



**East of England Clinical Senate  
Health Inequalities Workshop  
held on 27 June 2022**

**Outcomes Report**

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## 1. Introduction

The East of England Clinical Senate was delighted to invite clinicians from across the region to attend a workshop via MS TEAMS to learn about health inequalities from a national and regional perspective, the Core20PLUS5 (Adults) key clinical areas of health inequality, and how health inequalities can be improved in the East of England.

This discussion forum was aimed at raising awareness of the Core20PLUS5 programme, exchanging ideas and experiences to increase understanding of existing disparities, and to explore how healthcare could be targeted and delivered more effectively in five key clinical areas.

In particular, the Senate Council hoped it would assist members undertaking Independent Clinical Reviews looking at major service changes in the future to ensure that health inequalities are factored in as a key component of planning and to ensure that the plans address health inequalities in a meaningful way, or at the very least do not inadvertently widen existing variances. For example, panels should consider: **If this proposal goes ahead, who gets left behind? How does this change help the least advantaged?**

The workshop was chaired by Dr Bernard Brett, Clinical Senate Chair, and was attended by 52 delegates who listened to presentations from the following prior to joining their chosen breakout session:

Dr Helen Cliffe, National Healthcare Inequalities Improvement Programme:

A focussed approach to tackling health inequalities on behalf of the National Healthcare Inequalities Team [National Core20PLUS5](#)

Denise Darrell, Health Inequalities Operational Lead, NHS England:

[Regional Health Inequalities](#)

Dr Geetinder Kaur, Consultant, Healthcare Public Health, NHS England

[Regional Inclusive Recovery](#)

Five separate breakout sessions gave delegates the opportunity to discuss the key clinical areas of health inequalities identified in Core20PLUS5:

- Workshop 1     Early Cancer Diagnosis
- Workshop 2     Chronic Respiratory Disease
- Workshop 3     Annual Health Checks for people with Severe Mental Health Issues
- Workshop 4     Maternity & Perinatal Care
- Workshop 5     Cardiovascular Disease

In collaboration with the Health Inequalities National Team, the Clinical Senate provided the workshop chairs with five questions to stimulate discussion and encourage the exchange of experiences and ideas. The varying experience of individuals attending each workshop was recognised and these questions were intended to make discussions as pertinent as possible to those clinicians who do not currently have health inequality improvement at the centre of their work:

- a)    What work is being done in your Trust/ICS to address health inequalities improvement in this clinical area?
- b)    What ideas do you have to address health inequalities in this clinical area?
- c)    What could the Clinical Senates be doing to support work in this clinical area?
- d)    What tools or interventions can help?
- e)    What support do you need from the National Health Inequalities team?

On 13 December 2022 the Clinical Senate Council received a draft feedback report on the workshop and agreed that, given the importance of health inequalities and the early stages of work on how to address Core20PLUS5 as systems, a Clinical Senate Task and Finish Group should be convened to develop formal, specific and impactful recommendations and timescales for inclusion in the report. The chairs of each workshop, along with Clinical Senate Council Members, were invited to join the Task & Finish Group and further input and invaluable contributions were gratefully received from the following participants:

Dr Bernard Brett	Clinical Senate Chair
Dr Jag Ahluwalia	Clinical Senate Council Member
Linda Barr	Workshop 2 Chair, Respiratory Nurse Specialist, Essex Partnership University NHS Foundation Trust
Dr Shane Gordon	Clinical Senate Council Member
Dr Sunil Gupta	Workshop 5 Chair & Clinical Senate Vice Chair
Elizabeth Mabbutt	Clinical Senate Project Officer
Christina Massey	Workshop 4 Chair, Quality Improvement Manager - Maternity Clinical Network, NHS England
Dr Mary-Anne Morris	Clinical Senate Council Member
Dr Christine Moss	Clinical Senate Council Member
Dr Stuti Mukherjee	Workshop 1 Chair & Clinical Senate Council Member
Mary Parfitt	Head of Clinical Senate
Dr Anees Pari	Clinical Senate Council Member
Professor Asif Zia	Clinical Senate Council Member

*Please note that Core20PLUS5 (Adults) was subsequently updated with regard to Maternity services and a separate Core20PLUS5 for Children & Young People was published in December 2022. (Please see Appendix 5 – Additional Resources for details.)*

## **2. Key Themes Emerging from Discussions**

### **Improving Co-Production, Collaboration & Engagement**

Listening to the patient voice to fully understand the cultural, geographic and economic barriers to care is fundamental if health inequalities amongst need to reach and disadvantaged groups are to be reduced. Service design and equitable delivery across the region must be based on the needs of patients, carers and primary/secondary care staff with input from community groups and voluntary organisations (including Healthwatch and Citizen's Advice) to identify target areas and improve outcomes in all the five key clinical areas of Core20PLUS5.

Population health management and stakeholder engagement are core functions of Integrated Care Systems (ICSs), but good communication and links between key stakeholders (including Public Health) to capitalise on existing services, understand pathways and incentivise Primary Care Networks to “make every contact count” through holistic care is essential.

## **Digital**

Progress in all clinical areas is limited by significant digital challenges. Additional funding for IT systems is needed to broaden the primary/secondary care interface, address data silos and improve cross-referencing, access to records and diagnostic tests within and across systems.

