and evaluation.

PEACh's interventions are diverse, ranging from those based in community settings to e-health and apps. Examples of this work include:

- The Child Feeding Guide: a digital resource for families and healthcare practitioners wanting evidence-based information about child feeding. Used by over 100,000 users and widely recommended throughout the NHS.
- Vegetable Maths Masters: a free maths app using vegetables to improve the child's maths skills and increases their exposure to vegetables at the same time (funded by the British Psychological Society).

www.aston.ac.uk/research/hls/applied-health-research-group/peach

CASE STUDY: Small Steps Big Changes – The Healthy Start Scheme

Vitamin D is critically important for human growth, and adequate intake should be guaranteed throughout life[242]. In England, the Healthy Start Scheme offers free NHS vitamins to eligible pregnant women and children under 4, but stringent eligibility criteria and extremely low uptake of the vitamins[243] mean many families miss out.

Local workforce in Nottingham report that families often dismiss the importance of vitamin D if they need to purchase the supplements themselves, while women who used the supplement during pregnancy seem less well informed about the importance of continuing after birth and giving it to the baby from birth if the baby is breastfed.

Having a darker skin type, as well as having less skin surface exposed to the sun due to covering up for religious or cultural reasons, may contribute to vitamin D insufficiency. In Nottingham, maintaining healthy vitamin D levels across its ethnically diverse population may be more challenging.

Joining other local authorities who have provided enhanced access to Healthy Start Vitamins[244] [245], Nottingham and Nottinghamshire have now funded Healthy Start vitamins for all pregnant women in order to reduce health inequalities.

www.healthystart.nhs.uk

EXAMPLE: How to deliver these actions in practice

CASE STUDY: University Hospitals of Leicester NHS Trust (UHL) – Improving non-attendance at outpatients through a lens of health equality and inclusion

Health inequalities are avoidable differences in health experienced by groups of the population. The causes of health inequalities are multifactorial, intersectional, and complex. These are known collectively as the wider determinants of health and encompass factors such as education, work environment, and housing as well as access to healthcare services and other factors.

As detailed in this report, faced with the significant task of recovering the NHS from the impact of the COVID-19 pandemic, NHS England published a mandate for action on health inequalities that addressed 5 key areas (listed on page 24). Action against these 5 priorities can be supported by and measured against NHSE's Core20Plus5 framework.

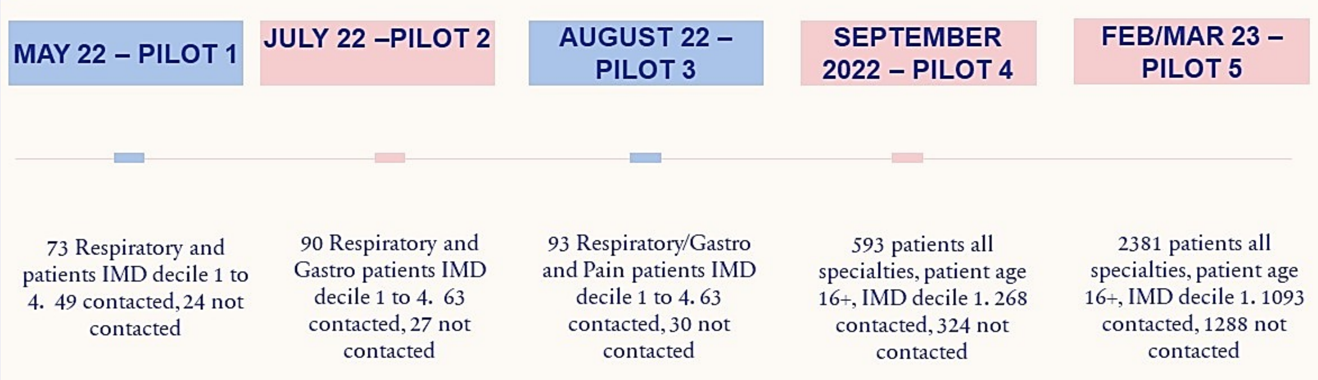
Aligning this mandate to organisational priorities, non-attendance at outpatient appointments was recognised as a key operational priority to focus on. UHL disaggregated outpatient waiting lists by ethnicity and postcode data to stratify waiting lists by deprivation (Indices of Multiple Deprivation [IMD]). This exercise highlighted that non-attendance at outpatients is consistently higher for patients from the most deprived populations (IMD 1-4).

The Core20Plus5 key clinical areas were reviewed in the context of non-attendance, and respiratory outpatients was highlighted as an area of concern and focus. It was decided that a pilot project would be undertaken with the aim of improving non-attendance at respiratory outpatients for patients from the most deprived populations from a baseline of 30-50% to the trust average of 8-10%. An early determinant of the intervention was the limited resource available to deliver this project, which restricted the initial pilot to a 1-month period before reviewing progress.

Recognising the multifactorial nature of non-attendance at outpatients, the intervention was defined as a targeted phone call to patients from IMD1-4 with a respiratory outpatient appointment within 2 weeks. The aim of the phone call was two-fold: to offer a reminder of the appointment, confirm attendance or rebook the appointment where relevant, and to offer support to attend, such as by arranging interpretation services, help with transport costs or addressing other unmet needs highlighted by patients or carers. A script was provided to colleagues making the phone calls to patients to ensure a standardised approach.

Continued over...

The initial pilot data identified 73 patients eligible to be contacted; 49 successful contacts were made. In the intervention group, the non-attendance rate was 8% compared to 33% for those not contacted. Given the success of the pilot stage, a further cycle was initiated, which was scaled up to include patients attending gastroenterology outpatient appointments based on non-attendance rates. The non-attendance rate for those contacted was 8% compared to 41% for those not contacted. The project was scaled up iteratively over three further cycles to include all specialities but, based on further analysis of the data, the decision was taken to focus on patients from IMD1 only.



MAY 22 – PILOT 1

73 Respiratory and patients IMD decile 1 to 4. 49 contacted, 24 not contacted

JULY 22 –PILOT 2

90 Respiratory and Gastro patients IMD decile 1 to 4. 63 contacted, 27 not contacted

AUGUST 22 – PILOT 3

93 Respiratory/Gastro and Pain patients IMD decile 1 to 4. 63 contacted, 30 not contacted

SEPTEMBER 2022 – PILOT 4

593 patients all specialties, patient age 16+, IMD decile 1. 268 contacted, 324 not contacted

FEB/MAR 23 – PILOT 5

2381 patients all specialties, patient age 16+, IMD decile 1. 1093 contacted, 1288 not contacted

The intervention proved consistently impactful. The most recent review of data demonstrates that patients who are contacted by telephone 2 weeks prior to a scheduled outpatient appointment have a non-attendance rate of 9.6%, compared to 17% for those not contacted. The intervention has therefore been successful in achieving the project aim of eradicating the differential in non-attendance for the most deprived populations. As well as the positive impact for patients, the potential operational productivity and efficiency gains are clear. Given this, the intervention has been funded for the 2023-2024 financial year with a view to expanding the cohort of patients contacted to include IMD2 and other at risk (Plus) groups, for example patients registered with Inclusion Health primary care services.

Additional learning from the project revealed challenges with internal systems and processes, such as several patients who had not received letters for their appointments and patients whose appointments were cancelled at short notice by the Trust. This has highlighted further areas for focused improvement work within the Trust's Outpatient Transformation Programme. Of note, no phone calls to landline numbers were successful.

Following feedback from this project, combined with additional non-attendance data, a series of community engagement events have taken place or are planned to take place, to further explore the challenges specific communities experience in accessing services with a view to co-designing solutions to address specific barriers.

Though we recognise the success of this project, and we anticipate further benefit to both patients and the organisation, UHL remains focused on and committed to embedding a health equality and inclusion approach to service improvement across the Trust, using this work as a blueprint for success. This will require broader cultural change across the organisation, and we are confident that the non-attendance work has laid solid foundations for this.

ACTIONS FOR LOCAL AUTHORITIES

This section brings together nationally and locally recommended actions with the excellent work already ongoing in places across the Midlands to provide a guide for local authorities on opportunities for further growth and collaboration.

Over the following pages (pages 56 to 63), we explore the creation of:

- a society that benefits from equitable services, employment, access and living conditions.
- fully integrated and collaborative anchor institutions/employers that understand their role and its impacts.
- forward-thinking service providers being given the opportunity to create the society of the future.
- an uplift in personal health awareness amongst the population of the Midlands.

Focus Area 1: Focus locally and collaborate

> *"At each stage of the life course there are particular structures, organisations and factors that impact on people's lives, affecting individual health and likely future health outcomes. Some factors, such as housing, relate to the whole life course, whereas others are specific to a particular stage – for example, the school environment during childhood. Effective local authority action requires intervention at each stage of the life course which is adapted and appropriate according to the stage being targeted, and the involvement of appropriate stakeholders in planning, delivery and evaluation." (Public Health England and UCL Institute of Health Equity, 2014)*[138]

Addressing the wider determinants of health is largely viewed as a task for local authorities but, despite their knowledge of local populations, delivering against this enormous task requires support and expertise from within communities, including both public and private employers.

Community Feedback:

a. Work with and within local communities and the organisations that serve them throughout every aspect of health delivery:

   i. ACTION ✓: Set commissioning and procuring from local businesses and VCSEs as a priority action.

   ii. ACTION ✓: Do more than just engage with communities: integrate them into processes, work with them to gather data and develop business cases, hire community members into multidisciplinary in-house teams, and train representatives to deliver community-based projects. By bringing communities on the journey with service development and delivery, it will tackle the perception of lack of understanding of community needs.

   iii. ACTION ✓: Advertise services proactively, focusing on those most in need, to raise awareness of what is available for communities experiencing different situations.

   iv. ACTION ✓: Provide multiple accessible ways to engage with a service, e.g. rather than "a phone number or email that is never answered" create contact points within communities (this could be a new champions network or key stakeholders established within existing community and faith groups) who have access to information, as well as direct contact with team members within services.

b. While the benefits of digital services are widely accepted, **digital exclusion** is high in the awareness of all communities. This ranges from parents worrying about their ability to facilitate their children's learning to limitations for remote workers and lack of options for older generations. In health, this translates to a lack of access to key services:

   i. ACTION ✓: Ensure that any services that are provided online also have an offline option that is easily accessible.

   ii. ACTION ✓: Raise awareness of which services can be accessed virtually and independently in which geographies and by whom.

Policy Recommendations:

c. Address the wider determinants of health in the region by creating **an inclusive, locally-focused, locally-staffed, and locally-procured service structure**, with inbuilt processes to ensure the needs of local communities are heard and met:

  i. ACTION ✓: Develop mechanisms for accountability and monitoring – publicly, organisationally, and politically – and adopt a 'health in all policies' approach to promote wellbeing, avoid causing harm, and reduce inequality between groups, e.g. Health Impact Assessment methodologies. This may include adding the improvement of health inequalities as necessary outcomes of all funded programmes, or creating workstreams to ensure that inequalities are considered in all aspects of response and recovery. To truly galvanise this process, local authorities may consider becoming a Marmot city region.[246] [247]

CASE STUDY: Birmingham Health and Wellbeing Board strategy – Creating a bolder, healthier city

This partnership strategy sets out clear intentions to achieve impact on health inequalities over the next 8 years within 5 thematic areas and 3 life course chapters. It was developed through a collaborative consultation and co-production approach with partners and citizens. Each section sets out clear accountability and governance, as well as a set of metrics to monitor and assess progress and success in addressing these inequalities. The metrics are published through a digital dashboard to ensure transparency and accountability to citizens.

www.birmingham.gov.uk/info/50119/health_and_wellbeing_board/1300/health_and_wellbeing_strategy .

CASE STUDY: Coventry City Council – Equality Impact Assessments

Equality Impact Assessments (EIAs) are used to ensure council policies, programmes, services, commissioning processes and new developments are not discriminatory to those with protected characteristics. Coventry took the approach of introducing new health inequality sections to their EIA process. The questions included were developed using the evidence-based Health Equity Assessment Tool (HEAT).

By including a health inequality section, the assessment now proactively identifies opportunities to improve health equity as well as requiring the identification and mitigation of any potentially negative impact on inequalities. A third section has now also been developed, which includes digital exclusion and inclusion in a bid to further reduce digital health inequalities.

www.gov.uk/government/publications/health-equity-assessment-tool-heat

  ii. ACTION ✓: Develop inclusive and locally-focused employment initiatives such as active labour market programmes, which have been proven to enhance personal development rather than focusing entirely upon occupational skills. Personal development is the characteristic most likely to create positive health impacts.[248]

CASE STUDY: Birmingham Public Health Division – Graduate intern programme

The Birmingham Public Health graduate internship programme provides fixed-term, paid 12-month roles for individuals with public health qualifications (and related topics), but little lived experience of public health practice. Graduates are recruited through open competition and the Division has worked closely with the 5 major universities in the city to raise awareness of the opportunities. Each graduate works with a specific team or Assistant Director and, following an initial training needs assessment, is given a major project for the 12-month duration and several smaller, competency-based projects to help build their experience and practical examples of applying their knowledge. The graduates are supported by the Director of Public Health and the Head of Office Team who provide a weekly touch-base and mentoring meeting. There are also monthly training and skills sessions, ranging from technical skills workshops to CV and job interview skills. Over the last 3 years, more than 20 graduates have been employed and all have gone on to substantive employment at the end of the 12-month contract. The programme has increased the diversity of the workforce in public health and provided new employment opportunities at an entry level for young people.

www.birmingham.gov.uk/info/50120/public_health/2418/training_and_work_placements_with_public_health

iii. ACTION ✓: Deliver greater job security by improving flexibility regarding recruitment age (e.g. post-retirement age), encouraging the creation or adaption of job roles so that are suitable for lone parents, carers, and people with mental and physical health problems.[37]

iv. ACTION ✓: Focus on building sustained economic, social, and skills resilience for the longer term by strengthening local communities. This includes providing greater protections for low-paid workers, designing and training for better quality jobs, creating stronger community bonds, and investing in higher quality public services to put upstream interventions first on the Government's inclusive growth agenda.[190]

v. ACTION ✓: Increase the diversity of those in key roles, including on local councils, advisory boards, school governing bodies, and health leadership positions. This could include also advertising these opportunities through faith organisations and local VCSE organisations.[136]

CASE STUDY: Birmingham City Council – Everybody's Battle, Everybody's Business

Everybody's Battle, Everybody's Business is a framework for action to improve diversity and inclusion across the Council. Launched in 2021/22, the framework sets out 5 objectives, including objective 2: Demonstrate inclusive leadership, partnership, and a clear organisational commitment to be a leader in equality, diversity, and inclusion in the City; and objective 5: Encourage and build a skilled and diverse workforce to build a culture of equity and inclusion. The Council has subsequently been working hard towards these objectives. The initial focus has been addressing the data gap and improving the understanding of the Council's workforce. This has been achieved through positive disclosure support, working with staff groups to understand and respond to their concerns (especially for LGBTQIA+ and disabled staff), benchmarking Council data against the local population, increasing understanding of gender and ethnicity pay gaps, and working towards this for sexual orientation and disability. Alongside this, the Council has worked with staff diversity networks, held listening events to co-create and shape solutions, rolling out unconscious bias training and inclusion recruitment practice training across all recruiting managers, and designed inclusive and targeted recruitment with underrepresented communities. This remains an ongoing programme of work, but there is clear political and senior management commitment to improving inclusion at every level and becoming a more representative workforce.

https://www.birmingham.gov.uk/news/article/1186/everyone_s_battle_everyone_s_business_action_plan_approved_by_cabinet

vi. ACTION ✓: Invest in urban renewal and community greenspace programmes to reduce obesity, cardiovascular disease, and respiratory diseases by enabling improved health behaviours (e.g. physical activity), reduced exposure to poor air quality, and enhanced psychosocial wellbeing of residents in deprived neighbourhoods. This should also include working with key community spaces such as youth centres, leisure centres, faith-based sites, pubs, cafes, libraries, and other places where communities gather, to ensure they are engaging in healthy conversations, connected with public transport and protected using the Social Value Act.[90 136 249 250]

vii. ACTION ✓: Update planning policy to ensure that a public health strategy designed to address health inequalities is incorporated into the way home-building is permitted.[65]

viii. ACTION ✓: Tackle internet access inequalities that underpin social, economic, and health challenges:[196]

- Ensure digital inclusion is built into key council and partnership strategies.
- Map and advertise places with access to free Wi-Fi.
- Work with the community libraries, local businesses, and other public sector organisations to establish computer loans service with connectivity.
- Work with housing associations and registered social landlords to establish ways of providing access to Wi-Fi in communal areas.

d. Support the development of an **interconnected network of peer-led, pan-regional community groups** that enable shared learning and experience across the region within and between groups from different backgrounds and geographies:

i. ACTION ✓: Map assets and gaps in peer-led provision and enable delivery with seed funding and capacity building, especially for groups at particular risk of social isolation, loneliness, and poor health outcomes.[136]

ii. ACTION ✓: Provide easy-to-access pots of seed funding, as well as capacity-building support, to enable communities to develop their own solutions to issues that they identify as important.[136]

iii. ACTION ✓: Enable community groups and organisations to work across geographies and generations, particularly when working with small minority groups within communities, and explore the potential of digital connection (while being mindful of the digital divide and the need for extra support where digital infrastructure is poor or participants are unable to access broadband).[136]

iv. ACTION ✓: Work with these community networks to integrate learning into decision-making, planning, and process design.[189, 251]

e. **Deliver consistent service provision, communicate information, and advertise services** using new and existing methods, working alongside in situ organisations:

i. ACTION ✓: Create schemes, such as the Birmingham Neighbourhood Network Schemes (help older adults to lead healthy, happy and independent lives)[252], across large geographies to support uplift as well as enable a consistent method for citizens to be signposted to these schemes.[253]

ii. ACTION ✓: Raise awareness of and signpost to existing local organisations focused on smaller geographies e.g. HealthWatch.[254, 255]

iii. ACTION ✓: Develop new ways of working that maximise use of technology, enable more flexibility, improve working from home, and increase access, as well as reducing environmental impact. Focus is needed to ensure equal access to these opportunities and reduce digital exclusion.[38]

iv. ACTION ✓: Confirm that all partners are using established interventions and programmes for alcohol, smoking, and obesity/weight management to prevent ill health, and are advertising them accordingly, such as:[46]

- Established Alcohol Care Teams
- CLeaR improvement tool
- Routine carbon monoxide level testing, behavioural support referrals, and Very Brief Advice on smoking within the pregnancy referral pathways within maternity services
- Tier 2 Weight Management Services

CASE STUDY: Nottingham and Nottinghamshire – Local authorities working together to reduce COVID-19 vaccine hesitancy in communities

During COVID-19, there was vaccine hesitancy within communities from ethnic minority backgrounds in Nottingham and Nottinghamshire, and it was important to increase take-up. In response, Nottingham City Council's communications and marketing team brought together counterparts across the 8 other local authorities in Nottinghamshire and the Nottingham and Nottinghamshire Integrated Care Partnership to devise a campaign to best target this audience.

Research shows that in Nottinghamshire ethnic minority residents consume most of their media via digital channels. The council worked with the Council Advertising Network (CAN) to place targeted vaccine videos onto these channels, e.g. for those from low-income backgrounds, they placed a video of footballers encouraging vaccine take-up on Facebook, meanwhile to target the Caribbean community, they placed a video of a Jamaican GP on West Indies Cricket news.

The results showed that the numbers of those coming forward for vaccinations increased during the targeted advertising campaign. The statistics also showed that the number of views and interactions of campaign videos were above the industry average, e.g. videos of celebrities from ethnic minority backgrounds encouraging vaccine take-up targeted at African and Caribbean communities had 45 times more impressions / interactions than the industry average.

Focus Area 2: Social care – the future of preventative care and upstream interventions

> *“Prevention in social care is about encouraging people to be more proactive about their health and wellbeing. It can increase independence and reduce or delay the need for care and support services.” (Social Care Institute of Excellence, 2021)*[256]

With reforms and funding promised in the coming years, there is a need to focus upon the role of social care in long-term health plans and ensuring its seamless integration with all services – be that at home, in care homes, or other settings. This can be done by ensuring social care colleagues have the time, training, and safe working environment to think outside the box and deliver tailored services, information, and signposting.

Community Feedback:

a. Support social care teams to change perception by becoming a **forward-facing ill health prevention and support mechanism for communities**:
    i. ACTION ✓: Develop evidence to support the future role of health visitors and social care in delivering preventative health interventions and their ability to deliver this within already constrained budgets.
    ii. ACTION ✓: Address the perception that paid healthcare workers are the only recognised source of care and not families and friends who are providing duties on a day-to-day basis by expanding engagement activities, bringing unofficial carers into the social care space and making them feel included and supported.
    iii. ACTION ✓: Work with communities to help them achieve their collective and person aims, building on their strengths, for example supporting those with disabilities to utilise their abilities to build confidence and independence, as well as targeting interventions to meet their ambitions instead of focusing on their disability.
    iv. ACTION ✓: Work with communities to tackle negative perceptions of social workers, e.g. seen as people who will take their children away, rather than as people who will help. This may involve ensuring colleagues are supported by another professional worker who is educated/experienced about the community when engaging.

Policy Recommendations:

b. Enable the ambitions of **social care staff to grow and transition, to drive preventative health measures** while carrying out their duties; a practice that is currently restricted due to available time, staff, resources, and training:
    i. ACTION ✓: Map social care provision against disease prevalence to address the gap, particularly in rural and coastal areas.[132]
    ii. ACTION ✓: Provide the training required for social workers to help them better engage with specific groups, particularly those that feel marginalised (e.g. travelling families) and carers.[156][257]
    iii. ACTION ✓: Facilitate the combination of social work interventions with outreach to increase take-up by children from disadvantaged families.[37]
    iv. ACTION ✓: Utilise 2 local authority statutory duties to support those with ‘no recourse to public funds’: families with ‘children in need’ and adults with care needs.[258]

CASE STUDY: University of Birmingham – IMProving Adult Care Together (IMPACT)

IMPACT is a £15 million UK centre for implementing evidence in adult social care, led by the University of Birmingham. Funded by the Economic and Social Research Council (ESRC) and Health Foundation. IMPACT operates across the UK to gather evidence of what works and to get this used in practice, making a difference to services and to people’s lives. With a strong focus on tackling inequalities, IMPACT builds the lived experience of people who draw on care and support into everything it does – via its staff, leadership, governance, and even its definition of evidence (lived experience is a form of valid evidence in its own right). All IMPACT projects seek to provide practical support to frontline staff to make evidence-informed changes in the reality of local services. Examples of forthcoming projects include: how to recruit more men into care work, improving the wellbeing of care workers, helping people with learning disabilities leave long-stay hospitals, and tackling loneliness in rural areas.

https://impact.bham.ac.uk/

EXAMPLES: How to deliver these actions in practice

CASE STUDY: Walsall Council – Together We Can

2022 saw the launch of Walsall's 10-year multi-agency wellbeing strategy: "Together We Can". The strategy focuses on encouraging residents to improve or maintain their health and wellbeing, thereby reducing inequalities and maximising potential. With this in mind, Walsall Council secured £368,000 from the national Better Mental Health Fund, to support the delivery of a suite of innovative community-based services over a 1-year period. These services aimed to improve mental wellbeing of Walsall residents and tackle disparities.

A range of pilot projects were delivered exclusively by voluntary and community sector partners, 5 of which are:

- Thrive Mobile Wellbeing unit – a mobile unit with onboard navigators to provide health and wellbeing advice/signposting, linked with finance/debt support.
- No Wrong Door – a network of organisations coordinated by Rethink Mental Illness, who provide mental wellbeing support through a single point of access.
- New invention Friends Together – led by Frank F Harrison Community Association, supported people to get out of the house and try new activities such as crafts and gardening, supported by a nominated peer.
- MindKind Projects CIC – supported diverse communities, young people, and men to come together to talk about mental health with a practitioner and take part in nature-based activities e.g. gardening sessions, advice on growing plants at home, etc.
- Creative Factory Well-Being – worked with individuals and used the arts, walks, and social meet-ups to help them improve their wellbeing. Participants were buddied up with workers or volunteers who were recruited to provide support.

These projects had the following in common:

- All of the projects were co-designed with the people they are intended to impact upon and/or community and voluntary sector staff. This ensures they are directly relevant and suited to the needs of that particular community.
- The majority of the projects have provided opportunities for participants to volunteer and to support their peers or new participants to the group. This has been instrumental in increasing the confidence of the volunteers and those accessing peer support, thereby increasing the reach of the programme. In one instance, an attendee started as a participant, developed in confidence enough to volunteer, and then developed their skills and confidence further to become a paid member of staff on the project.
- All of the projects were evaluated to ensure they delivered services that are relevant and making a difference to that particular cohort.
- All of the projects are exploring ways to become sustainable through use of volunteers or additional funding where needed.

At an average cost of just over £60pp, the projects have benefitted over 1,400 individuals in just 8 months, including achieving £502k of debt reduction/income maximisation for 300 residents. The full portfolio of projects ensured good reach into some of the most deprived communities. 81% of participants came from the 30% most deprived neighbourhoods in the borough. Wellbeing measures (ONS Personal Wellbeing measure) were also used as part of the evaluation, for a sample of participant. For 184 participants, 93% had a positive change in their "before and after" wellbeing scores.

Walsall Council is ensuring that any learnings from these projects are guiding the approach moving forward, with a number of these projects now sustainable for the medium term. This highlights Walsall's partnership approach and determination to work as equals with local communities, to support their wellbeing and use their views to help to create a healthier borough.

For more information about the projects, please see the evaluation report at www.walsallintelligence.org.uk/wp-content/uploads/sites/6/2023/03/Walsall-BMFH-Final-Report.pdf

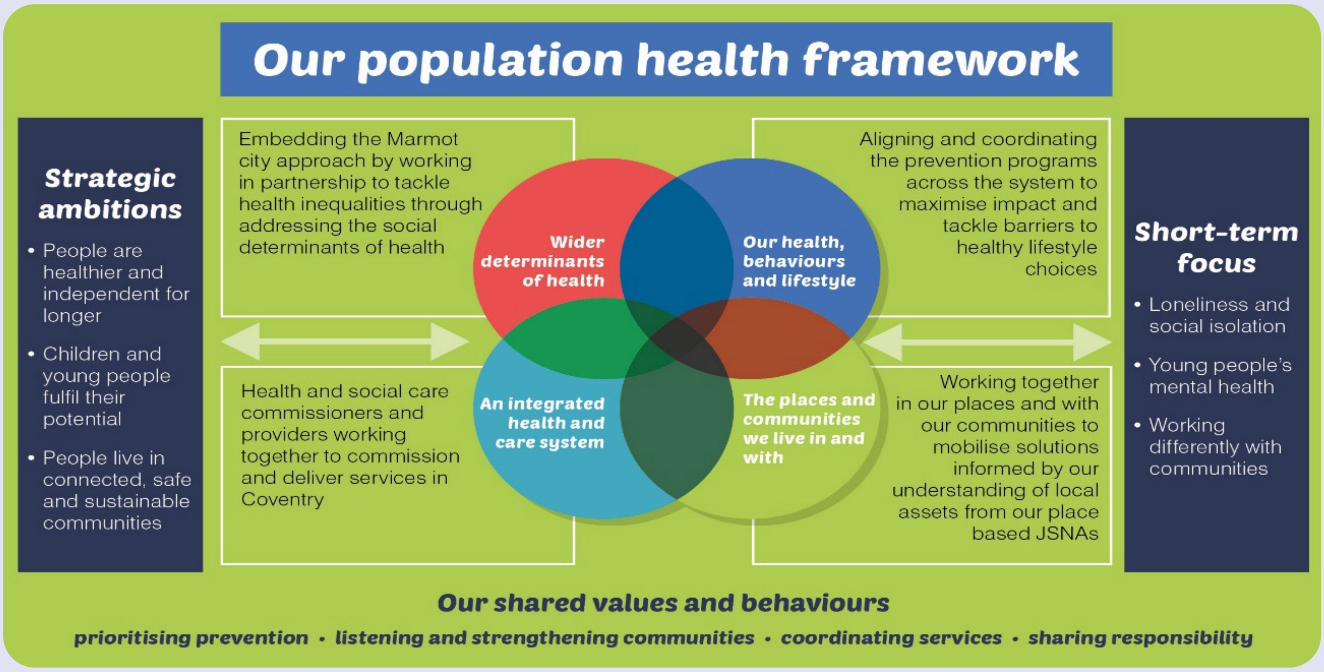
CASE STUDY: Coventry City Council – Coventry as a Marmot City

In 2013, organisations in Coventry committed to becoming a Marmot City, with an aim to reduce health inequalities. Being a Marmot City sets Coventry apart and makes clear the values that underpin our decision-making. The Marmot principles connect to every function of the council and has particularly influenced work in areas such as planning, transport, licensing, housing, procurement, education, and the early years. The Marmot work has also strongly influenced the council's adoption of the One Coventry approach, an approach which involves close working with partners and the public, sharing resources, and looking for opportunities to do things differently together. It has been said that "Partnership is now in our DNA as a city".

Becoming a Marmot City has provided a platform to bring together organisations across the public and voluntary sectors. A Marmot steering group, which was initially set up and has now evolved into the current 'Marmot Partnership,' drives forward actions across the city to address health inequalities. The Marmot Partnership reports directly to the Health and Wellbeing Board and is currently co-chaired by the Integrated Care Board Marmot Champion. Coventry's Marmot partners include Public Health, Education and Libraries, Employment and Skills, and Procurement from Coventry City Council, as well as West Midlands Fire Service, Office for Health Improvement and Disparities (OHID), Institute of Health Equity, Voluntary Action Coventry, West Midlands Police, Department of Work and Pensions, Working Together Welfare Reform Group, local voluntary sector partners, Coventry and Warwickshire Chamber of Commerce, Coventry Law Centre and Positive Youth Foundation.

Partners recognise the need to break the connection between poverty and poor health and that this is best achieved through working with communities who are often best placed to improve health. In the partnership's commitment to overcoming the lack of external resources, community assets have been utilised creatively to address local needs.

The importance of the Marmot principles and tackling the social determinants of health is shown in the population health management approach that Coventry have adopted, building on work from the King's Fund[259]. The Marmot Partnership takes the lead for addressing the social determinants of health as one of the four enablers of the population health management framework (Figure - The Kings Fund model of population health and Coventry Health and Wellbeing strategic ambitions):



Our population health framework

Strategic ambitions

- People are healthier and independent for longer
- Children and young people fulfil their potential
- People live in connected, safe and sustainable communities

Embedding the Marmot city approach by working in partnership to tackle health inequalities through addressing the social determinants of health

Aligning and coordinating the prevention programs across the system to maximise impact and tackle barriers to healthy lifestyle choices

Health and social care commissioners and providers working together to commission and deliver services in Coventry

Working together in our places and with our communities to mobilise solutions informed by our understanding of local assets from our place based JSNAs

Short-term focus

- Loneliness and social isolation
- Young people's mental health
- Working differently with communities

Our shared values and behaviours

prioritising prevention • listening and strengthening communities • coordinating services • sharing responsibility

Continued over...

