Addressing health inequalities in the Midlands

The Midlands Health Inequalities Group is a working group of the Midlands Strategic Transformation and Recovery (STaR) Board that aims to support the development of strategies that focus on reducing and preventing inequalities by informing high impact, evidence-based plans tailored to the needs and challenges within each area.

The Health Inequalities Group's guiding principles

- Improving health inequalities and workforce inequalities is mainstream activity that is core to and not peripheral to the work of the NHS
- Interventions to address inequalities must be evidence-based with meaningful prospects for measurable success

The Working Group is developing a toolkit of products that make it easier to share and adopt others' learnings and inspire your organisation's work to address health inequalities in your area. This toolkit of products will include an inequalities dashboard and case studies that share new approaches and others' success stories.

The first phase of work is complete and the following products are contained in this document:

1. an accountability framework that defines set of common policies for accountability arrangements within each STP/ICS.
2. a series of best practice standards for creating robust inequalities plans
3. the roles and responsibilities for system stakeholders in developing and delivering systems' inequalities programmes, as well as defining the role of partners within this work
4. a Charter for health inequalities (template for an STP/ICS agreement amongst partners to work together to tackle health inequalities)
5. best practice case studies and leadership stories are also included [Drafting note: to be included as part of finalising]

Contents

Section 1: Health Inequalities Accountability Framework

Introduction

Why is a Health Inequalities accountability framework required?

- Tackling health inequalities requires action and intervention across multiple partners which creates complexity for delivery but also for ensuring clear and effective lines of accountability, and responsibility, across partners and which transcend organisational sovereignty.
- There is further inherent complexity as many of the most meaningful outcome measures change over a longer-term time period (eg: life expectancy, healthy life expectancy) and it is, therefore, challenging to determine whether progress is being made through an annual planning and performance cycle.
- What is already in place (statutory duties, a moral imperative etc) has not enabled Health Inequalities to be at the core of current democratic and regulatory mechanisms within systems.
- There is a window of opportunity post-COVID and with the establishment of ICSs to develop new ways of working to ensure local actions deliver for local citizens.
- **It is clear that systems (ICS) need to have effective and practical arrangements to connect partners together across a broad programme of work, create cohesion, make progress and hold delivery partners to account.**

What is meant by a Health Inequalities accountability framework?

- **Development of a framework and set of common policies for establishing, implementing, and monitoring plans to address health inequalities within each system across the Midlands.**
- This should enable open and transparent accountability arrangements within the system, as well as a clear line of sight to regulatory or oversight bodies.
- The framework should enable a local consensus around:
    - What outcomes need to be achieved
    - How success will be measured (both long-term outcomes and short-term proxy measures)
    - The actions and contributions from each partner (based on a shared concept of the ‘model of health’)
    - When outputs and outcomes will be delivered
    - How feedback and decision-making will take place
    - Consistent and integrated reporting, assurance and support mechanisms
- Taking into account existing democratic arrangements, role of Health and Well-Being boards and the statutory responsibilities of partners, but within the ICS context and covering system, place and neighbourhood.

Context: Integrated Care Systems

1. The development of Integrated Care Systems (ICSs) since 2018 has enabled NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.
2. Legislative proposals are expected to result in ICS's having a statutory basis in future; although the collaboration with non-NHS partners is expected to continue to be on an alliance or partnership basis.
3. In particular, current proposals comprise:

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes.

4. There are options for giving ICSs a firmer footing in legislation, which sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally.

Developing ICS capability to address Health Inequalities

5. National policy outlines expectations of minimum requirements which systems must demonstrate are in place in order to be designated as ICS on or before 1 April 2021. However, current ICS policy does not specify leadership, governance and robust plans for tacking health inequalities specifically, as a core part of the minimum requirements for ICS designation. Further NHS Midlands conducted a regional COVID lessons learned report which outlined that significant work is required to embed Health Inequalities into the work of systems, and really make a tangible impact. Finally system plans to tackle health inequalities (submitted to NHSEI on 21 Sept 2020) were of variable quality, and further, variable processes have been adopted to produce the plans.
6. Therefore, NHS Midlands has endorsed further Health Inequalities core criteria for every system to address within each ICS development plan.
7. The recommended criteria are below. It is anticipated that systems will either demonstrate that they can meet these criteria or explain how alternative arrangements will enable them to deliver the same outcomes.