Organisations and systems need to recognise that digital solutions for individual patient management are not suitable or accessible for all patients. Deprived areas negatively correlate with high technology use and the rising costs of energy and telecommunications may increase digital exclusion.

Deprivation data in many systems is hard to locate, only relates to local systems and is often incomplete and therefore difficult to benchmark. Developing a national benchmarking system and making dashboards more meaningful would be helpful in highlighting ICS health inequality performance and delivery.

## **Workforce**

Workforce is a limited resource so work must be targeted to ensure the best and most effective use of staff to improve patient outcomes. It is recognised that health and social care outcomes are poorer for populations in the areas of greatest deprivation. These areas also often experience significant workforce recruitment challenges, which add to the deprivation gradient and create a vicious circle of poorer patient outcomes. Strategies to address this inverse care relationship between workforce supply and capacity to health and care need must be developed.

## **Sharing Good Practice**

All workshops highlighted that proactive sharing of good practice but also disseminating learning from unsuccessful projects, is highly valuable.

The positive outcomes of the Covid-19 vaccination programme with high vaccination rates across the population could be transferred to health inequalities, for example bringing people and organisations together from all parts of the system to focus on a single clear objective to effect real change very quickly.

It is essential to have access to the impact assessments of health inequality campaigns and connections to the regional work undertaken around, for example, homelessness, migrants, care and prison leavers.

### **Resources Needed to Address Health Inequalities**

Progress is most limited by workforce; digital technology; availability of data and education and training. Additional funding for both education and training of personnel and for modern IT systems, would broaden the primary/secondary care interface and improve access to records across systems. SystmOne, for example, has some excellent modules around early diagnosis, but clinicians rarely have time to explore them. Self-management of hypertension alongside better pharmacological management are also important areas for investment.

Understanding the demographics of the local population and the best way to promote two-way engagement is essential. Developing trusted relationships with local groups and using accurate data to identify need, would raise awareness amongst the population and encourage people to access health and social care services more readily (please see Recommendation 6 – Access). For example, repurposing the principle of the “Covid Vaccination Bus” as a targeted innovation for cardiovascular disease including blood pressure checks.

The Health Inequalities Improvement Team is working with Academic Health Science Networks (AHSNs) on identifying local ICS health inequality projects for future funding. Any ideas, which include an innovation element, could be forwarded to the local AHSN.

### **3. Recommendations**

#### **Recommendation 1: Digital and Data Usage**

It is recommended that enhanced digital services are used to help address population health inequalities by:

- improving the ability to manage individual patients, including better linkage between IT systems
- system-wide identification of those most at risk of poor outcomes, including enhanced data collection regarding the nine protected characteristics and deprivation data
- enhanced use of virtual technologies, whilst avoiding digital exclusion, to help manage those most at risk of both poorer physical and mental health outcomes.

For the individual patient it is recommended that better linkage between primary care, secondary care, mental health services and, where possible social care, should be developed to enable more joined-up management and a better understanding of all the risk factors that need to be considered to improve the health and wellbeing outcomes for each patient.

It is recommended that the identification of individual patients who are at particular risk of poorer health outcomes should be followed-up with a patient involved Multi-Disciplinary Team (MDT) to develop an appropriate shared plan.

It is recommended that virtual solutions must look to avoid digital exclusion and should aim to provide psychological support and assist with independence and self-management where possible, as well as enabling remote management support and monitoring of physical conditions.

#### **Recommendation 2: Clinical Senate Support**

It is recommended that Independent Clinical Review Panels ensure that proposals have been developed with addressing health inequalities as a key aim.

The Clinical Senate should assist systems to tackle health inequalities by:

- sharing good practice from within the East of England and from other Senates nationally
- signposting to key documents and reports
- promoting workforce changes
- promoting the integration of physical and mental health, including lifestyle interventions
- helping to identify key research questions
- helping to identify and share new innovations with other systems and with the AHSN
- being mindful of the sustainability of interventions
- understanding the impact of inequalities on hospital admissions
- supporting organisations to include addressing health inequalities within their transformational proposals

### **Recommendation 3: Regional Health Inequalities Team Support**

It is recommended that the Regional Health Inequalities Team should

- help build connections between systems
- share good practice
- ensure campaigns are appropriately focussed and take account of those with literacy or digital literacy issues and/or for whom English is not their first language
- help provide educational materials for teams
- undertake careful impact assessments of health campaigns

### **Recommendation 4: Workforce Issues**

It is recommended that workforce strategies and planning include a clear focus on addressing the impact of reduced workforce availability to meet the needs of deprived populations.

This should include developing co-produced solutions to improve the funding, recruitment, retention, education, training and development of the workforce serving deprived communities and incorporating best practice examples regionally and nationally. A diverse workforce should help identify solutions relevant to all groups.

### **Recommendation 5: Innovation & Research**

It is recommended that innovations to address health inequalities should be considered from the outset.

Given the scale of the challenge and reliance on constrained resources, innovation and how it can best be used should be a key principle of all work undertaken. Systems should work with regional universities, AHSNs and other interested parties to undertake research within the East of England to address key questions such as:

- what prevents certain groups from accessing care
- the impact of differential primary care provision
- the impact of impaired access compared to the impact of lower referral rates (i.e. patient factors versus clinician factors)
- new research questions as they are identified by the Systems and the Clinical Senate.