One of the many examples of specific activities in Coventry aimed at tackling the social determinants of health using a Marmot approach is The Job Shop, which provides a service open to everyone living in Coventry. In working with customers, staff identify those who have lower and moderate levels of need and those who are more vulnerable, with higher levels of need. Services are then offered according to levels of need, with those who are assessed as being furthest from the job market being able to access a wide range of services suited to their needs. Since it opened in 2013, the Job Shop has supported over 12,500 people into employment. This has contributed to a fall in economic inactivity from 31.7% in 2013 to 25.2% in September 2022. This is despite continued increases in student numbers over this period, with Coventry having disproportionately high numbers of students compared to other areas. It has also played a key role in cutting youth unemployment from 5.6% in 2013 to 2.7% in 2020. Despite post-COVID pressures, the cost-of-living crisis and Brexit challenges, youth unemployment is still lower than 2013 at 4.6% in January 2023. This is below the national average and significantly below the West Midlands average of 6.3%.

The Marmot city approach in Coventry has been formally evaluated. It is likely too early to be sure of population-level outcomes, but there are encouraging signs. Healthy life expectancy is improving, and the city now ranks high compared with statistical neighbours on this measure. Fewer Coventry neighbourhoods are now amongst the 10% most deprived in England; 18.5% of the city's Lower layer Super Output Areas (LSOAs) were amongst the 10% most deprived in 2015 (rank: 46th) and this has improved to 14.4% in 2019 (rank: 64th). Across the West Midlands region, only Coventry and Staffordshire saw an improvement in the relative ranking at the local authority level.

In addition to the population-wide outcomes, there are many individual pilots and programmes that have contributed to a reduction in health inequalities. The Marmot City approach is likely to have made a significant contribution to securing benefits such as the UK City of Culture 2021.

After 10 years as a Marmot City, Coventry refreshed its Marmot plan for 2023 with a new range of indicators to monitor progress against health inequalities and to identify areas for focused action. Whilst they build back fairer following the pandemic and through the cost-of-living crisis, Coventry will continue to work with partners taking a Marmot approach to improving health inequalities and building on existing strengths and alignment of priorities across the public, private and voluntary sector.

www.instituteofhealthequity.org/resources-reports/coventry-marmot-city-evaluation-2020

CASE STUDY: Mablethorpe – Campus for Future Living

South and East Lincolnshire has a population ageing at twice the rate of the national average, bringing with it a unique set of health challenges. These challenges include 8 of the 9 local authorities ranked in the worst 15% for cardiovascular disease in the UK and 20.4% of the population having a limiting long-term illness or disability. The partnership is focusing on how to improve health outcomes for all communities, including the ageing population.

The Campus for Future Living is a £8.5million Town Deal-funded programme to be delivered by the Connected Coast Board, Health Education England, the National Centre for Rural Health and Care, the University of Lincoln, and Nottingham Trent University's Medical Technologies Innovation Facility. This project is creating a new centre of health and care excellence, which will pilot best practices in rural settings and enable the professional development of clinicians to support the provision of health and care in the local area. This coalition of local, regional, and national partners will also deliver an uplift in teaching, research, and innovation.

The campus will also provide a base for the development and testing of medical technologies, the opportunity for training and development of care entrepreneurs, and facilitate a self-employed 'Care Network' of carers.

"The Campus for Future Living is responding directly and proactively to all the reasons why we couldn't grow Mablethorpe economically, in terms of skills and health, education and opportunity in general" (Lydia Rusling, Assistant Director for Economic Growth, East Lindsey District Council)

"The campus will be a pioneering approach that will be nationally and internationally leading in the development and delivery of future healthcare to people in these communities. We are delighted to be a partner in this exciting opportunity and deliver new approaches to healthcare." (Professor John Hunt, Medical Technologies Innovation Facility)

https://townsfund.org.uk/our-town-stories-collection/mablethorpe-a-centre-for-health-innovation

ACTIONS FOR EDUCATION AND RESEARCH

This section aims to provide guidance for organisations across the sector (primary, secondary, further, and higher) on steps that can be taken to create education, research, innovation, and clinical activity that meets the responsibilities held as anchor institutions embedded in local communities, trusted with the development of the bright minds of the future.

While it might be easy to separate the education and research aspects currently delivered by our schools, colleges, and universities, if delivered correctly (and in collaboration), their role in these 2 areas is interlinked and inseparable.

This section (pages 64 to 76), therefore, covers actions that will support the:

- creation of a population that is knowledgeable, open, and aware of both their own health and that of others.
- delivery of the workforce of the future which provides appropriate, adaptable, and compassionate care.
- incorporation of the wealth of lived experienced and knowledge that exists outside of traditional routes.

Focus Area: Building a better future through inclusive learning environments

> *"As early as primary education White British children are 10% more likely to achieve the expected standard in reading, writing and maths and, at A-level, White British students are more than three times as likely to achieve high grades as Black Caribbean students. By the time they reach university, there is a 13% attainment gap between Black and White students." (A review by Baroness Doreen Lawrence, 2020)*[157]

The extent of the challenge presented to the education sector is not insignificant, nor the responsibility minor. Setting the framework for and delivering the baseline knowledge upon which our society is grounded, whilst simultaneously searching for new health and lifestyle improvements is no small task. It is also constantly evolving, with data showing a concerning decline in performance amongst White working-class pupils, linking to issues such as the availability of free school meals.[260]

It is the view of this Policy Commission that the only way to strike a balance between meeting the educational needs of the local population, inclusively delivering the national workforce of the future, and striving for representative international academic excellence is to work together regionally to pool resources and expertise. This activity has begun with university partnerships such as Midlands Innovation, Midlands Enterprise Universities and, locally, Civic Agreements, University Technical Colleges, and collaborations (such as Universities for Nottingham, Birmingham Health Partners, and the Life Sciences Talent and Skills Institute), but there is a great opportunity to expand to meet its full potential.

Community Feedback:

a. **Update healthcare and medical education, placements, and processes** to build the workforce of the future:

    i. ACTION ✓: Embed health inequalities in healthcare and medical education at an earlier stage to educate people about differences in symptoms, medical outcomes, cultures, and language.

    ii. ACTION ✓: Embed the empowerment of the future workforce with the necessary skills, confidence and awareness of support systems to progress confidently into the health and care service and medical academia within the frameworks and curriculums of the medical and life science schools. This should include a student-staff collaboration group dedicated to empowering students and ensuring equity of experience and education.

    iii. ACTION ✓: Institutions to streamline and signpost their reporting and escalation procedures and remind students of them annually. This should include signposting to the hospital's reporting concerns process and pastoral support during induction for every placement block. Work with student-led groups to ensure that institutional signposting to support services is effective for all students.

    iv. ACTION ✓: Deliver strong, cross-organisational, and continually reviewed processes, linked to an accountability structure which quickly addresses racism from other staff members while on placement.

    v. ACTION ✓: Build tailored resilience training into healthcare and medical education to give the future workforce the tools to deal with the pressures of the healthcare service. This should run alongside improved cultural competency and inclusion training (supplemented with face-to-face workshops) as part of the annual training regimen including, but not limited to, active bystander training.

  vi. ACTION ✓: Implement initiatives to support underrepresented students to pursue careers in academia including, but not limited to, mentoring schemes for those from diverse backgrounds and financial support for students from low socioeconomic backgrounds.
  vii. ACTION ✓: All institutions to employ a full-time staff member, with a protected budget, trusted with the responsibility of leading EDI initiatives across institutions e.g. Pro-Vice-Chancellor for Equality, Diversity and Inclusion, ideally supported by a member of staff with a specific focus upon medical schools.

b. Transform the research and education environment to **reflect community needs**:
  i. ACTION ✓: Build local communities into the research environment consistently through the research pipeline and reinforce appropriately so that they feel heard.
  ii. ACTION ✓: Look at recruitment practices for clinical trials including reimbursement methodologies and acceptance criteria.
  iii. ACTION ✓: Transform healthcare education (and supporting research) to reflect the need for a more holistic model of health than the current diagnosis-driven model. This should tackle the assumption that the role of healthcare is only to “fix people”, rather than embracing their differences and supporting appropriately. For example, developing an ethos within the future workforce that seeks to support the life goals of those with disabilities, rather than just treating/managing their condition.

Policy Recommendations:

c. **Ensure that education (particularly healthcare and medical education) is accessible and inclusive**. This will take steps towards addressing the attainment gap while providing the foundation skills for a lifelong awareness of the importance of good health, links with physical activity and diet, and the importance of self-care:[37]
  i. ACTION ✓: Deliver health interventions as early as possible, by delivering parent-focused, family-based activities in schools and community settings. Ensure that promoting health literacy is fully integrated into early years and school curriculums and reinforce with families by health and social care professionals. This has been found to be the most effective method to improve health and physical activity in preschool children.[181 261]
  ii. ACTION ✓: Combine lifelong skills training (e.g. general literacy, language, and numeracy skills training) with overall health awareness and empowerment strategies to increase self-efficacy and attitudes towards health.[181 262]
  iii. ACTION ✓: Deliver inclusive lessons and educational systems that not only teach about the challenges that anyone could fall into (e.g. financial), but also actions a curriculum for life and promotes inclusivity.[263]

CASE STUDY: University of Nottingham – Faculty of Medicine and Health Sciences inclusive curriculum toolkit

The FMHS inclusive curriculum task and finish group developed an inclusive curriculum toolkit following a yearlong project involving both staff and student contributors. The intention for this toolkit is for use by everyone, whether at the start of their inclusive curriculum efforts, or much further along it.

The toolkit is full of personal narratives brought to life through the multimedia-rich digital videos filmed across our various campuses. The toolkit includes a series of checklists that list EDI considerations at programme-, module- and session-delivery levels. The checklists provide reflective statements that help staff see curricula through the eyes of the student and encourage reflection on the extent to which the student experience of EDI is embedded throughout the educational process.

https://midlandsinnovation.org.uk/UoN-inclusive-curriculum-toolkit

CASE STUDY: Aston University Medical School – Inclusive education

Traditionally, medicine has been seen as an elite profession with multiple barriers to entry such as high grades, additional examinations, work experience requirements, and several years of funding. Aston University Medical School's vision is to break down those barriers and offer a socially inclusive medical school, aiming to offer 40% of UK/EU places each year to students who meet specified widening participation criteria. To support local students from the West Midlands, Aston University runs the Introduction to Healthcare (years 8, 9 & 10) and the Pathway to Healthcare programmes (years 12 & 13) to expand knowledge, develop skills, and give an insight into what university life is really like to those students with ambitions to study medicine.

CASE STUDY: The Autism Centre for Education and Research (ACER), University of Birmingham – Beyond the margins of marginalisation

As a result of schools being inadequately resourced and professionals not receiving appropriate training, it is evident that many autistic pupils are being let down by the English education system. Strikingly, ACER are increasingly hearing that when autistic adults reflect back on their time in school, they describe it as traumatic. ACER's earlier research[264] highlighted that a lack of reasonable adjustments made for autistic pupils in English schools was leading to poor outcomes in terms of employment, mental wellbeing, and physical health. Since publishing this report, the situation has worsened, and teaching staff are unable to manage with the squeeze on school budgets[265.] This is at a time when the number of autistic pupils in English schools has increased annually at 9.5%[265] since 2015/2016 (Department for Education).

Most autistic pupils and their families experience marginalisation. two recent ACER projects (with significant Midlands representation) have focused on those who are further marginalised because of two additional factors:

- Educational exclusion: Autistic pupils in English schools are not only more likely to be suspended and expelled than non-autistic pupils, but they are also more likely to be illegally excluded[266]. ACER found that 25% of parents reported that they had been asked to come collect their children or for them to stay at home because the school could not manage. Even as adults, autistic people continued to feel the stigma associated with being excluded, as well as their opportunities negatively impacted.
- Ethnicity, language, or financial status[265]: Asian Pakistani and Asian Indian families, as well as those with English as a second language, were less likely to receive an autism diagnosis. Families with autistic children were also more likely to be on Free School Meals than the general school population (28% versus 17%). Importantly, many parents ACER spoke to had lost jobs or found it impossible to work because they are frequently being called in to school.

The studies collected clear recommendations from all families with autistic children, but particularly from those who are marginalised, to: provide swift and equal access to diagnosis; offer pre-diagnostic low-intensity interventions; provide strategies to reduce school anxiety and increase attendance; offer short and accessible professional development materials; provide better workforce representation; have family liaison officers in most schools; provide greater employment protection for those parents with SEND children.

ACER have also developed AET Good Autism Practice Guidance, presenting 8 principles of good autism practice. These summarise the ethos, values, and practice that need to inform inclusive education for all children and young people whilst specifying the distinctive knowledge, teaching approaches, and methods that are needed in the education of autistic children and young people.

www.autismeducationtrust.org.uk/resources.

iv. ACTION ✓: Increase the number of post-school apprenticeships and support in-work training throughout the life course.[267]

v. ACTION ✓: Promote to, and accept students with, a broader range of backgrounds and experiences and support them to flourish and be retained within the academic sector.[181]

CASE STUDY: Birmingham Health Hacks

NHS Ladywood and Perry Barr Locality Partnership (LPBLP) and Birmingham City Council's Public Health Division have been working together to develop "Health Hacks" to introduce students in deprived areas to health-related professions (includes allied health, public health, and nursing).

A Health Hack involves the co-production of an approach with schools called "Best Start in Life" which aims to enable school-aged children – girls in the first instance – to discuss what factors can lead to better health outcomes in pregnancies. The first event focused on developing action to improve health behaviours, and identifying and discussing early detection of problems. Its objective was to empower young women to make healthy life choices that minimise their infant mortality risk factors.

Presentations from health professionals provided up-to-date information about infant mortality, and information on the current scale and likely future trends of genetic problems caused by social and cultural factors in Birmingham. The events have brought together a wide variety of partners and introduced students to a range of different professions.

CASE STUDY: University of Birmingham – Better than Well

Better Than Well, the university's Collegiate Recovery Program (CRP), provides university-led peer-to-peer support to students in abstinent recovery from any form of addiction (drugs, alcohol, or behavioural addictions). This is the UK's first university-led CRP and has been supported by a philanthropic donation by the CrEdo Foundation. It is estimated that approximately 4% of students are in recovery from addiction, but stigma and fear of institutional sanction mean that students rarely approach welfare services for help. The programme has exceeded all expectations, delivering daily 'drop-in' time in a dedicated space, 12-step and SMART recovery meetings, "celebration of recovery" meetings, recovery-focused accommodation, and meditation, mindfulness, and gym-based sessions. There are also monthly "sober social" events and a thriving WhatsApp community. This work is now achieving national prominence, with 2 features in The Times and has been highlighted by the Universities UK Task Force on Drugs as best practice.

www.birmingham.ac.uk/research/mental-health/better-than-well.aspx

vi. ACTION ✓: Ensure that all data collection, communication practices, and processes are inclusive and support involvement. This should be effectively communicated to staff and students, for example when the use of legal names is a requirement (enrolment and qualification certificates) and when it is not (graduation ceremonies, letters, and attendance lists).[268]

vii. ACTION ✓: Update medical and healthcare curriculums and other educational opportunities to create a socially/culturally aware, understanding, and resilient workforce:

- Continue to decolonialise the medical curriculum and to actively update it to include examples of how different conditions present and/or have differences in outcome measures across different ages, genders, and ethnic backgrounds e.g. BMI versus waist-to-height measures, age of heart disease onset for NHS Health Checks, depressive symptoms in childhood, and influence on lifetime physical health.[90]
- Include nutritional education in all healthcare education professionals, both childhood and cultural awareness.[269]
- Ensure that medical training includes information on the need for- and how to deliver- contraceptive and pre-pregnancy planning advice to women of reproductive age, which is aware of both cultural issues and medical problems, such as cancer.[230]

CASE STUDY: Birmingham Public Health – Student placement programme

Working with the 5 major universities in Birmingham, the Public Health division at the city council has provided over 100 placements each year to students. The student placements range from programme-specific placements (such as the Euniwell programme) to course-specific placements (such as the partnership with University College Birmingham undergraduate public health programme). There is also a rolling programme of project placements which cover a broad range of skills and have attracted students from diverse backgrounds including media studies, politics and economics, language courses, and medicine. The students have clearly defined projects with specific outputs so that they are able to describe at a job interview something that they were responsible for and delivered. Student-led work to date includes creating posters for the Commonwealth Games to raise awareness and understanding of health behaviours in Commonwealth countries of heritage and the implications for migrant populations in Birmingham, evaluating strategies for women's health in different European countries to inform Birmingham's developing gender health inequalities approach, and undertaking local food diary interviews and food affordability mapping that fed into the creation of the Food Revolution Strategy for Birmingham. To date, 2 of the students have gone on to successfully secure substantive roles within the team through open competitive recruitment, demonstrating the value of this type of approach to future workforce development.

www.birmingham.gov.uk/info/50120/public_health/2418/training_and_work_placements_with_public_health/3

viii. ACTION ✓: Sign up to the University Mental Health Charter framework, which provides evidence-informed principles to support the adoption of a whole-university approach to mental health and wellbeing.[270]

ix. ACTION ✓: Work with the General Medical Council (GMC), local NHS Trusts and Health Education England to support the development and implementation of a zero-tolerance policy on racism from patients (similar to the existing policy against tolerating violence) to combat apprehension about facing racism on placement.[271]

CASE STUDY: Midlands Racial Equality in Medicine – Tackling racial inequality within medicine

The Midlands Racial Equality in Medicine (MREM) network aims to build connections between regional medical schools to provide both staff and students with a platform to share upcoming initiatives, disseminate research, and create joint ventures. Through this platform, research related to improving racial equality and reducing the attainment gap will gain more visibility and raise the profile of the individual working groups and their members. Positive role modelling and visible commitment towards improving outcomes for ethnic minorities will inspire students and staff alike. Improving the experiences and overall graduate outcomes amongst ethnic minority medical students is the paramount objective of the network.

MREM has successfully delivered the £1000 Elevate Research Grant (supporting equality-related projects led by ethnic minority students), a Midlands Health and Care Inequalities Commission Taskforce, and dissemination activity, including 2 annual conferences, been featured in the Keele University "Racism in the NHS" documentary, and delivered presentations at the inVisible, Social Inclusion and Medical Schools UK EDI conferences.

https://midlandsinnovation.org.uk/Midlands-Racial-Equality-in-Medicine

TASKFORCE 3 SUMMARY: Welfare, education, and development of the future healthcare workforce

Tackling problems that occur as a result of a lack of knowledge, understanding, empathy, tools, and support mechanisms is an activity that should begin as early as possible. It is vital to build these into medical students' education and placement process opportunities, so that the future workforce is empowered to address poor behaviours/processes. However, to do so, the challenges that already exist in the system need to be addressed. This Taskforce looks to identify these issues.

Key Finding:

The General Medical Council (GMC) published the Midlands Charter (2020) regarding the effect of COVID-19 on inequality in medical practice. The charter "recognises the determination of providers to restore and reset education and training and to establish the Midlands region as a beacon for postgraduate education," focuses particularly on equality and diversity targets set by the GMC. Despite this, a number of areas of concern were raised across the groups engaged as part of this Taskforce.

- **Finding 1:** Students may not always be aware of how best to raise a concern or the support services available.
- **Finding 2:** Further work is needed to improve the curriculum and the teaching environment to ensure inclusive thinking is encouraged.
- **Finding 3:** The challenges presented by academic progression are not the same for all.
- **Finding 4:** Student and staff collaboration groups were valued by all as a key method of building working relationships and trust, and were seen as facilitating escalation of concerns.
- **Finding 5:** It is critical to implement effective training that explores how best to support students who may experience discrimination and bullying.
- **Finding 6:** Despite many institutions having staff who are passionate about tackling discrimination, staff reported having difficulties dedicating enough time to these activities.

Recommendations on how to tackle these issues have been built into this chapter and can also be found in the full Taskforce report in the Appendix.

d. Become a beacon for the future of research that represents and works on behalf of the stable and ethnically diverse population that is present in the region:

   i. ACTION ✓: Improve participation and ease of access in research and clinical trials to ensure findings are representative, accurate and applicable. This includes creating more inclusive communications, opportunities, processes, and reimbursement methods.[200 272 273]

   ii. ACTION ✓: Support funders to provide stronger guidance on participation in the research and clinical trials (such as the National Institute for Health and Care Research [NIHR] INCLUDE Ethnicity Framework), to actively fund inclusive studies and to consider challenges (for example reimbursement methods and recruitment times) when reviewing costs. This mirrors activity already being implemented by certain journals and charity organisations.[200 273]

   iii. ACTION ✓: Tailor research aims to local community needs and deliver studies in partnership with communities and groups that understand the unique character of a place and/or culture and the specific health challenges.[10]

   iv. ACTION ✓: Continue and further co-development and co-delivery of research programmes, including the upskilling and employment of community members, thereby creating new job opportunities as well as improved research outcomes.[7 65]

CASE STUDY: NIHR Nottingham Clinical Research Facility (CRF)

One of the largest clinical research facilities in the Midlands, the Nottingham CRF is based at Nottingham University Hospitals NHS Trust (NUH). With a catchment area of 4 million people, it comprises 16 adult and 4 children's inpatient beds alongside dedicated outpatient and specialist facilities.

The CRF operates 24/7 with dedicated clinical and medical staff skilled in the delivery of early phase and experimental medicine trials. The CRF also provides a purpose-built Mobile Research Unit, fully staffed and equipped to deliver research trials on the move with clinical, laboratory, and patient seating areas. The unit is fully accessible and can operate in conjunction with other sites/facilities or independently.

It is based at the Queen's Medical Centre with specialist research units in all 3 of NUH's hospitals, providing access to world-leading expertise in Magnetic Resonance Imaging, cancer, respiratory, gastrointestinal and liver, gene therapy, stem cell transplantation, neurology, and hearing loss.

www.nottinghamcrf.nihr.ac.uk

CASE STUDY: NIHR and the universities of Leicester, Nottingham and Birmingham – Midlands Liver Research Alliance

Inclusive growth requires health research to be conducted in geographical areas and with populations where health and social care needs are greatest. This also means working to improve prevention, diagnosis, treatment, delivery of services, and outcomes for people who face health and social care inequalities, including carers of people in receipt of services, and/or those working in the sector.

To achieve this, the recent NIHR liver research partnership funding has brought together national partnerships in order to bridge research gaps and address areas of need in liver research. Obesity-related or non-alcoholic fatty liver disease prevalence is disproportionally affected by ethnicity, socioeconomic status and geographical location.

The Midlands Liver Research Alliance builds on existing NIHR infrastructure, led by three Biomedical Research Centres (Leicester, Nottingham and Birmingham). Through expertise and knowledge sharing across the partners, supported by emerging and established research leaders, it is instituting a network of research centres of excellence and reaching out into communities with high prevalence and low research activity. Engagement work with the public will identify research priorities and obesity-related liver disease questions to inform high-quality research. The Midlands Liver Research Alliance is prioritising cultivating a sustainable public and stakeholder engagement network, providing culturally appropriate resources, and raising awareness in underserved communities.

CASE STUDY: Aston University, Birmingham Community Healthcare NHS Foundation Trust and Citizens UK – Understanding barriers to healthy and sustainable communities

This innovative partnership developed a collaborative project aimed to better understand health inequalities in some of the most deprived wards of East Birmingham by engaging local communities and students in co-designed conversations on local health challenges to better understand barriers to co-producing solutions.

Key findings: Barriers to accessing healthcare services were reported by community members, for example:

- GP-related concerns, largely related to the difficulties in getting GP appointments including lengthy waits before receiving an appointment.
- Language barriers and lack of suitable translation that is made available.
- Issues raised across wider NHS services/departments, quality of care and ‘poor’ mannerisms or behaviour of staff towards patients.
- Wider determinants affecting general health and wellbeing that highlight further inequalities.

A sandpit event was then run with community partners to discuss and generate their own project ideas to address health issues and co-create localised solutions.

Coventry Health Determinants Research Collaboration: Need for evidence to tackle health inequalities

Sue Frossell, Director of the Coventry Health Determinants Research Collaboration

Dmitri Nepogodiev, Public Health Registrar

"The COVID-19 pandemic has clearly amplified inequalities in health. Initiatives such as Core20Plus5 are highly welcome, but on their own they will have only a small impact on inequalities in health outcomes. Peoples' health is determined by a wide variety of factors, including where they were born and where they live, are educated, work and age. This means that many of the levers to address health inequalities lie outside the NHS, with local authorities strongly positioned to take a lead.

Coventry has been a Marmot City since 2013, led by a multi-agency partnership which includes the local authority, other public agencies, the voluntary sector, business, and the NHS. In the context of the ongoing austerity in local government since 2013, there was less – rather than more – resource to support programmes targeted at the wider determinants of health, and there was no research infrastructure or funding to support robust research programmes around the innovative work we were doing. Our evaluation of the Marmot City approach, published by University College London in 2020, did find our Marmot City approach was likely to have contributed to an improvement in Coventry's deprivation ranking, although it was difficult to be clear.

We continue to have ongoing and significant resource restrictions and believe that it is now even more important to have a robust evidence base for the effectiveness of any potential interventions, to ensure that the greatest possible impact is achieved with the resources available and to ensure that learning can be shared.

The NIHR has recognised this need for robust research to inform decision making by local authorities seeking to effectively address the wider determinants and health inequalities. The Health Determinants Research Collaboration (HDRC) programme was designed by the NIHR to invest in developing both research infrastructure and an evidence-based decision-making culture within local authorities. Each HDRC is a partnership between a local authority and one or more universities and other partners. A total of 10 such collaborations were funded in 2022, with plans for a further 20 HDRCs to be funded over the next few years.

Coventry has been selected as one of the initial HDRCs. They will use this opportunity to grow deep collaborations with our university and NHS partners (Coventry University, University of Warwick, University College London, and University Hospitals Coventry & Warwickshire), and will strengthen our engagement with the voluntary sector and residents. Our strategic objectives are to develop a high-quality research infrastructure within Coventry City Council that can be used to achieve research funding for delivering research; to promote culture change within the local authority so that evidence-based decision making is embedded in everything it does; to find new and effective ways of engaging the public in research; and to use this HDRC platform to support and learn from other local authorities across the West Midlands and nationally.

We want to help grow this NIHR investment in research into the wider determinants of health, helping us and others to determine the best approach to tackling a variety of issues in our society and to drive change towards a fairer and healthier society."

EXAMPLES: How to deliver these actions in practice

CASE STUDY: The Centre for Ethnic Health Research (CEHR) – Developing inspiring collaborative partnerships to reduce ethnic health inequalities

The Centre for Ethnic Health Research
national centre for tackling health inequalities

CEHR (hosted by the University of Leicester within the NIHR Applied Research Collaboration, East Midlands) has built a national reputation for leading applied health research to tackle health inequalities through meaningful engagement and collaboration with ethnic minority communities. The centre is located in one of the most ethnically diverse cities in the UK, making it ideally placed to conduct research on issues affecting the health and wellbeing of ethnic and migrant communities.

The centre aims to utilise research excellence and innovation, advanced community engagement, and equality principles to drive forward ethnic health research and to improve the health and wellbeing of diverse communities in a way that is globally applicable. This is achieved by delivering interdisciplinary work that is co-developed with partners and based on key societal requirements.

Since its establishment in 2016, CEHR has been working to raise awareness, identify the needs of different communities, disseminate health information, and implement key research findings that address health inequalities regionally, nationally, and internationally. This work has directly impacted the health outcomes of Leicester's ethnically diverse populations and the health inequalities they experience, as a result of CEHR's close partnerships with local authorities, community organisations, and faith groups. The deep understanding and trust that the centre has developed with local community has been utilised to address disparities in access, treatment, and provision.

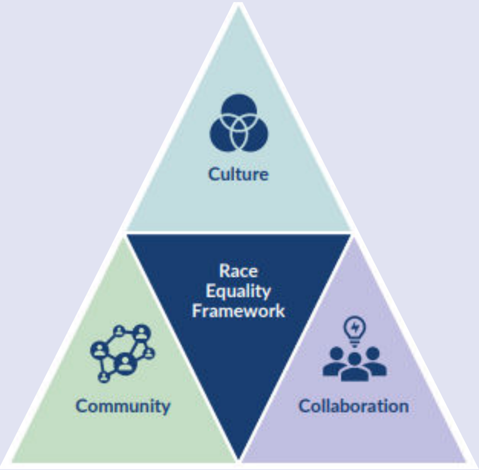
Patient, public involvement and engagement remains crucial to the centre's work. To help achieve this, CEHR trained a community partner panel of lay members to bring patient, public, and partner involvement and perspective to all activity. It also has a number of research community-based staff, who engage with seldom-heard communities and inspire community-led research.

CEHR designs and delivers resources and alternative methodologies that are informed and led by communities who are not often reached by some clinicians and researchers. The use of novel methods (such as visual arts, dramatic performance, yoga, dance, sport, and pictorial storytelling) has allowed the team to demonstrate that ethnic minority communities are not 'hard to reach'. Rather, the methods and approach used for engagement need to adapt to community needs and dynamics. Accordingly, CEHR have been guided by communities to provide culturally sensitive health education in places such as faith and community centres that hold a prominent place in the lives of people from diverse communities.

These methods and involvement with local populations allow the centre to promote culturally sensitive resources and raise awareness of community engagement and collaboration across research and healthcare delivery. This learning has informed the development of training curricula, which are delivered to clinicians, academics, and health service providers to encourage equality, community engagement, and culturally competent delivery of care.

https://ethnichealthresearch.org.uk/

CASE STUDY: Keele Impact Accelerator Unit – Piloting the NIHR Race Equality Framework for public involvement in research



The national Race Equality Public Action Group (REPAG) is supporting the NIHR to build understanding and competence in the area of race equity, with the aim of giving racialised communities a stronger voice in shaping priorities for research.

"The feedback from our consultation events reveals that people from Black African-, Asian- and Caribbean-heritage communities do not expect perfection but also do not want tokenism. What they want to see are organisations doing their best to eradicate racial inequality in a respectful, open and transparent manner." (Fay Scott, 2022)[274]

Keele's PPIE team, hosted by the Impact Accelerator Unit, became a pilot for the REPAG Framework for public involvement in research and audited their practice in race equality.