Establishing ICS: Health Inequalities core criteria for all Midlands systems

Aim: ICS must be set up to ensure that improving health inequalities and workforce inequalities is mainstream activity, core to, and not peripheral to, the work of the NHS and its partners

Leadership and management arrangements	Governance and accountability	Development support
• Health equality champion (board exec) for system and every NHS org, inc PCNs. • All ICSs and place based bodies to adopt population health, prevention and health inequalities as a core priority. • Agreed system HI plan which outlines ambitious goals and objectives for improvement, and commitments across all organisations inc work programmes on secondary prevention and health improvement. • The process of planning and delivering HI commitments should involve full engagement with community and third sector groups and new, supportive relationships with care homes. • Identification of sufficient capacity to co-ordinate HI work across the system. • HI intelligence strategy and KPIs to provide shared and transparent view of progress with the plan and critical programmes.	• Consistent, system wide arrangements to oversee and monitor progress • Cross system metrics available covering full scope of local services and local inequality priorities • The role of non executive, democratic and public/patient challenge should be defined in the oversight arrangements. • Confirm board level objectives across all organisations which confirm the commitments and objectives of all leaders iro Health Inequalities and undertake a regular assessment of effectiveness • Programme to strengthen accountability to local population and listen to their concerns, particularly those at risk of health inequalities. Data should be regularly published at the lowest meaningful geographical level possible to support this.	• ICS should establish arrangements for ongoing leadership development to build expertise, insight and skills relating to population health improvement health inequalities; and appropriate collaborative behaviours. • National and regional offer in place, including Health Equality Partnership Programme. • HI WG will act as a peer reference group alongside the leads, to support ICS to define and evaluate their arrangements.

Midlands aspiring ICSs must agree an ambitious development plan for building Health Inequalities into the foundations of work at system, place and neighbourhood level.

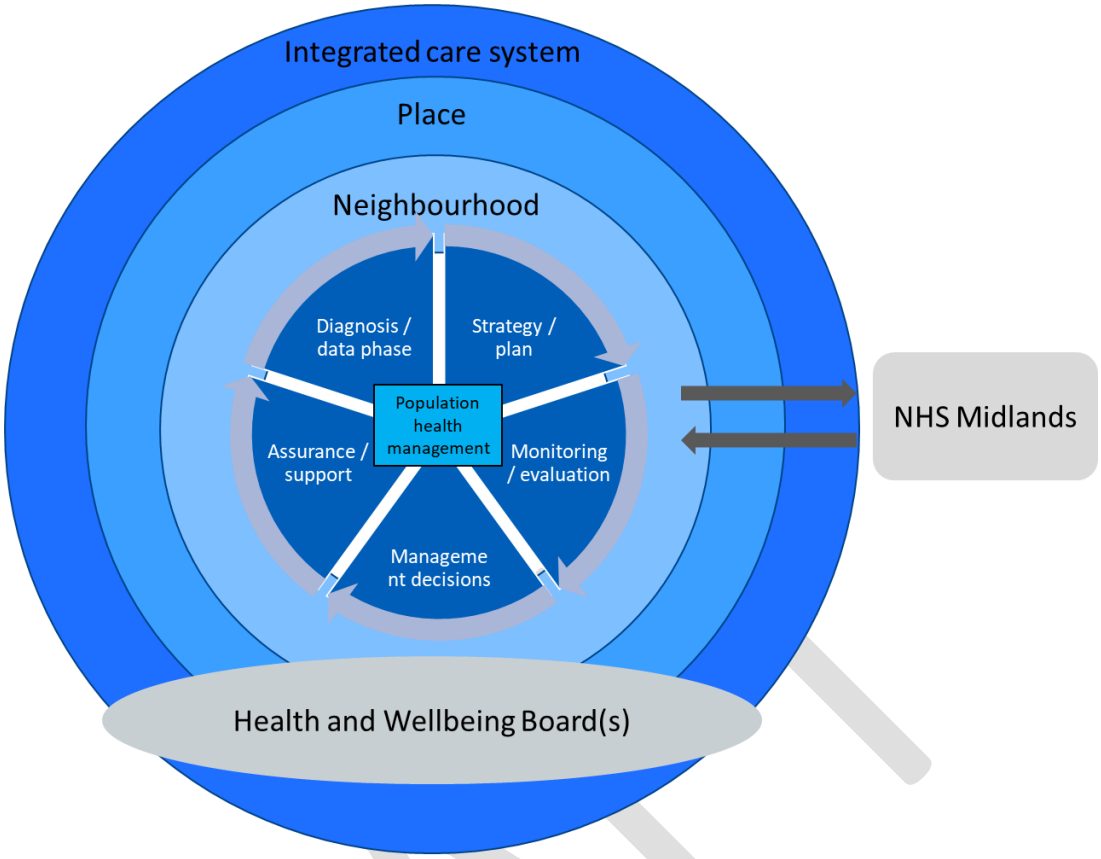
HI accountability arrangements within ICS