### **Recommendation 6: Access**

It is recommended that all systems develop solutions to improve access to services for deprived populations.

This should include:

- utilising community, faith and voluntary groups, Citizens Advice and community champions to engage with minority groups and unregistered patients
- building in a comprehensive approach to ensure every contact is utilised to help address health and care need

- co-produced solutions to ensure services really meet the needs of deprived populations
- taking account of rural as well as urban deprivation
- consider the location of new health and care estate developments, for example the Community Diagnostic Centre at Clacton Hospital
- consider using mobile solutions to take services closer to populations
- where appropriate build in digital solutions to enable virtual access when physical access is challenging
- ensure primary care access is assessed and addressed where possible
- a focussed piece of work supporting those with poor mental health aimed at developing a supportive dialogue and pathway which promotes continuing engagement with mental and physical health services.

#### **Recommendation 7: Public Health**

It is recommended that Public Health organisations should continue to provide data and guidance to help address the wider determinants of health.

As many health, wellbeing and social care outcomes are influenced by factors outside of health, for example poor housing, these need to be addressed by all systems. Greater emphasis on a holistic person-centred approach through stronger links with local government, housing associations, social care and third sector organisations would ensure that the benefits of health innovations are maximised for individuals and any unintended barriers identified at an early stage. For example, during the Covid-19 pandemic those on low incomes not in receipt of sick pay had a negative incentive for Covid-19 testing.

#### **Recommendation 8: Further Work**

It is recommended that the Clinical Senate revisit this work with a further workshop 12 months after publication of this report and incorporate health inequalities into a Chair's Checklist to be used to assist with Clinical Panel Reviews.

The workshop identified key factors at this point in time and therefore the Clinical Senate plans to keep abreast of developments and ensure this aspect is at the forefront of its independent review work by revisiting this topic 12 months after publication of this report. Please see Appendix 2 for a checklist of issues which Clinical Senate Members should focus on when undertaking Independent Clinical Review Panels relating to service changes for a given population.

Health inequalities is a broad and important area which will require significant on-going clinical input to address the highly complex national and regional challenges. Focussed work on reducing health inequalities to improve patient outcomes is now being prioritised across public health and is a key function and performance indicator for all ICSs.

#### **4. Clinical Senate Support for Health Inequalities**

- a) Clinical Senate could add value and support work to:
  - i. address barriers to care by ensuring that all service change proposals put forward for Independent Clinical Review have been developed with a key aim to address health inequalities.
  - ii. promote integration of mental and physical healthcare at Primary Care Network level
  - iii. be mindful of sustainability of interventions and the impacts of short-term funding
  - iv. understand hospital admissions, for example as suggested in the Respiratory Workshop for Chronic Obstructive Pulmonary Disease (COPD).
- b) Clinical Senate to regularly promote the workforce agenda by recognising recruitment and retention challenges within Clinical Senate Independent Reviews.
- c) Clinical Senate to aim to influence the sharing of best practice and signpost resources/pathways by creating an educational resource accessible to all East of England systems and key stakeholders, including hyperlinks from Health Education England (HEE), UK Health Security Agency and other NHSE Regions, illustrating how different teams work across clinical pathways.

- d) Clinical Senate should support organisations developing plans to prioritise a specific cohort of patients or engage a particularly disadvantaged group by providing leadership, direction and support which identifies regional priorities. For example, Clinical Senate work on the ethical considerations of positive discrimination/differential prioritisation.
- e) Clinical Senate could influence Public Health commissioned lifestyle interventions to ensure greater accessibility for people with mental health issues at all levels.

## 5. Next Steps

The three health inequalities presentations given on the day have been circulated to delegates and uploaded to the Clinical Senate's Website. This report will be shared with all delegates, the National and Regional Health Inequalities Teams and published on the Senate's Website [www.eoesenate.nhs.uk](http://www.eoesenate.nhs.uk) following presentation to the East of England Clinical Senate Council on 29 June 2023.

The Clinical Senate will revisit this work with a further workshop 12 months after publication of this report.

The East of England Clinical Senate would like to thank Dr Helen Cliffe, Denise Darrell and Dr Geetinder Kaur for their most interesting presentations; all the delegates for giving up their time to actively participate and share their clinical expertise and experiences, and the workshop facilitators and secretariat team for their invaluable support in organising this interesting and worthwhile event.

## **APPENDIX 1 - Examples of Practice for Shared Learning**

### **Workshop 1 - Early Cancer Diagnosis (at stage 1 & 2 and reduce stage 4)**

- The Network Contract Directed Enhanced Service: Early Cancer Diagnosis [https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357\\_PCN-ECD-Guidance-SUPPORT-PACK-FINAL\\_March-2022.pdf](https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357_PCN-ECD-Guidance-SUPPORT-PACK-FINAL_March-2022.pdf) provides a framework for primary care to address health inequality in early cancer diagnosis.
- Cancer Alliances supporting each system establish universal coverage of clinical decision support tools.
- Early diagnosis rates in the most disadvantaged 20% of areas are around 8% lower than the most affluent areas. Availability of patient information leaflet in various languages of their 2-week wait referral for worrying symptoms to support practices to maximise the impact in those areas. <https://support-ew.ardens.org.uk/support/solutions/articles/31000162445-2ww-and-fast-track-leaflets>
- Improving cancer screening including focus on any patient group who are low participants. Cambridgeshire & Peterborough ICB are promoting videos for people with Learning Disabilities, with people who have Learning Disability & Autism acting in those videos for promoting cervical, breast and bowel cancer screening and also the Annual Health Check. <https://www.cpics.org.uk/learning-disability-gp>
- Patient Faecal Immunochemical Test (FIT) is an important investigation in Primary Care to determine risk of colorectal cancer and when these patients are being referred for suspected colorectal cancer. Availability of patient information leaflet in various languages on how to do this test <https://www.canceralliance.co.uk/fit>
- Prostate cancer awareness raising in black UK communities - prostate cancer UK toolkit that can support to engage with and increase prostate cancer awareness in black men in the UK. <https://prostatecanceruk.org/prostate-information/are-you-at-risk/black-men-and-prostate-cancer>