The pilot highlighted the areas which could be falling short of best practices, e.g. race competency, being comfortable with the uncomfortable, and system biases. A Race Equality Ambassador (Natalie Knight) was appointed to engage effectively with communities to build trust and confidence, and (in collaboration with the CRN West Midlands) to prepare the unit for the next steps. One key area for improvement was the recruitment of communities and members from African-, Asian- and Caribbean- heritage to the Keele Research Users Group.

Since completing the Framework pilot, community partnerships were prioritised as the focus of the unit's work in 2022-23, recognising community need for honesty and openness while tackling inequalities. This includes working with African-, Asian- and Caribbean-heritage people as equal partners and increasing the diversity of public involvement leads. Communities and their members are now reporting: "it has given me more confidence" and "these projects help further work and help to build trust, network and engage the community".

www.nihr.ac.uk/documents/nihr-race-equality-framework/30388

www.keele.ac.uk/iau/

CASE STUDY: University of Leicester – Stoneygate Centre for Empathic Healthcare

Funded by the Stoneygate Trust and based at the University of Leicester, the Stoneygate Centre for Empathic Healthcare's mission is to improve patients' lives by developing and delivering a robust new approach to medical education and training. It positions empathy at the heart of healthcare delivery, fostering health and care services that are fit for the future. These plans are bold, and the vision is transformative. The centre is driving forward real and meaningful change on a national and international scale through a programme of globally-recognised research, a revolutionary new medical curriculum, and professional development training across the wider healthcare sector.

Evidence shows that a more empathic approach to healthcare can nurture greater trust between patients and practitioners, calm anxiety, improve patient outcomes, and enhance practitioner wellbeing. This must also include the environment that practitioners work in, with empathy and compassion embedded right across the system.

The Centre team has produced several publications including:

- Turning diversity from a barrier to a facilitator of empathy in healthcare (BJGP)[275]
- A survey of clinical empathy training at UK medical schools (BMC MedEd)[276]
- Why might medical student empathy change throughout medical school? (BMC Med Ed)[277]
- Towards an empathic hidden curriculum in medical school: A roadmap (J Eval Clin Prac)[278]
- Just do it! Ten easy ways to enhance empathy in the consultation (BJGP)[279]
- The effect of empathy on patient satisfaction: A systematic review (Annals of Int Med)[280]

They are translating these findings into the Leicester Medical School curriculum by reversing the decline in medical student empathy, involving patients in pathophysiology teaching, and enhancing student wellbeing. The Centre is also delivering continuing professional training for healthcare professionals in the NHS and beyond.

https://le.ac.uk/empathy/about

CASE STUDY: University of Leicester – MedRACE

MedRACE (Raising Awareness Celebrating Excellence) is a student/staff group at Leicester Medical School. Since March 2020, it has been working to progress the British Medical Association Charter for medical schools to prevent and address racial harassment. MedRACE activities are broadly shaped by the charter commitments of:

- supporting individuals to speak out.
- ensuring robust processes for reporting and handling complaints.
- mainstreaming equality, diversity, and inclusion (EDI) across the learning environment.
- addressing racial harassment on work placements.

MedRACE also works in sub-groups on specific projects that raise awareness and celebrate excellence in equality, diversity, and inclusion, these include:

Active inclusion in surgery: Amardeep Sidki, Student, Leicester Medical School

"As a Sikh man; part of my religious identity includes wearing the kara, a metal bangle which represents one's unbreakable bond with God. When washing my hands on placement, the surgeon told me to take my kara off. He told me if I wanted to enter the operating room and to have a career in surgery that I would have to abide by this due to the infection control risk. I refused to do this and did not attend any more of his surgeries.

I researched the local NHS policy and found a discrepancy in the protection afforded to a wedding ring compared to a kara. One where, if it cannot be removed, can remain on if thoroughly cleaned, while the other must be removed or 'secured above the elbow'. This is a clear example of policy created without consulting those it affects, as it is impossible for the kara to reach the elbow.

I relayed my experience to the MedRACE team who formed a practical plan and supported me during my surgical rotation. We agreed to learn about the experiences of other Sikh students and healthcare staff in order to present evidence to policy makers. This was then shown to the Leadership Team at the University Hospital Leicester Trust who changed the policy to be more inclusive. I am confident that this work by MedRACE and the Trust means that future Sikhs will not face this barrier like I did. We hope to address the national discrepancy around wearing a kara in theatres, and to help highlight to other Trusts how creating an inclusive environment will benefit everyone."

https://le.ac.uk/cls/cls-equality/medrace/medrace-voices/amardeep-sidki-policy

Co-delivering active bystander training: Anna Brown, Student, Leicester Medical School

"An active bystander in this context notices something is wrong, names it (e.g. racism, sexism, ableism) and then does something about it. Each situation is unique and so there are many active responses, for example challenging the person at the time, asking questions or reporting are just a few.

I had been looking for a way to get involved with diversifying the teaching since the dermatology teaching in second year where I was shocked by the lack of representation of darker skin tones. So when I heard about MedRACE I jumped at the opportunity, and both received and, now, co-deliver Active Bystander training to small groups of Phase 1 students. We promote the confidence to speak up and use real situations from students, which for me acted as a wake up call to the fact these are these comments are not from history books but from today! Active bystander training is now something that we deliver to every year group at the start of the year."

https://le.ac.uk/cls/cls-equality/medrace/medrace-voices/anna-brown

Driving change towards a more inclusive curriculum: Kike Solanke, Graduate, Leicester Medical School

"Racial inequality in medical schools and the NHS is rife. And having been on the receiving end many a time, I jumped at the chance to be involved with a project that promised to try to tackle this head on. Looking at how jaundice is identified in black and brown babies and patients, I loved that the project facilitated tangible change and had outputs that I saw changing as the project unfolded. I was able to create a quiz that challenged students to think about how they would tackle different clinical scenarios on patients with different skin tones. I subsequently then had students asking me to create more questions as they felt ill equipped to answer so many of the previous ones but wanted to do better! It was a surreal experience, but it allowed me to raise awareness amongst my fellow students and ultimately I was able to help deliver active bystander training which was amazing."

https://le.ac.uk/cls/cls-equality/medrace/medrace-voices/kike-solanke

More blogs can be found on the MedRACE Voices page: https://le.ac.uk/cls/cls-equality/medrace/medrace-voices

https://le.ac.uk/cls/cls-equality/medrace

ACTIONS TO BE DELIVERED VIA JOINT WORKING

This section details activities that, if they are to be effective, must be performed collaboratively between different regional organisations and sectors, for example the health and care services, local governance, VCSE, education, research, and communities.

Over the following pages (77 to 93), actions are outlined that will allow the region to:

- create whole system approaches and standards for planning, processing, and delivery across all organisations that impact health and care.
- deliver better informed care that brings together and empowers communities.
- enable the development of a regional strategy that will allow regional organisations to collaborate in order to provide equitable, people-focused health, as well as addressing the wider determinants.

Focus Area 1: Approach, planning, and process

> *“Working in partnership is central to reducing health inequalities – one department acting alone cannot tackle an issue that does not respect organisational boundaries” (The King’s Fund, 2009)*[281]

> *“Interventions for tackling healthcare inequalities need to be informed by understanding of how they are created and perpetuated..... [This includes] careful analysis of data [that] can expose systematic inequalities that are having a significant impact on certain communities.” (NHS England, 2022)*[282]

In the first instance, systems need to ensure that processes and policies do not reinforce existing inequalities, create new ones, or block the impact of interventions created to tackle them. This requires whole system impact assessments and shared learning that crosses departments and, more often than not, organisations. Joined up and standardised delivery must, however, go further than simply “getting out of the way” – it presents an opportunity to be an active mechanism for advanced and forward-thinking health interventions. From recruiting and working within communities to creating the routes through which trusted, people-powered health is achieved, by collaborating around a common set of principles, Midlands anchor institutions can deliver significant impact through effective and intentional approaches.

Community Feedback:

a. Integrate and grow community strengths to ensure delivery, further local growth in terms of skills and jobs, and to improve trust and health outcomes in communities:
    i. ACTION ✓: Deliver a grassroots approach, with projects that are led by and embedded in the community. This includes embracing the flexibility and tailoring that VCSE can provide.
    ii. ACTION ✓: Senior management should meet people from different communities, faiths, and backgrounds to discuss and understand their concerns around health inequalities. This would address communities feeling excluded from important decision-making processes by the higher-level management.
    iii. ACTION ✓: Utilise faith and community centres and VCSE organisations as key links with the community to seek information.
    iv. ACTION ✓: Come together and agree to view each organisation as an anchor institution for their local area at the centre of a network of untapped expertise. Accept the roles and responsibilities that come with that on behalf of the local area and the Midlands region.

CASE STUDY: Birmingham City Council – Birmingham Poverty Truth Commission

Thrive Together were commissioned to establish a Birmingham Poverty Truth Commission (Brum Poverty Truth; BTPC#2) to strengthen the connection between the council, city partners, and citizens through learning from lived experience of poverty and incorporating it into policy and decision making. It is a citizen engagement approach to hold a mirror up to the council and its strategic partners on the impact of poverty on citizens' lives. It starts with listening to the people who really know what the sharp end of poverty looks like because they live it daily. The Birmingham Poverty Truth Commission work is overseen through the Creating a City Without Inequalities Forum, which is a sub-group of the Health and Wellbeing Board. In 2022, the Commission focused on housing, and this has directly shaped the Birmingham Housing Strategy in the pre-consultation and consultation phase.

www.birmingham.gov.uk/info/50266/other_public_health_projects/2410/birmingham_poverty_truth_commission

b. Empower people to take care of their own health (physical and mental) and seek healthcare, including preventative healthcare and lifestyle changes.

   i. ACTION ✓: Address the considerable number of challenges that need to be overcome for people-powered health to be effective:

      - Little self-care knowledge – particularly amongst the most disadvantaged, relating to issues such as cardiovascular disease, diabetes, dental care, and lifestyle illness.
      - Lack of awareness of care path – individuals are not sure of who to seek help from.
      - Lack of accessibility – in terms of integrated care pathway, healthcare workers can be overburdened when people do not know and rely on them too much as a source of information.
      - Stigma around mental health – these issues are common, yet they are not viewed the same across different cultures, genders, and age groups. In some communities there is only awareness of sane or insane people, with little awareness of depression or other common issues. This is connected to limited self-care and prevention activities, which were of particular interest to communities.

CASE STUDY: Birmingham City Council – "Healthy Faith Settings Toolkits"

Faith leaders are well placed to support improvements in health and wellbeing, and this was clearly demonstrated during the pandemic, where there was close partnership working between Public Health and faith leaders. Building on this, Birmingham City Council has produced a set of Healthy Faith Settings Toolkits for the 6 dominant faith communities in Birmingham. The toolkits are divided into a set of health outcomes for community wellbeing, highlighting any specific challenges for each community. Topics cover the life course and include issues such as healthy eating, preventing infections, and health screening. Each section contains a snapshot of local health and wellbeing needs, and local service and support information. At the end is a development opportunity checklist for organisations and groups to identify training and development requirements and help develop an action plan. Following their launch in 2022, embedding community partners have been commissioned to work with local faith settings to pilot them and collect practical case studies of implementation.

www.birmingham.gov.uk/info/50265/supporting_healthier_communities/2436/faith_and_religious_communities/4

c. Tackle the drivers of health inequalities by addressing social determinants and multiple disadvantage:

   i. ACTION ✓: Strengthen the bonds between different health, care, and research organisations, as well as private employees, both within a local area and across the region, to unpick the issues associated with deprivation, to enable joint action and sharing of learnings and good practice across the region and, critically, with all stakeholders. Deprivation is a key factor of concern (particularly given the current rates of inflation and the cost of living) when discussing health and social care as well as education (viewed as having a positive impact) and opportunities for employment. Economic inequality underlies health inequality, creating the need to work on both simultaneously and in partnership.

   ii. ACTION: ✓ Develop a mechanism from recognising poverty in health outcomes and patient information – this isn't a protected characteristic, but it is important for intersectionality including social characteristics such as intergenerational, overcrowded, or poor living conditions (e.g. with mould, damp, and sometimes pests).

d. Create an environment in the workplace that normalises conversations about health and wellbeing:
   i. ACTION ✓: Provide new employees with a list of reasonable adjustments, accommodations, or adaptations that can be made to make their working practices and environment supportive of their needs, whilst normalising this process.
   ii. ACTION ✓: Make details about working cultures easily available to ease transitions into new organisations and roles.

Policy Recommendations:

e. Building on the activity already delivered in response to the Social Value Act 2012, and linking to the suggested individual activity already identified, work in partnership across the health and social care to deliver joined up, community-centred, place-based, and local asset-driven approaches directly addressing inequalities:
   i. ACTION ✓: Extend social value commissioning to all contracts and encourage local businesses to do the same. Utilise existing local assets (including community groups, VCSEs, and businesses), rather than commissioning something new, which can often destabilise small providers of valuable local services. This can be furthered by promoting downstream social value-based activity, for example by investing in firms that employ from local underemployed groups, demonstrate strong commitment to addressing inequalities, or deliver inclusive provision, equality training, and accreditation though initiatives such as Pride in Care. Changes to processes should include developing a local supply chain, incorporating mandatory social value requirements within contracts, and looking at how to capture social value for in-house services and activity.[46, 136, 186, 283, 284, 285, 286]
   ii. ACTION ✓: Meaningfully co-develop services through the active involvement of local communities and VCSEs in programme development, delivery, and decision making – particularly those that have trusted relationships with LGBTQIA+ people, ethnic minorities, older people, and others who are at particular risk of health inequalities. The benefits include the potential to identify novel ways to adapt, deliver and promote services to meet local needs, utilising a flexible workforce with inbuilt place and culture awareness, and accessing a mechanism for reaching those who are most vulnerable and least likely to access services (particularly those at risk of isolation, such as older people and disabled people).[136, 185, 186, 190, 200, 286, 287]
   iii. ACTION ✓: Pool and share intelligence and engagement resources and analysis to become a regional health systems network.[38, 283]
   iv. ACTION ✓: Develop links between primary care, and activities and support in communities, for example utilising social prescribing services to bridge the gap between GPs and specialist support in the community.[136, 288]
   v. ACTION ✓: Build wider existing place-based community assets and strengths within activities identified above, utilising place-based planning tools. Community embedded projects, voiced by community members and delivered in partnership with assets (such as faith centres, youth clubs, schools, universities, mental health facilities, and green spaces), have been proven to be more effective than those delivered in isolation. [46, 127, 189, 262, 283, 289]

CASE STUDY: Aston University – Health services hub

Partners are developing a 21st century, technology-enabled health services hub on the Aston campus, involving a broad stakeholder alliance of local NHS partners, technology companies, and business partners. The hub will offer comprehensive health and wellbeing services for all Aston University students and the local community, with a particular focus on young adults and children. The hub will bring together new primary health services provision and existing optometry, audiology, medical imaging, and dentistry clinics, providing a 'front door' to community health services on campus and delivering personalised health solutions that support the students and the local community towards healthy living. It will operate as a triage service in some areas to relieve pressure on the NHS workforce and reduce patient waiting times, whilst providing healthcare students with essential clinical experience.

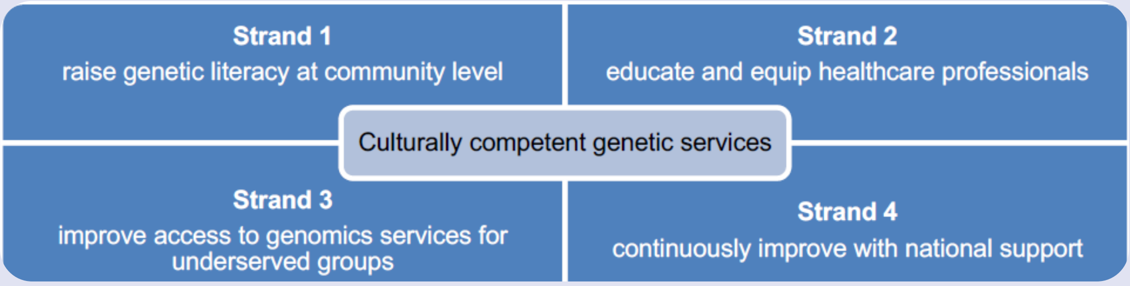
www.linkedin.com/pulse/how-can-universities-help-shape-healthcare-future-subic/

f. Implement more mechanisms to promote and harness prevention, population-tailored, people-powered health:
   i. ACTION ✓: Take the opportunities presented through the ICS structures to collaboratively develop a system-wide, continuous approach to upstream interventions (mitigation of the onset and development of preventable illnesses and chronic conditions), public health messaging, and health and social care provision that balances the need to tackle social determinants and multiple disadvantage, whilst addressing conditions causing the greatest burden within our population. These activities can not only create positive benefit for the patient but also generate net savings for the health system.[290, 291]

ii. ACTION ✓: In line with the NHS Long Term Plan, provide and promote easily accessible opportunities for the public to have more control and choice over their own health (and health budget), where and when they need it. This needs to be delivered and supported in partnership with services outside of the health sector, for example social prescribing link workers, social care activity, champions/peer support, healthy eating initiatives, social resources, social networks, self-management education, and population-tailored care/support planning. [38,46,286,292]

CASE STUDY: Local Maternity Neonatal System (LMNS) – Culturally competent approach to genetic services

LMNS for Birmingham and Solihull has established a working group which will be developing a culturally competent genetics service for the system. The first national genetics strategy for England has been developed and the LMNS will be aiming to improve access to high-quality genetics services for underserved groups. It will give families opportunity to make informed reproductive decisions, whilst respecting their culture, values, and beliefs. The NHS England strategy was co-produced with parents, clinicians, and academics. The strategy is informed by research evidence and national consensus on how this unmet health need should be addressed (Salway et al., 2019). It has 4 strands, illustrated below and which the service will be developed on:



The LMNS are committed to rollout a culturally competent genetics service for consanguineous couples in Birmingham North and East and Birmingham Central and West Birmingham.

g. Work with private employers across the region to build awareness of the costs of ill health and inequalities to them and to their workforce, support them to increase the health and knowledge of their employees and to achieve their potential health impacts, as outlined by NHS England[293]:

   i. ACTION ✓: Extend engagement and planning activities by working with local employers to improve their organisational health literacy – defined as “the degree to which an organisation implements policies, practices, and systems that make it easier for people to navigate, understand, and use information and services to take care of their health.”[294,295]

   ii. ACTION ✓: Engage with and educate major employers in the region on evidence-based interventions that can help keep their workforce healthy and productive, including digital skills initiatives. This also involves promoting the importance of their role in supporting a healthy population as well as tackling wider socioeconomic disparities.[10,196]

   iii. ACTION ✓: Build on the current Health Adjustment Passport and recommendations made in the Government Health and Disability White Paper to support more regional companies to work with occupational health teams and to implement processes to develop and implement reasonable adjustment measures for new and current employees. This should include raising awareness with both employers and communities of the Department for Work and Pensions' Access to Work funding and the ability to develop a bespoke workplace support plan.[296,297,298,299]

CASE STUDY: Project Limitless – Neurodiversity in the workplace

Many organisations are starting to realise that they could be missing out on talented employees because of the traditional methods of recruitment they still follow. They are spending lots of money on new recruitment because they don't know how to hold on to productive but unhappy or unsupported staff. Project Limitless seeks to help organisations understand how to leverage talent and understand what life is like for a neurodivergent individual through a series of exercises including a virtual reality experience. Businesses receive a workplace review in terms of helping the business to offer accommodations and adaptations, as well as reasonable adjustments to all staff regardless of neurotype. Most people usually move jobs because they do not feel valued, listened to or respected. The recruitment process from job advert, application process, interview, and onboarding often needs to be upgraded to be more inclusive. Communication training includes giving and receiving useful feedback, handling difficult conversations, and managing conflict. It also covers how to give and receive clear instructions, how to use the induction period to set staff up for success, and ask individuals how they like to be rewarded and recognised.

www.get-your-message-across.com

CASE STUDY: Centre for Health and Development (CHAD) – Joint working to tackle health inequalities in Stoke-on-Trent and Staffordshire

CHAD was established as an innovative partnership between Stoke-on-Trent City Council, Staffordshire County Council and Staffordshire University in 2015, and was subsequently adopted as a mainstream university research centre. Its purpose is to undertake translational, applied research to improve the health and wellbeing of the local population and contribute to the reduction of social and health inequalities. By bringing together local government, academia, and local communities, CHAD has been endorsed by Sir Michael Marmot as being 'exactly what is needed' to tackle heath inequalities and address the social determinants of health. In a time of diminishing public sector resources and evidence of increasing health inequalities, the two local authorities recognised the need to be able to evidence effectiveness of public health interventions locally, whilst developing the evidence base of not only what works, but also how interventions work to improve health and wellbeing and reduce health inequalities. CHAD has 3 thematic areas: Healthy Communities and Place, Health across the Life Course, and Health Inclusion. Example projects include:

- Evaluation of VOICES – part of the national Fulfilling Lives programme to improve support for people experiencing multiple disadvantage in Stoke-on-Trent. www.voicesofstoke.org.uk
- Evaluation of Changing Futures Stoke-on-Trent – part of the national Changing Futures programme for systems change to improve support for people experiencing multiple disadvantage in Stoke-on-Trent (ongoing https://expertcitizens.org.uk/changing-futures)
- COVID-19 and homelessness
- Feasibility study of digital NHS Health Check
- Evaluation of the online Heart Age Test (HAT) for self-assessment of cardiovascular disease risk.

Reports from completed work can be found here: www.chadresearch.co.uk/reports. CHAD also co-host a webinar series with the Faculty of Public Health around health inequalities (www.chadresearch.co.uk/past-events).

Focus Area 2: Communication, understanding, and access to information

> *"Over the past 20 years a wealth of studies has shown the positive effects of interventions to improve communication between clinicians and patients. Studies from around the world demonstrate that effective patient/clinician communication can improve patient experiences and health outcomes." (NHS England, 2021)*[300]

> *"It has never been more important for councils to communicate effectively with residents, media, partners and employees. Whether it's to encourage greater self-service or to promote understanding of local priorities, effective communication has the power to engage communities, challenge misconception and help your council achieve its objectives." (Local Government Association, 2023)*[301]

Trust and visibility of services and their providers were primary concerns for communities during the pandemic. When combined with a wealth of misinformation and limited health literacy, this had the potential to undermine many of the public health campaigns (particularly vaccination programmes). It was only by closing the distance between the services delivered and community members that this risk was overcome, often through advanced engagement programmes that involved community representatives, such as the COVID-19 Champions networks. Bringing together this activity in a coordinated way across health and social care, in partnership with the education and VCSE sectors, will reduce confusion, increase awareness, and increase trust both within communities and the workforce.

Community Feedback:

a. Deliver joint and consistent communication, promoting community, health, and care assets so that people can understand what is available where:
    i. ACTION: Support both the region's communities and health and care staff by being consistent, joined-up, and proactive in communicating what people can realistically expect from their local services. Much of the confusion and frustration comes from a lack of awareness of the constraints impacting a service at a particular time. By communicating what is available locally (through effective and up-to-date signposting or perhaps even via a postcode-filtered platform), patients will be empowered to access the correct services, with managed expectations, without "going from pillar to post".
    ii. ACTION: Actively signpost community assets such as health champions, peer support groups, and voluntary activity, as well as how the public can get involved.
    iii. ACTION: Encourage the showcasing of health and care in a positive light (where appropriate). The media spends a lot of time highlighting issues, but rarely are communities exposed to the good work that takes place.
    iv. ACTION: Work together to address language gaps in public health messaging that can lead to misinformation and inequalities. Information about conditions, symptoms, prevention, or what to do when in need are either very general or broadcast only to a specific local community (costly). By working together to share communication pipelines for tailored messaging, these costs can be reduced, and the efficiency improved.

Policy Recommendations:

b. Increase access to public health information and services:
    i. ACTION: Make all health information and health systems as easy as possible to understand (including making it available in multiple languages and formats, including BSL, easy read, and audible formats) and navigate using the universal precautions approach, consistently linking across institutions to key resources. This should include utilising social media to help reach those less often engaged and designing communications to overcome literacy and education gaps.[200][302]
    ii. ACTION: Build a regional pool of trained community workers, while also training more community health champions/peer advocates to relay health messages – the most effective method for sharing health information to those from disadvantaged socioeconomic backgrounds, different cultures, and those less likely to seek health information, particularly formally.[181][184][303]
    iii. ACTION: Provide clear information on the benefits of a healthy lifestyle, delivered in conjunction with preventative medical interventions to reinforce the implications of health choices. Examples include:
        » Enhancing understanding of, and appreciation for, the many benefits of regular physical activity, according to ability and at all ages. [250]
        » Support further understanding of intersectionality and MLTC.[136]

CASE STUDY: The Centre for Ethnic Health Research (CEHR) – Using art to increase awareness of living kidney donation in people from ethnic minorities

CEHR is running a project to develop an innovative, virtual art exhibition to increase awareness about living kidney donation amongst ethnic minority groups. Funded by the NHS Blood and Transplant Community Investment Scheme, the project will primarily target South Asian, African and African Caribbean communities. These groups have higher rates of kidney disease, and people from these groups wait on average 6-12 months longer for a kidney transplant, in which time they may need life-saving dialysis treatment.

CEHR's community engagement officers reached out to community members who have been impacted by kidney disease, listened to their experiences, and asked to submit them (as pieces of art or stories) into a virtual art exhibit. Some of these powerful stories were then transformed into a piece of animation art by an artist who had further conversations with the contributors.

The aim is to spark conversations about the wider issue of kidney disease, raise awareness of the benefits of living kidney donation, and to inspire people to donate a kidney to someone who needs it.

Visit the virtual art exhibition: https://artspaces.kunstmatrix.com/en/exhibition/10472516/increasing-awareness-of-living-kidney-donation-in-people-from-ethnic-minorities

Once visited, please leave feedback here: https://forms.office.com/e/vLZki2C4Tm

c. Improve **health literacy** to ensure strong foundations of understanding within and across communities, to create motivations to live healthier lives and to strengthen communications with health and care professionals:

> *"The term 'health literacy' refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services." (PHE, 2015)*[181] *"The inverse information law [states that] those with the lowest levels of health literacy have the least access to health information." (Rowlands, 2013)*[342]

i. ACTION ✓: Create community-based, peer-support approaches to health literacy that help to distribute health literacy among social networks.[126, 183]

ii. ACTION ✓: Empower professionals through training, continued education, and interdisciplinary initiatives to improve health literacy and strengthen public–professional communications.[181, 295]

iii. ACTION ✓: Support health professionals to involve family members or other caregivers in health decisions, and in general and health literacy initiatives.[181]

iv. ACTION ✓: Deliver specific actions to enable improved health literacy for:[136, 181, 305]

  - disadvantaged socioeconomic groups: Make education (including lifelong learning) and communication styles more accessible (including community champions)
  - migrant and ethnic minority groups: Ensure inclusive development, initiatives, and messaging
  - older people: Deliver clear and consistent support that includes peer groups/advocates
  - disabled people: Use clear and repeated messaging in targeting strategies and technologies that make audible and visual forms of communication easily accessible.

Say My Name

Dr Jane Bryan, Reader in Law, University of Warwick

Calling someone by their name recognises their individuality and encourages a sense of visibility, inclusion, and belonging. Yet whilst names can connect us, they can also exclude some who are, through routine name avoidance, misspelling, and mispronunciation, sent the message that they are 'different'. This can be a problem particularly for those with non-Eurocentric names, where name misuse often forms part of a wider pattern of microaggression and harassment.

At the University of Warwick, we conducted research with over 840 people into the importance of names and the negative impacts of routine name misuse. We found that over half of survey respondents worked or studied alongside someone they could not confidently call by name and that many people live with names that they do not recognise as their own, either because they feel compelled to adapt their name to ease communication, or because their name is routinely mispronounced or misspelled.

If we are to take seriously our ambitions to build respectful, inclusive communities, it is important that we recognise practices around names that disempower and alienate, and identify measures to reduce this, as the first step to bringing about change. Small shifts in practice can have a large impact upon the lived experience of name-users and name-bearers and can create a culture where names, and name-bearers, are respected.

Recommendations for institutions:

1. **Ensuring data systems collect accurate names:** Name fields should provide sufficient character limits for names to be recorded in full; non-standard naming patterns (e.g. the Spanish tradition of having two last names), diacritics and non-Latin script should be accommodated where possible; legal names should be used only where necessary and procedures for changing and correcting names in systems should be straightforward and well signposted.
2. **Creating a culture where names matter:** Provide guidance and training to raise awareness of the importance of respectful name use and the negative impacts of name avoidance, misspelling, and mispronunciation. Intentional name misuse should be recognised as unacceptable behaviour. This should include normalising the use of pronunciation guides and audio name badges in profiles and email signatures by all, to signal the importance of getting names right and to provide tools for private practice.
3. **Ensuring chosen names are used where possible:** This can be particularly important for trans people. Provide transparent guidance to name-bearers about how/what names are used in systems; ensure procedures for changing names and pronouns in systems are straightforward and well signposted and use name-bearers' chosen names unless required by law to use a legal name.

Recommendations for individuals: Respecting names STARTS with us:

- **Say** someone's name to build connection and show respect for others.
- **Try** to get names and pronouns right: they are a key part of someone's identity.
- **Ask** if you are unsure how to say a name – in private and advance, if possible, or use Google.
- **Respect** names: never shorten or change without invitation; never joke or comment about them.
- **Tech** help. Use audio name badges and phonetic guides in email signatures and profiles.
- **Spelling** and pronouns: details matter. Check twice.

1. **Respect names:** They are key parts of someone's identity, often chosen with care and laden with meaning. Never joke or comment about them or shorten or change without invitation. Caring about getting names right is particularly important for those in leadership positions as they are harder to correct and more likely to be imitated.
2. **Make names matter**: Greet everyone by name, use names in interactions, and care about correct pronunciation and spelling. Encourage everyone to check and correct pronunciation, and to use the names they genuinely prefer.
3. **Familiarity is key:** Create spaces for name-bearers to say their own names. Look online for guidance on how to say names that are unfamiliar – confirming with the name bearer this is how they say their name.
4. **Use technology:** Normalise the use of audio name badges and pronunciation guides in profiles and email signatures to signal the importance of getting names right and to provide tools for private practice.