Scope of Health Inequalities accountability framework

8. There are already frameworks in place governing NHS organisational and programme accountability and similarly for local government. Further distinct accountability frameworks also apply to key partners such as educational institutions, third sector and voluntary organisations etc.
9. The Health Inequality accountability framework accepts the organisational frameworks but recognises the need to build in accountability to each other and mutual accountability with the public.
10. A successful accountability framework requires that all partners acknowledge and accept that tackling inequalities is an inherently complex area. There are limitations in both key performance measures and, often, the evidence for those measures. However, a well-developed health inequalities accountability framework should apply the discipline and rigour used in more straightforward and 'mainstream' settings and enable system partners to tell a convincing story, which is backed by credible evidence, about the value added by the programme of work and key initiatives and the contribution of the partnership to the public and other stakeholders.
11. Effective arrangements will require partners creating robust local arrangements, which are appropriate to local circumstances, are cognisant of differing locally democratic and nationally mandated structures, but which, ultimately, better enable Health and Well Being boards to fulfil their critical role to ensure the local populations needs are being met.
12. The reality is that addressing Health Inequalities requires the public's involvement. This has to be a collaborative effort with the Health and Well Being boards. So co-production with Health and Well Being boards to develop this **mutual accountability framework** – ie: what the NHS and wider public sector will do, but in return what it needs from the local population – is fundamental to the development process.

Case study 1:
'The Wigan Deal' - is an informal agreement between the council and everyone who lives or works there to work together to create a better borough and it has both pledges from the council as well as asks/commitments from the public.
This example highlights that in exemplar cases elsewhere in England there is also a clarity about the relationship between the institutions and the public (and the public's responsibilities as well).

13. The diagram below illustrates the different local footprints over which arrangements should apply, and anticipated business cycle.



Oversight and governance

System arrangements for oversight

14. Oversight should be through regular scrutiny by the Health and Well Being Board or Boards, on a frequency agreed locally.
15. Additionally, it is anticipated that systems will apply governance best practice and ensure effective non-executive led board oversight arrangements are in place as well as systems for regular internal and external assurance on internal control systems and response to risk.
16. Key factors for systems to consider when establishing arrangements to oversee the delivery of the system's health inequalities plan of work:

- A board comprising some non-executives, representatives of the community, and consideration of democratic representation, to provide independent challenge of progress.
- Confirmation of what assurance has taken place on performance data and organisational processes critical to delivery of key actions or objectives.
- Routine review of critical risks and mitigations, in particular jointly held risks across the HI programme.
- Development programme to ensure members of the board are kept up to date with both strategic context, and local developments.

- Accessibility of plans and performance reports for the public and other key stakeholders should underpin strong local accountability arrangements. For health inequalities overt community engagement should also be built into the accountability cycle at all stages. This is particularly important for designing and then assessing the impact of initiatives on communities.

17. A critical component of local oversight arrangements is to ensure system evaluation and learning as it is this learning process that is going to enable organisations and systems to adapt and modify what they are doing in order to keep to the overall purpose. Working with and through Health and Well Being boards to directly engage the public on what is and isn't working is critical to strong mutual accountability and embedding improvement and learning into the cycle.