### **Workshop 2 - Chronic Respiratory Disease, particularly Chronic Obstructive Pulmonary Disease (COPD)**

- Virtual wards were established during the pandemic to support patients with COPD and post-COVID-19 respiratory problems. These maintained psychological and independent condition management support.
- Promoting “wrap around” care and advice, such as pre-op smoking cessation.
- Mid & South Essex Health Care Partnership (MSE) linked with Ford to provide mobile assessment vans and is starting co-production work with Healthwatch Essex to survey need to reach groups.
- Digital inequality is being addressed by providing dongles for some Norfolk & Waveney patients without Wi-Fi.

### Workshop 3 - Annual Health-check for people with Severe Mental Health Issues (SMI)

- Pre-Annual Health Check facilitated by community nurses in Hertfordshire. This raises the patient's understanding and engagement in a supported way outside a GP or hospital setting, promotes liaison between carers/clinicians, reduces GP time and identifies any lifestyle issues/interventions. However, other aspects and tests still have to be carried out face to face.
- Dual Diagnosis: [Phoenix Futures](#) in Essex is a resource and model developed and run by service users to support multiple needs around drug and alcohol addiction and mental health.
- Joint clinics between primary care and mental health teams to reduce pressure on GP practices

### Workshop 4 - Maternity and Perinatal Care

- James Paget Hospital focussed on vaccine inequalities during the pandemic with particular emphasis on pregnant women; an example of good practice now being adopted across the ICS.
- Appointed a Public Health focussed midwife to support health inequalities.
- Created Maternity Smoking Cessation Ambassadors at James Paget, with plans to roll this out to the other two regional hospitals.
- Established a Norfolk-wide Perinatal Mental Health Service.
- Successfully rolled out 'Maternity Continuity Carer' at James Paget.
- Suffolk & North East Essex ICS (SNEE) has set up 'Maternity Continuity of Carer' with its own Consultant led web service in a disadvantaged part of West Suffolk

### Workshop 5 - Cardiovascular Disease (hypertension case finding)

Examples of where data silos can be overcome and additional on-line resources were highlighted:

- Radiology through shared Picture Archive and Communication Systems (PACS)
- Frailty, End of Life and Dementia Assessment) (FrEDA) now shared on SystemOne. Essex Partnership University NHS Foundation Trust (EPUT) also plans to support carers and include prevention in Band 4 roles as a cost-effective way of flagging health inequality issues.
- University College London (UCL) developing toolkits for Hypertension diagnosis and management, identifying at risk groups and where/how to target resources, see: [CVD resources - UCLPartners](#)
- [WHZAN](#) is a clinically led digital healthcare monitoring system whereby a clinician decides whether intervention is needed. See [Telecare | Whzan digital health | United Kingdom](#)
- The Deep End Network supports GPs in specific deprived areas with funding and performance management. See: [The Scottish Deep End Project](#)

Although many health issues can now be monitored through smart phones, deprived areas negatively correlate with high technology use and the rising costs of energy and telecommunications may increase digital exclusion. Highlighted innovations include:

- 40,000 home blood pressure monitors distributed in Mid and South Essex
- Access to mobile electrocardiogram (ECG) devices
- [“Fibricheck”](#) (an irregular pulse App)
- Use of Direct Oral Anticoagulants (DOAC) via the [Investment and Impact Fund \(IIF\)](#) and quality improvement projects funded by the pharmaceutical industry.

Positive examples of learning from the Covid-19 vaccine programme which could be transferred to Core20PLUS5 are:

- Physically locating services in the community, for example the MSE/Ford Covid Vaccination Van video: <https://www.youtube.com/watch?v=yObOlwGn-hQ>
- Generating a “community spirit” by understanding the population’s needs, appointing “Champions” and engaging with local groups to overcome cultural issues.
- Simple messaging to raise awareness and create momentum.
- Real co-production from the outset.
- A single shared health and social care supported objective with clear clinical targets and outcomes.
- Combining physical and mental health initiatives which include carers.
- Adequate funding.
- Physically locating services in the community

## APPENDIX 2 – Clinical Senate Health Inequalities Checklist

Health inequalities is a relatively new area of focus for the NHS and therefore examples of specific pieces of work which have successfully delivered major change and improved health inequalities are currently limited. However, discussions at the East of England Clinical Senate Health Inequalities Workshop in June 2022 suggested that Clinical Review Panel members should consider:

- **If this proposal goes ahead, who gets left behind?**
- **How does this change help the least advantaged?**

Panel members could consider the following generic factors when reviewing proposed service changes:

- Listening to the patient voice – early co-production in service design
- Collaborative working with key stakeholders (patients, clinicians, staff, faith, community and voluntary groups, 3<sup>rd</sup> sector and social care)
- Culturally appropriate engagement/communication with need to reach, faith, community and voluntary groups
- Holistic person-centred healthcare (“Every Contact Counts”)
- Equitable access to services (travel)
- Potential for digital exclusion
- Best use of the workforce in deprived areas
- Accurate data, modelling, benchmarking and sharing across systems
- Shared learning/evidence and patient outcomes
- [Healthcare Inequalities Improvement Planning Matrix Tool](#)

## APPENDIX 3 - Workshop Evaluation

Delegates were sent a short Evaluation Survey following the workshop to provide feedback which has been shared with the National and Regional Health Inequalities Teams. The responses are summarised below:

1. The presentations given by the National and Regional Health Inequalities Teams were relevant and helped set the scene for the breakout sessions.  
Scale 1 (disagree strongly) - 5 (agree strongly) – Average Rating 4.14
2. Did your breakout session meet the objectives set?  
99% Yes
3. My understanding of the Core20PLUS5 approach has improved as a result of the workshop.  
Scale 1 (a little) - Scale 5 (significantly) – Average rating 3.86
4. My understanding of health inequalities has improved as a result of the workshop.  
Scale 1 (a little) - 5 (significantly) – Average rating 3.86
5. I am better equipped to tackle health inequalities as a result of this workshop.  
Scale 1 (strongly disagree) - 5 (strongly agree) – Average rating 3.43
6. The Clinical Senate is better equipped to tackle health inequalities as a result of the workshop.  
Scale 1 (strongly disagree) - 5 (strongly agree) – Average rating 3.71

## APPENDIX 4 - Breakout Session Summaries

### Workshop 1 - Early Cancer Diagnosis (at stage 1 & 2 and reduce stage 4)

8 delegates attended the breakout session facilitated by Dr Stuti Mukherjee, Macmillan GP, GP Clinical Lead & Member of Senate Council

The discussion focussed on:

- Improving access to primary care.
- How cancer care reviews ensure those in the highest health risk cohorts are reached.
- Greater engagement with patients, need to reach and disadvantaged groups, including ethnic minorities.
- Ensuring organisations and systems recognise that digital solutions are not suitable or accessible for all patients.
- Integration of primary and secondary services to achieve holistic care and annual health check assessments to improve outcomes for patients which also meet the needs of carers.
- Ensuring vulnerable groups are reached and tested either as part of an Annual Health Check or through other screening mechanisms-
- Quick access to diagnostic tests to minimise treatment delays.
- The need to promote non-site-specific pathways alongside other established cancer pathways.
- Learning from best practice, innovation and research undertaken by others by improving access to evidence and data.

Suggestions for reducing health inequalities:

- Sharing best practice by creating an educational resource (PowerPoint) accessible to all East of England systems and key stakeholders, including hyperlinks from Health Education England (HEE), UK Health Security Agency and other NHSE Regions, illustrating how teams work differently.
- Clinical Senate could support ICSs, Cancer Alliances or other groups with developing any plans to prioritise a particularly disadvantaged group, for example those with Learning Disabilities, by reviewing and providing independent advice on their proposals.

*Following the workshop, Dr Stuti Mukherjee provided the following examples and links to innovations in early cancer diagnosis:*

- The Network Contract Directed Enhanced Service: Early Cancer Diagnosis [https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357\\_PCN-ECD-Guidance-SUPPORT-PACK-FINAL\\_March-2022.pdf](https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357_PCN-ECD-Guidance-SUPPORT-PACK-FINAL_March-2022.pdf) provides a framework for primary care to address health inequality in early cancer diagnosis.

- Cancer Alliances supporting each system establish universal coverage of clinical decision support tools.
- Early diagnosis rates in the most disadvantaged 20% of areas are around 8% lower than the most affluent areas. Availability of patient information leaflet in various languages of their 2-week wait referral for worrying symptoms to support practices to maximise the impact in those areas. <https://support-ew.ardens.org.uk/support/solutions/articles/31000162445-2ww-and-fast-track-leaflets>
- Improving cancer screening including focus on any patient group who are low participants. Cambridgeshire & Peterborough ICB are promoting videos for people with Learning Disabilities, with people who have Learning Disabilities and Autism (LDA) acting in those videos for promoting cervical, breast and bowel cancer screening and the Annual Health Check. <https://www.cpics.org.uk/learning-disability-gp>
- Patient Faecal Immunochemical Test (FIT) is an important investigation in Primary Care to determine risk of colorectal cancer and when these patients are being referred for suspected colorectal cancer. Availability of patient information leaflet in various languages on how to do this test <https://www.canceralliance.co.uk/fit>
- Prostate cancer awareness raising in black UK communities - prostate cancer UK toolkit that can support to engage with and increase prostate cancer awareness in black men in the UK. <https://prostatecanceruk.org/prostate-information/are-you-at-risk/black-men-and-prostate-cancer>

## Workshop 2 - Chronic Respiratory Disease, particularly Chronic Obstructive Pulmonary Disease (COPD)

7 delegates attended the breakout session facilitated by Linda Barr, Respiratory Nurse Specialist, Essex Partnership University NHS Foundation Trust.

The discussion focussed on:

- a) **What work is being done in your Trust/ICS to address health inequalities improvement for patients with Chronic Respiratory disease?**
- Collaborative working with ICSs, GPs and Trusts to understand the data and pathways available to avoid hospital admission and enable patients to self-manage respiratory conditions whenever possible.
  - Virtual wards were established during the pandemic to support patients with COPD and post-COVID-19 respiratory problems. These maintained psychological and independent condition management support.
  - Promoting “wrap around” care and advice, such as pre-op smoking cessation.
  - West Essex is working to address rural and economic pockets of deprivation for drug and alcohol dependency, as well as COPD.

- The need to understand why fewer people from ethnic minorities, travellers and the disabled community access respiratory services: Is this through poor GP access or non-referral?
- Remote monitoring has had limited success due to poor access, engagement or trust in technology and/or patients preferring to see a clinician.
- Digital inequality is being addressed by providing dongles for some Norfolk & Waveney patients without Wi-Fi.
- Access to accurate/current patient data and different classifications/terminology across primary/secondary care systems remains a challenge, particularly for community services staff.
- Improving housing for those living in poverty is key to reducing respiratory disease.
- Mid & South Essex Health Care Partnership (MSE) linked with Ford to provide mobile assessment vans and is starting co-production work with Healthwatch Essex to survey need to reach groups.
- Greater workforce engagement and co-production.

**b) What ideas do you have to address health inequalities for patients with Chronic Respiratory disease?**

- Primary concerns are the accessibility/cost of internet services and patients not using oxygen for financial reasons.
- Promoting wider and easier connections between Local Authorities, Housing Associations and the voluntary sector.
- Understanding what patients and staff need/want by engaging them in co-production, for example clinic locations.

**c) What could the Clinical Senates be doing to support work in this area?**

- Regularly promoting the workforce agenda by raising awareness of recruitment and retention challenges.
- Connecting to examples of best (and worst) practice.
- Senate guidance on:
  - How to access and engage with this specific cohort of patients.
  - Access to data, such as signposting to resources for pathway information.
  - Understanding why people are admitted to hospital, focusing on COPD.

**d) What tools or interventions can help?**

The Health Inequalities Programme could target people not registered with the NHS and/or Benefits System by linking with Citizens Advice and working with trusted community/religious leaders by mirroring the COVID-19 vaccination programme.

**e) What support do you need from the National and Regional Health Inequalities Team?**

- Connections to regional work being undertaken around, for example, homelessness, migrants, care and prison leavers, is essential.
- Assurance that campaigns are advertised via notice boards/multi language leaflets (not on-line only) to avoid digital exclusion.

- Detailed impact assessments of the health campaigns run by the Health Inequalities Team.

### Workshop 3 - Annual Health-check for people with Severe Mental Health Issues (SMI)

17 delegates attended the breakout session facilitated by Dr Ambiga Ravi, Consultant Forensic Psychiatrist, Hertfordshire Partnership NHS FT

The discussion focussed on:

- A “self-serve”, Pre-Annual Health Check facilitated by community nurses in Hertfordshire. This raises the patient’s understanding and engagement in a supported way outside a GP or hospital setting, promotes liaison between carers/clinicians, reduces GP time and identifies any lifestyle issues/ interventions. However, other aspects/tests still have to be carried out face to face.
- An active Improving Health Outcome Group in Hertfordshire to action mental and physical health improvements.
- WHZAN’s “Blue Box Tele-health case” offering remote physical healthcare monitoring was debated at length. Using the 6- lead ECG in the community is a good indicator but is unsuitable for those on antipsychotics who are high risk for QT prolongation (an extended interval between the heart contracting and relaxing), or asymptomatic patients. Good practice guidelines specify offering 12 lead ECGs to avoid creating health inequality and the Care Quality Commission is very strict about lithim checks. ECG should be included in the core elements of the Annual Health Check (NICE are currently looking at this).
- Difficulty in communicating data between services is a widespread issue, so better communications between services around referral pathways is needed.
- Patient data needs to be cross-referenced, for example how many SMI patients are diabetic, to ensure “every contact counts”, individuals can be targeted and issues tracked at a population health level.
- Work to connect PARIS (mental health electronic patient record system) so mental health activity is recorded in primary care systems (and vice-versa) is underway. Connecting across multiple ICSs (i.e. 3 in Essex) is a significant IT challenge.
- Hosting joint clinics with primary care mental health teams to reduce pressure on GP practices.
- In Essex annual physical health checks are undertaken in mental health inpatient settings which empower patients to attend a GP with an issue which they already know is unrelated to, say, their Schizophrenia, but closer integration to improve access to primary care is needed.
- Engagement difficulties with SMI patients, but also those who are stable, disengage from mental health and/or refuse primary care services, can mean they are overlooked by both mental health and physical health services. Therefore, a supportive dialogue and pathway which promotes continuing engagement with mental and physical health services needs to be developed.
- Is the difference in SMI life expectancy driven by late/failed diagnosis or less than optimal management of disease? How can we identify and measure this?

- Is an Annual Health Check enough? Does the time and effort convert into increasing the life expectancy and well-being of patients?
- A holistic approach needs to be adopted to avoid giving conflicting/ confusing information and optimise the time with the patient to prioritise their needs.
- Individuals with varying levels of SMI/Learning Disability or Autism who don't fit standard models or thresholds also need effective adaptations (i.e. specialist LD community stroke care) to optimise their physical wellbeing.
- Successful pilots in Cambridgeshire & Peterborough for roll out across the system include:
  - co-production of leaflets with service users so patients understand what the health check is/why they are invited and
  - offering a follow-up appointment and creating a Personalised Care Support Plan (PCSP) which ensures the health check is not just a tick box exercise (although creating a digital PCSP is a challenge).
  - Tobacco cessation for people with mental health needs (national roll-out in 2023/24), which includes mentoring to provide the flexible, longer-term approach often needed. Each of the five aspects of Core20PLUS5 are impacted by smoking and SMI patients have a smoking rate of c.40%.
- Use of link workers, health coaches and public health services to bridge inequality gaps. However, it was noted that Public Health commissioned services vary across the region, for example. a weight management programme specifically designed for SMI and LDA patients is available in Cambridgeshire & Peterborough.
- Dual Diagnosis: [Phoenix Futures](#) in Essex is a resource and model developed and run by service users to support multiple needs around drug & alcohol addiction and mental health.
- Clinical Senate could support work to understand and address barriers to care and promote integration of mental and physical healthcare at Primary Care Network (PCN) level to avoid silo working and ensure checks are not tick box exercises but improve patient outcomes and life expectancy.
- The Clinical Senate could highlight/influence lifestyle interventions to ensure services are commissioned, prioritised and delivered in an accessible way for people with mental health issues at all levels, through leadership, direction and support to identify the regional priorities.
- Systems should be challenged to also reach out to those who have lower end mental illness and/or are socially isolated. These individuals are often invisible to GP and mental health services because they don't quite reach a threshold.

#### Workshop 4 - Maternity and Perinatal Care

4 delegates attended the breakout session facilitated by Christina Massey, Quality Improvement Manager - Maternity Clinical Network, NHS England.

The discussion focussed on:

- What work is being done in your Trust/ICS to address health inequalities improvement in maternity and peri-natal care?**

- James Paget Hospital focussed on vaccine inequalities during the pandemic with particular emphasis on pregnant women; an example of good practice now being adopted across the ICS.
- Appointed a Public Health focussed midwife to support health inequalities.
- Created Maternity Smoking Cessation Ambassadors at James Paget, with plans to roll this out to the other two regional hospitals.
- Established a Norfolk-wide Perinatal Mental Health Service.
- Successfully rolled out 'Maternity Continuity Carer' at James Paget.
- SNEE has set up 'Maternity Continuity of Carer' with its own Consultant led web service in a disadvantaged part of West Suffolk
- Active maternity safety and governance meetings across Bedfordshire and work on the draft Local Maternity System (LMS) Plan, albeit focussing on safety, rather than health inequalities.
- The EAHSN, Regional Maternity Clinical Network and East of England Local Government Association (EELGA) are highlighting maternity service variations and community engagement across the region at an Equality & Equity Conference on 20th July 2022.
- Plans for 'Maternity Continuity of Carer' to be rolled out across those regional teams who have yet to implement it and to support Core20PLUS5 targets.
- Equality & Equity action plans being developed across the region are due for submission to the National Team in October 2022.

**b) What ideas do you have to address health inequalities for pregnant women?**

- Patient voice and co-production are key, i.e. listening and understanding expectations to design services that work for the patient and deliver an equitable service.
- Consider the locations where services are best placed – are they acceptable and easily accessible for the community?
- Recruiting Community Champions/Cultural Support Workers who can support minority groups through greater understanding of cultural differences, transport issues and language barriers.
- Offering shadowing or volunteering opportunities, including engagement with schools/career workshops, may also support maternity teams.
- Staff engagement through cultural intelligence, equality and diversity training, coaching and mentoring.

**c) What could the clinical senates be doing to support work in this area?**

- Share good practice/success for the benefit of other services.
- Promote improved data quality and accessibility.
- Funding is outside the Clinical Senate's remit but evaluating the sustainability of interventions and the impact of short-term funding on patient outcomes would be helpful.
- How do we support clinical decision making and avoid health inequalities for an individual given "maternity" is such a short period?

**d) What tools or interventions can help?**

- Protect Now – a risk stratification tool used on the ‘ECLIPSE’ system (Electronic Checking Leading to Improved Prescribing Safety & Efficiency).
- Call handlers to help people book appointments.
- Public Health Management System – collecting data on patient health behaviours enables patient groups within the community to identify problems.
- Making dashboards more meaningful in relation to health inequalities at an operational level, for example Maternal Mental Health Service (MMHS), Mental Health Services Data Set (MHSDS).

**e) What support do you need from the National and Regional Health Inequalities Teams?**

- Funding: having the resources and infrastructure to deliver ambitions.
- Timely and accessible data across systems.
- Owning and addressing health inequalities should be the ICSs’ principal concern. The roles of ICSs, Regional and National Teams need to be defined.
- Developing a national benchmarking system underpinned by a data set highlighting ICS health inequality performance and delivery to enable under achievers to identify good practice.

**Workshop 5 - Cardiovascular Disease (hypertension case finding)**

6 delegates attended the breakout session facilitated by Dr Sunil Gupta, GP and Senate Council Vice Chair

The discussion focussed on:

- Cardiovascular Disease (CVD) is an area where health inequalities and disparity in life expectancy is most marked and an ageing population also indicates a future massive increase in Atrial Fibrillation (AF)
- The East of England CVD Prevention Board is looking at improving data collection from Community Pharmacies regarding take up of Hypertension (HT), Atrial fibrillation (AF) and lipid management.
- Primary Care Networks (PCNs) need levers to incentivise the extra support and effort needed for need to reach groups and every opportunity to “make every contact count” should be taken. For example blood pressure and pulse checks when attending a healthcare setting for another purpose or diabetes checks in dental surgeries.
- Workforce is a major issue, particularly when managing diagnosed people in the groups known to have the poorest outcomes. Workforce is a limited resource, so must be targeted to ensure its best use across all systems.
- Practices in the most deprived areas also often experience significant workforce recruitment challenges, which add to the deprivation gradient and poorer patient outcomes.

- The Deep End Network supports GPs in specific deprived areas with funding and performance management. Please refer to: [The Scottish Deep End Project](#)
- Incomplete data is not trusted and difficult to benchmark (for example 10% of patients' ethnicity is unknown). Data for all nine protected characteristics should be available but some are very difficult to capture, such as sexual orientation.
- Deprivation data is hard to locate and only relates to local systems, making it difficult to identify good practice and disseminate learning.
- Primary and Secondary Care each have good information systems but there are data silos within systems. For example GPs cannot access diagnostic test results and patient data is not contemporaneous, but once in place, digital systems will pay for themselves by avoiding repeat tests.
- Examples of where data silos can be overcome and additional on-line resources were highlighted:
  - a) Radiology through shared Picture Archive and Communication Systems (PACS)
  - b) Frailty, End of Life and Dementia Assessment) (FrEDA) now shared on SystmOne. Essex Partnership University NHS Foundation Trust (EPUT) also plans to support carers and include prevention in Band 4 roles as a cost-effective way of flagging health inequality issues.
  - c) University College London developing toolkits for hypertension diagnosis and management, identifying at risk groups and where and how to target resources: [CVD resources - UCLPartners](#)
  - d) Whzan is a clinically led digital healthcare monitoring system whereby a clinician decides whether intervention is needed: [Telecare | Whzan digital health | United Kingdom](#)
  - e) The Deep End Network supports GPs in specific deprived areas with funding and performance management: [The Scottish Deep End Project](#)
- Utilising Public Health to build services into their primary care contracts such as the NHS Annual Health Check.
- Closer working with Public Health who are empowered to access contemporaneous data and are experts in analysing, evaluating and assimilating it to identify the wider determinants of health.
- Positive examples of learning from the Covid-19 vaccine programme which could be transferred to Core20PLUS5 are:
  - a) Physically locating services in the community
  - b) Generating a "community spirit" by understanding the population's needs, appointing "Champions" and engaging with local groups to overcome cultural issues.
  - c) Simple messaging to raise awareness and create momentum.
  - d) Real co-production from the outset.
  - e) A single shared health and social care supported objective with clear clinical targets and outcomes.
  - f) Combining physical and mental health initiatives and including carers.
  - g) Adequate funding.
- Core20PLUS5 is an easy to understand and comprehensive approach concentrating on the five things with the greatest impact, but we need to decide which aspects of these are relevant to particular communities and how to target

them. However, conceptually there is a lot for stakeholders to grasp before it can move forward.

- Population health management and stakeholder engagement are core functions of ICSs and they will develop their own mechanisms. Local Authority engagement teams can also provide good gateways.
- The sustainable impact on patients and services through the contributions of voluntary organisations must be understood, especially when project bids are complex and funding is often short-term.
- Although many health issues can now be monitored through smart phones, deprived areas negatively correlate with high technology use and the rising costs of energy and telecommunications may increase digital exclusion.

Highlighted innovations included:

- a) 40,000 home blood pressure monitors distributed in Mid and South Essex
- b) Access to mobile electrocardiogram (ECG) devices
- c) “Fibricheck” (an irregular pulse App)
- d) Use of Direct Oral Anticoagulants (DOAC) via the [Investment and Impact Fund \(IIF\)](#) and quality improvement projects funded by the pharmaceutical industry.

## [APPENDIX 5 - Additional Resources](#)

Core 20PLUS5 (Adults) - Maternity Section updated since 27<sup>th</sup> June 2022  
Workshops: [NHS England » Core20PLUS5 \(adults\) – an approach to reducing healthcare inequalities](#)

Children & Young People - The CYP Core20PLUS5 was published in December 2022 with a slightly different focus to adults: [NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people](#)

[The Health Inequalities Dashboard](#) provides information to monitor progress on reducing inequalities within England. It presents measures of inequality for 19 key indicators, the majority drawn from the [Public Health Outcomes Framework](#). The dashboard measures trends in each indicator since a baseline period, with longer term data provided where these are available.

The [Healthcare Inequalities Improvement Planning Matrix](#) outlines key areas for consideration when services are designed, implemented, and evaluated. The matrix is being used by the National NHS programme and workstreams leads, and service leads at a regional, system and provider level. It helps to ensure that programmes do not widen healthcare inequalities.

In January 2023 Professor Sir Michael Marmot, Director, UCL Institute of Health Equity launched [The Health Equity Network](#) a country-wide network to help towns, cities and regions build back fairer.