Focus Area 3: Data and Connectivity

> *“Poorer households are being left behind in the “broadband slow lane” despite relying more heavily on the internet at a time of rising prices, risking their future job prospects.” (Local Government Association, 2023)*[306]

> *“Despite progress on broadband and mobile rollout in recent years, rural areas remain more likely to face difficulties accessing a decent internet connection.” (House of Lords Communications and Digital Committee, 2023)*[307]

> *“Local councils are responsible for the management of public infrastructure and services. But they are also in charge of reliably and securely collecting information on citizens’ needs that they can use to create better policies.” (Intelligent Delivery Solutions, 2022)*[308]

> *“Data from patient health and adult social care records helps us to improve individual care, speed up diagnosis, plan local services, research new treatments, and ultimately, save lives. Ensuring that staff and patients have access to the right data, at the right time, is vital to the NHS providing effective, safe, good value services.” (NHS England, 2023)*[309]

With ever increasing reliance on data and fast, stable internet connections – be that for business, education, research, socialising, or access to reliable information sources – it is vital that inequalities be addressed. This begins with the necessary infrastructure to provide connectivity, it encompasses accurate and representative data collection and analysis, and it ends with the skills and ability of the region’s citizens to get online. This is a complex and potentially expensive process and must be delivered collaboratively if equality of opportunity is to be achieved.

Community Feedback:

a. a) Update the **language and terminology** used during data collection techniques such as forms, questionnaires, and registration pages (the traditional framework is too rigid):

   i. ACTION ✓: Work together to develop standards to address concerns regarding inclusivity. This includes updating the wording used for ethnicity grouping (e.g. ‘White Other’ and ‘Asian’ are considered too general, while colour associated ethnicity marginalises those who may be under-reporting and under-recorded). This activity should be supported by tools and examples of how to have conversations around this.

   ii. ACTION ✓: Broaden language options to create increased accessibility of data collection techniques, including accommodating non-English speakers, compliance for text-reader software and braille.

   iii. ACTION ✓: Ensure that intersectionality and multiple long-term conditions can be recorded.

   iv. ACTION ✓: Challenge the use of the label ‘hard to reach’ for certain groups and communities. Instead look at whether their needs are being met and, if not, how they might be accommodated. Cross intersectionality of people who may have several layers of characteristics.

b. Increase available data across health and social care organisations through data sharing initiatives:

   i. ACTION ✓: Link increased data accuracy with data sharing initiatives across different organisations to address, for example, the lack of information about Gypsy, Roma and Traveller communities.

Policy Recommendations:

c. Develop a **comprehensive, inclusive, and accessible health and care dataset** across the Midlands that includes wider determinants and other background details to support effect delivery of support:

   i. ACTION ✓: Improve joint working between local authorities, NHS Trusts, and academic institutions via larger and more collaborative data sharing arrangements.[132]

   ii. ACTION ✓: Work with and across the Midlands ICSs, NHS Trusts and local authorities (with support of organisations like OHID and Midlands Innovation Health) and to create and maintain a health equity dashboard at both local and system-level using agreed metrics (including wider determinants such as digital exclusion). This activity should also contain a drive for data uplift for example by ensuring the availability of detailed datasets by reviewing the accessibility, access and applicability of data on health and wellbeing outcomes and their determinants at lower geographical levels.[7 124 132]

   iii. ACTION ✓: Collaborate to provide resource and expertise to local anchor institutions (such as Voluntary Community and Social Enterprise organisations and housing associations) embedded in their communities, to enable them to capture high-quality quantitative and qualitative data about their members/service users and their needs. They can also provide additional support roles for example digital champions. This will also help to build trust around confidentiality and the use of data, as well as continually checking progress of interventions and policies.[38, 124, 136, 196]

   iv. ACTION ✓: Encourage key national stakeholders (such as NHS England) to issue guidance and standardised protocols to NHS providers, GPs, social care workers, and VSCEs when collecting ethnicity data.[124, 200]

   v. ACTION ✓: Move towards the systematic collection of ethnicity data linked to patient health records (including GP records, hospital records and NHS Digital's central records, built into a Trusted Research Environment.[200]

d. Continue to upgrade **digital infrastructure** to support current and future digital needs in a way that is inclusive and accounts for different socioeconomic factors:

   i. ACTION ✓: Further partnerships between local authorities, community libraries, local businesses, care homes, youth/day centres, universities, and other public sector organisations to ensure access to computers with connectivity across the region. This activity should be supported by a mobile data and connectivity mapping exercise to highlight areas across the Midlands where digital exclusion is most likely to occur and new intervention could have the highest impact.[136, 310]

   ii. ACTION ✓: Use digital technologies and innovations to accelerate local growth of key strategic programmes and also impactful initiatives into geographically remote areas that might not otherwise benefit. To that end, local strategic and economic planning should include digital as a key priority.[136, 310]

CASE STUDY: WM5G – Remote monitoring – Health and social care

Due to the severe pressure in the health and care system, Midlands NHS and local authority partners are working to implement creative and innovative digital solutions to allow the population to access safe and efficient alternatives to NHS bedded care, enabled by technology. This includes solutions such as virtual wards, remote consultations, remote diagnostics, and assisted living solutions.

Born from a 3-year Department for Culture, Media and Sport-funded programme, WM5G is a new digital acceleration company (formed by the West Midlands Combined Authority) supporting the roll out of 5G across the region and helping organisations become future fit through digital and connectivity solutions, “Internet of Things”, and artificial intelligence. This has involved working in partnership with public and private sector organisations to support and deliver projects such as:

- carrying out a focused strategic virtual ward review for South Warwickshire NHS Foundation Trust to understand the current state of service delivery and what will be needed to accelerate their programme at scale and pace.
- collaborating with University Hospitals Birmingham NHS Trust (UHB) and technology partner BT to showcase how 5G can transform paramedic services in a “Connected Ambulance”. This was particularly effective utilising the greater speed, low latency (or lag), capability and bandwidths of the commercial 5G network to enable real-time off-site ultrasound assessment.
- partnering with telemedicine company, Tekihealth, to explore how 5G can support the provision of GP care in care homes via the use of connected diagnostics tools. Thanks to 5G capability, the care solution can move beyond standard video consultations, allowing the GP to assess and record clinical information in real-time via the device to a degree as accurate as an in-person check-up.
- joining forces with leading healthcare organisations, NHS Arden and GEM CSU, University Hospitals Coventry and Warwickshire, and Corporate Health International to deliver a colon capsule endoscopy at home under medical guidance. Supported through a private 5G network, patients could access a virtual assistant, as well as connectivity to remote care professionals to guide and answer questions throughout the procedure.

Organisations across the Midlands (and nationally) are at different stages of this journey, with some being more advanced in their implementations and others just embarking on theirs. It is important to recognise that there are steps that can be taken at all points along this journey to create effective digital solutions that supplement and advance existing patient pathways without creating further inequalities and exclusion.

Through the combined efforts of local stakeholders, there has already been fantastic progress, with the West Midlands and Birmingham being ranked highest in a 5G mobile coverage study by an independent telecoms advisory company.

www.wm5g.org.uk/wp-content/uploads/2023/03/Remote-Monitoring-Case-Study.pdf

CASE STUDY: Worcestershire County Council – West Mercia 5G project

WEST MERCIA RURAL 5G PROJECT

The West Mercia Rural 5G (WMR5G) commenced in April 2020, after being funded as one of 7 'Rural Connected Communities' 5G R&D projects within the then Department for Digital, Culture, Media, and Sport's 5G Testbeds and Trials programme. This programme has since closed and learnings transferred into the Digital Infrastructure and Connectivity Team of Worcestershire County Council, however, it remains a prime example of what can be achieved in this space.

Led by Worcestershire County Council, key organisations on the network side are Airband, BT and nexGworx, who planned, built, and operated the 5G network. WMR5G set out to explore infrastructure challenges when planning, building, and operating a 5G network in a rural setting and how 5G can enhance services for the benefit of residents; particularly researching 5G-enabled health and social care applications.

It was recognised during the programme (and it remains the case) that rural communities require the same, if not greater levels of connectivity as their urban counterparts, yet this is often sadly lacking. Rural areas, largely due to their low population density, often fall towards the end of, or do not fall within, the commercial mobile deployments of the mobile network operators. At the same time, providers of public services in rural areas are facing increasing demands from an ageing population, at a time when their funding has been under increasing pressure. Maintaining current approaches to service delivery is not sustainable and alternative models are required. Smart connected technology solutions are often seen as an alternative way to deliver these services, to enable efficiencies to deal with increased demand and focus resources on those with highest need. However, for health and social care services to be delivered in this way, a more reliable and more widely available level of connectivity is required.

The WMR5G project highlighted the huge ambitions of the innovative public and private sector partners in the region, striving to find ways to improve connectivity and provide access to key services in rural areas. In addition, faced with increasing demands for critical care services, organisations responsible for health and social care were (and continue to be) looking to new models for clinical delivery utilising cutting edge technology, which require the enhanced connectivity that 5G brings. WMR5G developed 2 use cases to test whether 5G enabled technology could improve health and social care delivery:

- Connected Worker: Giving GPs and community nurses access to support workers in care homes equipped with wearable connected cameras and examining how effective the increased connectivity is in providing rapid access and information to assist the resident's welfare. It was found that patients benefitted from staying in the familiar setting of their care home (especially important for dementia patients), and GPs benefitted from being able to see the patient's environment. The intervention also saved GPs, nurses, and patients time and travel costs, and also reduced patients' exposure to the additional health risks seen when being moved into a clinical setting.
- Health XR: Supporting the development and evaluating the impact of an extended reality (XR) solution to track improvements in gait and movement for people using hospital musculoskeletal services. This use case found that the testbed environment was highly useful for advancing innovative connectivity products through Technology Readiness Levels, particularly before trialling on patients. This demonstrated the potential to provide an additional testing layer before companies approached clinical settings, reducing their in-situ testing requirements.

Further details of these use cases can be found with the high-level summary report:

https://wmr5g.org.uk/?page_id=1276

Focus Area 4: Target areas for joint interventions identified from policy literature

a. Ensure that children across the Midlands are given the ‘Best Start in Life’ to provide the nutrition, behaviours, habits, knowledge, education, and mindset needed to live full and healthy lives. Tackling the challenges associated with children and young people is a multi-dimensional problem that requires a collective, coordinated approach and the understanding that prioritising activity in the early years will mitigate long-term impacts, which ultimately create costs across the health and care service: [37]

> *“We [the UK] have some of the worst child health outcomes compared with other nations in Western Europe [and] our inequalities are widening” Alison Morton (Nursing Times, 2022)*[311] *“The most promising approach to improving population health is to continue to focus on the health and well-being of children.” (Case and Kraftman, 2022)*[36]

i. ACTION ✓: Further improve and invest in the valuable role that health visitors (specialist community public health nurses, registered midwives, or nurses[312]), social care workers, and community support workers play in ensuring the safety and health of children across the region (especially for pre- and post-natal care[37]). Two approaches which could be broadened to include a range of local organisations include: [46, 218]

   » The Healthy Child Programme – an early intervention and prevention public health programme focused on a universal preventative service for children and families. Looking to identify families that are in need of additional support and children who are at risk of poor outcomes.

   » The Early Intervention Programmes for supporting children and young people’s mental health and wellbeing.

ii. ACTION ✓: Develop and widely share learnings from engagement groups or mechanisms that speak directly to children about their concerns, coupled with conversations from their parents, to identify their challenges. Utilising the Thrive Framework (a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people, and families) consistently across the region in conjunction with these engagement mechanisms would create an avenue for needs-based system change.[263, 313, 80]

iii. ACTION ✓: Work collaboratively to support schools to take an extended role in supporting families and communities and to implement a ‘whole-child’ approach to education by:

   » Delivering a full range of extended services within and around schools, such as speech and language services for <5s and creating links with sexual health services to facilitate monthly drop-ins for students within schools in wards with high numbers of teenage pregnancies.[37, 46, 314]

   » Facilitate the school-based workforce to work across school–home boundaries and address social and emotional development, and physical and mental health and wellbeing.[37]

   » Provide peer education and support embedded in schools.[314]

CASE STUDY: Aston Villa Foundation, Aston University’s Optometry School and Essilor Vision For Life – Villa Vision

The Aston Villa Foundation team are delivering a programme of eye-health awareness lessons in the classroom, free vision, and colour vision screening, followed by a comprehensive eye test and free glasses to those children who require them, using a fully operational custom-designed mobile eye care unit.

Funded by the Premier League, the Professional Footballers’ Association and Aston University, the project is designed to improve eye health by addressing a crucial lack of knowledge surrounding the importance of having an eye test and how preventative measures can ensure, among a host of benefits, a lifetime of good vision.

To date, more than 60 schools have received the full Villa Vision programme, accessing over 10,000 children in more than 15 priority areas in Birmingham.

www.avfc.co.uk/foundation/our-areas/community-engagement/villa-vision

iv. ACTION ✓: Provide improved support and information across all touch points (e.g. GP, hospital, community centres, family planning, and school waiting areas) for new and expectant families to fully cover challenges associated with childhood nutrition. Diet and availability of information were raised as particular area of concern amongst communities – most notably within Gypsy, Roma and Traveller communities. Linking this activity to improvements in guidance regarding dental health would also see benefits in outcomes.[237]

> *“The influence of poverty on children’s health and wellbeing is undeniable. Children living in poverty are more likely to have poorer health outcomes including low birth weight, poor physical health, and mental health problems. The health impacts of growing up in poverty are significant and follow children across their life.” (Royal College of Paediatrics and Child Health, 2022)*[263]

v. ACTION ✓: Utilise the RCPCH Health Inequalities Toolkit[263] to determine priority areas and actions across the region:

- » Improve your understanding of child poverty.
- » Develop skills for talking to families.
- » Prepare your own quality improvement project.
- » Advocate for change.
- » Take national political action.
- » Influence local children’s services.

b. Tackle loneliness and social isolation across all age groups, particularly for older people (notably older LGBTQIA+ people and older people from ethnic minorities, who can struggle to identify peers in their local area), carers, and those insecurely housed or experiencing a disability. Maps to identify local loneliness levels across local authorities can be found at http://data.ageuk.org.uk/loneliness-maps/england-2016: [132 134 136 190 315]

i. ACTION ✓: Provide a supportive environment in locations where communities meet regularly to offer activities with a practical outcome, which generate a sense of purpose, and to share skills (for example crafts).

ii. ACTION ✓: Support the provision of social groups that bring people together across geographical areas and across generations to ensure that people can come together with peers.

iii. ACTION ✓: Encourage mainstream providers of social activity to take specific steps to include older people from ethnic minorities and older LGBTQIA+ people, including by using images of diverse older people in marketing materials and engaging staff from minority communities as outreach workers.

iv. ACTION ✓: Build peer-led support and services, including around caring responsibilities and dementia.

v. ACTION ✓: Address the increasing challenge of travelling to services through review of public transport, developing peer support networks for isolated individuals, and supporting volunteer groups that fill in gaps in transport services/private transport availability.

vi. ACTION ✓: Encourage employers from all organisations (public and private) to commit the Campaign to End Loneliness pledge that asks them to commit to supporting their employees’ social wellbeing. To ensure that all age groups are involved, this activity should also include actively supporting local Age UK campaigns.[316 317 318]

CASE STUDY: The Centre for Ethnic Health Research – Gypsy, Roma and Traveller communities

Following a Gypsy, Roma and Traveller Leicester conference, the health needs of this community were discussed with the organiser and a number of health inequalities were identified. An initial exploratory focus group was set with the support of Leicestershire GATE (representing Gypsy And Traveller Equalities) asking community members the following:

- › What are the most important health issues to your community?
- › What initiatives would you like to see? What would its main focus be? For instance, this might be to increase access to physical activity opportunities, improve access to services, information, education.
- › Why do you think this is important?

A community-based event was then organised to explore the health priorities of the community in greater detail, with the information generated informing a successful funding application to Wellcome. The subsequent project facilitated sessions to be held that were informed and co-designed by members of the community. A ladies’ walking group was established, alongside regular yoga sessions, and an informal lunch club to address social isolation in providing a place for community members to spend time together. A ‘chill out’ bus was also provided at a leisure centre in Lutterworth to enable the younger community members to socialise in a safe space.

The team have also been approached by the organisers of the Travellers Movement to run a workshop based on their experience of effective engagement and action.

c. Work in partnership to improve **mental health provision**. Areas of focus should be addressing the lack of parity between physical and mental health across all services, delivering interventions and policies to prevent factors that contribute to mental illness, to challenge the barriers that create long wait times for services, and to support those who are most at risk:

   i. ACTION ✓: Advance mental health equality to ensure care is fair, compassionate, high-quality, timely, accessible, and meets user needs, regardless of any structural, resource, societal or cultural barriers, or protected (or other) characteristics.[46]

   ii. ACTION ✓: Use the THRIVE model (white paper on workplace wellbeing) to improve workforce health and wellbeing, and to address inequalities in education, skills, and employment across the region to support long-term, sustainable, good mental health and also contribute towards inclusive growth objectives. [38,134,159,319]

   iii. ACTION ✓: Provide clear and joined-up information about how to access services (such as mental health and bereavement services) to offer support in a timely and consistent manner, which is followed up and not reliant on families to overcome barriers.[65,80]

d. Collaborate to **tackle the root causes of homelessness** as well as the severe reduction in health outcomes that people who experience homelessness suffer from:

> *"The NHS alone cannot reduce poor health outcomes for people sleeping rough. Tackling rough sleeping involves improving people's health, social wellbeing and housing situation as well as supporting them to find long-term solutions."(The King's Fund, 2020)*[176]

   i. ACTION ✓: Ensure that the national framework (St Basils) to develop the 'Positive Pathway' is being utilised by regional partners to reduce youth homelessness.[320]

   ii. ACTION ✓: Share accountability for ending rough sleeping across health, social care, housing, education, and public health. Tackling this complex problem requires organisations to work together across communities to draw on strengths and resources, particularly for preventative services around issues such as mental health and substance misuse. [176,321]

   iii. ACTION ✓: Share learnings across the Midlands of successes tackling the following specific societal challenges to address the underlying causes of homelessness. This may take the form of an annual cross-regional meeting where outcomes are shared. Societal challenges may include: [321]

      - A lack of affordable homes combined with the rising cost of living.
      - Difficulty meeting the criteria for support.
      - Hospitals lacking facilities to help those with a dual diagnosis of mental illness and drug dependency.
      - Access to good employment and support from an employer when their staff are facing hardship.

CASE STUDY: Leicester Homelessness Charter

Led by the Diocese of Leicester with support from the City Mayor, the Bishop of Leicester, local MPs, the Police and Crime Commissioner, and the Dean of Leicester, the Leicester Homelessness Charter launched in 2018. The Charter aims to improve the way organisations and individuals work together to tackle homelessness in the city, as well as to engage the general public who would like to help and don't know how. The key objectives are to:

- Ensure the voice of those with lived experience is at the heart of designing services.
- Improve local systems for homeless people through better partnerships and coordination.
- Tackle rough sleeping to ensure no-one is sleeping on the streets.
- Increase the availability of affordable accommodation for those in housing need.
- Ensure that anyone with no recourse to public funds has access to safe accommodation.

Key achievements of the Charter are the creation of the HOPE Forum, where people with lived experience of homelessness are able to influence Charter partners' organisations, including working with the local authority in 2023 on their new homelessness strategy. By working in partnership with Bid Leicester and the City Council, the Charter created the GIVE Leicester campaign – 14 contactless donation points across the city that direct funds to homelessness organisations providing frontline support. In 2023, the Charter has also created MyPlace, which is a fund specifically aimed at people who are moving out of homelessness into their own accommodation.

www.leicesterhomelessnesscharter.co.uk

e. Encourage **physical activity** across all age groups to maintain a healthy lifestyle:

> *"Adults should aim to be active daily and should include muscle strengthening activities on at least two days a week, but any strengthening activity is better than none." (Derek Ward, 2019)*[98]

i. ACTION ✓: Creating the leadership, governance, partnerships, and workforce capabilities across sectors to utilise new and existing resources/pathways (e.g. clinical pathways, neighbourhood integrated teams, locality teams, district council networks, and planning/transport services) in a coordinated way to reduce sedentary behaviour.[250] [324]

ii. ACTION ✓: Update public messaging to reframe physical activity as an opportunity to be outdoors, socialise and improve wellbeing, rather than solely as a tool to promote healthy weight.[134]

iii. ACTION ✓: Encourage volunteers to reengage in supporting physical activity – an area that has seen a significant drop in numbers since the pandemic and will take time to recover.[323]

iv. ACTION ✓: Review the effectiveness of different interventions (including promotion, public health messaging, innovation and technology) in creating uplift in activity across specific target communities and deliver them in a coordinated and consistent way across the region.[323] [250]

CASE STUDY: Belvoir Cricket and Countryside Trust – Building lifelong interest in sport

The Belvoir Bees project sees the Belvoir Cricket and Countryside Trust and its volunteer coaches work with cricket clubs or local venues without cricket to introduce, develop, and sustain young people's interest in the game – increasing their levels of physical activity with the aim of creating lifelong habits.

One of the success stories has been the partnership with Melton Mowbray Cricket Club, which, just 9 years ago, did not have a juniors' team and was situated in an area where obesity levels of children in reception were 25.5%[324]. The Trust trained their club members to become coaches, took assemblies in local schools and started up a kwik cricket training night at the club for children aged 6-11. At the first session, more volunteer coaches were present than children but, by working together, encouraging parents to get involved, and creating a community atmosphere, numbers grew, and word spread.

The Trust was the catalyst and today the club is flourishing because it was willing to invest in its future. It now has 3 competitive senior sides, 2 kwik cricket teams and teams at U11, U13 and U15. Several of the initial volunteer coaches have gone on to take ECB accredited coaching qualifications, are still actively involved in the cricket club and support the Trust in its other core activities. 8 of the initial intake are now playing senior cricket and a number of current junior players are playing at county level.

The Trust has now left Melton Mowbray and moved onto other venues, as they are a fully sustainable cricket club with a thriving junior section, who will be their stars of the future.

CASE STUDY: Leicester Diabetes Centre and Leicester City in the Community – Healthy Goals

Healthy Goals is a 12-week education and physical activity programme developed to reach the South Asian community, who are amongst those more at risk of developing type 2 diabetes.

The first phase saw the development and delivery of this programme in collaboration between the Leicester Diabetes Centre and Leicester City in the Community. The second phase, impacted by COVID-19 and no face-to-face sessions, worked on adapting this successful face-to-face programme to a virtual programme via Zoom. Whilst the messages remained relatively unchanged, the physical activity sessions focused on showcasing home-based activities individuals could do without expensive equipment and in the comfort of their own home. Whilst health measures (such as blood pressure, weight, BMI, etc.) could not be collected due to the virtual nature, an online survey was developed to assess changes in physical activity, sedentary behaviour, and diet following the programme.

Healthy Goals continues to have a positive impact on the individuals who attend. Many report increasing their physical activity levels and reducing their prolonged sitting time since attending the programme. Others note that they have changed some of their cooking practices and made healthier options when it comes to food choices. 100% responders were more active, 89% reported sitting less and 89% made positive changes to diet.

"Healthy Goals has made me more aware of my not so healthy food habits and encouraged me to do more physical activities" "I have become more aware & alert to my cooking style, including the amount of oil & ghee I use. Plus, I now opt for more fresh vegetables in my cooking."

CHAPTER 4. PRIORITIES FOR CHANGE

This section details the top 10 priority challenges that must be tackled to address the health and care inequalities, racism, discrimination, and wider determinants of inequitable health outcomes in the region. Without addressing these priorities, communities will continue to suffer.

CALL TO ACTION: What are you doing to tackle health and care inequalities?

[To be reviewed with accompanying Midlands Equality Impact Assessment Tool – page 8]

1. PRIORITISE TACKLING HEALTH INEQUALITIES

Prioritising actions that address health inequalities in all policies and procedures is crucial, as both process and ambition can greatly impact outcomes.

Actions to address health inequalities can range from simple (e.g. raising them first in senior meetings, to set the tone) to complex (e.g. actively prioritising local procurement over lower-priced options, accepting the role anchor institutions play in tackling the wider determinants of health). The systems and mechanisms that underpin service delivery not only determine their impact, but also how staff members view and prioritise them. To fully embrace the opportunities to improve health will require a culture shift for all organisations – internally, externally, and collaboratively. Leaders must, in seeking this shift and establishing standards of behaviour/practice, understand system leadership beyond their immediate influence. While significant steps can be made within organisations to improve outcomes, internal improvements alone are insufficient to solve health inequalities. The Policy Commission team received feedback on the damage caused by inequalities, racism, and discrimination across the region, highlighting the need for core deliverables on race equality, intersectionality, and proportionate universalism to tackle health inequalities effectively.

OUR CHALLENGE TO THE MIDLANDS: Does your organisation prioritise addressing health and care inequalities as the foundation of your strategy, highlight it in the first slide of quarterly reviews, link it to departmental activity, and make it a key criterion for procurement? Increase awareness of the potential impacts of your services and keep it at the forefront of colleagues' minds, serving as a driving force for progress. Be the change.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Through process development, monitoring, and incentives, provide greater opportunity for health and social care organisations to implement population-tailored, people-driven measures, processes, and pathways.
- Develop national standards for cultural competency training, along with guidelines for its integration into ongoing personal development, recruitment, and promotional requirements.
- Fund research on the necessity and potential benefits of social care organisations and community pharmacists being more involved in patient-focused preventative care.
- Implement flexible funding for local pilot programmes that could be used, for example, to allow cities to experiment with drug consumption rooms, consistent with the objectives of the 10-year drug strategy and the Homelessness Reduction Act. These pilots, if successful, should be backed by the necessary policy changes, e.g. a shift from a harm reduction model towards a recovery model for addiction.

2. POSITION PEOPLE-POWERED HEALTH AS AN ESSENTIAL

Public-facing organisations must increase awareness of service availability and healthcare choices. This empowers communities to make informed decisions about their treatment and lifestyle, improving health outcomes and trust.

To enable people-focused pathways, providers must increase awareness of patient and community service choices and personal health budgets. This requires more than just making information available – it also relies on health literacy, numeracy, trust, staff service awareness, and understanding of language and jargon. The responsibility for ensuring ease of communication and delivery of focused care should not solely fall on the patient. The health and care system must adapt and develop new methods to empower communities, with the necessary support and guidance.

To facilitate people-powered health, it is crucial to offer cultural competency training that is tailored to the local community, regularly updated, progression-linked, and connected to dedicated community health champions or workers. This training will help health and care professionals understand the challenges and circumstances that lead to certain cultural beliefs/practices, such as the acceptance of diabetes as an "inevitable aspect of aging" in some Asian communities. National guidelines should be established to ensure consistent development and delivery of this training.

To ensure the longer-term sustainability of the health and social care system, the regional education ecosystem must act to improve health knowledge and personal responsibility, whilst also developing healthcare education programmes that are patient-centred and inclusive. Moreover, to provide a demand-driven health and care service that improves quality of life, it is essential to continue and enhance upstream interventions. This includes public health programmes and wider determinant interventions that mitigate the onset and development of preventable illnesses. The population is our greatest asset, but unless we make this shift to harness its full potential, the region and the UK will continue struggling to overcome mounting health challenges.

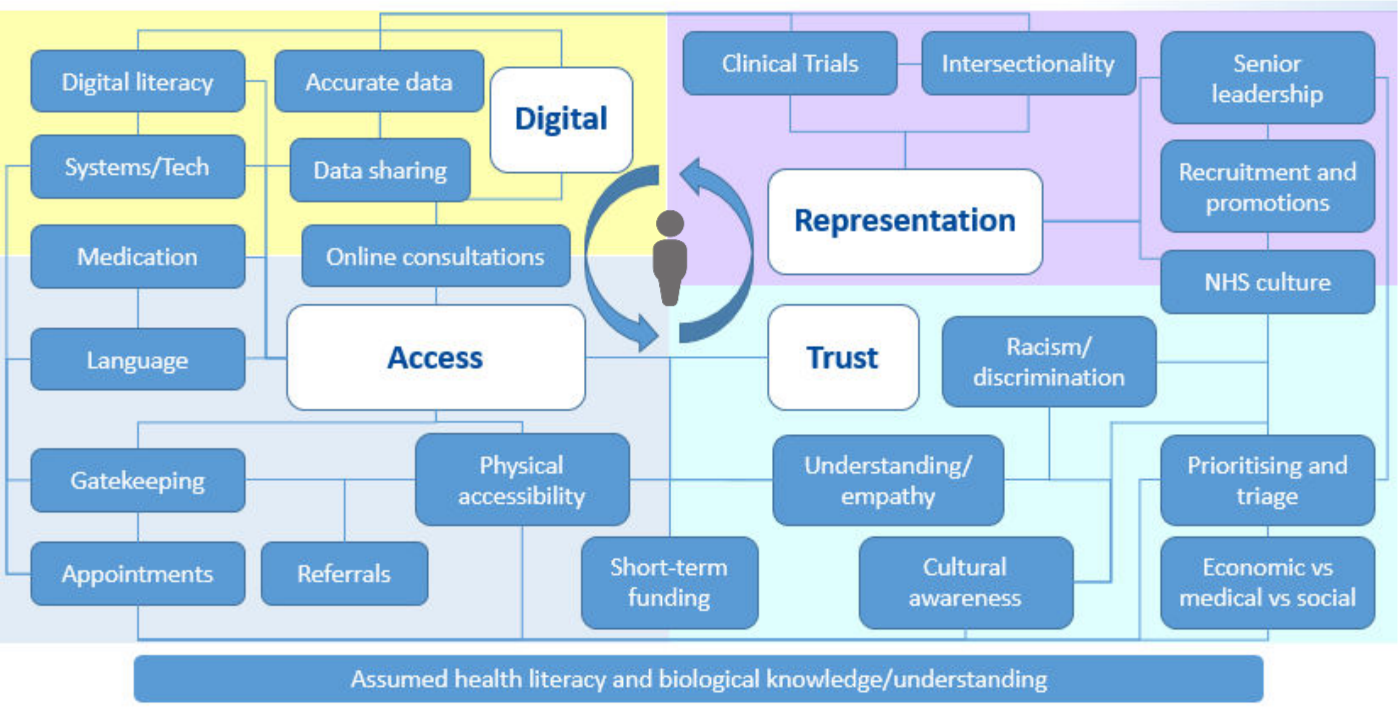
OUR CHALLENGE TO THE MIDLANDS: Does your organisation have a clear understanding of the diverse communities, abilities, and needs that you serve or support? Do you have a system in place for tailored delivery? Can you assist other organisations in understanding the community accessibility and literacy challenges that must be considered when enhancing the health and care infrastructure? Are you providing education to the current and future workforce regarding the advantages of people-powered healthcare? The whole region must come together to build this multi-faceted expertise.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Through process development, monitoring, and incentives, provide greater opportunity for health and social care organisations to implement population-tailored, people-driven measures, processes, and pathways.
- Develop national standards for cultural competency training, along with guidelines for its integration into ongoing personal development, recruitment, and promotional requirements.
- Fund research on the need and potential benefits of greater involvement of social care and community pharmacists in patient-focused, preventative care.
- Implement a flexible funding model for local organisations to create pilot programmes that could be used for example to allow cities to experiment with drug consumption rooms, consistent with the objectives of the 10-year drug strategy and the Homelessness Reduction Act. These pilots should be supported by the necessary changes in policy, if successful, e.g. a shift from a harm reduction model towards a recovery model for addiction.

3. DELIVER WHOLE SYSTEM APPROACHES

Whole system approaches are vital to tackle the complex and interlinked barriers to health equity.



The above diagram illustrates the complex and interconnected barriers identified by community members as hindering efforts to address health inequalities in the Midlands. To effectively tackle these challenges in the long term, comprehensive whole system approaches are required that go beyond the health and care system and encompass the wider determinants of population health. This necessitates genuine, inclusive, trustworthy, and collaborative partnerships, which hold positive care transfer (reducing the number of steps required for patients, families and carers to access care, information) at their core. Whole systems working acknowledges that there is no single solution to address complex public health problems and that a coordinated strategy that adheres to a "health in all policies" approach is necessary[189]. This also extends to processes such as integrated commissioning and social value in procurement practices.

OUR CHALLENGE TO THE MIDLANDS: Can you work with local and regional partners to develop a population health framework, such as the one proposed by the King's Fund[325]? Which organisations and systems are required to address these obstacles? By bringing them together and initiating change, the region can make progress.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Work with regional and national stakeholders to co-develop a whole system framework for an agile health and care service that addresses the identified barriers to health equity.

4. ENABLE EFFECTIVE DELIVERY AND IMPACT

Experiences of health and care inequalities are common across communities, making intervention delivery key.

The concerns, challenges, and experiences raised across the communities we engaged were similar in nature. While the intensity of these issues varied slightly among different groups (such as the impact of cultural stigma on cancer diagnosis in the Bangladeshi community versus fear/fatalism among the homeless), there were common themes. One such theme was access which can be a barrier to digital services for the elderly, rural communities and the financially disadvantaged, and to healthcare services for those sleeping rough or suffering from mental health or substance abuse problems. Therefore, it is reasonable to conclude that overarching interventions to improve health and care in the Midlands are applicable to a wide range of communities. However, this work has also demonstrated that the delivery method of any intervention must be tailored to the local population and led by/with the help of community champions, leaders, and trusted staff members. Only through deep understanding and engagement with local populations and their health infrastructure can the goal of efficiency and effectiveness be achieved.

Examples of how this could be achieved in practice can be seen when we consider targets for reducing NHS waiting lists and increasing GP appointments. Suggested interventions include providing flexible appointments, improving public health messaging, implementing patient-focused pathways, engaging closely with social care services, improving health literacy, and more. However, the effectiveness of these interventions may vary if implemented without considering the local populations. Therefore, to ensure the most effective and impactful use of resources, these interventions should be combined with local expertise and community-based healthcare champions.

OUR CHALLENGE TO THE MIDLANDS: Has your organisation developed and implemented an impact assessment process/review to determine which communities are being served, which are not, and if their needs are reflected in your approach? It is essential to consistently consider impact (both positive and negative) to ensure that delivery reflects the needs and preferences of the communities you serve, especially when implementing universal policies and practices. This approach will help to guarantee the effectiveness, relevance, and impact of services.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Form an alliance of different medical and social care professionals, alongside a broad range of patients with lived experiences, to consider how best to speed up the referral process and reduce waiting times.
- Consider existing funding mechanisms and how they might be adapted to enable sustainable community-based champions to support the health and care sector.

5. DEVELOP AND DELIVER A REGIONAL APPROACH

There is a clear demand for ambitious regional strategies, standards, and practices to address inconsistent access, negative experiences, and lack of awareness of available health and care services. Coordination, collaboration, and alignment between local government, ICS, NHS England, and OHID are crucial to effectively tackle these issues.

This Policy Commission found that health and care inequalities in the Midlands are not a result of a widespread lack of empathy, effort, or innovative thinking, but rather of ineffective processes and increasing pressure. What is needed is definitive leadership that fosters collaboration, peer-learning, and coordination among NHS trusts. The ICS infrastructure must also develop effectively to ensure that systems and procedures align with health inequalities strategies.

Additionally, it is recognised that clinical care alone cannot fully address health inequalities, as they are significantly influenced by factors such as behaviours, social and economic circumstances, and the built environment. To resolve the debate around responsibility ownership for tackling inequalities between health and care, the ICSs should collaborate with partners outside of the health services, such as local authorities, charities, universities, and community leaders, sharing budget, expertise, and skills to address these shared challenges. By following agreed standards, this approach can deliver proactive and proportionate universalism approaches across communities and their life course. The NHS and OHID, with local representatives, should facilitate this process to maximise the impact of interventions and expand horizontal conversation that integrates the NHS within the wider world.

This highly connected approach is crucial in developing upstream services which prevent ill health, long-term conditions, and complex inequalities, such as people living in deprived areas tending to develop multiple health problems 10-15 years earlier than those in affluent areas[215].

The Hewitt Review[326] and the response[327] from the government at the time to it shows support within ICSs for a connected approach to represent and deliver for the whole local health and care system, not only major NHS partners..

OUR CHALLENGE TO THE MIDLANDS: Foster peer-learning, support, and sector-led improvement approaches by expanding your focus beyond your designated location and engaging with the wealth of expertise across the Midlands.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

› Ensure that local governance routes support and seek out collaborative, cross-boundary approaches.

6. CAPITALISE ON REAL COMMUNITY INVOLVEMENT

Additional recruitment, optimised training, and formalised integration processes must be developed to build upon the existing community involvement model, which does not go far enough and relies too heavily on volunteers.

Individual organisations have a significant role to play, most notably through direct employment of diverse communities and individuals, but there is also a considerable unmet need for a shared community involvement platform at a minimum of county level (ideally, regional). This platform would recognise the importance of the voluntary and community sector's expertise and experience and expand community involvement beyond public patient involvement and engagement (PPIE). Expanding involvement may include formalised leadership, design and implementation of community engagement training, assistance in data collection, sampling opinions, and targeted signposting of interventions. Building services, processes, and research with communities from the beginning will improve quality, trust, and impact. To achieve this, however, fundament actions must be taken regarding representation, including the review and expansion of workforce accessibility and inclusive roles. This Policy Commission also strongly suggests the development of a regional network of community-based, lived experience champions, integrated into long-term health and care systems.

For local organisations to truly act as anchor institutions, they must accept their civic responsibility to improve the health of their workforce (and wider community) and invest directly in communities as health assets in themselves. Examples of this could be developing community knowledge and skills programmes, supporting local voluntary organisations, sponsoring sports facilities, or investing in community halls. These actions should not be made in silos, but rather as part of a coordinated effort, utilising high-level systems leadership to ensure direct investment activity draws communities in and manages their expertise and needs within (rather than outside of) the system.

This process must be managed carefully so as not to add undue stress to communities. It is not their responsibility to fix the issues, nor are they an endless well of information to be used over and over. Communities must see rewards (through effective renumeration, feedback, and impact) for the fantastic and continuous efforts they put in to support service, research, and policy development, or else we risk frustration and distrust[328]. Thus, community involvement must be robust, inclusive and impactful.

OUR CHALLENGE TO THE MIDLANDS: How can you and your organisation bring communities closer into the development, delivery, and evaluation of your services? Is your workforce representative? Every organisation, no matter how big or how small, that employs, contracts, educates or engages with Midlands residents has the power to drive significant economic and societal change through their choices. Choose to include and build for the long-term.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

› Develop and pilot the new models for collaborative partnership proposed in response to the recommendation to create a "Community Right to Serve" in the Kruger report[329], such as Community Covenants. This should include guidance on best practice for direct investment into communities as health assets.

› Build on the request made by the government (at the time) Health and Disability White Paper[299] to "look in detail at the issue of workforce participation" by issuing national guidance for all organisations on how to provide reasonable adjustments (including clear documentation) for new starters to support seamless integration into the workforce, for example, for neurodivergent workers and those with carer responsibilities.

- The Department for Education to set clearer actions and targets to diversify the education workforce, especially into senior leadership roles, as the ambassadors for the future workforce. Diversity characteristics may include ethnicity, gender, age, neurodiversity, chronic conditions, disability, and lived experience. This should be emulated by other national and local government departments, taking on learnings seen when implementing changes within this complex environment.
- Embed NHS 'Working in partnership with people and communities'[330] guidance in all developing services.

7. REBUILD TRUST AND RESPECT

More needs to be done to mend the bonds between communities and frontline health and social care workers, as well as with health and care organisations nationally. Without trust and respect, change may never come.

Trust in healthcare is a challenging concept for many in the UK, which varies significantly across cultures, social positions, and generations. The public struggles to put their faith in large, complex organisations and often reserve their respect for "their doctor/surgeon/consultant" and have little interest in the highly qualified and experienced support teams that enable their care. Whether it be the GP receptionist surgery working to triage patients, the ward nurse delivering care, or the social worker advising parents on nutrition, more needs to be done to ensure that they are respected and safe, without risk of harassment or violence.

It is vitally important that patient safety, respect, care, and equality of access remains a priority, but this can only be achieved by mending relationships with communities, demonstrating real change, and challenging the trend of negative press coverage. This activity should be accompanied by long-term representative recruitment, empathic training, and detailed monitoring, ensuring staff members are able to perform at their full capability, replacing blame and bullying culture with renewed trust between colleagues at different levels, and addressing any issues immediately.

OUR CHALLENGE TO THE MIDLANDS: Can you bring together communities and healthcare workers? Can you raise awareness of issues that are damaging trust? Can you demonstrate impact to those who need it most? Are you representative of your target community, so that you can build trust from within? Are you educating/training the workforce of the future? Can you encourage understanding of the importance and need for change, particularly in inner-city, coastal and rural communities? We can all help to tackle misinformation, challenge discrimination, and support positive change for our communities and our healthcare services.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Deliver national leadership and consolidation of the evidence for the development of mandatory, in-depth, and long-term cultural competency career development.
- Build public awareness of how NHS systems work to reduce frustration and ease access to services.
- Perform a whole system safety and efficiency review of the NHS patients and staff complaints systems.
- Create a Charter for Patient's Families and Friends, which sets out the standards for communication with patients and their families.
- Consider how local and national media outlets, as well as social media, can support this activity.

8. CAMPAIGN FOR LONG-TERM INVESTMENT

Long-term, proportionate investment is essential to addressing the critical issue of resourcing within the health and social care systems.

Perhaps the greatest concern of those involved in the strategic delivery of health and care interventions in the Midlands is access to funding over a sufficient timeframe to make positive impacts. There has been - especially since the pandemic - an influence of political cycles on funding and strategic direction. The Commission team has been told that services would rather have slightly less funding if it was secured and guaranteed for longer periods – with some even considering turning down offers of short-term intervention funding. This is not just a process issue (with procurement, change management, recruitment, and training timelines not accounted for), it is primarily about trust and awareness within communities, who see services advertised only to find that they have ended by the time they need them. Short-term programmes also do little to tackle systemic issues and create a reliance on grant funding. It was noted that, even unanimously agreed approaches (such as the community-based health champion model) only work in practice if they have adequate long-term resources to maintain a sustainable network and coverage.

There are also opportunities for systemic regional change within the NHS funding model, following the development of ICSs. For example, the amount of funding redistributed through the Health Inequalities and Unmet Need adjustment, where and how this funding is spent and presented in systems plans and, most notably, the underlying principle of tackling health inequalities with a ring-fenced budget rather than embedding awareness of health inequalities into all spending decisions. Midlands ICSs, working together across the region, have the potential to lead in the strategic delivery of coordinated, consistent, and effective long-term funding models.

OUR CHALLENGE TO THE MIDLANDS: Come together! Shout about it! Make the case!

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Increase the overall longevity and flexibility of funding allocated across the health and care system to improve efficiency and community trust, which has been damaged by short-term and fragmented Public Health investments. Examples of flexible use of funding include increased spending on early years and community-based interventions and addressing budget inconsistencies across HealthWatch organisations.
- Maintain and build on positive funding streams such as the flexible Household Support Fund[331].
- Move past the ethos of dividing national health and care spending into 'everyday spending' and 'spending on health inequalities'. This needs to come together so that inequalities spending is an integral part of the everyday spend. The prioritising and allocation of resources needs to be reviewed.

9. LEAD THE WAY IN DATA AND DIGITAL DONE CORRECTLY

Data and digital is a key opportunity for the Midlands to not only tackle its health inequalities, but also to coordinate and drive activity in the Digital Health space.

The importance of accurate data and a clear understanding of current and future trends cannot be overstated, not only at a national policy level, but also for local disease control and, most importantly, for the patient journey. This is particularly apparent given the growing complexity of the UK health and care system due to the ageing population, prevalence of multiple and chronic diseases, and deep-rooted inequality. In the Midlands, we have nationally leading strengths in 3 core themes of digital health (one of our primary sectors):

1. Digital infrastructure and architecture – such as the West Midlands Secure Data Environment[332];
2. Data science, AI, and analytics expertise – showcased in the Health Data Research Midlands Regional Community[333];
3. Digital innovation – as seen through our large and growing cluster of digital health companies (largest outside London).

For the Midlands to be truly leading in the area, however, these 3 strengths must be leveraged to deliver a 4th: Data collection. Improved data accuracy (critically for ethnicity and clinical coding) and accessibility (be that for family members, across different medical facilities, or for research) will be the difference between the NHS data assets being an expensive necessity and a world-leading source of innovation.

Unlocking the full potential of the NHS requires digital interventions that not only save costs, but enable equity and access. Consequently, all activity in this space must mitigate against digital exclusion and ensure datasets are timely and complete (for example, carer information).

OUR CHALLENGE TO THE MIDLANDS: Ensure that all projects (infrastructure or analytical) prioritise maximum inclusion and active reduction of inequalities. Where possible, this should cover large geographies and communicate the learnings across the region. It should also utilise the latest developments in Secure Data Environments/Trusted Research Environments (TREs), at a regional level, to deliver safe and effective data storage and sharing.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Support the Midlands to become the UK's leading cluster for data-driven health innovation. Create a space for companies of all sizes to access the required support, expertise, and testing opportunities via connected TREs.
- Realise the potential of the region's science and technology assets as a vehicle for growth.
- Conduct a comprehensive review of ethnicity coding and issue national guidance that is both sufficiently detailed as to support local health programmes and avoids excluding communities through the use of colour (e.g. Black) and generalised terms (e.g. Asian).
- Support and provide national guidance for data sharing (including secondary use within and between public sector organisations).
- Provide additional opportunities for NHS Trust and local authority digital teams to work with the research community to increase the availability of advanced data analytics expertise within the public sector.

- Build upon recent pilots and demonstrators to address gaps in broadband infrastructure across the region, recognising for the challenges in access to devices and connectivity.

10. REFLECT LOCAL COMMUNITY NEED IN POLICY, EDUCATION AND RESEARCH

Address misalignment between the focus of policy and research, and community needs through demand-evidence.

The focus of policymakers, think tanks and research organisations is misaligned with the primary concerns identified by communities. This Policy Commission has found areas where policy activity matched community need (such as communications, workforce challenges, and collaborative engagement with the voluntary and community sector), but there were just as many where misalignment existed. For example, there have been recent moves to reduce the NHS waiting lists, but this has not extended to addressing the challenge of securing a GP appointment in the first place; there are many discussions about NHS staff burnout as a result of the pandemic, but little change in processes to make their working environment safer and more equitable; and there are many conversations ongoing regarding how to best to combine and innovate NHS medical data, while communities simply want to be able to speak to doctors about the health decisions that impact their loved ones across healthcare sites. Many policy discussions focus on funding and governance, but this process-driven approach forgets the lived experience.

In addition to reviewing policy development, research organisations and their partners need to pivot from the current direction of research (focusing largely on global health challenges) to meet the needs of local populations, which are often globally representative in themselves. This is vitally important for the delivery of future policies (as well as medical treatments and healthcare processes) due to the fundamental role these institutions play in creating the evidence that underpins them. Local community needs should also be reflected in wider education (such as through personal, social, health and economics [PSHE]), particularly for younger children, ensuring health information is culturally, socially, and financially relevant. By prioritising local needs in combination with collaborative regional actions to embed the fundamentals of equity into the education of medical and health professionals, the region can lead the way in tackling current and future health and care inequalities.

OUR CHALLENGE TO THE MIDLANDS: Whether you work within the lead organisation or a partner organisation, help to build local motivation and evidence to cement the Midlands as a beacon of community-focused policy, research, and educational activity.

OUR CHALLENGE TO NATIONAL POLICYMAKERS:

- Establish a cross-government health inequalities strategy with explicit targets for improvement and a designated Minister responsible for each target (as per the Levelling-up Missions).
- Engage closely with communities and the organisations that represent them, and ensure that policies and funding allow the same level of engagement to happen effectively at regional and local level.
- Leverage local expertise, strong place-based stewardship, and regional vision by empowering the current and future devolution authorities to tackle health inequalities, including the means to collaborate.
- Update national planning policies to incorporate a public health strategy targeting health inequalities into home-building regulations.
- Expand initiatives such as the NIHR's HDRCs, boosting local authorities' capacity and capability to conduct high-quality research to tackle health inequalities and to better understand their impact on health, e.g. the recently awarded Coventry Health Determinants Research Collaborations[334].
- Support the Midlands to leverage its scientific excellence and cutting-edge facilities (including the second largest clinical trials infrastructure in Europe) to become a global testbed for inclusive clinical trials that are data-driven, industry-paired, and closely integrated with the region's population.
- The Department for Education to develop a national strategy with clear targets to close the attainment gap at every stage in a child's education.

ALREADY DOING ALL THESE THINGS? FANTASTIC! NOW HELP OTHERS IN THE MIDLANDS TO DO THE SAME.

CHAPTER 5. CONCLUSIONS

Summarising the findings

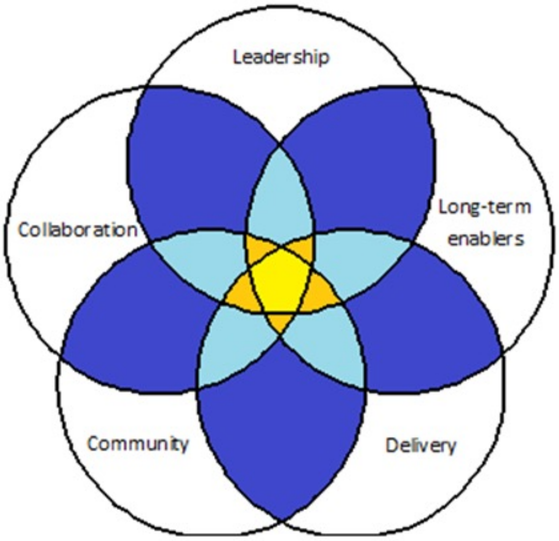
Through the extensive community engagement work and policy review performed, this Commission has found that:

- Health inequalities do exist across the Midlands.
- There are significant barriers to healthcare that are preventing them from being addressed.
- Small changes can have a big impact locally, but large-scale interventions based on community knowledge will have the greatest effect. This report has highlighted that both types of changes to enable targeted short-term action as well as long-term strategic planning.
- The priority for local and national organisations needs to be working together and learning from each other to remove these barriers across the whole of the Midlands region. This report has shown that this can be done and is being done across the Midlands, but it needs to be linked up, showcased, and uplifted to be delivered in a more consistent way.

Regional Strategy

It is the view of the Policy Commission that significant improvements can be made to address health inequalities both in the short and long term through the identification and agreement of a clear regional strategy. This strategy should address the 10 Priorities for Change and include the delineation of the role and responsibilities of individual organisations across the Midlands. To achieve this, the Commission recommends 5 core strands of activity:

- **COLLABORATION:** There is a strong case for a Midlands approach to inequality and inequity in healthcare. As shown by the examples within this report, clusters of excellence exist within the region and yet the opportunity to transfer knowledge and experience regularly and systematically across the region is not currently taking place. In this time of low resource, it is vital that the region does not continue to reinvent the wheel in each locale, but works together and learns from the success of others (particularly in senior leadership). Shared approaches and standards should also be developed in partnership, the most important of which is a joint approach for engaging with communities, which is relevant across the Midlands. The need for collaboration is driven by the deprivation, ethnic diversity, and difference in opportunity available across the region. Health inequalities have no boundaries. There is, therefore, a duty to learn across the region.



- **COMMUNITY:** Any health inequalities strategy must be a bottom-up process, led by our communities and health and care workers (including the VCSE). This was the defining factor of the Policy Commission and its approach, providing an almost unique opportunity to deliver community-driven work at a regional level, and should be integral to any future regional strategy, policy, service, and research development. This is not just about how the system engages with communities, reaches out to them, and involves them in decision making and design, it is also how the health and care systems and partners invest in communities themselves as health assets and sources of improved health outcomes. It also involves the genuine and honest development of people-powered health structures, making choice central.
- **DELIVERY:** This strand of activity should be focused on evaluating, monitoring, and adapting process and delivery mechanisms so that they are accountable, practical, and supportive of health equity policies. It should promote practical steps to implementing policies (such as Core20Plus5), act as a continual reminder and encouragement to prioritise health equity, and utilise the most effective delivery for implementation (e.g. community-based health champions). This strand should focus not only on uplifting the aforementioned joint activity, but also increase individual equalities activity.
- **LONG-TERM ENABLERS:** To help to transfer the system, over a reasonable time, to where it needs to be to facilitate equitable, forward-thinking and adaptive health and care, there are key factors that need to be considered. These may be structural in nature, such as the prime opportunity presented by data and digital technologies, or financial,

such as the critical need for long-term investment. Each must be regarded within a whole system approach and developed inclusively to ensure the people and mechanisms are in place for effective delivery.

- **LEADERSHIP:** Leaders at all levels need to sign up to this strategy and take responsibility for supporting whole system delivery, not just focusing upon their local geography and delivery outcomes. It is also crucial that conversations not dissolve into debate on which aspect of the health and care system is the most important or hold the greatest responsibility. All organisations and geographies have a role to play. What is important is how leaders come together to create a cohesive and supportive system across the region, utilising regional assets and expertise.

Reflections from the Policy Commission team

Clear messages from communities:

There is significance in the ease with which community feedback (despite different cultures, geographies, ages, and experiences) can be effectively summarised, while the policy guidance requires many and often niche interventions dividing by organisation. This reflects the shared experience and clarity of their needs that communities hold, compared to the complex and siloed infrastructure upon which policy focuses. It is the responsibility of local and national organisations to collaboratively overcome these unnecessary process challenges to meet community needs.

It would also be easy to assume that the difference in complexity of message stems from communities only caring about their current health concerns, with no long-term aspirations. The Policy Commission team has not found evidence of this. The shorter-term focus of the community feedback related directly to the severity of the immediate challenges and the passion that community members felt from their experiences of them. It would be a considerable oversight to assume that communities do not have an interest or a role in shaping their long-term health.

Driving change within the health and social care sectors needs an agreed joint strategy and support structure:

The Policy Commission team faced significant difficulty accessing frontline workers in any of the organisations that influence health outcomes when compared to managerial and senior roles. It is the view of this Commission that this is primarily a result of the considerable constraints placed on all frontline staff. Moving forward, unless addressed, the implications of this lack of time will act as an additional challenge weighing upon those who wish to implement change across the system going forwards. For example:

- Capacity to think and deliver differently: In high stress situations where time is at a premium, it can be a challenge for even the most willing to think laterally and to deliver services differently, without the remit, support, and training to do so. An understaffed GP surgery delivering for a full timetable of patients may wish to tackle health challenges in their most unwell patients but, as these are often the least likely care seekers, they may have little ability to act upon this.
- Capacity to participate: Without the time to engage in the proposed equalities training and awareness building exercises, poor behaviours could remain unchallenged, reporting processes unused, and wellbeing continuing to be impacted. Space needs to be made to incentivise involvement, particularly with the unwilling who may in fact be the target audience.
- Capacity to research and innovate: Without funding and supporting resources to recruit, train, and engage frontline workers in research, activities such as data gathering, clinical trials and change management will be almost impossible to deliver (or even trial). It is not simply the case of convincing senior staff and clinicians (who spend relatively little time with patients), it is the supporting network of staff that make the changes a reality and understand the steps needed to achieve it.

Phase 3 Activity

Despite national targets and initiatives, overall, Midlands Healthy Life Expectancy (HLE) has been falling since 2013, with both the East Midlands and West Midlands due to miss the Levelling Up mission (to narrow the HLE gap by 2030 and to raise HLE by 5 years by 2035) for all areas and genders[335] [336] [337] [338]. This should be seen as a call to action for Midlands organisations. If we do not deliver for ourselves and each other, waiting for others to “fix the problem”, nothing will change. This message stands strong in this report, and we champion those already taking responsibility.

As was repeatedly raised by the region’s communities, this Policy Commission is clear that inaction is unacceptable. Raised in this report, there are many fantastic local, and scalable, examples from across the Midlands of those that are actively tackling the inequalities, which have been highlighted through the case studies. The ambition for the Midlands going forwards should be to demonstrate the power of collaborative, people-focused health and care delivery that is forward facing and, vitally, inclusive. By delivering this, the Midlands will not only be leading the way in improving the lives of our citizens but will also demand recognition, support, and change nationally.

To determine the impact of this work and to make clear that the Commission do not shy away from our responsibilities, following the launch of this report, the Commission team will continue to work with regional partners to support and drive collaborative action to tackle inequalities. Building on the delivery of the actions outlined previously, for the next 12 months, the Commission will deliver (via Phase 3) a wide range of actions that will culminate in an impact report. Anticipated actions include but are not limited to:

- Engage national and regional stakeholders and seek opportunities to explore and implement the wider recommendations of this Commission. Most notably for those that require collaborative efforts to achieve.
- Work closely with Commission partner, the King's Fund, to build on their work across 2 areas:
    - Getting the most from Midlands assets: In May 2022, NHS Midlands commissioned The King's Fund to work with them and OHID Midlands to review their work to support action on ways of working to address health inequalities across their 11 ICSs and with 24 upper-tier local authorities. Interviews and virtual events were conducted with senior leaders to develop and test key ideas and review the key strengths and challenges of the current approach. It has been agreed that the recommendations from this work will provide the structural framework through which the Commission can facilitate change, utilising the actions listed in this report and their strong community focus.
    - The role of communities in health: The King's Fund has published numerous articles discussing how communities can effectively be involved in the delivery of public health, including the Communities and Health explainer[339]. The Commission will utilise these principles, tailored with local community views, as we further engagement across the Midlands.
- Support regional and national initiatives that align with the actions and recommendations within this report. A key example is the development of recommendations to deliver ethnicity coding and training by the Centre for Ethnic Health (University of Leicester) and the UK Health Data Research Alliance[193].
- Work with regional and national organisations (such as the Midlands Engine Observatory, the Midlands Decision Support Network and the Office for National Statistics) to assess the impact of the report in the 12 months following launch. This activity should include consideration of existing monitoring dashboards (such as the NHS Health Inequalities Improvement Dashboard and OHID Fingertips Tool), the agreement of standardised metrics that indicate progress, and the creation of a data and mapping platform to visualise improvements and challenge areas that can be used across the Midlands.
- Continue to develop relationships between and with the region's ICSs, including:
    - Meeting twice yearly to discuss priority themes including health inequalities and research opportunities (a summary of previous meetings can be found below, with further information on page 134).
    - Mapping the priorities across the Midlands ICS health inequalities strategies, to identify opportunities and develop joint actions, such as a joint Midlands ICS strategy to tackle diabetes, and a potential Midlands-wide NHS apprenticeship scheme[142].
- Build a community network across the region to allow sharing of experiences, opportunities, and learning.

The Midlands Integrated Care Systems Research and Innovation Workshop Series

Workshop series aims

- To discuss the critical role that research and innovation play in tackling health inequalities and in the wider health agenda.
- To begin conversations between ICSs that involve the relevant stakeholders and, ultimately, make tackling health inequalities regionally easier.

These free sessions are delivered virtually and are co-chaired by Professor Patrick Vernon OBE (Birmingham and Solihull ICS) and Dr Chris Weiner (Joined Up Care Derbyshire ICS). Anyone interested in practical actions and ICS process development regarding health inequalities and research is welcome to attend.

Opening presentations

Previous sessions saw 50-80 attendees from across the Midlands, including the NHS, Higher Education England, academia, and local authorities. Each workshop begins with an opening presentation to kick off discussions. These have included:

- ICS Health Inequalities Strategies and Boards – Prof Patrick Vernon OBE (Birmingham and Solihull ICS)
- Collaborative working with the University of Nottingham – Prof Ian Hall (University of Nottingham)
- Health Innovation Network facilitated discussion on how Innovation and Real-World Evidence plays an integral part in the NHS – Tim Robinson and Chris Taylor (East Midlands Health Innovation Network)
- The Midlands Diabetes Blueprint and Diabetes Joint Strategy – Prof Melanie Davies (University of Leicester)
- Workforce Challenges: Health Inequalities – Dr Chris Weiner (Joined Up Care Derbyshire ICS)
- Connecting across systems – John Vesey (West Midlands 5G)
- Partnership working in response to the Midlands Health and Care Inequalities Policy Commission – Alex Archibald (MI Health)

Early opportunities are demonstrated by the agreement to work towards a joint Midlands ICS strategy for diabetes and consideration of regional NHS apprenticeship activity.

https://mihealth.org.uk/MIHealth/Joint-ICS-Meetings

CHAPTER 6. FUTURE RESEARCH, TRANSLATION, AND IMPLEMENTATION REQUIREMENTS

As highlighted in this report, there is a clear necessity to further investigate not only the aforementioned health and care inequalities, but also the large, growing, and interlaced factors that create and drive them. It is vital that our researchers comes together with key regional partners to work directly with communities in order to create impact from Midlands research. The following chapter discusses the research gaps identified through community feedback and policy analysis. These have been grouped by area of focus below, and are supported by the relevant papers where appropriate:

Focus and representation in research and clinical trials: [36 133 135 136 181 200 258 340 341 342 343 344 345]

Lack of inclusion – There is a significant lack of research focused on and/or studies involving:

- a locally representative range of ethnic minority communities
- disadvantaged, vulnerable, or underserved groups or those not registered with a GP
- those experiencing severe/enduring mental health problems, drug or alcohol harm issues, communication difficulties, or people with low literacy levels
- care leavers, Gypsy, Roma and Traveller communities, refugees, asylum seekers, sex workers, those in prison, the homeless, or unemployed people
- either younger (<16 years old) or older (>70 years old) people compared with the recently retired
- those experiencing challenges of intersectionality and MLTC.

A lack of representation in research not only impacts clinical outcomes (such as the effectiveness of medical equipment on different ethnicities), but also the efficiency of non-medical interventions aiming to tackle health inequalities. The difficulties in engaging and recruiting from these groups (including a lack of trust, reduced opportunity, and process challenges/tax implications in reimbursement) need to be addressed in trial design and by working with, for example, the Research Support Service (RSS).

To build confidence in future health interventions, the NIHR and the NHS Race & Health Observatory should both seek to increase representative participation in clinical trials and research, for example by promoting the INCLUDE Ethnicity Framework[346] and incentivising studies to do so.

Taskforce 4 Summary – Improving ethnic minority participation in health and social care research

Underrepresentation in research contributes to the persistence of inequalities in health outcomes, access to healthcare, and healthcare provision, and is contrary to plans to tackle health inequalities. This Taskforce reviewed the barriers and facilitators for increasing participation that should be considered when developing future work.

Barriers to representation

1. Features of research and researchers
   - Cultural competence of researchers
   - Increased research costs (e.g. translation)
   - Healthcare provider attitudes
2. Factors from the perspective of minority groups
   - Sociocultural factors
   - Not understanding research
   - Inaccurate or unregistered housing
   - Fear of the unknown, mistrust, and stigma
   - Low use of health services
   - Cultural norms
3. Contextual factors
   - Practical barriers, such as transport
   - Underrepresentation in academia, science, health services
   - Facilitators to representation
   - Effective PPIE
   - Effective feedback
   - Effective recruitment strategies
   - Representation

Limited scope of research with certain groups: Evidence of health outcomes in homeless people relates mainly to tobacco use, while the evidence on people with learning disabilities focuses mainly to physical inactivity. These evidence gaps may limit efforts to tackle risk behaviours in specific groups. Similarly, few systematic reviews have studied smoking, diet, alcohol use, and physical inactivity in low income or disadvantaged groups. Further research is, therefore, required (similar to what has been achieved through this Policy Commission) to investigate interventions, barriers, and facilitators of change for specific groups experiencing lower health outcomes.

Differences between and within rural and coastal communities: Significantly more research is needed on small scale geographies, particularly rural and coastal health. This is largely due to limited data availability, compounded by a lack of an agreed definition of a coastal or rural community. Future research outcomes should include the efficacy and cost-effectiveness of health, social care, and technology-enabled interventions to reduce inequalities; the strengths and assets of non-rural coastal areas; and multi-disciplinary research to understand the multiple drivers of poor health outcomes.

Research utilising high-quality methods (such as randomised controlled trials) is essential, as is the continual improvement/development of new deprivation indications specific to rural communities. The Index of Multiple Deprivation (IMD) – widely-used datasets to classify relative deprivation – is considered to be of reduced accuracy in rural communities compared to urban counterparts. There is a need for either further improvement to the IMD (including variables, such as the cost of living in rural areas, infrastructure for access and cost of services) or for an entirely new index of rural deprivation. It is recommended that any new index be made up of a different set of metrics and reflect the differing contributory factors that impact rural or coastal areas. This would enable improved statistical information on health outcomes in these areas and could reveal differences and inequalities within small areas that are masked by national statistics. The IMD has been described as over-aggregated, thus missing the extent of deprivation and the full range of benefits to the fortunate, making it less effective for use in health inequalities work than its intended deprivation comparison. Further investigation is needed to determine the benefits of both approaches.

The increasing challenge of and for our ageing society: A significant gap in research exists on social connections in later life (particularly for groups such as LGBTQIA+ or those living alone) and the implications of this on health. To support this, further data is needed on those who may be living without social connects (e.g. those living alone and ageing without children) to ensure adequate provision to meet future care needs of groups more likely to need paid care and support services. More research is also needed into inequalities in healthy ageing felt by particular groups such as the Gypsy, Roma and Traveller community, prisoners, veterans, ethnic minorities, the homeless population, and those in rural and coastal areas.

There were also several questions raised over the course of the Policy Commission:

- What are the implications of medical information being conveyed in non-native languages or via third parties (e.g.

translators, interpreters, family members, or non-specialist liaison officers)?

- Is trust a determinant of health outcomes? Is this a positive indicator of health outcomes, considering that racism has been found to have a detrimental effect on health, and those who experience it have worse outcomes across many areas of mental and physical health.
- How do intersectionality and MLTC impact upon health outcomes?

Innovation and Change Management: [10 90 126 127 132 134 135 136 181 183 189 190 248 341 347 348 349 350 351 352 353]

New research techniques or processes – Opportunities exist to deliver innovative approaches in the following areas:

- Ensure that all research on health interventions includes health equity impact assessments.
- Deliver a systematic cost-benefit analysis of interventions to improve clinician communication with patients.
- Investigate and clearly outline how research and innovation can address health inequalities through driving better healthcare outcome and increasing economic activity.
- Develop an agreed framework and standards for proportionate universalism in the current UK context.
- Consider how social prescribing can bridge the gap between formal services and community activities.
- Perform qualitative analysis into the views of disadvantaged groups about behaviour change interventions, allowing common barriers across groups to be identified, as well as factors that are unique to a specific group.
- Explore opportunities to work with local VCSEs to plug gaps in provision.
- Study the use of technology, peer groups, and other techniques to support the region's social care sector in responding to the increase in demand for services to address isolation.
- Investigate the effectiveness of nature-based activities through social prescribing in promoting wellbeing and mental health, and in reducing social isolation.
- Investigate a broader anti-poverty narrative as a basis of more systematic reform.
- Work with the NHS to perform root cause analysis and evaluation of interventions. Ensuring that all quality assurance measures include consideration of staff experiences and other indicators by ethnicity.
- Evaluate how positive collaborative responses to the COVID-19 pandemic can be recreated given the pivot back to slower and less innovative pre-pandemic approaches.
- Consider how working within funding restrictions may limit the potential to develop intergenerational projects to reduce isolation and tackle stigma.
- Investigate the effectiveness of testing children before the age of 6 against updated tools for diagnosing autism and ADHD, including potential reduction of stigma, assistance with learning patterns, and raising awareness of behaviours across different ages, genders, and condition combinations.

Understanding impact (short- and long-term effects): Research studies and trials should routinely examine the quality and distribution of intervention impacts across communities, in particular on socioeconomically disadvantaged areas and underserved groups. This is particularly important where the intervention relates directly to a lack of access to health services, e.g. assessing the impact of interventions to improve screening uptake in groups that see lower engagement and are perceived as more difficult to reach.

There is a considerable lack of information on the 'unintended consequences' of activities to generate an uplift in skills and employment. One such example is the use of active labour market programmes to generate economic growth, which can lead to health improvements (particularly mental health benefits), but little has been done to understand these impacts and identify the key factors that lead to their creation. Interventions also have the potential to increase health inequalities (intervention-generated inequalities) if impacts are not planned and monitored appropriately, for example, where there is a lack of service consistency across communities and where certain interventions are not accessible for all, e.g. nature-based social prescribing.

There is little evidence regarding the 'reversibility' of disadvantage on health. This is of particular importance given the wide range of impacts created by the COVID-19 pandemic, not just on people's physical and mental health (including those of health and social care workers who battled against these inequalities despite already constrained resources and budget) but also on the wider determinants of health that are the key drivers of change (for better, or in this case, often worse). The long-term impacts of the interventions utilised to tackle the COVID-19 outbreak (including health outcomes, societal behaviour, childhood development, mental health, and economic growth) also require further investigation.

In terms of health outcomes, the need to understand impact requires additional investment and infrastructure to support **further investigation into research topics which require long-term study**:

- Investigate the interaction between multiple disadvantage, intersectionality and poor health outcome.
- Assess the indirect impacts of COVID-19 and the measures used to restrict its spread, e.g. the social and cultural impacts across all age groups, ethnicities, and faiths; for example, the impact of children's development, and understanding of facial expressions and emotions, and the communication of health information when living in a multi-generation household.
- Learn from effective interventions methodologies (for example, those used for flu vaccination amongst ethnic minorities and deprived populations) to inform future vaccination programmes and other interventions.
- Understanding the short- and long-term impacts created for a family when one or more parents/guardians are in prison.
- Further research working with those suffering from long COVID, both therapeutic and through rehabilitation.
- Prioritise research to improve understanding of chronic conditions with growing prevalence, such as diabetes and obesity, linking to improvements to care and services.
- Investigate the incidence of long-term health conditions, such as in diabetes, focusing on the timing of onset, cardiometabolic, or mental health conditions in relation to ethnicity and socioeconomic status.
- Identify specific risk factors within local populations that are potentially driving increases in rates of chronic diseases, linking to the development of targeted interventions to help address these risks.
- Study maternal health in those who have a history of complications, such as gestational diabetes.
- Examine the impact that reduced mobility (for example, for those that stay at home) will have on chronic conditions.

Supporting the development of community-based approaches: A firm evidence base that identifies the strengths and assets within communities is fundamental to effectively building community contributions into a central role within place-based strategies to address health inequalities. It is important that all partners – including communities – understand their potential and collaborate to develop actions based on this understanding. All assets within communities should be included, such as the skills and knowledge, social networks, local groups, and community organisations. Research funding should allow these approaches to expand to include actively engaging and educating major employers on evidence-based interventions that can help keep their workforce healthy and productive.

Additionally, if all future research with communities built in capacity and skills development for community providers as part of 'action research', it would not only deliver improved outcomes but also enable effective evaluation of interventions and create a cycle of upskilling attached to community-based approaches.

There were several questions raised over the course of the Policy Commission:

- Who is responsible for delivering change in health outcomes and patient/staff experience? Should it always be the responsibility of the victims of inequalities to report injustices?
- Is there an opportunity for innovation in the triaging of patients as it impacts emergency response care and times?
- Can the current medical model of care be translated effectively into a social model? For example, the development of a social model of care for those with disabilities that values their abilities and ambitions instead of focusing on their weaknesses.
- Could technology be utilised to support parents/carers/patients to record symptoms, diet, environment, and experiences that can be seen and used by medical professionals to diagnose and monitor conditions such as autism, ADHD, dementia, and other conditions that change/present differently over time and in different situations, etc.?

Health Literacy: [90 181 183 188 241 305 354]

Intervention efficiency – Creating the foundations and necessary skills effectively within our current and future communities requires a deeper understanding of the effectiveness of different interventions:

- Large-scale, robust, and clearly defined research is needed to better understand the effect of health literacy interventions on health inequalities, including how best to improve the health literacy of disadvantaged or vulnerable people (appropriately adapting information and services, and strengthening people's skills and capabilities), how to improve organisational health literacy and the effects of initiatives on clinical and health outcomes over time and cost-effectiveness (including people's abilities, and the information and systems they are presented with).

- Further evidence is required to identify the best strategies to improve the health literacy of specific disadvantaged or vulnerable groups – that is, appropriately adapting information and services, and strengthening people's skills and capabilities – and to reduce health inequalities.
- Efforts should be made to ensure adequate detail about the health literacy baseline and/or associated interventions is presented in studies, to enable shared learning, as well as more regular reporting health-related self-efficacy outcomes (as opposed to clinical outcomes).
- Investigation should be performed into the link between levels of health literacy and the provision of clear and accessible health and social care services and information for all (service responsiveness).
- The ways in which the burden of improving health literacy can be shifted from patients/citizens to services should be considered, matching their abilities, and connecting in a relatable and understandable way.
- Rigorous evaluation studies and theory-based interventions applying quality research design should be prioritised.

Childhood dietary practices and their impact on health: There is a gap in research regarding interventions to improve the understanding of what and how children are fed, particularly for very young children. Despite the known risk factors for child obesity, few intervention studies (including feasibility studies) have been undertaken for pregnant women that continued during infancy. There is some international evidence that multicomponent obesity prevention interventions delivered during early life have a positive impact on short-term weight trajectories[355]. Interventions that contain information and support for caregivers about responsive feeding are more effective[356]. However, there is currently no universal offer of information and support about responsive feeding to caregivers, although the NHS offers support and advice for mothers who breastfeed. This disproportionately impacts infants living in socioeconomically deprived areas and those of an Asian background, who are more likely to be fed with formula milk and who are also more likely to develop childhood overweight and obesity.

There were also a number of questions raised over the course of the Policy Commission:

- What is the impact of the 'breast is best' blanket messaging for those that can't or won't breast feed? Is there a significant impact on breast feeding rates when wider information on nutrition is available?
- What are the impacts of further incorporating fathers into maternity care and child service activities?
- Maternity services are housed within healthcare while childhood health interventions are often approached more collaboratively (as reflected in this report's structure), but is this correct? What would the impact be of bringing maternity care into a collaborative, multi-organisational space?

Data, linkage, and infrastructure: [10 64 90 190 249]

> *"The pandemic saw greater use of new and collaborative data sources and rapid data and evidence collection to inform policy, as well as the high-profile use of scientific expertise in making key policy decisions." (The Health Foundation, 2021)*[190]

Inclusive, accurate, and linked data collection – further study is needed to harness the potential of digital health:

- Additional research is required to understand the most needed, representative, and deliverable methodology and standards for recording ethnicity, gender, sexual orientation, language, lifestyle, living environment, cultural differences, and other important and protected characteristics, ideally linking to patient health records through TREs. This activity must be delivered with an understanding of the current and potential use for the data gathered and protected sufficiently (whilst remaining collaborative) to maintain trust.
- Careful consideration is needed in the deployment of artificial intelligence (AI) and precision medicine so as not to exacerbate health inequalities further, particularly considering the lack of diversity in genomics data, clinical trial participant representation, and the current access and uptake of innovative medicines.
- Despite the valiant efforts of many across the region, there is still work to be done to organise and correct existing NHS data. This should be viewed as a priority as it undermines the accuracy of future data collection.
- Work is needed to engage communities to understand the degree of granularity at which they feel ideally represented and not 'lumped together'.
- There is an opportunity to understand who communities feel should and shouldn't be trusted with their data and

when. For example, this Policy Commission found that participants would have been happy for Public Health Directors to have details at house- or individual-level regarding COVID-19 status and recovery condition during the pandemic, and would be happy for this to be done should a future outbreak occur.

Collaboration to address societal need: Continuing and expanding these collaborative data sources has the potential to provide the evidence and monitoring opportunity to identify and even address many of the digital and service challenges highlighted through this Policy Commission. These actions must be delivered in conjunction with appropriate support for data entry and analysis. For this to be achieved effectively, silos need to be broken down and partners given the ability and support to collaborate to challenge societies biggest problems. To that end, this Policy Commission strongly recommends the creation of a regional centre of evidence:

The Midlands Centre for Evidence:

Establish a long-term centre for evidence, which works collaboratively across the Midlands to develop essential underpinning data for the joint delivery of interventions and research programmes, and detailing frameworks for delivery, such as for clinical research and data sharing. This centre would bring together and further existing networks, promote agreed standards in line with both national guidelines and local requirements, and share tested innovation and best practice. Partners in this centre should include academic, industry, VCSE, local authority, regulatory, and NHS organisations. There should be a focus on those who understand system delivery as well as data analytics, health inequalities, and policy. The priority should be identifying, testing, and scaling solutions to societal challenges across the region. To facilitate national impact, the centre should also partner with organisations such as NHS England, OHID, and the Institute for Health Equity.

The centre should also help to navigate the complex research environment and provide signposting to evidence. This is of particular interest to Midlands ICS infrastructure as they further develop their strategies and research opportunities. To facilitate this and to provide a single place for comparable metrics upon which public health and interventions can be monitored by regional partners, the centre should facilitate a long-term data platform with open and protected areas depending on the data to be displayed. A partnership approach is essential to produce measurable and comparable health outcome data.

A question was raised over the course of the Policy Commission:

› How can systems and policies be updated to record/monitor patients turned away before accessing services or those that are rejected from care (e.g. being removed from a GP’s register)?

CHAPTER 7. APPENDIX

Taskforce leads and representatives

Taskforce 1

Prof Kamlesh Khunti	University of Leicester	Primary Care Diabetes and Vascular Medicine
Dr Alexis Paton	Aston University	Sociological Bioethics in NHS Decision-Making
Dr James Brown	Aston University	Ageing and Metabolism
Prof Kate Jolly	University of Birmingham	Public Health and Primary Care
Prof Krysia Dziedzic	Keele University	Musculoskeletal, Knowledge Mobilisation, and Public Involvement
Dr Ash Routen	University of Leicester	Public Health
Prof Paul Downward	Loughborough University	Economics: Health and Wellbeing, and Social Capital
Prof Liz Orton	University of Nottingham	Public Health
Prof Swaran Singh	University of Warwick	Social and Community Psychiatry
Prof Paramjit Gill	University of Warwick	Health Inequalities
Dr Alan Dolan	University of Warwick	Director of Social Work, Centre for Lifelong Learning
Prof Dieter Wolke	University of Warwick	Developmental Psychopathology, Social and Emotional Development
Prof Sudhesh Kumar	MIH Convenor (Until July 2021) and Dean of Medicine at the University of Warwick	
Alex Archibald	MIH Project Manager	
Sarah Alton	MI Public Affairs Manager	

Colleagues engaged offline:

- Prof Denise Kendrick – University of Nottingham
- Prof John Gladman – University of Nottingham
- Prof Adam Gordon – University of Nottingham
- Prof Justin Waring – University of Birmingham
- Prof Catherine Needham – University of Birmingham
- Prof Derek McGhee – University of Stirling (previously Keele University)

Taskforce 2

Dr Laura Kudrna	University of Birmingham	Research Fellow
Dr Paul Edmondson-Jones	Staffordshire & Stoke-on-Trent Integrated Care Board	Chief Medical Officer
Professor Carol Graham	Brookings; University of Maryland; Gallup	Senior Fellow; College Park Professor; Senior Scientist
Dr Spencer Gibson	University of Leicester	Research Associate

Taskforce 3

Ramat Ayoola	University of Warwick	Medical student and MREM Network Chair
Kiran Bhavra	University of Leicester	Medical student and MREM Conference Director
Amy Jaiteh	University of Warwick	Medical student and MREM Student Collaborator

Taskforce 4

Dr Krysia Canvin	University of Keele	Research Fellow for Involvement and Engagement,
Dr Laura Kudrna	University of Birmingham	Research Fellow,
Dr Winifred Ekezie	Diabetes Research Centre, University of Leicester	Research Associate

Policy Forum and Survey Participants

Asylum Seekers Policy Forum.

Facilitator: Barbara Czyznikowska, Community Engagement Officer, Centre for Ethnic Health Research, NIHR Applied Research Collaboration East Midlands (NIHR ARC EM)

Carers Policy Forum.

Facilitator: Barbara Czyznikowska, Community Engagement Officer, Centre for Ethnic Health Research, NIHR ARC EM

Nottingham Black Community Policy Forum – Senior Leaders Group.

Facilitator: Denise McLean, Community Member and Senior Technical Specialist, School of Life Sciences, Faculty of Medicine and Health Sciences, University of Nottingham

Nottingham Black Community Policy Forum – Members Group.

Facilitator: Denise McLean, Community Member and Senior Technical Specialist, School of Life Sciences, Faculty of Medicine and Health Sciences, University of Nottingham

Eastern Europeans Policy Forum.

Facilitator: Barbara Czyznikowska, Community Engagement Officer, Centre for Ethnic Health Research, NIHR ARC EM

Faith Leaders Policy Forum.

Facilitator: Barbara Czyznikowska, Community Engagement Officer, Centre for Ethnic Health Research, NIHR ARC EM

Gypsy, Roma and Travellers Policy Forum.

Facilitator: Barbara Czyznikowska, Community Engagement Officer, Centre for Ethnic Health Research, NIHR ARC EM

Keele South Asian Men Policy Forum.

Facilitator: Adele Higginbottom, PPIE Project Co-ordinator, Impact Accelerator Unit, Keele University

Keele Research User Group.

Facilitators: Dr Alice Moult, Post-doctoral Researcher, Keele University. Anna Hough, PPIE User Support Worker, Impact Accelerator Unit, Keele University

Dance vs Diabetes – Leicester Bollywood Dance Group.

Facilitator: Rebecca Pritchard, Patient and Public Involvement Manager, Leicester NIHR Biomedical Research Centre

South Asian and Black Women Policy Forum.

Facilitator: Barbara Czyznikowska, Community Engagement Officer, Centre for Ethnic Health Research, NIHR ARC EM

West Midlands Trauma & Burns PPI Group.

Facilitator: Dr Laura Nice, Patient & Public Involvement/Engagement Manager, NIHR Surgical Reconstruction & Microbiology Research Centre (Trauma Research) & The Scar Free Foundation Centre for Conflict Wound Research. Dr Laura Kudrna, Research Fellow, Institute of Applied Health Research, University of Birmingham (NIHR ARC WM)

West Midlands ARC PPIE Group.

Facilitators: Magdalena Skrybant, Patient and Public Involvement and Engagement Lead, NIHR Applied Research Collaboration West Midlands (ARC WM). Niyah Campbell, Public Involvement and Engagement Officer, NIHR ARC WM

Midlands Medical Student Survey (online).

Facilitator: Midlands Racial Equality in Medicine (MREM) Network

Midlands NHS Staff Survey (online and via email).

Facilitator: Dr Laura Kudrna, Research Fellow, IAHR, University of Birmingham (NIHR ARC WM)

Opinion Pieces

Dr Carter Singh MBE: Partner, Willowbrook Medical Practice

Dr Singh MBE is a GP Partner at Willowbrook Medical Practice, GP Governing Body Board Member at NHS M&A CCG, Notts LMC Committee Member and RCGP Faculty Board Member. He has been awarded an MBE for services to healthcare in Nottinghamshire.

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Christiana Melam: Chief Executive Officer, National Association of Link Workers

Christiana Melam is an influential, award-winning CEO of the National Association of Link Workers and was listed in the 2021, 2022 Health Service Journal's 50 Black, Asian, and Minority Ethnic Influential Health Leaders Power List.

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Dr Jane Bryan: Reader in Law, University of Warwick

Dr Bryan is a Reader in Law and the Community Values Lead at the University of Warwick. She is a Senior Fellow of the Higher Education Academy and a non-practising solicitor. Her research interests include the power of dialogue to build, maintain, and restore relationships.

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Prof Mark Lewis: University Academic Lead for Strategic Partnerships, Loughborough University

Professor Lewis is Dean of the School of Sport, Exercise and Health Sciences at Loughborough University. He is Professor of Musculoskeletal Biology and his research interests focus on the basic sciences of musculoskeletal regeneration and repair.

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Dr Mubasshir Ajaz: Head of Health and Communities, West Midlands Combined Authority

Dr Ajaz is the Head of Health and Communities at the West Midlands Combined Authority, focusing on health inequalities, mental health and wellbeing, physical activity, and place-based health. He has 20 years' experience in health and care, ranging from cancer research to local and regional public health.

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Prof Pip Logan: Professor of Rehabilitation Research, University of Nottingham.

Professor Logan is an occupational therapist researching health services rehabilitation, with particular emphasis on the community. She also works clinically for Nottingham City Care Partnership (NHS) and in the Acute Hospital for the Health Care of the Elderly Directorate.

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Dr Ruw Abeyratne: Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust

Dr Abeyratne is University Hospitals of Leicester's Director of Health Equality and Inclusion, accountable for how the Trust understands and addresses health inequalities. She works closely with the ICS, local government and VCSE to meet community needs, and is a practising consultant in Geriatric and General Medicine. ruw.abeyratne@uhl-tr.nhs.uk

Sue Frossell: Director, Coventry Health Determinants Research Collaboration

Sue Frossell is a Public Health Consultant working within Coventry City Council. One of her key public health interests is the impact of the wider determinants (housing, jobs, education, etc.) on health inequalities; Coventry's 'Marmot City' agenda is currently one of her lead areas.

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Case Studies

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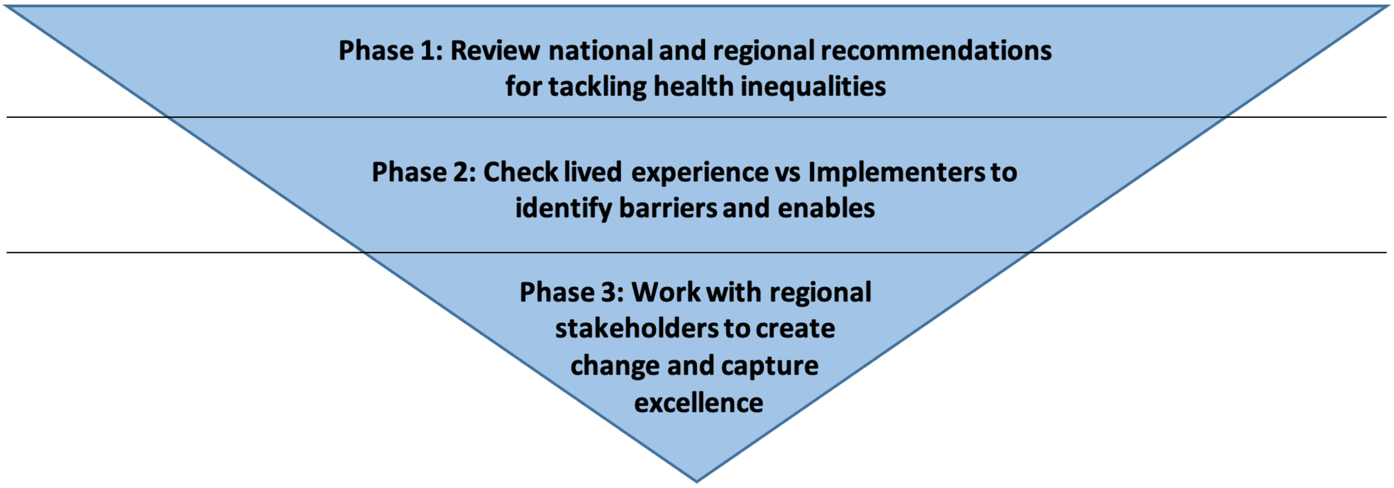
Methodology – A phased approach

The Commissioners developed a 3-phase approach for delivery, designed to narrow down decades of research, policy work, and health interventions. By combining this knowledge with the latest community needs and working with regional health and care leaders, the team created a roadmap for change. This is depicted in the diagram below:



Phase 1: Report collation, policy interviews, and recommendations review

The Policy Commission performed an extensive policy literature review, looking at national, regional, and local recommendations and policies for tackling health inequalities. This activity was supplemented by interviews with key stakeholders to identify critical themes, reports, and data sets that needed to be built into the initial analysis. In total, the Commission reviewed over 400 reports, the recommendations from which were then grouped and combined to form the proposed activity list that has facilitated the engagement work.

Phase 2: Policy forums, further interviews and testimonials and collation of draft actions

Co-development and championing of our communities, frontline staff and local leadership have been central to the Policy Commission. It was vital that we work alongside the extensive expertise of individuals, groups, and organisations to enable a wide range of opinions to be captured whilst not ‘reinventing the wheel’. This approach allowed the Commission to appropriately acknowledge critical areas of inequalities, without pre-empting results or introducing bias.

The primary mechanism through which we engaged with communities and community-focused organisations were 90-minute in-person or virtual group in-person or virtual discussions (Policy Forums) and individual interviews. Each group was led by a community member or trusted researcher, with a member of the Commission team present to answer questions and take notes. Participation in the Policy Forums with communities ranged from lay community members to specialist PPIE groups. These participants were recruited through registration via an online form (the link for which was shared extensively through Midlands Innovation Health partner networks, regional contacts, and the Commissioners), email contact with the team, working to spread the opportunity through regional community projects/studies, social media, and personal contacts of colleagues and interviewees.

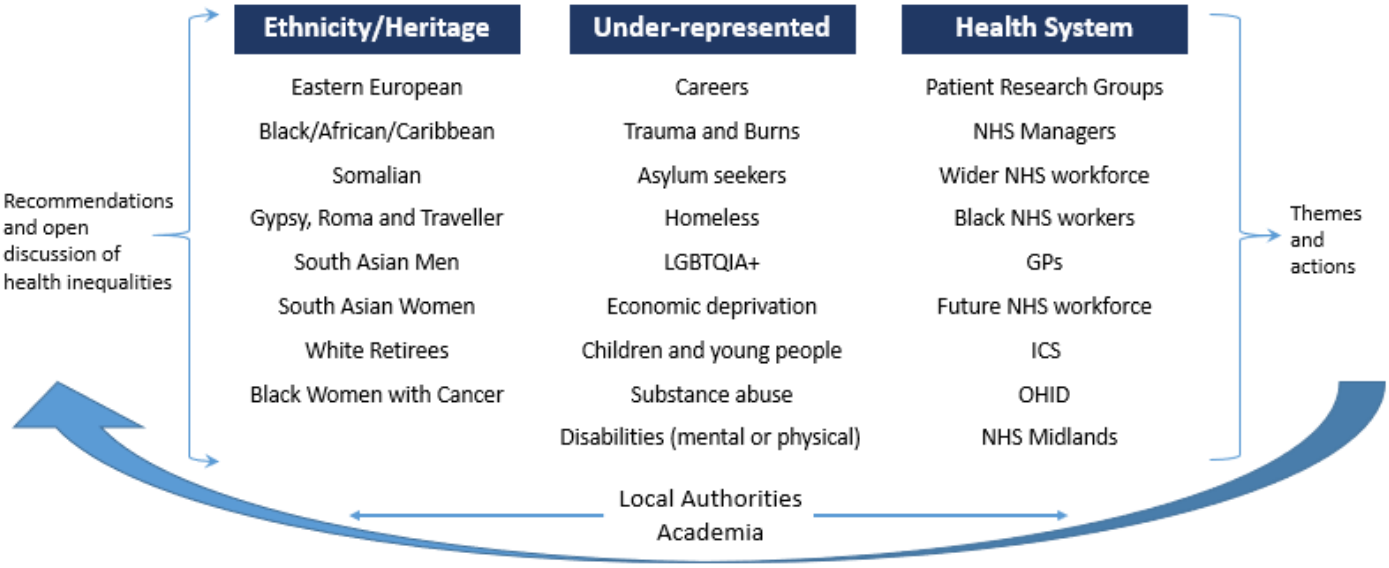
The Policy Forums were structured to facilitate conversations that loosely followed the appreciative inquiry methodology (questions to build a vision for the future, focusing on past and potential future successes to tackle challenges), whilst also allowing facilitators and participants to lead the conversation. Following the meetings, the meetings notes were coded using thematic analysis[357][358] (taking information discussed and summarising it into key topics and points).

Engagement was achieved following the principles of NIHR guidance on co-producing a research project, which includes standards on PPIE and reimbursement[359][360]. Done poorly, co-creation can lead to negative outcomes, “including fatigue, distress and frustration arising from the strain of sustaining joint decision-making”, which we aimed to prevent by using established guidelines in our approach[207].

Discussions from the Policy Forums were further supplemented with input from interviews with key regional stakeholders (such as local authorities and charities) and virtual workshops with Midlands ICSs. This was then combined and fed back to communities to consider and was adjusted where necessary (this was achieved either via email, virtual group meetings, or 1:1s with community leaders).

Information gathered during this process was then coded using thematic analysis. Coding is the process of taking a discussion and summarising it into key topics and points. Notes from the first meetings were used to create a ‘coding frame’ and these codes were applied to future meetings[361], with any future codes added to the frame. Thus, this was an inductive and deductive approach.

Across the programme, 318 people were engaged directly. The diagram below demonstrated the Phase 2 engagement process:



Taskforces

Running alongside the programme of work were a series of Taskforces designed to delve into or highlight specific areas that were identified as priorities of concern or necessary regional context. The findings of these activities supplemented the findings of the Policy Commission:

- **Scoping health inequalities landscape and challenges in the Midlands (Phase 1)**
- **An early warning system for preventing ill health and wellbeing (Phase 2)**
- **Welfare, education, and development of the future healthcare workforce (Phase 2)**
- **Improving ethnic minority participation in health and social care research (Phase 2)**

Phase 3: Stakeholder engagement and change management

To ensure that this work delivers impact for the Midlands, the Commission team will continue to work directly with local, regional and national stakeholders to assess change for 12 months following the report launch. Activity of note includes delivering joint projects across the regional ICSs and working with the King’s Fund (Commission partner) to utilise their work in the region on systemic intervention models.

Health and Care in the Midlands

A snapshot of Midlands' health outcomes

As defined earlier in this Policy Commission (page 24), Core20PLUS5[108] is a national NHS England approach to support the reduction of health inequalities at both national and system level. This approach has been selected to guide our understanding of health inequalities across the Midlands given its nationwide acceptance and flexibility at a local level.

The following health conditions have, therefore, been reviewed across the Midlands. The first 6 conditions align with the Core20PLUS5, plus smoking cessation across these 5 areas, while healthy state life expectancies, diabetes, and obesity have been identified as persistent issues for the Midlands.

1. **Infant mortality**
2. **Premature mortality in adults with severe mental illness (SMI)**
3. **Chronic obstructive pulmonary disease (COPD)**
4. **Cancer diagnosis**
5. **Hypertension**
6. **Smoking cessation**
7. **Health state life expectancy (HSLE)**
8. **Diabetes**
9. **Obesity**

Infant mortality[362]: In 2021-23, the infant mortality rate in the Midlands was 5.3 per 1,000, above the England rate of 4.1 per 1,000. At a regional level, the West Midlands remains the highest region for the infant mortality rate at 5.9 per 1,000. The East Midlands rate was 4.4 per 1,000, which was the 4th highest region – both above the England rate. Five of the top 10 districts were in the Midlands – Birmingham (1st, 8.4 per 1,000), Leicester (3rd, 7.7 per 1,000), Stoke-on-Trent (4th, 7.6 per 1,000), Sandwell (6th, 7.1 per 1,000) and Stafford (10th, 6.6 per 1,000). While areas like Chesterfield and West Lindsey were on the lower end at 1.1 per 1,000 and 1.8 per 1,000 respectively.

Premature mortality in adults with severe mental illness (SMI)[363]: At a sub-region level, the premature mortality in adults with SMI in 2021-23 was 118.3 per 100,000 for the East Midlands (4th highest) and 115.1 per 100,000 for the West Midlands (5th highest), while the England rate was 110.8 per 100,000. Where data is available, local areas in the Midlands show Stoke-on-Trent was 198.5 per 100,000 and Leicester was 174.2 per 100,000. Areas such as Rutland (81.5 per 100,000) and County of Herefordshire (82.7 per 100,000) were much lower.

Chronic obstructive pulmonary disease (COPD)[564]: In 2023/24, the prevalence of COPD was 1.9% for overall Midlands; matching the England-wide figure. However, figures vary across the 65 local authorities with East Lindsey (3.6%), North East Lincolnshire (3.0%), and Bassetlaw (3.0%) the highest down to Rushcliffe (1.3%), Rugby (1.3%) and Leicester (1.2%) the lowest.

Cancer diagnosis[365]: In 2021, approximately 53.9% of cancers were diagnosed at stages 1 and 2 for the Midlands area, this was slightly below the England-wide figure of 54.4%. At a local level within the Midlands (where available), there were higher proportion of cancers diagnosed at stages 1 and 2 in Broxtowe (61.3%), Stafford (61.0%), and Dudley (60.5%), while areas such as Oadby and Wigston (43.5%), Boston (45.9%), and Charnwood (46.7%) had lower rates of cancers diagnosed.

At a sub-regional level (excluding London as a value cannot be calculated), the East Midlands region had the 3rd lowest rate for cancers diagnosed at stages 1 and 2 at 52.9%. The West Midlands was 4th highest at 54.7%. The England rate was 54.4%.

Hypertension[366]: In 2023/24, the prevalence of hypertension was 15.7% for the Midlands area; this was above the England-wide figure of 14.8%. At a local level across the Midlands, areas with higher levels include: East Lindsey (22.3%), Staffordshire Moorlands (20.7%), Malvern Hills (20.7%), and Wyre Forest (20.6%), while areas such as Nottingham (11.0%), Birmingham (12.4), and Coventry (12.5%) had lower levels.

At a sub-regional level, the East Midlands region had the 3rd highest rates for hypertension at 15.9%. The West Midlands was 4th lowest at 15.5%, however, this was still higher than the England-wide rate.

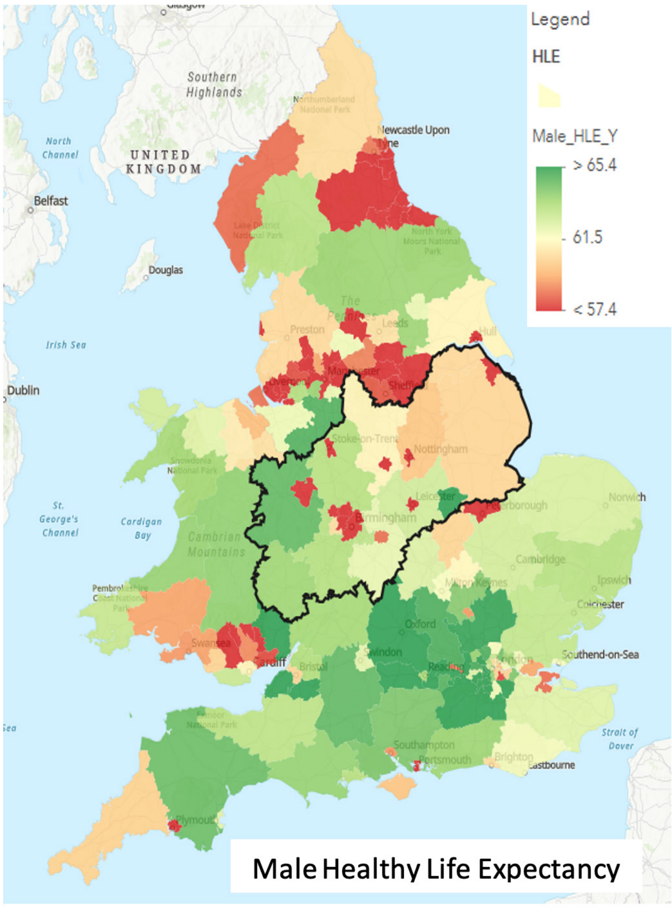
Smoking[367]: In 2022/23, the smoking prevalence in adults (aged 18+) for current smokers was on average 12.6% for the Midlands area, which was lower than the England proportion of 13.6%. Within the Midlands, smoking prevalence for current smokers was higher in Redditch (18.8%), Nottingham (18.2%), and Stoke-on-Trent (18.1%), while 10 areas were under 10%, the lowest: Lichfield (7.0%), Rutland (8.3%), and Derbyshire Dales (8.3%).

As of 2022/23, 28.4% of adults in the Midlands area would class themselves as ex-smokers, above the England-wide figure of 26.3%. Within the Midlands, ex-smokers were higher in Melton (40.6%), High Peak (34.1%), and South Holland (33.7%), while areas which were lower include Leicester (16.0%), Birmingham (20.6%), and Coventry (21.2%).

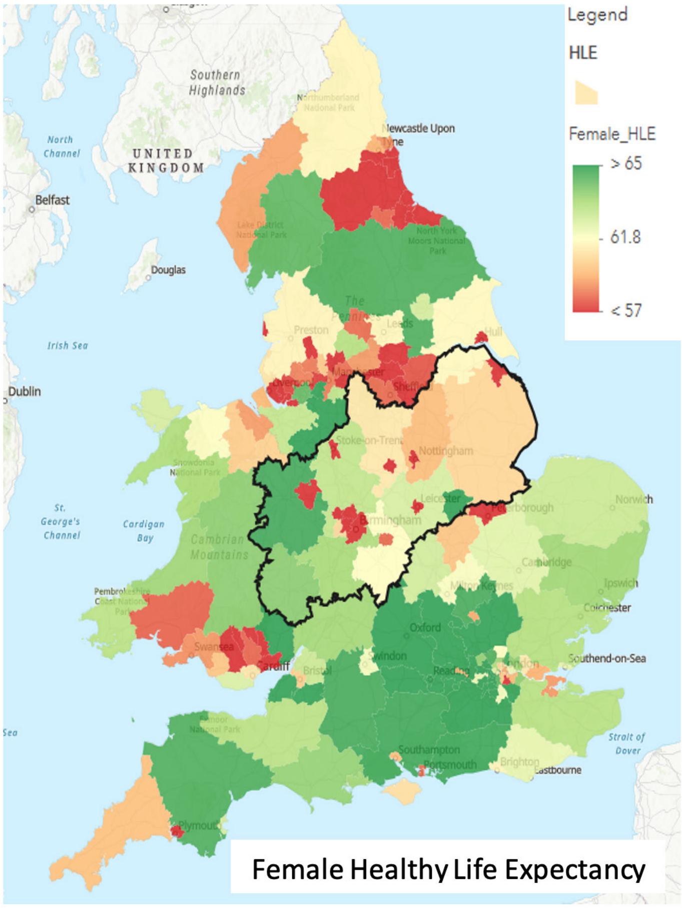
Health state life expectancy (HSLE)[368 369]: The average male HSLE for the Midlands area for 2021 to 2023 was 59.9 years, below the England-wide figure of 61.5 years. The average female HSLE for the Midlands for 2021 to 2023 was 59.7 years, below the England-wide figure of 61.9 years. This means that, on average, 23.5% (male) and 27.6% (female) of the lives of Midlands citizens is spent in 'poor' health.

Across all Midlands, Stoke-on-Trent, and North East Lincolnshire have low levels of full life expectancy and healthy life expectancy, while Rutland has high levels.

The average male disability-free life expectancy for the Midlands area for 2018 to 2020 was 60.9 years, below the UK-wide figure of 62.0 years. The average female healthy disability-free life expectancy for the Midlands area for 2018 to 2020 was 58.9 years, below the UK-wide figure of 60.7 years. This means that 22.6% (male) and 28.6% (female) of the lives of Midlands citizens is spent experiencing a disability.

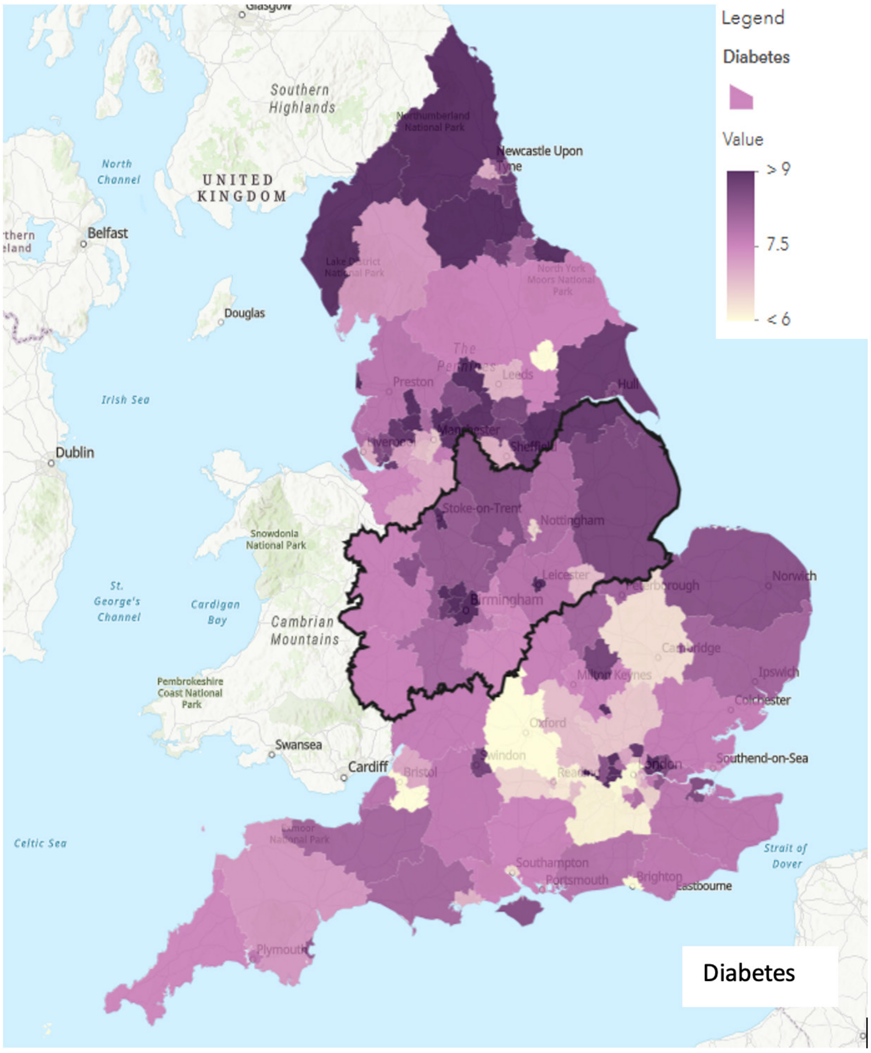


Male Healthy Life Expectancy



Female Healthy Life Expectancy

Diabetes[370]: The prevalence of diabetes (aged 17 years and over) was recorded at 8.4% for the Midlands in 2023/24, above the England-wide proportion of 7.7%. As seen in the following map, there are particular hotspots in Sandwell (10.5%), Walsall (10.4%), and Leicester (10.3%). At a regional level, the West Midlands had the highest prevalence of diabetes at 8.6% nationally, with the East Midlands having the third highest at 8.1%.



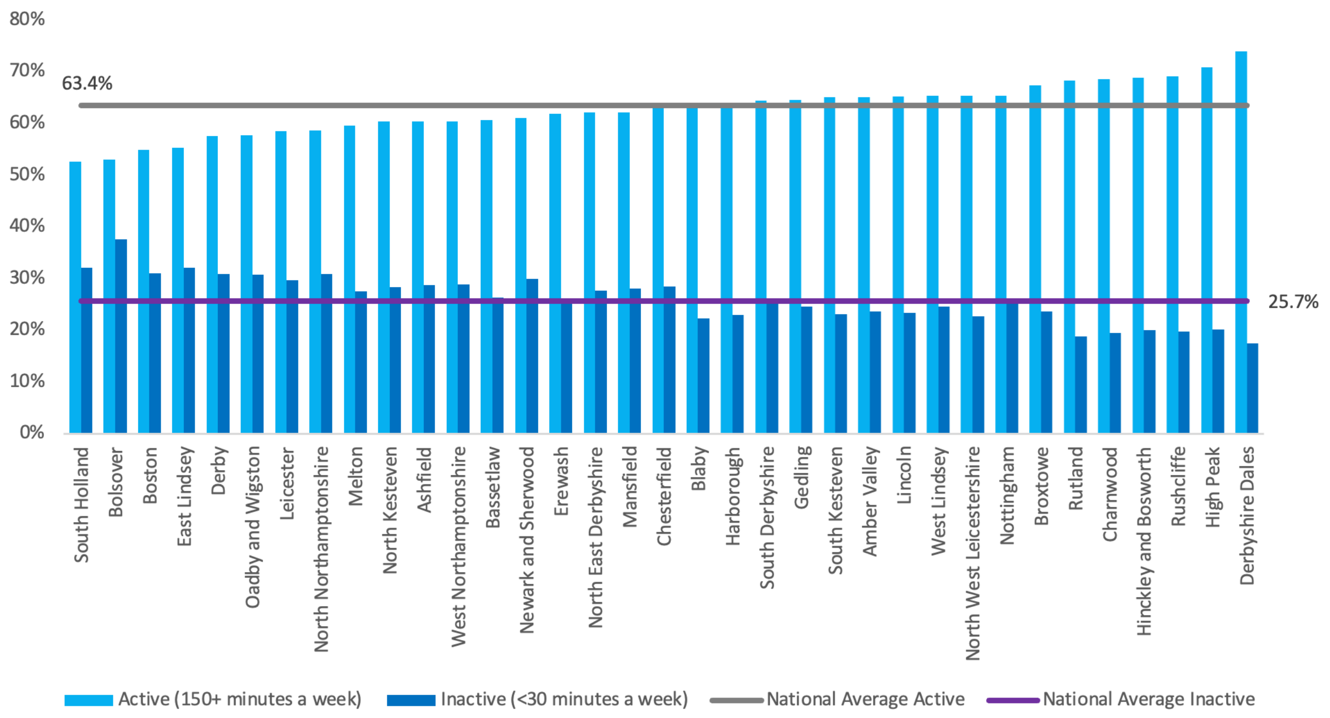
644,190 people have been diagnosed with type 2 diabetes in the Midlands – approximately 15% of the UK diabetic population (4.32 million). Research from Novo Nordisk (NHS Digital, National Diabetes Audit) shows that, over 10 years, the potential saving through avoiding lost workplace productivity by improving type 2 diabetes control is estimated to be £1.795bn across the UK. The Midlands 15% share would equal £269.25m.

Obesity[371]: On average, 67.1% of Midlands residents (aged 18+) were classed as overweight (including obesity, using adjusted self-reported height and weight) in 2022/23 – above the England-wide figure of 64.0%. The West Midlands region was the second highest at 67.0%. Within the Midlands, 48 local areas were above the England-wide figure, with Cannock Chase being the highest at 76.0%, which was followed by Stoke-on-Trent at 73.8% and Tamworth at 73.8%. At the other end of the scale, Warwick (57.3%), High Peak (59.1%), and South Kesteven (59.6%) had the lowest proportion of adults classed as overweight or obese in the Midlands.

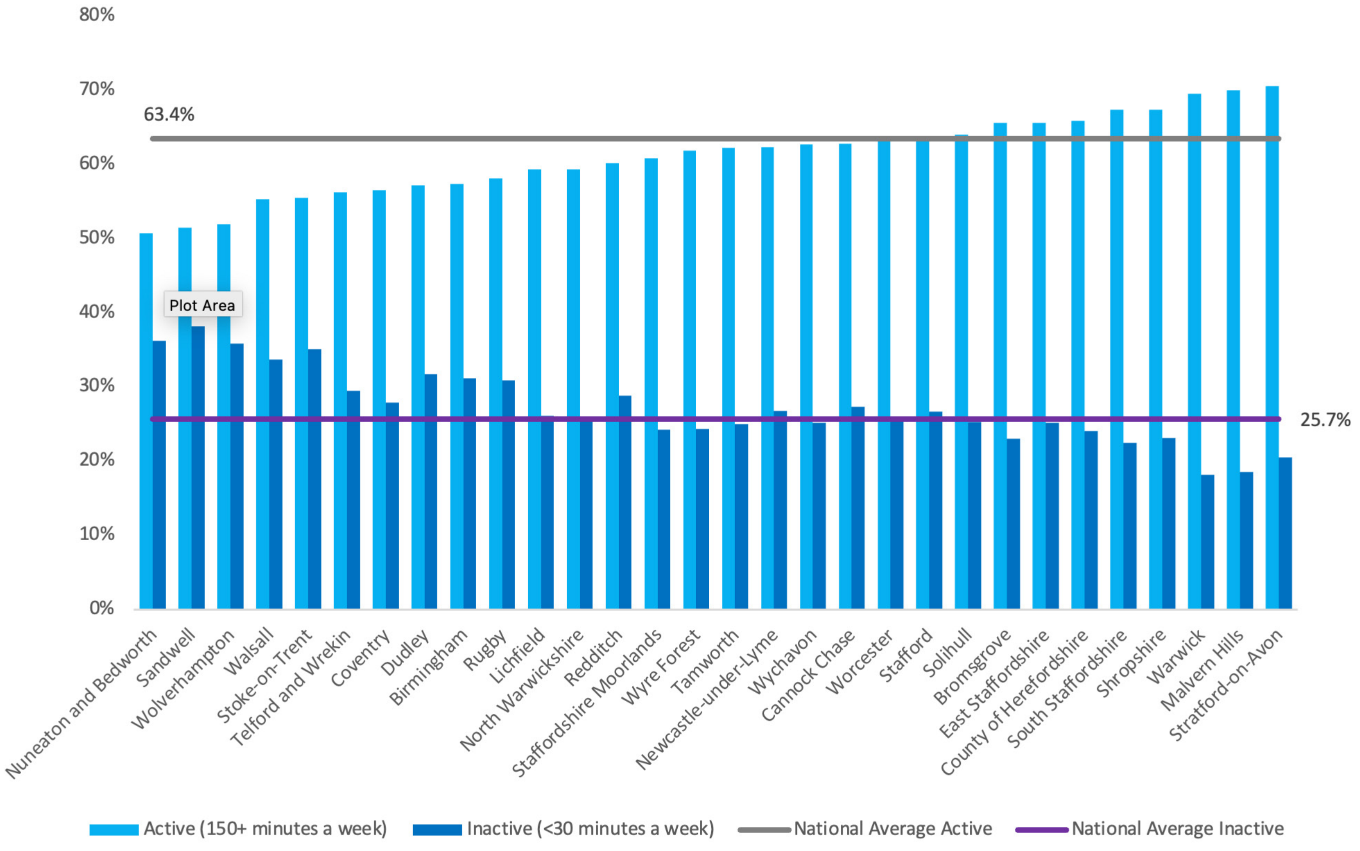
In 2023/24, approximately 37.6% of year 6 children were overweight (including obese) in the Midlands – above the England proportion of 35.8%. Within the Midlands, Sandwell had the highest rate for year 6 children that were overweight (including obese) at 44.6%, this was followed by Wolverhampton at 44.3%, and Mansfield at 42.7%. In contrast, Rushcliffe (26.8%), Warwick (27.5%), and Rutland (28.6%) had the lowest levels in the Midlands.

Obesity levels link to many complex and interdependent factors, most of which are difficult to monitor and have limited data available. Regular physical activity has been associated with a reduced risk of obesity (as well as reduced risk of diabetes, osteoporosis, and colon/breast cancer, and with improved mental health), the levels of which are shown for the region in the following charts (November 2022-2023)[323].

East Midlands Physical Activity – Adults



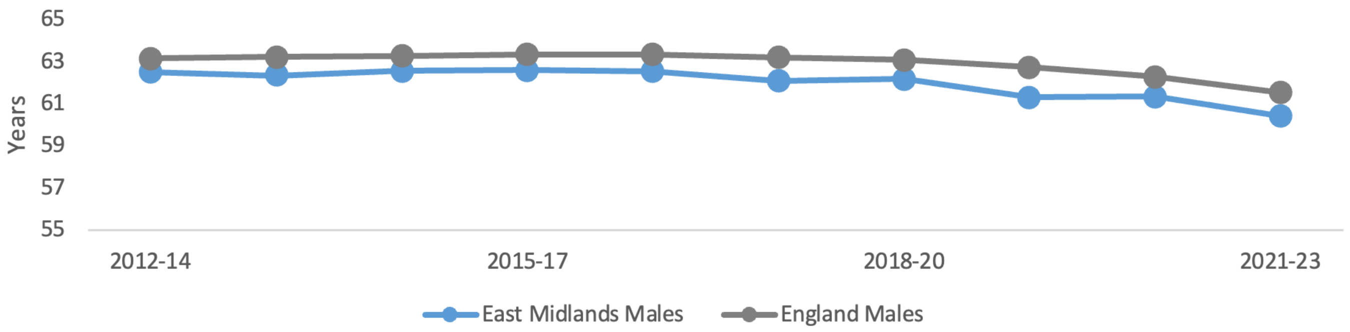
West Midlands Physical Activity – Adults



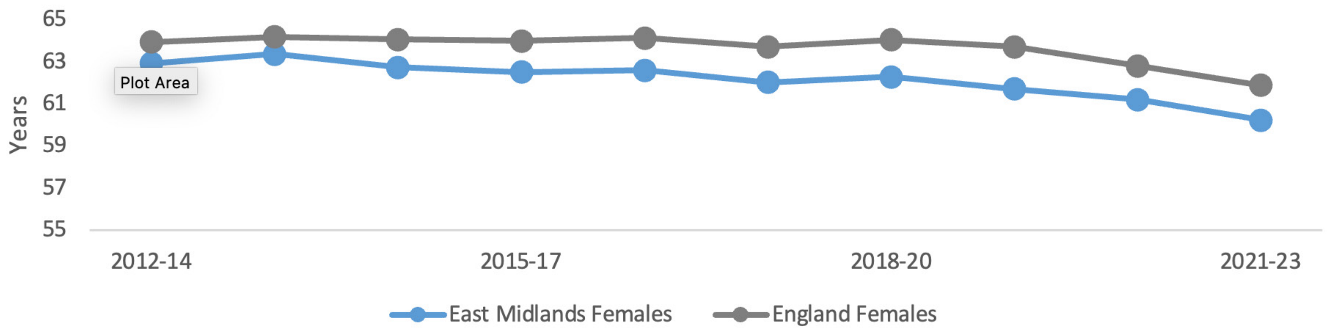
Trends in Healthy Life Expectancy

Healthy Life Expectancy (HLE) is a key indicator of a population’s health. In the Midlands, average HLE (at birth) shows downward trends, as shown below.

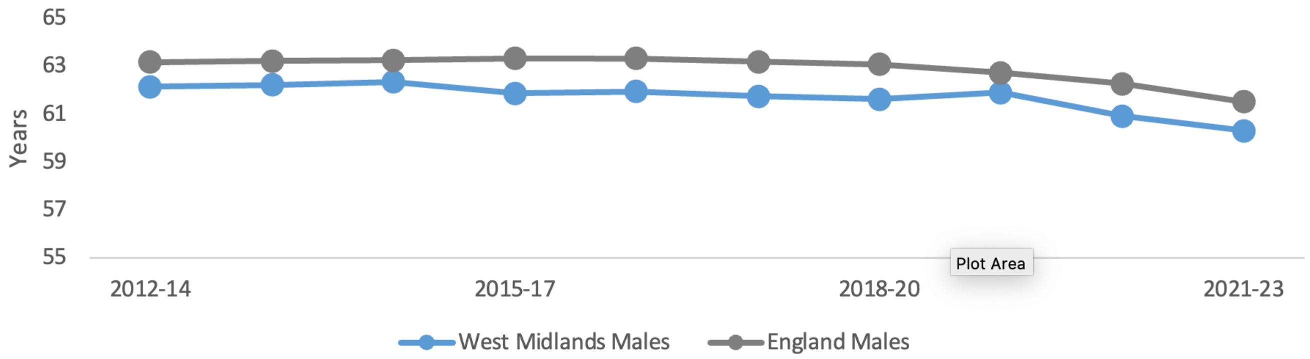
East Midlands – Male[372]



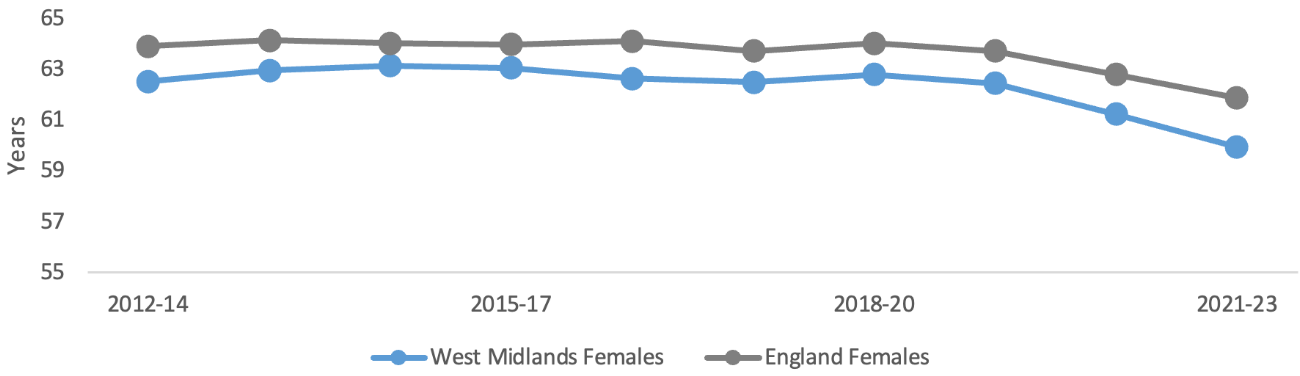
East Midlands – Female[373]



West Midlands – Male[374]

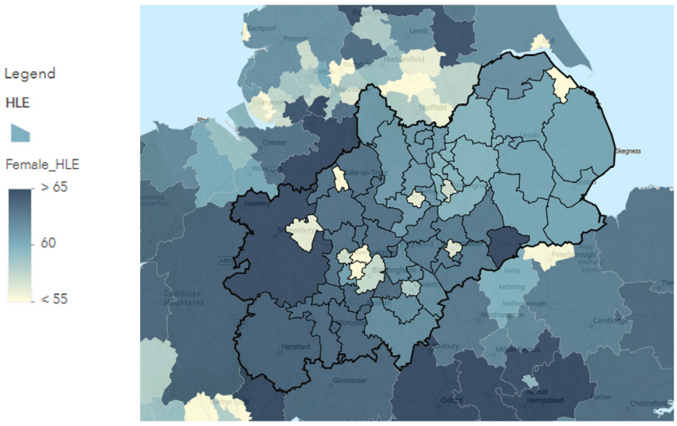


West Midlands – Female[375]

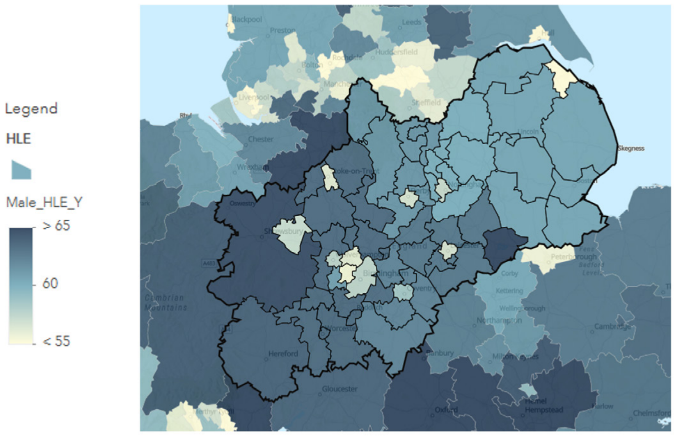


The following maps depict the number of healthy years expected by sex and local authority across the region (2021–2023).

Female Healthy Life Expectancy



Male Healthy Life Expectancy



Taskforce 1 – Scoping health inequalities landscape and challenges in the Midlands

To consider the landscape and fundamental themes (including wider determinants) that underpin health inequalities in the Midlands (including the impacts of the COVID-19 pandemic) a group of multidisciplinary experts were brought together from across the Midlands Innovation Health partnership to determine whether the views of the expert group reflect those of the wider healthcare community and the public.

Virtual meetings with experts: Over the course of 2 virtual scoping sessions (1 hour each), the experts were asked to share their views on the different aspects of health inequalities, consider which have had the biggest impact in the Midlands, and review how this might have changed as a result of the pandemic.

Online survey: An online survey was distributed asking respondents to rank the identified impacts in order of highest priority for the Midlands (1 high – 7 low) and to make suggestions of any other themes that might have been missed. The survey was distributed via social media, academic and clinical projects, partnerships with clinical colleagues, and via the region's PPIE infrastructure. 88 responses were collected.

Discussion summary:

Ethnic minority health:

- Need a deep understanding of how to reach communities and gain their trust. Ethnic minorities can act as an exemplar for other groups, e.g. traveller communities.
- Tackle issues that have underpinned low uptake of the vaccine.
- Improve public health messaging within these communities. Translate recommendations between health promotion and prevention strategies, e.g. cancer trials, blood transfusion and organ transplants.
- Disproportionate impacts of COVID-19 and indicators other than deprivation.

Elderly:

- What impact has COVID-19 had on our elderly and care home populations?
- With a considerable proportion of services now delivering online, what impact has this had?
- If there is a long-term shift to online healthcare delivery, what does this mean for access for the elderly?
- Staying at home has reduced injuries, but what impact will reduced mobility have on chronic conditions?
- Infection control in and between care homes.

Youth:

- Children/adolescence – poverty, mental health, and long-term health impacts of loss of education and development.
- Students/first job – mental health and economic impacts on health outcomes.
- Family settings, bullying, and domestic violence
- What do we need to be monitoring?
- Practical interventions, e.g. school- and university-based mental health interventions.

Deprivation:

- Place: location, service availability, and housing availability.
- Engaging socially/economically deprived groups.
- The impact of COVID-19 on lifestyle behaviours such as diet and physical activity.
- Housing availability, local air quality, and access to green space.
- Digital exclusion (can we collaborate with our strong medical technologies sector?)

Public health and social care provision:

- What are the 1-, 2- and 5-year impacts on health service demand due to suspended provision?
- What will the impact be on long-term condition management?
- What impact will a reduction in public funding have on health, dignity, and quality of life?
- How will care be delivered going forwards?

Multiplicity for providers of social care and managing quality across the sector.

- Barriers to access and the medium-/long-term impacts of this.
- The role of co-production in rebuilding services.

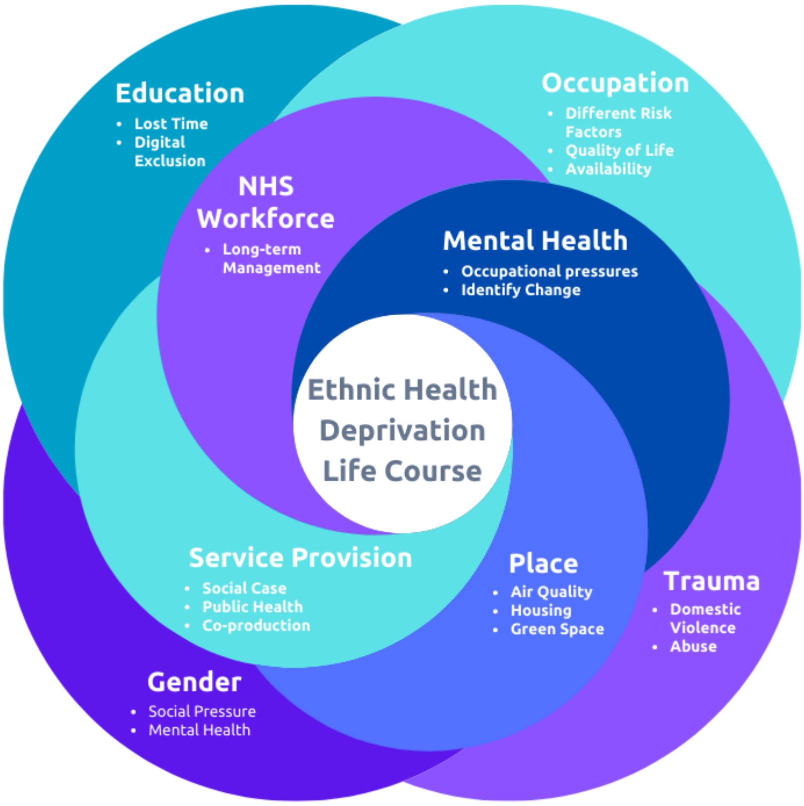
Employment:

- How has the ability to work from home vs frontline workers altered outcomes?
- What do we need to do to train the NHS workforce of the future?

Gender:

- How have social and economic pressures varied across gender?
- Mental health issues.

The views of the expert group regarding the health inequality concerns for the Midlands in the context of COVID-19:



Online survey:

The key areas highlighted though the survey were similar, but not identical to those chosen by the academic experts. The majority of the 88 respondents identified **deprivation as the highest priority** area for the Midlands (average rating 2.47), health and **social care provision as second** (3.18), **ethnic minority health as the third** (3.23).

Mean priority rank (1 = highest priority; 7 lowest):

1. Deprivation = 2.47
2. Health and social care provision = 3.18
3. Ethnic minority health = 3.23
4. Young people = 3.93
5. Elderly populations = 4.20
6. Employment = 4.53
7. Gender = 6.02

Other areas of interest (within or outside of the existing areas) included:

- Access (healthcare / support / advocacy / information)
- Intersectionality
- Education
- Housing
- Unemployment
- Community engagement and co-production
- Social interaction / wellbeing / mental health
- Childhood environment
- Criminal activity
- Addiction – alcohol, drugs, gambling, etc.
- Faith / spirituality
- Investment into research
- Linking health and wealth

Full Phase 1 – Community Feedback

What are the barriers to fair and equal health for all?

We spoke to community members from a wide range of backgrounds and received many responses. Some were specific to certain communities, but most were common across many.

Access: [Recruit more staff with varied skills, Community liaisons officers, and Place-based community services]

- Recruit more staff with varied skills – There is a deep understanding that many issues come from an extreme shortage of staff across the healthcare system.
- Community liaisons officers, social prescribing link workers and health champions – more of these, particularly in GP surgeries, would improve trust, tackle language / cultural barriers, and improve communication / health outcomes.
- Place-based community services – Volunteer transport networks are a great example of ways to improve access, attendance, and wellbeing.

Trust: [Community involvement, Faith/community leaders in healthcare settings, Mandatory cultural competency programmes, Long-term, inclusive planning, and Improved community relationships with services]

- Community involvement – Use networked, bottom-up, and community-led approaches to change and information sharing, including health champions.
- Faith/community leaders in healthcare settings – This would improve trust and mental health, facilitate communication, and improve health outcomes.
- Mandatory cultural competency programmes – Making cultural awareness a long-term, planned, ever-developing part of career development for all staff.
- Long-term, inclusive planning – Breaking the culture of short-term thinking, small-funded projects and tick-box attitudes will improve service consistency.
- Improved community relationships with services – Dedicated staff going into the communities with the worst health outcomes and building trust.

Representation: [Employment policies, Oversight and process, Workforce development, and Diverse clinical trials]

- Employment Policies – Furthering the existing NHS policies to recruit based on values not qualification. Anchor institutions to create more senior opportunities.
- Oversight and process – Ensure both senior decision-making processes and daily delivery include health inequalities through policy and impact measures.
- Workforce development – Ensuring inclusive and diverse education is available to create a representative and understanding future workforce.
- Diverse clinical trials – Funders should require people from all backgrounds to be involved in the testing / development of new drugs / devices to ensure accuracy.

Digital: [Data sharing for vulnerable people, Digital inclusion awareness / training / champions, and Non-digital alternatives]

- Data sharing for vulnerable people – Developing a set of policies that enables information to be shared with carers as well as next of kin.
- Digital inclusion awareness, training, and champions – Understanding the limitations of digital literacy and access can help as much as digital skills training.
- Non-digital alternatives – Paper / in-person options should always available e.g. online / in-person appointments, sign-in pods / reception, online / in-person prescriptions.

Knowledge: [People powered health and Wider determinants]

- People powered health – Empower people to care for their physical / mental health and seek help, including preventative healthcare and lifestyle changes.
- Addressing / understanding wider determinants – Build a better understanding of the interconnected nature of the economic, social, and environmental factors that impact health. This will enable prioritising tackling health inequalities over cost-effectiveness.

Taskforce 2 – An early warning system for preventing ill health and wellbeing

We need to be proactive rather than reactive

Addressing health inequalities requires an approach that is proactive rather than reactive. We need to identify and address the causes of ill health and wellbeing before they manifest in disparities across groups. The systems aiming to address disparities should intervene early rather than reacting to problems once they arise.

In social care it is often said that it is important to prevent, reduce, or delay[376] needs. Although it will not be possible to prevent every fall or each infection, reducing their number or delaying them for a period would be beneficial. We should seek to prevent, reduce, or delay problems like multiple disadvantage[37]7, whereby someone experiences a combination of homelessness, substance misuse, mental health issues, domestic abuse, and contact with the criminal justice system. Often, it is easier to intervene before problems like these arise.

We need an effective early warning system

We should start using screening systems that act as an early warning system for later problems with health and inequalities. People and groups scoring poorly on certain indicators should be referred to local community and voluntary services[378] that can intervene. Ideally, data should come from already existing official sources, such as the Annual Population Survey, although we need this data to be disaggregated by group (age, ethnicity) at local authority or lower geographic levels for effective targeting.

What should go into the early warning system? Some indicators are known. In the United States, deaths of despair[379] (due to self-harm and drug misuse) in local areas are preceded by high levels of worry and low levels of optimism. We can look at local levels of personal wellbeing[380] in the UK to understand where to target in this region. A social needs screener[381] could be useful but it would need to be brief and ideally not require new data collection. Could we forecast which areas need more assisted care buildings? Predict cardiovascular disease or Alzheimer's from local activity levels? Researchers can help by identifying the best predictors.

What existing data do we have available to use in the Midlands?

Datasets that could feed into an early warning system include:

1. Office for National Statistics (ONS) datasets

- Personal wellbeing (regional data[382])
- Gross disposable household income (regional data[383])
- ONS deprivation scores[50] (including income), excel sheet data for main deprivation score (file 2 – ranking for deprivation, file 3 deprivation for children and adults384, file 7: All rankings[50]
- Labour market statistics[385]
- Wider socioeconomic data via ethnicity[386]

2. SHAPE datasets (SHAPE Place Atlas[387])

- Nitrogen dioxide levels
- Sulphur dioxide levels
- Particulate matter levels

3. Air Pollution

- Air pollution vulnerability indicator (NO2)
- Air pollution vulnerability indicator (PM2.5)
- Air quality management areas

4. NOMIS Labour market data

- Labour market profiles (including employment by local authorities)[388]

5. OHID fingertips data

- Respiratory Disease - previously known as Inhale389 - (lung function indicators including asthma)

Taskforce input:

- Dr Laura Kudrna, Research Fellow, University of Birmingham – Policy Fellow of the Commission
- Dr Paul Edmondson-Jones, Chief Medical Officer, Staffordshire & Stoke-on-Trent Integrated Care Board
- Professor Carol Graham, Leo Pasvolsky Senior Fellow at Brookings, College Park Professor at the University of Maryland, Gallup Senior Scientist
- Dr Spencer Gibson, University of Leicester

Taskforce 3 – Welfare, education, and development of the future healthcare workforce

Methodology

Focus groups and interviews were conducted with representatives from the General Medical Council (GMC) and the Medical Schools Council Equality, Diversity and Inclusion Committee (MSC EDIC). Academic and clinical staff representatives from 5 member institutions of the Midlands Racial Equality in Medicine (MREM) Network (Medical Schools of Leicester, Lincoln, Keele, Birmingham, and Warwick) also participated in the focus groups.

Students from across all Midlands medical schools were invited to partake in a mixed methods survey. 53 students from across Midlands institutions who are enrolled on a variety of medical courses completed the survey. Although the call was open to all students, respondents all identified themselves as being from an ethnic minority background (EMB).

Findings and Recommendations

The GMC have recently published the Midlands Charter (2020) regarding the effect of COVID-19 on inequality in medical practice. The charter "recognises the determination of providers to restore and reset education and training and to establish the Midlands region as a beacon for postgraduate education", with a particular focus being equality and diversity targets set by the GMC. Despite this, a number of areas of concern were raised across the groups engaged.

An overall lack of trust (across all organisations) was raised by students and several of the stakeholders as a primary barrier to reporting harassment and discrimination, including fears of facing retribution for raising concerns. The MSC EDIC is concerned that this lack of trust also plays a key role in the underrepresentation of people from EMB in the later stages of academia.

This Taskforce recognises that supporting the development of the future healthcare workforce is a multifactorial process and, therefore, we have outlined a series of recommendations to help to build trust and support welfare, education, and development.

Finding 1: It was highlighted that despite many institutions having robust reporting processes, **students may not always be aware of how best to raise a concern or the support services available**. This is especially felt during clinical years, which see students rotate around various hospitals on placement, leading to additional confusion about whether to raise the concern with their home institution or the hospital's Trust. Concerns were also raised about the ability of different support mechanisms to enact change. This compounds distrust in the efficacy of reporting systems.

Recommendations:

- Institutions to streamline and signpost their reporting and escalating concerns procedure, as well as annually reminding students of the appropriate procedures.
- During induction for every placement block, students should be signposted towards the hospital's reporting concerns process and the pastoral support available to those that may experience harassment and discrimination.
- The GMC to liaise with NHS Trusts and Health Education England to develop and implement a zero-tolerance policy on racism from patients (similar to the existing policy against tolerating violence) to combat apprehension about facing racism on placement.
- Strong, cross-organisational, and continually reviewed processes, linked to an accountability structure, to be further developed to quickly address racism from other staff members while on placement.

Finding 2: The most important role education has to play in the development of the future workforce is to establish a diverse and culturally aware medical knowledge across the health sector. To deliver this, it was felt that **further work is needed to improve the curriculum, as well as the teaching environment to ensure encouragement of inclusive thinking**.

Recommendations:

- The GMC to hold medical schools accountable for implementing inclusivity and teaching on health inequalities within the curriculum, including releasing specific EDI objectives for medical schools to achieve.
- Continue to decolonialise the medical curriculum and to actively include examples of how different conditions present across different ages, genders, and ethnic backgrounds.

Finding 3: The challenges presented by academic progression are not the same for all. It is thought that discrepancies in equitable awarding of research grants and promotions limit the progression of those from between undergraduate and post-graduate studies. Furthermore, data has shown that students from certain EMBs are more likely to be from low-income backgrounds, and are therefore, alongside other students from low-income backgrounds, more likely to be impacted by the financial strain of academia (i.e. conference costs, etc.).

Recommendations:

- Programmes to encourage and support the progression of EMB students through academia to be embedded within the frameworks and curriculums of the medical schools.
- Initiatives should be implemented to support underrepresented students to pursue careers in academia including, but not limited to, mentoring schemes for students from EMB and financial support for students from low socioeconomic backgrounds.

Finding 4: Student and staff collaboration groups were valued by all as a key method of building working relationships and trust, and were seen as facilitating escalation of concerns. This is because students reported feeling more comfortable reporting concerns to people they identified with, for example, other EMB students or staff. Furthermore, many institutions were proud to have active staff and student collaboration groups (such as the University of Leicester's MedRACE group) working towards racial equality by addressing topics such as the Awarding Gap. The GMC encourage utilisation of both informal and formal networks for peer support (such as Melanin Medics, who they collaborate with on research and campaigns).

Recommendations:

- All medical schools to have a student–staff collaboration group dedicated to empowering students from EMB and ensuring equity of experience and education.
- The response to the Midlands Charter should seek to create a professional link with student networks to acknowledge students and trainees as active and important participants in tackling equality.

Finding 5: Implementing effective training exploring how best to support students that may experience discrimination and bullying was felt to be a critical method of empowering staff. Face-to-face active bystander training is generally well received at the institutions that offer it, especially when compared to online training modules which often do not integrate the capacity to explore any concerns staff may have. Furthermore, students also emphasised the importance of including sensitivity to cultural and religious practices within training.

Recommendation:

- Supplementary face-to-face EDI training should be introduced for students, clinicians, student-facing staff, and academics as part of the annual training regimen including, but not limited to, active bystander training.

Finding 6: Despite many institutions having staff who are passionate about tackling discrimination, **staff reported having difficulties dedicating enough time to these activities** alongside their existing roles. Limited departmental budgets also impact the implementation of more inclusive resources, and initiatives.

Recommendation:

- All institutions to employ a full-time staff member, with a protected budget, trusted with the responsibility of leading EDI initiatives across institutions – ideally with a specific focus upon the medical school or similar.

Taskforce 4 – Improving ethnic minority participation in health and social care research:

A Taskforce to learn and build on other and ongoing work to create specific actions for change

Taskforce Chair: Dr Krysia Canvin. Supported by: Dr Laura Kudrna and Dr Winifred Ekezie

Remit: The Taskforce was convened to examine the impact of disproportionate representation in health research and clinical trials and to agree on specific actions to tackle those impacts in the Midlands.

Objectives:

1. Assess the current situation and ascertain what is known about the implications of this imbalance.
2. Examine barriers and facilitators.
3. Identify approaches that have been tested, and their impact.
4. Agree on actions for change.

Method: The Taskforce consulted with representatives from across the region and beyond to identify and collate existing evidence and examples of innovation that can inform recommendations.

Background: In the UK, people from minority ethnic groups have a higher burden of disease, lower mortality, and poorer health outcomes compared to White British citizens. Examples include higher rates of heart disease in the African population, type 2 diabetes in people of African-Caribbean and South Asian origin, asthma-related admissions in people of South Asian and African-Caribbean origin, psychotic disorders including schizophrenia and mania in the Caribbean and African heritage population, and depression and common mental disorders amongst British South Asian women. Yet they experience inequalities in access to care for conditions such as cardiovascular disease, dementia, and mental health services[390 391 392 393] and negative experiences of healthcare and public health interventions deter their uptake of health services in general[394].

Underrepresentation in health and social care research: The Declaration of Helsinki[395] states that medical research involving human subjects must provide 'appropriate access' to participation for underrepresented groups, yet rates remain low[391 394 396 397]. For example, one review found that the mean percentage of South Asian participants in 8 of the 12 trials reviewed was 5.5%, despite South Asians comprising 11.2% of the UK type 2 diabetes population[396]. In the summer of 2020, there were 1,500 COVID-19 trials registered on ClinicalTrials.gov, but only 6 collected data on ethnicity – despite overrepresentation of patients from ethnic minority backgrounds with severe COVID-19[398 399]. Although these populations are sometimes perceived as 'hard to reach', they are willing to take part in research when it is explained clearly[400]. It is important than involvement efforts are not tokenistic, which includes a consideration of power imbalances in the research process and building trust[401].

Why does representation matter?

> *"An intervention offered in a place people do not visit, at a time when they cannot engage, in a language they do not understand by a person their community is unable to trust will not benefit these individuals even if it works well for others in society."[397]*

Representation in research matters because:

1. **Potential for treatment differences:** Evidence suggests that ethnic origin can affect the metabolism of drugs, concurrent diseases, and counter-indications; examples include treatments for diabetes, hypertension, and hepatitis C.[397]
2. **Potential influence of societal and cultural backgrounds:** Behavioural change interventions, for example, may be affected by perceptions of causation and attitudes to services (e.g. how illness and its causes are perceived, or attitudes towards healthcare providers).[397]
3. **Relevance and generalisability of the results:** The composition of the sample affects the generalisability of the trial results to the general population[390 393] and affects opportunities to conduct subgroup analyses specifically pertaining to ethnicity.[397]
4. **Equity:** Clinical trial participants have better health outcomes, access to 'state of the art' treatment and closer disease monitoring and management.[393 397]

5. **Expense:** When patients are not able to contribute to the economy by working because they are unwell, this has significant economic costs. In the United States, the costs are estimated in the billions over time.[401]

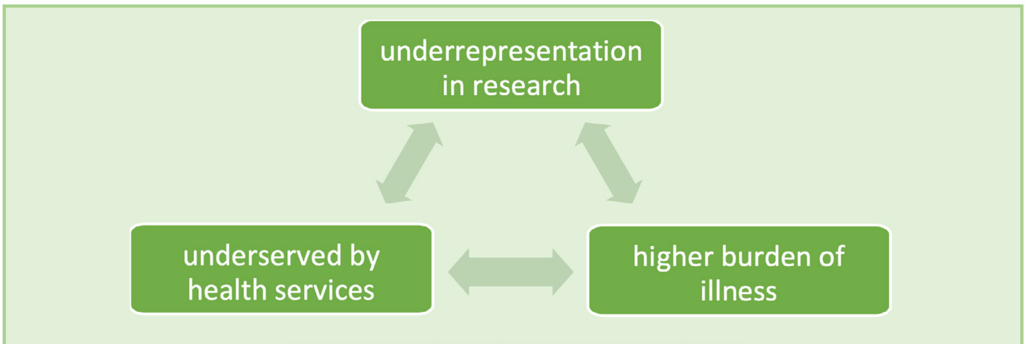


Figure: Cycle of health inequalities

Underrepresentation in research contributes to the persistence of inequalities in health outcomes, access to healthcare, and healthcare provision,[390] (Figure) and is contrary to plans to tackle health inequalities[393].

Why are ethnic minority groups underrepresented in health research?

Key barriers to representation

1. Features of research and researchers
Hussain-Gambles et al.[394] argue that current research methods and designs often result in ethnic minority groups not being given a choice to participate – language and cultural barriers can present unfair access to research for almost the same reasons as why they may have unfair access to services[392 402]. It has been noted that many exclude ethnic minorities (Britton et al. 1999)[392] and non-English speaking participants, often without justification[390].
› Cultural competence of researchers › Increased research costs (translation, etc.)[393] › Recruitment of staff from underserved groups[403] › Need for a diverse community advisory panel to oversee research process[403] › Healthcare provider attitudes
2. Factors from the perspective of minority groups
› Sociocultural factors › Not understanding research › Inaccurate or unregistered housing › Fear of the unknown, mistrust, and stigma › Low use of health services › Cultural norms
3. Contextual factors
› Practical barriers, such as transport › Underrepresentation in academia, science, health services

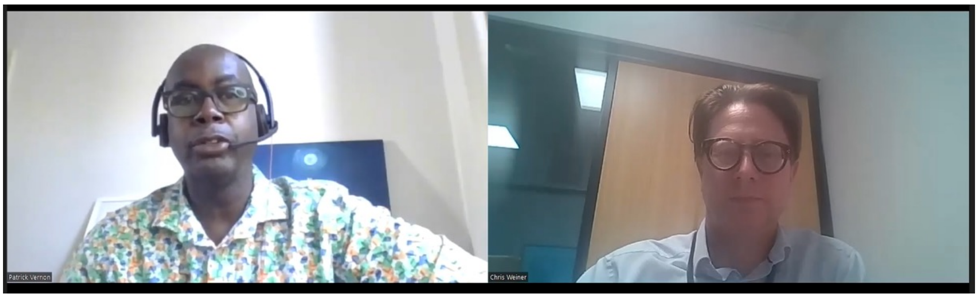
Key facilitators to representation

In the US, the mandatory inclusion of minority groups in clinical trials has led to participation rates of around 30%.[390]

- Clearly explaining the benefits of participation[400]
- Effective PPIE including involvement at the outset to shape the research question
- Effective feedback that engages with communities to refine findings and impact
- Effective recruitment strategies including going out into communities rather than expecting communities to come to researchers
- Translating recruitment and study materials for study participants and PPIE[402]

Resources: Toolkits & Frameworks	
Toolkit for increasing the participation of African, Caribbean, Asian and minority ethnic communities in health and social care research[402]	Toolkit developed in the Midlands to capture best practice and provide researchers with a framework on how to improve the participation of ethnic minority groups in health and social care research.
Equality Impact Assessment (EIA) Toolkit | arc-em.nihr.ac.uk[404]	An Equality Impact Assessment (EIA) is an approach designed to improve equality analysis, practice, and outcomes. This toolkit consists of comprehensive training and a directory of useful resources, as well as ongoing advice and guidance.
The INCLUDE Ethnicity Framework[346]	The INCLUDE Ethnicity Framework397 focuses on identifying the ethnic groups needed for a trial and on identifying challenges to ensuring their inclusion. The framework can be used for any stage of trial, for a healthcare intervention in any disease area, and is aimed primarily at the people who design and run trials, clinicians, and others who plan and design studies. 1. Who should my trial apply to? 2. Are the groups identified likely to respond in different ways? 3. Will my study intervention make it harder for some groups to engage? 4. Will the way I have designed the study make it harder for some groups to engage?
Leadership Framework for Health Inequalities Improvement[405]	The Leadership Framework for Healthcare Inequalities Improvement programme is an NHS England and Improvement (NHSEI) programme to ensure that the NHS better prevents and responds to the health inequalities which many communities experience.
NIHR Race Equality Framework[274]	This framework is a tool to help organisations deliver the change needed to address systemic inequities in health and care research. It includes self-assessment questions that will challenge thinking, approach, and practice. Its purpose is to bring together patients, the public, and research organisations as partners working to understand the needs of African-, Asian- and Caribbean-heritage people, overcoming barriers to their participation in research, and increasing the number of them directly benefitting from it.

The Midlands Integrated Care Systems Research and Innovation Workshop Series



Co-Chairs Professor Patrick Vernon OBE and Dr Chris Weiner

As the Midlands continues to progress the development of its Integrated Care Systems (ICSs), particularly their health inequalities priorities, MI Health is convening a series of workshops on behalf of the Policy Commission. The aim is to discuss the critical role that research and innovation plays in this activity. Research is a core part of an innovative and forward-thinking health and care system, and learning from the pandemic shows that embedding research within the NHS is achievable and delivers both for patients as well as for the NHS.

Within this context, and in conjunction with key regional stakeholders, MI Health has created an opportunity to come together to explore how ICSs, with their wider partners, can further consider research and innovation as a key element of planning, developing, and improving services.

These free sessions are delivered virtually and are co-chaired by Professor Patrick Vernon OBE (Birmingham and Solihull ICS) and Dr Chris Weiner (Joined Up Care Derbyshire ICS). Anyone interested in practical actions and ICS process development regarding health inequalities and research is welcome to attend. 3 sessions have been run so far with over 120 attendees from across the Midlands, including the NHS, Higher Education England, academia, and local authorities.

The focus of the series is to begin conversations that can then be continued offline between the ICSs that involve the relevant stakeholders and, ultimately, make tackling health inequalities regionally easier.

Each workshop begins with an opening presentation to kick off discussions. These have included:

- ICS Health Inequalities Strategies and Boards – Prof Patrick Vernon OBE (Birmingham and Solihull ICS)
- Collaborative working with the University of Nottingham – Prof Ian Hall (University of Nottingham)
- Academic Health Science Network-facilitated discussion on how Innovation and Real-World Evidence plays an integral part in the NHS – Tim Robinson and Chris Taylor (East Midlands HIN)
- The Midlands Diabetes Blueprint and Diabetes Joint Strategy – Prof Melanie Davies (University of Leicester)
- Workforce Challenges: Health Inequalities – Dr Chris Weiner (Joined Up Care Derbyshire ICS)
- Connecting across systems – John Vesey (West Midlands 5G)
- Partnership working in response to the Midlands Health and Care Inequalities Policy Commission – Alex Archibald (MI Health)
- Social Prescribing - Christiana Melam (National Association of Link Workers) and the Active Wellbeing Society Team

Recording of opening presentations from previous workshops can be found here: https://mihealth.org.uk/MIHealth/Joint-ICS-Meetings

Early opportunities are demonstrated by the agreement to work towards a joint Midlands ICS strategy for diabetes and consideration of regional NHS apprenticeship activity.

“Attempting to raise adult safeguarding concerns out of normal working hours is almost impossible, online safeguarding referrals are prescriptive and do not offer options for (for example) modern slavery or human trafficking concerns. This means that patients who are admitted out of hours or over weekends may have to be discharged without these concerns being fully addressed” (Midlands GP)

“It’s like a lottery whether you’ve got a good doctor or good surgery or not” (Community Member)

“After I came back from maternity leave, I was unable to negotiate a flexible working pattern. My manager stated that as it was may choice to have a child, the hospital had no reason to offer me anything that I had requested. In fact, if they did, I should see it has a favour.” (Midlands Allied Health Professional)

“Maybe it’s about learning how to advocate for ourselves - this should be taught” (Community Member)

*“Trusts and Local Authorities will exist, and be on the same patch, way beyond the specific structures of the NHS and partnerships. Embed anchor mindset that will survive organisational change” (ICB inequalities lead)**

“The nature of inequality in health is that people are ill and/or vulnerable – so to complain is an added burden, [especially] to complain about the people who are supposed to help them/us in our hour of need” (Community Member)

*“Covid has made people become very, very insular within their local area and just worry about the here and now. And we can all understand why, you know, from a system point of view, health and care has been horrendously challenged” (Third sector leader)**

*“Difficulties arise in data - can’t always or easily share it properly to build an established picture of need” (ICB inequalities lead)**

“I believe our community (all ages) needs educating on what we are entitled to regarding our rights in healthcare.... Also, somehow whatever this team is, it, this should be affordable... who on earth will fund this though! ” (Community Member)

*“Needs to move away from performance to a grown-up model of mutual assurance/ accountability. Region’s role is to join up, and synergise” (ICB inequalities lead)**

“Corporate memory is repeatedly lost if the education and learning is not [transferred] at induction and practically passed on by the people who use the service like we did with the Check Tings Out Community clinic. It’s like a repetitive dream that is starts again every day.” (Community Member)

“Whilst we know that some care helps (for example, Tai Chi in falls prevention), and this has been used in the past, projects often stop. However, with a more integrated approach, this service can continue “outside” the health service arena.” (Dr Leslie Borrill – Charnwood GP)

Clinical trials for some reason are poorly representing people of colour and economical backgrounds!” (Community Member)

CHAPTER 8. REFERENCES

All links accessed and valid as of **25/06/2025**

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