- Case study here: Lincolnshire HWB and STP oversight arrangements to support focus on HI

NHS Midlands

18. The primary responsibility of the regional team is to ensure that the NHS in the Midlands delivers its objectives as agreed nationally and in line with the mandate given by the SoS. In this context, there are several key functions;

- Ensure delivery of the plan to tackle Health Inequalities (noting that this plan will be co-produced with shared responsibilities)
- Provide necessary support systems might require
- Add value by "doing once" and facilitating development of initiatives and sharing of best practice that delivers economies of scale on behalf of local systems
- work with other regulators to ensure alignment on collective oversight of the organisations in the region so that addressing inequalities is at the forefront of everyone's agenda.

19. The primary method of achieving the regional objective is to work through local systems and their stakeholders through; oversight, co-production and peer support and scoping and delivering expertise not available within the region.

20. Local systems and their partners take responsibility for planning, implementing, monitoring and resourcing the broad range of services that local communities need. From a health and care context this includes services that promote health & wellbeing, prevent ill health, diagnose and treat, rehabilitate and support individuals and communities achieve a dignified and culturally relevant end of life process.

21. The following arrangements should be in place to support meeting the key functions of the region to oversee delivery:

- A regional SRO for the programme

- The regional SRO and the system SROs will form the key group to deliver the programmes on behalf of the NHS and in the context of the local government accountability framework. Maybe advisable to involve the LGA reps on the group.
- The SRO will report to NHS Midlands Regional Director and the Midlands leadership team (made up of NHSEI regional leadership plus ICS/STP leads from each system).

22. Reporting of progress will take place according to agreed annual cycle and an agreed sub-set of key performance indicators which will include performance against specified national targets but should also include metrics which are important to local population health objectives.

Leadership and management arrangements within systems

23. Local leadership in the first instance is key and the following arrangements are anticipated to support enhancing co-ordination and delivery across the system:

- An SRO to supported by leads appointed by key stakeholders within the system.
- The SRO will be responsible on behalf of both the NHS and local government.
- Local systems will need to agree processes and structures that will enable the SRO to deliver work to tackle health inequalities on behalf of the NHS and local government.
- The SRO through the STP/ICS processes and structures will contribute to the NHS accountability framework in relation to health inequalities.
- The SRO will be responsible for work on health inequalities that will include the following;
- A model of health that is owned by the NHS and local government and enables the development of a coherent set of actions that will have a measurable impact on health inequalities in the short, medium and long term.
- The work will need to be resourced and it is the responsibility of the Finance Directors working with the Executive teams to ensure appropriate resourcing is made available.
- Facilitating the appropriate use of Health Inequalities Impact Assessment within core programmes, at inception and to determine progress
- Actions need to cover determinants of health and programmes that prevent cure, rehabilitate and provide for a dignified death that all their communities can access based on needs.

24. Due to the complexity; co-ordination of joint actions across partners will be required. There should be sufficient shared capacity to facilitate effective programme management arrangements and this should include applying the discipline of standard programme management practice:

- Defining the shared programme of work, responsibilities of each partner, key inputs, outputs and outcomes and metrics to measure progress
- Management arrangements and processes to regularly update on progress and take decisions

- Agreeing a joint risk register and mitigations, particularly for risks which are not solely for one partner to own and mitigate.
- MOUs or other arrangements for personnel working together, which are consistent and aligned to organisational objectives
- Defining consistent internal validation or assurance arrangements around tracking progress and measurement of impact.

25. ICSs need to ensure leaders have the knowledge and capability to deliver on the broad health inequalities agenda, both in terms of technical expertise but also behavioural skills around effective collaboration, engagement and joint working. Therefore, specific developmental support should be in place. Further tackling health inequalities is everybody's business and there should also be support and training available for key personnel across partner organisations to reinforce this message and how they, in their role, can ensure that health inequalities are addressed.

Case study here: Walsall Together emerging arrangements to deliver place based integrated care, with reducing health inequalities as core objective

Planning, implementation and monitoring within systems

26. The development of system plans should follow the best practice standards set out below and be underpinned by a robust approach to population health management.
27. All ICSs/STPs and place-based bodies are adopting population health, prevention and health inequalities as a core priority and should set ambitious goals and objectives for improvement. There are strong prospects for positive impact at place level- based on active partnerships between NHS providers, local government, primary care, public health specialists, third sector and local communities.
28. All healthcare providers should make significant contributions, recognising every interaction in primary, community and secondary care offers an opportunity for health improvement. All Trusts and primary care providers should therefore specify the work programmes they will pursue, particularly in relation to secondary prevention and health improvement.
29. Fundamental to a strong framework for accountability are joint objectives, clarity on contribution and role of each partner, what risks there are and where data and intelligence will flow.
30. Given the challenge over timeframes and which measures to use, it will be important for each ICS to produce a logic model that sets out assumptions about which proxy indicators are likely to be a good predictor for the outcomes that are desired over the long-term; the activities that will be undertaken to impact on these proxy measures; and the evaluation/feedback process for assessing

whether or not they are effective. Otherwise you could be aiming for targets but missing the overall objective. Supporting this learning and evaluation should be a part of the ICS remit; with a system decision support function to support this way of working.

31. Individual health and care providers can do much internally to measure, take action, and advise on prioritisation of actions during recovery phases. Whilst most interventions will take place locally at a neighbourhood level, data analysis and leadership/coordination might take place more at place- and system-level.

32. Partners will need to define a consistent set of key metrics (which include nationally prescribed indicators) that enable progress against key deliverables, and outcome targets, to be tracked over both the short- and medium-term. Some metrics may vary between systems due to the need for local plans to tackle the health inequalities priorities for the local population.

Section 2: Tackling inequalities in Health Outcomes - System Inequalities Plans: Standards

1. Introduction

This paper sets out the standards for local systems to meet in presenting high quality plans to tackle inequalities in health outcomes. The fundamental purpose of standards is to describe what good looks like and therefore, where plans can demonstrate that they do meet the standards, that should give local communities confidence that the plans will achieve their objectives.

In setting standards, it is important to understand the complexities involved in tackling inequalities. A useful definition is that inequalities in health outcomes are avoidable and unfair differences in health between different groups of people. There is a rich history of UK based scientific effort to describe communities affected by these differences and what can be done about those differences. The most recent report is the Marmot Review first published in February 2010 with an update published on February 2020.

In addition to the scientific literature, there is also legislation underpinning the effort in reducing inequalities;

1.1 The Equality act 2010 and the public sector duty

1.2 The Health and Social Care act of 2012; a duty to have regard to the need to reduce inequalities in access to care and outcomes of care.

However, turning those aspirations into actions with demonstrable improvements is more challenging because of the complexity underpinning inequalities in health outcomes;

1.3 Multiple interacting factors determined not only by a variety of major stakeholders including national and local government but also individuals, the public, and voluntary sector.

1.4 Interactions between factors can continually change with considerable unpredictability associated with any given input

1.5 The system including organisations, individuals and communities continuously adapt to policy and interventions. The unintended consequences can be challenging to identify until they occur.

1.6 Moreover, organisational constraints, governance structures & processes and ways of working can have a major impact on development and delivery of effective plans and for the output of those plans to be sustainable over the longer term

For those reasons, a set of standards may add value to the approach at a system level and by focussing on the output of the

planning process, enable judgements to be made by the viability of plans for tackling inequalities. The principles underpinning the standards are;

1.7 Primary purpose is to support local systems and not formal assurance purposes and therefore, are primarily for use by local systems

1.8 Designed to ensure the quality of plans to reduce inequalities are robust and give confidence that inequalities will be reduced and that the benefits are sustainable over the longer term.

There are a range of standards that support high quality planning systems and for the NHS, the most recent initiative was the World Class Commissioning Competencies programme (2007). Those competencies are just as appropriate now as they were then. The work described in this paper is not about standards for planning but is about defining standards if applied to the plan itself should give confidence that the system has a robust and implementable plan.

2. Measurement systems

Effective plans depend upon good data and intelligence systems to enable progress to be assessed and for plans to adapt to changing circumstances. In the context of inequalities, the challenge is to ensure that the distribution of benefits (health outcomes) from interventions are equitable across all individuals and communities. In effect this means being able to describe health outcomes by particular characteristics of communities; the protected characteristics as set out in the public sector duty with a focus on variation by social deprivation. This needs to be the bed rock of the data and intelligence systems needed tackling inequalities in every system.

3. Standards

Standards	**Rationale and comments**
A. The bedrock of the plan	
A1. Model of Health and Inequalities Framework	Given the complexity described previously, a framework is needed to support; system wide understanding of the key local factors in the context of the science underpinning inequalities, prioritisation, development of interventions and metrics and scaling up of programmes. The framework needs to be co-developed by the system and be understandable by local communities. The Director/s of Public health should lead the development supported by the NHS and local stakeholders. The topics set out below should fit cogently within the framework and provide a sense of the extent to which the identified inequalities will be

	reduced as a consequence of implementing the plan.
A2. Metrics, Data and Intelligence	Both quantitative and qualitative intelligence and data is required to both monitor implementation as well as enable plans to be adapted as national and local politics and policies change. In the context of the framework, ambitions of the systems need to be articulated and in a way that is understood by all partners and local communities.
A3. Description of local communities and critical demographic features	Recognise the different communities within the system, their demographic and other characteristics, epidemiology and the risks of poor access to services. This is a critical element of the work that is required.
B. Topics within the plan	
B1. Application of Health Equity Assessment on priority programmes and appropriate action plans to address any challenges. The NHS LTP describes the major programmes which should be the priority for HEA.	This is an assessment of the extent to which communities and individuals most at risk, either, because of access challenges and/or higher epidemiological risk of ill health have timely access to major programmes. Several tools are available, and webinars will be used to provide training to systems. The importance of this action lies in the fact that many of the programmes identified within the LTP are supported by cost effective interventions which if implemented at scale across the Midlands have the potential to transform both health and productivity.
B2. Promotion of wellbeing and prevention of ill health: a) Health promoting NHS (ensuring in all aspects of business, health is actively promoted. Includes smoke free sites, availability of fruit and vegetables, etc) b) Incorporation of Making Every Contact Count and active referrals to support health promoting life styles (tobacco, alcohol and physical activity and nutrition). Prevention interventions included in all clinical care pathways	Numerous surveys have shown the influence that the NHS (the clinicians in particular) has on the public. It is important therefore, for the NHS to role model and integrate key health promoting messages in everything it does. http://www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx Both training for public facing staff and routes for specialist support for individuals need to be in place and actively monitored and adapted to suit needs of communities within the geography concerned. Element of this is the inclusion of assessment and referral processes within clinical care pathways This programme of work should be co-developed with the local government public health team.

c) Ensuring vaccination and immunisation programmes meet national ambitions d) Ensuring screening programmes meet national ambitions	S&I programmes through their underpinning principles are about reducing inequalities. However, to do so, uptake of the programmes needs to in the 90%+. There is considerable evidence to show that uptake can be low amongst communities most in need and if so, service delivery redesign may be required to improve uptake amongst those communities.
B3. Improvement plans based on national bench marking programmes	The benchmarking available through the NHS (RightCare), enable the scale of the inequalities gaps to be identified and brought to the attention of local systems. These programmes demonstrate the geographical variation in both process and outcomes which is incapsulated within the notion of unwarranted variation in the context of social deptivation. This variation is an important contributor for the variation in outcomes between different communities. All plans need to have identified priorities from these national programmes for action locally and in doing so, systems need to have used the inequalities challenge as one of the criteria.
B4. Strengthening of primary and community services with a focus on those supporting deprived communities and within the context of community assets in the locality concerned	Evidence about the importance of primary care and community services in supporting local communities in the context of inequalities is strong and the importance of the links with the 3rd sector in order to ensure a holistic approach is also strong. This standard is about translating that evidence into action in the Midlands.
B4. Determinants of health	The importance of the determinants of health (employment, education, housing, etc) are well recognised and it is for system to develop programmes based on needs of local communities. The NHS LTP recognises the value the NHS brings to the local place and expects the local NHS to contribute to this work through the anchor institution (social value) programme agreed with stakeholders
B5. Inclusion health	Working with partners identifying communities for whom access may be challenging (e.g. homeless, travellers, etc) and developing programmes that enable appropriate and timely access. Application of health equity assessment should ensure this risk is mitigated.
B6. Resources: Financial plan for inequalities programme and appropriate use of tools supporting return on investment	Appropriate financial planning and budget allocation is critical. Finance professionals need to be active team members in developing plans on inequalities. Needs to include deployment of current resources to address

	inequalities within existing programmes and transformation funding for key priorities. Return on investment tools need to be chosen carefully and the assumptions underpinning those tools need to be congruent with the science of inequalities.
B7. Interventions that deliver in the short, medium and long term	Complexity of the factors and their interactions leading to inequalities are rooted in the socioeconomic factors within which communities live, work. And so, some interventions (e.g. determinants) may well take time to delivery whereas others will delivery benefits very quickly. Plans need to demonstrate that this insight is understood and reflected.
C. Enablers	
C1. Workforce initiatives; training on inequalities, equality and diversity etc.	Effective planning, delivery and benefit realisation cannot be assured unless the workforce involved in those activities are committed and are actively encouraged to do so. The CEO and exec directors need to have both, training on inequalities and inclusion of inequalities in their objectives as a primary prerequisite to effective support. The importance of ensuring the workforce reflects local communities cannot be over emphasised and notions of workforce diversity is not only morally right but is also right in terms of rooting the NHS in local communities and using that as a means of maximising the influence and impact of the NHS within communities.
C2. Community/patient engagement	Proactively build continuous and meaningful engagement with public and patients to shape services and improve health. Local systems are responsible for investing public funds on behalf of their patients and communities. In order to make effective decisions that reflect needs, priorities and aspiration of local communities, local systems will need to have methods of engagement with local communities and in particular with those communities who are least able to act as advocates for themselves.

4. Responsibilities of key partners in the context of Inequalities

4.1 Strategic Place based approach to Inequalities: Local Government and its DPH

Section 12 of the 2012 Act introduced a new duty for all upper-tier and unitary local authorities in England to take appropriate steps to improve the health of the people who live in their areas and the DPH has the overall responsibility in relation to this group of

functions. Although not specified in the legislative framework, there are strong arguments, for the DPH to take on the responsibility for leading and facilitating the development of the place-based model of health framework and the subsequent planning process, with the expectation that the NHS will contribute.
At a structural level, a partnership board is inevitable but its relationship with the statutorily defined Health and Wellbeing Board, needs to be carefully considered in developing partnership arrangements. On behalf of the key stakeholders, the partnership board should take responsibility for the strategic elements of enabling the system to reduce inequalities but also expect accountability within the partnership for delivery of co-developed plans.

4.2 Determinants of health in the Place: Local government and stakeholders including the NHS

This is about understanding how factors such as education, economy, housing, health and so on are impacting on local communities. The challenge is partners coming together to understand that impact, prioritising and developing programmes in collaboration with local communities to strengthen community resilience to adverse social circumstances. From an NHS perspective, this is about the anchor institution programme as set out in the LTP and is about adding social value.

Case study 4: Meeting the needs of rough sleepers in Nottingham

During the first lockdown, rough sleepers in Nottingham were accommodated in two city hotels. Local health and care partners worked together to provide around-the-clock care and support to people staying at the hotels. This included daily visits from the local homeless health team, and drug and alcohol support where appropriate. GPs gave consultations by video and were on call 24 hours a day if face-to-face assessment was needed. A mental health clinic was set up at one of the hotels, enabling people to receive assessments and, where needed, referring to secondary mental health care. As a result, more than 35 people who were sleeping rough before the pandemic are now in permanent accommodation with wrap-around support. The City partnership have since established a team made up of colleagues from different professional backgrounds and settings to meet the health and care needs of those actually or at risk of sleeping rough.

4.3 Promotion of health and prevention of ill health: Local government and stakeholders including the NHS

Considerable scientific literature on the key factors and the interventions needed by communities. Both the NHS and local government have specific responsibilities and the challenge is to align those services in such a way, as to make it straight forward for diverse communities to utilise services appropriately. Primary care and community services are vital for communities to benefit from major innovations and clinical advances and need to be strengthened in order to support communities with socio-economic challenges.

4.4 Ill Health: diagnosis, cure/rehabilitation and dignified death: NHS institutions

In delivering these services, the responsibility is to ensure that the needs of diverse communities within the geography concerned are accounted for in service delivery. Of all the NHS sectors, primary care and community services are critically important.

4.5 Engaging with communities: NHS and local government

The complexity of inequalities is such that, regular engagement with local communities and enabling those communities to contribute to development of communication plans, service design and delivery is critical. Partners individually and as a partnership need to have methods in place to facilitate that engagement.

4.6 Health and Care Regulatory Functions: CQC [DN: need to explore with CQC]

The CQC has identified inequalities as a key requirement of health and care services and was/is developing its approach. The focus is on; person Centred care, accessible information, equal access to pathways of care and equality and well led provider.

5. Conclusion

This report should be disseminated to STP/ICS Inequalities Leads to utilise in developing inequalities plan for 2021/22.

Section 3: OUR COMMITMENT TO TACKLING THE CAUSES OF INEQUALITIES

THE MIDLANDS' CHARTER

Purpose of the Midlands Charter

NHS Midlands in partnership with PHE Midlands agreed to make the reduction of inequalities in health outcomes a key priority. This commitment has been further strengthened by the NHS LTP and the lessons from the COIVID-19 experience within communities. In order to galvanise actions and to make the commitment explicit across all health and care systems, we propose that a Charter is co-developed by the partners involved in the system and signed off for public display.

What should the Charter contain?

The proposal is that the co-produced Charter should include a combination of the following outputs/outcomes as agreed by the local system;

- ✓ Recognition that communities are different and therefore their epidemiological risk and access risks vary. The system partners will work to ensure service delivery takes account of these differences.
- ✓ Ensure all local communities benefit from the services provided by partners and therefore, have appropriate monitoring systems describing differences by protected characteristics and deprivation.
- ✓ Access to advice on staying well, preventative services and straightforward joined up care and treatment in appropriate languages and culturally sensitive formats
- ✓ Proactive support for vulnerable and/or high risk individuals and communities
- ✓ Support for determinants of health (economic and educational) regeneration of XXXXXX

The principles that the partners will uphold:

1. Collective responsibility for the health and wellbeing of the communities in the place
2. Working together in ensuring effective action on;
   - ✓ Determinants of health: education, employment, housing and poverty reduction programmes
   - ✓ Health and wellbeing services; smoking, alcohol, nutrition, physical activity and recreational drug use promoting parity between mental and physical health
   - ✓ Ill health prevention programmes; vaccinations, screening programmes
   - ✓ Health care services (mental and physical health); diagnostic, treatment and rehabilitation programmes
   - ✓ Social care programmes; care in the community including hospital at home, domiciliary support and residential care support
   - ✓ End of life support: services that support a dignified and pain free death
3. Engaging with local communities and the 3rd sector to; understand their health and wellbeing needs, to commission and deliver culturally competent services so that every individual who may benefit do access those services and to monitor access and outcomes to ensure equitable benefit realisation.

4. Recognise and accept that reducing the inequalities in physical and mental health outcomes experienced by communities will take time and so we and the organisations commit to programmes that cover the short, medium and long term.
5. In developing these programmes commit to meeting the requirements of the public sector duty (Equalities act), the equalities duty and challenges posed by social deprivation.
6. Recognise that the tax payer provides funds and so commit to ensuring the money given is used effectively, efficiently and productively to improve the mental and physical health and wellbeing of all the communities.
7. Commit to working with national government in accessing initiatives and funding that are relevant to the mental and physical health and wellbeing needs of local communities.

Conclusion

It is for local systems to determine the need for a public declaration of their commitment of reducing inequalities in health outcomes. On the assumption that, such an act is important to galvanise action by the partnership and local communities, a Charter co-developed by the partnership containing the range of issues described above may be helpful.

Annex A: Core competences of leaders in tackling health inequalities

[Drafting Note: to update detail here from leadership competency framework (cross-ref People Plan urgent actions)]

Working effectively on health inequalities needs a collaborative and system wide approach to leadership, supporting everybody to work together more effectively.

The leadership skills required for a whole system approach to addressing health inequalities include developing four critical capabilities[i]:

- **systems leadership** for staff who are working with partners in other local services on joining up local health and care services for their communities

- **established quality improvement methods** that draw on staff and service users' knowledge and experience to improve service quality and efficiency

- **inclusive and compassionate leadership**, so that all staff are listened to, understood and supported, and so that leaders at every level of the health system demonstrably reflect the talents and diversity of people working in health and care services and the communities they serve

- **talent management** to support NHS-funded services to fill senior posts and develop future leadership pipelines with the right numbers of diverse, appropriately experienced people

[i] Page 14, NHS interim People Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf