NHS RESET
FOR THE FUTURE OF HEALTH AND CARE

NHS CONFEDERATION

HEALTH INEQUALITIES
TIME TO ACT

About NHS Reset

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the pandemic.

Recognising the sacrifices and achievements of the COVID-19 period, it brings together NHS Confederation members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

NHS Reset is part funded through sponsorship by Novartis Pharmaceuticals UK Limited.

Find out more at www.nhsconfed.org/NHSReset and join the conversation on social media using #NHSReset

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit www.nhsconfed.org and follow us on Twitter @NHSConfed

Key points

- The COVID-19 pandemic has thrown into sharp focus the issue of health inequalities in the UK and exposed the consequences of a long-standing failure to tackle this deep rooted and multi-faceted problem. This report reflects our engagement with members, gleaned from focused discussions and webinars between June and September 2020. It also draws on the results of a survey of more than 250 healthcare leaders on health inequalities and how to make progress in this area.

- This report does not offer a comprehensive analysis of all dimensions of health inequalities or policy approaches. Instead, it provides an overview of feedback and reflections from our members on how – and if – the COVID-19 pandemic will be a turning point for the NHS.

- In our member survey, nine out of ten (91 per cent) respondents agreed that addressing health inequalities must be at the forefront of the reset process and that the time to act is now. The majority of respondents (84 per cent) agreed or strongly agreed that COVID-19 has shown that the NHS must deliver a step change in how it cares for diverse and marginalised communities.

- Our engagement with members is showing an increasing awareness that the NHS has not designed services in a way that accounts for the diverse needs of communities, and as a result, the outcomes experienced have been unequal. Seventy-six per cent of respondents agreed that black and minority ethnic (BME) communities have poorer access to, and outcomes from, NHS services. More than half (55 per cent) said they were concerned about institutional racism within the NHS.

- Members recognise that having diverse leadership must be part of the overall strategy to tackle health inequalities, but there are differing views as to whether it is possible in the medium term to have leadership that reflects the communities being served. Just under half (48 per cent) of respondents agreed with the statement: 'I am confident that my board will be

representative of the local community that we care for within the next five years.'

- Leaders supported the need for a cross-government approach and joined-up national policy for issues such as homelessness and housing, poverty and support for marginalised and vulnerable groups. They suggested that without consistent national policy, local partners are often left to manage competing priorities. Instead they argue for action, at scale and pace, with a commitment to address the underlying factors of inequality.

- While health leaders are committed to prioritising and addressing health inequalities, only two in five agreed with the statement: 'I feel that I have the knowledge, tools and support available to me to play my part in addressing health inequalities and improving health outcomes for marginalised communities.' However, our discussions with leaders have highlighted some excellent examples of system-wide working to address inequalities before COVID-19 and as part of the response to the pandemic. Leaders are keen to continue this approach, building innovation, sharing ideas and designing services around the needs of our most deprived communities and populations.

- At the NHS Confederation, we are determined to play our part in addressing health inequalities. Our chair, Lord Victor Adebowale and Mala Rao shone a light on racism in the NHS in a special edition of the BMJ in February 2020. We are delighted to host the new NHS Race and Health Observatory, which will focus on gathering evidence and identifying actions to tackle the specific health challenges facing people from BME backgrounds. It will also link this back to the diversity and inclusion agenda within the NHS workforce.

- We will also continue to support our national equality, diversity and inclusion leadership networks which have enabled peer support and learning for their members, while challenging policy and practice in relation to race, gender and more recently, LGBTQ+ staff.

- We recognise that health inequalities is an area of increasing concern across our membership. As an organisation we are supporting our members to systematically address health inequalities both within the NHS and wider society. We also recognise the actions set out by NHS England and NHS Improvement's (NHSEI) letter, detailing actions for phase three of the NHS's COVID-19 response and supporting materials for leaders.

Introduction

The COVID-19 pandemic has had a devastating impact on millions across the globe. Far from being a "great leveller",[1,2] it has exacerbated inequalities, disproportionately affected particular groups and exposed the consequences of failing to take systematic action to redress disparities.

Despite being thrown into sharp focus by recent events, health inequalities have been a long-standing issue in the UK. Forty years ago, the seminal Black Report raised the social and economic factors contributing to the wide disparities in ill health and death among Britons.[3] Since then, several other major reports have highlighted the same issues and drawn similar conclusions.[4,5,6] Among them, the Marmot report, published in 2010, highlighted the scale of health inequalities in England and the actions required to address them.

" The health of the population is not just a matter of how well the health service is funded and functions, important as that is: health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.

Professor Sir Michael Marmot, Director UCL Institute of Health Equity

The NHS has a long history of recognising health inequalities and their impact on life expectancy and experiences of care. But it also has a long history of piecemeal attempts to tackle them.

The Health and Social Care Act 2012 introduced a new duty on the Secretary of State, NHS England and clinical commissioning groups to 'have regard to the need to reduce inequalities in access to care and outcomes of care.' Under the terms of the legislation, tackling inequalities in health should be one of the overarching purposes of integration. Fast forward to 2019, the NHS Long Term Plan

reinforced the need for a systematic approach to prevention and reducing health inequalities, as part of the government's ambition for five extra years of healthy life expectancy by 2035.

Yet the second Marmot report, published a decade after the first, showed that health inequalities had widened between 2010 and 2020, with continuous improvements in life expectancy grinding to a halt – a trend that coincided with years of austerity measures which have taken a disproportionate toll on deprived communities. Neither legislative provisions nor policy directives have so far succeeded in shifting the needle.

The COVID-19 pandemic has cast a long shadow over this lack of progress. Several members of the NHS Confederation – organisations that plan, commission and provide NHS services in England, Wales and Northern Ireland – have expressed concern over the poor track record and raised the need to re-frame the debate.

" **For decades there has been multiple explorations and government initiatives on the correlation between health, inequalities and the social determining factors… we are still asking how we can address the wider social determinants of health. There is a high level of national interest now and new openness to discuss race, communities, systems and inequalities in a way that has not been done before.**

Samira Ben Omar, Assistant Director of Equalities, North West London Collaboration of CCGs and Co-Founder of the Community Voices movement for change

> **"** The NHS suffers from 'classism': if you are disadvantaged you simply don't get what you deserve. Our current services are designed around what is best for the provider not what is best for the patient. People living in affluent areas access every benefit of the NHS; those in the poorest areas are seen as a burden. We are not addressing the wider determinants of health and this should be our number one priority. We cannot afford to sleepwalk into another ten years of deprivation and increasing inequalities.

Dr Mark Spencer, GP and Co-Chair of the NHS Confederation's PCN Network

> **"** We should never for a moment forget that we don't all have the same chance in life and do not all have equal opportunities.
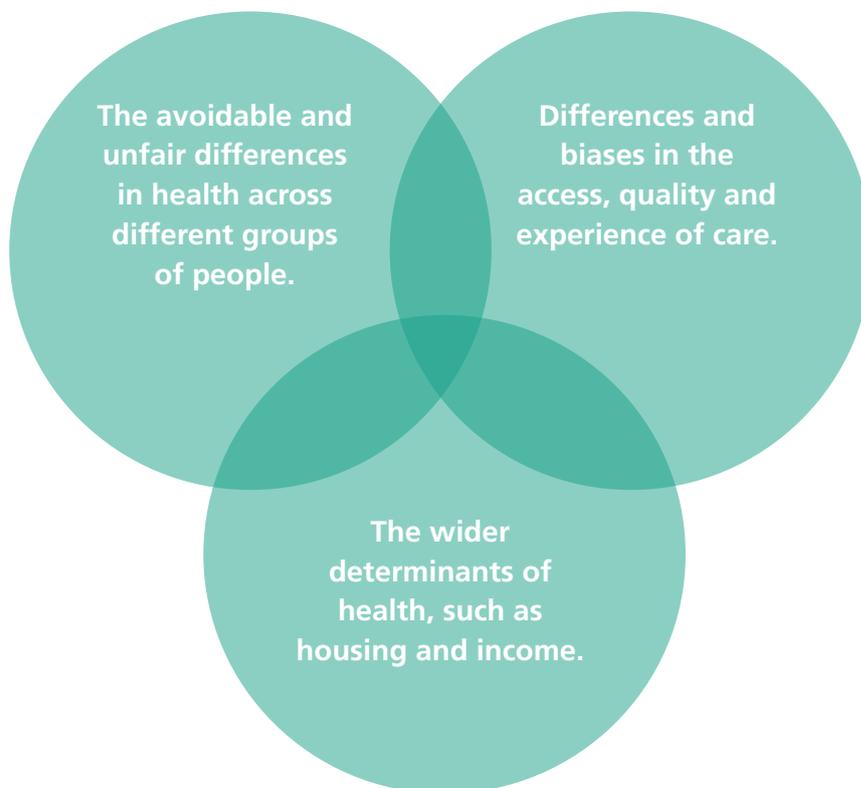
Dame Jackie Daniel, Chief Executive, Newcastle Upon Tyne Hospitals NHS Foundation Trust

This report reflects our engagement with members on this issue, gleaned from focused discussions and webinars between June and September 2020. It also draws on the results of a survey of more than 250 NHS leaders on health inequalities and how to make progress in this area.

The insights here are placed in the context of a long history of attempts to tackle health inequalities and the need to fundamentally reset the approach to address them. This report does not offer a comprehensive analysis of all dimensions of health inequalities or policy approaches. Instead, it provides an overview of feedback and reflections from our members on how – and if – the COVID-19 pandemic will be a turning point for the NHS.

Health inequality and inequity

There are many kinds of health inequality and several ways in which the term is used. Various definitions exist,[7,8] but broadly speaking, health inequalities can be defined as:

The avoidable and unfair differences in health across different groups of people.

Differences and biases in the access, quality and experience of care.

The wider determinants of health, such as housing and income.

Health inequalities often lead to health inequities. The World Health Organization defines health inequities as entailing a failure to avoid or overcome inequalities that infringe on fairness and human rights.[9]

❝ **Inequality is the way of the world; inequity is what we do with the way of the world.**

Lord Victor Adebowale, Chair, NHS Confederation

The unequal impact of COVID-19

Even before COVID-19 struck, life expectancy in the UK was lower than in other western European countries and had improved the least between 2011 and 2018.[10] Far from being the great leveller it was originally claimed to be,[11,12] COVID-19 has disproportionately affected certain groups, sharply exposing and worsening existing health inequalities.[13,14]

The Public Health England review into the differences that have emerged in the risk of infection and death from COVID-19 showed that while increased age is the largest risk factor, it is closely followed by gender (male), certain ethnicities and areas of deprivation.[15]

The review found that working-age men with COVID-19 were twice as likely as their female peers to die from the disease, while the death rate in the most deprived areas was more than double that in the least deprived, for both sexes. This is greater than the differences seen in death rates in previous years.

Younger disabled males were 6.5 times more likely to have died due to COVID-19 than non-disabled males, while disabled females between nine and 64 had a rate of death 11.3 times higher than non-disabled females in the same age group.[16] Similarly, the risk of death from COVID-19 for those with learning disabilities and autism is also higher. Those with a learning disability are approximately 11 times more likely to die.[17]

People of black ethnicity were most likely to be diagnosed with the disease, and those of black and Asian ethnicity the most likely to die from the disease, with people of Bangladeshi ethnicity around twice as likely to die as people of white British ethnicity.

COVID-19 deaths among people born outside the UK and Ireland have also been higher, with the biggest relative increase among those born in Africa, the Caribbean, South-East Asia and the Middle East.

The Royal College of Psychiatrists has warned that people from a BME background face a "triple whammy" of blows to their mental health due to suffering disproportionately from COVID-19, the despair following the killing of George Floyd and ongoing institutional racism in the NHS.[18]

❚❚ **The NHS was not designed for inequality or inequity; it was designed to eradicate it. It should shame us that we are heading in the wrong direction. We have to make this core business. There isn't a plan B for the NHS.**

Lord Victor Adebowale, Chair, NHS Confederation

Racism in the NHS

Mounting evidence, both long-standing and new, implicates systemic racism and discrimination as a cause of the disproportionate impact of COVID-19 on BME communities.[19,20,21] This is a societal issue and not exclusive to health and social care. Nonetheless, this period offers the opportunity for the NHS to reflect and openly acknowledge the inconvenient truths, unconscious bias and hidden prejudices in its own structures and processes that affect BME communities' access, experience and outcomes from healthcare.[22–27] Recent evidence indicates an increasing dissatisfaction with the services provided to BME communities.[28] Research from the NHS Confederation's BME Leadership Network, due to be released in autumn 2020, will explore this in more detail.

❚❚ **The NHS needs to reflect on its role in helping to promote some of the inequalities it's now concerned about and its role in enabling the spread of racism.**

Wayne Farah, Co-Facilitator of the NHS Confederation's BME Leadership Network

" The pandemic has reinforced the need to deal with the challenges posed by inequality…add the impact of the Black Lives Matter movement to this context and social inequality, economic inequality and structural racism is a mix of challenges that demands a response from our major institutions. And they don't come more major than the NHS.

Alan Higgins, Head of Programme, Public Health England in the North West

Evidence shows that racism is associated with poorer mental health, (including depression, anxiety, psychological stress and various other outcomes), poorer general health, and poorer physical health.[29]

Racism in health services is also associated with negative patient experiences, including lower levels of healthcare-related trust and satisfaction, worse communication, leading to poorer outcomes from delayed or restricted access, and a lack of adherence to treatment uptake.[30]

The term 'institutional racism' was first used by the Macpherson Inquiry into the actions of the Metropolitan police and lessons learned following the death of Stephen Lawrence. More recent public debate following the death of George Floyd and the prominence of the Black Lives Matter Movement has led to further questions being raised about institutional racism in a range of public bodies, including the NHS.[31] Our survey demonstrated a willingness among health and care leaders to accept this challenge, with just over half (55 per cent) agreeing with the statement: 'I have concerns about institutional racism within the NHS'.

Resetting health inequalities

How the NHS now chooses to respond to the inequalities highlighted by COVID-19 is crucial. As the renowned economist and academic, Angus Deaton, reflected in April 2020, the virus itself is not to blame for health inequalities – it is behaviour and social structures which are responsible, not biology.[32]

Paradoxically, the impact of COVID-19 presents the NHS with a unique opportunity to do things differently and make tackling health inequalities and inequity front and centre of the health and care system. Not only is there a strong moral imperative for action, there is a strong business need: failure to provide comprehensive preventive health services to people living in poor communities, for example, costs the NHS nearly £5 billion a year.[33]

In this section, we explore a range of insights gleaned from engagement with members between June and September 2020. This includes focused discussions with senior leaders, webinars and a survey on inequalities in health. It reflects several areas where they believe there is opportunity to go further faster, as well as reflections on what they may need to fundamentally reset health inequalities.

" It feels as if we have reached a particular moment in the NHS. The increased focus in the NHS on inclusion and diversity provides an opportunity to amplify voices and accelerate change so that we can transform the NHS and ensure that members of the LGBTQ+ community receive the best care and work in an inclusive environment where they can thrive.

Peter Molyneux, Chair, NHS Confederation's Health and Care LGBTQ+ Leaders Network and Chair, Sussex Partnership NHS Foundation Trust

What health leaders need

Paradigm shift

Our survey of members found that three-quarters (76 per cent) of health and care leaders agreed that black and minority ethnic (BME) communities have poorer access to, and outcomes from, NHS services. Most respondents (84 per cent) agreed that COVID-19 has shown that the NHS must deliver a step change in how it cares for diverse and marginalised communities.

Our engagement with members points to an increasing awareness that the NHS has not designed services in a way that accounts for the diverse needs of communities and that the outcomes experienced have been differential. Services have often been designed through a white/ male paradigm, and as a result, the outcomes experienced have been unequal. While there are some notable exceptions, for example the midwifery work being led the chief midwifery officer and the review of the Mental Health Act, much more needs to be done the re-frame how the NHS designs and delivers services.

" Moving forward there are new opportunities for proactive engagement with diverse local communities, which will ensure that their views and needs are fully integrated into what we commission and how we deliver it.

Jason Stamp, Lay Member for Patient and Public Involvement, Hull CCG

Equitable access to culturally appropriate services is now essential. Members emphasised the importance of shifting the focus back to prevention and the need for this to be part of a longer-term strategy.

Knowledge, tools and support

Fewer than half of respondents (41 per cent) felt they had the knowledge, tools and support to enable them to tackle health inequalities. Our discussions with members also suggests that the structures and processes running through the NHS, such as funding mechanisms, regulatory frameworks and red tape, can often stifle innovation and change.

Local flexibility, national framework

They have indicated that local flexibility is key to tackling local health inequalities. An overwhelming majority of survey respondents (91 per cent) agreed that there must be much more flexibility and freedom for local NHS bodies to do this.

Our engagement suggests that a national framework is needed for this. A framework which reconciles local and national accountability and affords the autonomy to co-design services to meet specific local needs, backed by appropriate ringfenced funding, and to make services genuinely inclusive and accessible. This is especially important for population health planning. A move to a blended payment model would encourage care on the basis of outcome rather than activity.

Sustained approach to community engagement

Leaders acknowledged the need for a sustained and proactive approach to community engagement. They also raised the need for better knowledge sharing and learning between different parts of the health and care system, if the service transformation envisaged by the Long Term Plan is to be achieved. Work undertaken by Public Health England has clearly demonstrated the importance of community-centred approaches to health and wellbeing,[34] and the importance of sustaining and strengthening resilience throughout the pandemic.[35]

A system-wide approach to addressing health inequalities

Integrated care systems (ICSs), and their constituent place-based partnerships, have created new ways of partnership working. They will be central to these efforts. Premised on strong joint working between the NHS, local government and voluntary sector, they have the ability to act on and influence the wider determinants of health. One sector cannot do this alone. A keen understanding by all partners of the range of inequalities or particular challenges in a local area is essential.

Our discussions with leaders highlighted some excellent examples of system-wide working in STPs and ICSs to address inequalities before COVID-19 and as part of the response to the pandemic. Leaders are keen to continue this approach, building innovation, sharing ideas and designing services around the needs of our most deprived communities and populations. Deepening relationships with the voluntary sector, as explored in a September 2020 NHS Reset briefing, provides further opportunities for systems to engage more effectively with groups with the poorest health and who are most marginalised.[36]

Primary care networks (PCNs) were also seen as having a key role within ICSs as they can develop effective collaborations across their patch, harnessing the expertise and know-how of those working in public health, housing, education, social care, economic development, and sports and culture to tackle the social determinants of health.

" **PCNs have a new opportunity to engage with their populations and patients, to reconnect and to have the discussion about what they really need, what they can realistically expect and what they can do to stay in the best health possible.**

Lord Victor Adebowale, Chair, NHS Confederation

" We need to have a different conversation with our communities. We are always telling communities what they need, rather than genuinely listening and co-producing. PCNs have an opportunity to re-frame the narrative, to listen and build bridges and to work with communities in a meaningful way over the longer term to address health inequalities once and for all.

Dr Mark Spencer, GP and Co-Chair of the NHS Confederation's PCN Network

CCGs also play a number of important roles within the system-working model by ensuring that health inequalities are at the centre of the commissioning process and will hold providers to account for restarting services inclusively, as set out in guidance on the third phase of the NHS response to COVID-19. Many CCGs had been using data to work within a population health management model[37] to design services before the pandemic. CCGs play a key role in building coalitions of partners and leading the system to address health inequalities.

" We already know the impact that wider determinants of health can have, with potentially 80 per cent of our population's health outcomes determined by their social and economic situation, home environment and other key inequalities. The pressures created by COVID-19 have brought all of this into sharp focus, magnifying the health, social and economic disadvantages suffered by many people.

Dr Dan Alton, GP and Berkshire West CCG Chief Clinical Information Officer and Population Health Management Clinical Lead

" These aren't normal times and, over the last six months, our aim has been to be as flexible and proactive as possible – leading programmes of work, facilitating system working and helping out our provider colleagues. We haven't focused on what a 'commissioner' does; we have concentrated on what the city, its residents and our partners need us to do.

Ian Williamson, Chief Accountable Officer, Manchester Health and Care Commissioning

As services are redesigned, the NHS has a unique opportunity to make genuinely integrated person-centred care a reality by listening to patients as experts in the management of their own care. This includes making strides to better understand and engage with communities and patient groups, transform communications, support carers and the social care sector, and involve voluntary, community and social enterprise sector organisations as key partners.

" It's about making reducing inequalities as important as every other statutory obligation that we have, be that financial balance, be that meeting performance and quality indicators. Because it's that important in terms of what benefits it can bring to people's lives, health outcomes and the opportunities they have for the future.

Rachel O'Connor, Assistant Chief Executive, Birmingham and Solihull STP

ICSs and STPs need to provide demonstrable evidence in their business plans and as part of their strategic and operational focus on how each organisation and the system they sit within intends to reduce health inequalities and respond to Public Health England's seven recommendations.[38]

Our members feel that the time has come to set specific stretching but achievable goals and standards to drive the health inequalities agenda, backed by targeted incentives and ringfenced funds allocated by NHS England and NHS Improvement. Members also recognise that now is the time to take personal responsibility for the change.

" We've spent a lot of time, rightly, sorting out waiting times and 18-week access to healthcare so the incentives and the narrative are often all about that when what we should really now be doing is looking at the gross inequalities in front of us.

Rob Webster, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust and Chief Executive, West Yorkshire and Harrogate Health and Care Partnership

" Systems should be held to account as much for their performance delivering on health inequalities as for ED and 18 weeks. We can do this locally as part of our self-regulatory arrangements, but it also needs to be central to the way in which we are assessed externally on our effectiveness.

Similarly, our progress as a system in areas such as integration and inequalities is often in spite of, rather than enabled by, national frameworks, which still deal with health, care and wellbeing in very siloed ways. We need to think more holistically about how we address health inequalities in a coherent way as part of our core purpose and business as usual.

Tracey Lee, ICS Programme Readiness Director, Cornwall and the Isles of Scilly Partnership

" My board and I have a clear strategy that we will work with anybody who wants to work with us on addressing health inequalities. This enables all our staff to work on the agenda with a clear purpose, and board support opens the door for colleagues and partners to work with us in an inclusive way. However, if we want to make rapid and impactful change, we also need to take personal responsibility and not leave the agenda for others.

Let's not get into a blame game: let's make a commitment to do whatever we personally and collectively can do and do it to address health inequalities. All health organisations need a plan and to commit to deliver. We have seen what happens during COVID-19 if we do not have a clear focus on health inequalities and actions we can take.

Jagtar Singh OBE, Chair, Coventry and Warwickshire Partnership NHS Trust

Leadership and the workforce

Most survey respondents (81 per cent) agreed or strongly agreed that success in tackling health inequalities must be a key measure when reviewing the performance of senior NHS leaders and their organisations. Some members feel people should not be recruited to senior leadership positions, trusts awarded an outstanding rating, or STPs allowed to become ICSs, unless they can prove they are actively tackling health inequalities. Others are optimistic that we now have an opportunity to deliver services in a much more inclusive way.

Diverse leadership and diversity across the workforce contribute to better patient outcomes and more inclusive services.[39–42] But diverse representation in senior NHS posts is still patchy. Only half of survey respondents were confident that their board would reflect the local community it serves within the next five years.

The NHS Workforce Race Equality Standard report for 2019 shows that 8.4 per cent of board members in NHS trusts were from a BME background, which is significantly lower than the 19.9 per cent of the BME workforce across all NHS trusts in England.[43] The NHS Workforce Disability Equality Standard report in 2019 found that overall 2.1 per cent of board members were disabled; 1 percentage point lower than the percentage of disabled staff in the wider workforce.[44]

Recommendations

The COVID-19 pandemic has exposed the impact of piecemeal attempts to address inequalities in health. Our engagement with members – leaders of organisations that plan, commission and deliver NHS services – has revealed a determination to address the challenge once and for all. This report has drawn together reflections from leaders on the issue of health inequalities in the round, not just the impact on BME communities that has been thrown into sharp focus by the pandemic.

The government needs to renew its commitment to acknowledge and address health inequalities and the double impact of discrimination wherever possible through upcoming guidance and policy reform. The government's obesity strategy is an important step, but it must be part of a wider strategy to reduce health inequalities. Similarly, the recommendations outlined in NHSEI's phase three letter in July 2020 are welcome. We recognise the eight urgent actions set out by NHSEI that are needed to tackle health inequalities as the NHS continues to respond to the COVID-19 pandemic. This includes restoring NHS services inclusively; developing digitally enabled care pathways in ways that increase inclusion; strengthening leadership and accountability; and accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes. NHSEI has produced a range of supplementary materials to support implementation on its website, which will be very helpful for leaders tackling these issues. At the same time, leaders also recognise that more work for the longer term is needed, as is wider action across public services, following the government-wide process being led by the equalities minister, Kemi Badenoch MP.

There must be more support for initiatives and programmes looking to research, analyse and develop solutions to the links between COVID-19 and health inequalities. The commitment from NHSEI with the recent launch of the NHS Race and Health Observatory, hosted by the NHS Confederation, is welcome, but the lack of tools to tackle health inequalities that health leaders say they have must be addressed fully. Expanding the share of research and innovation funding for health-related work would generate significant regional and national benefits.

" Ethnicity and race have been shown to influence our health, independent of factors such as age, sex and socio-economic status. More action is needed to both understand and tackle deep-seated and long-standing health inequalities facing people from BME backgrounds.

The NHS Race and Health Observatory will carry out the vital work of evidencing and providing practical solutions, which will enable the NHS to systematically address the inequalities that exist. It will involve experts from this country and internationally and will offer analysis and policy recommendations to improve health outcomes for patients, communities and staff.

Dr Habib Naqvi, Incoming Director, NHS Race and Health Observatory

Health and wellbeing must be included as an outcome in all economic development policies. This includes deals and agreements at a local level, including local industrial strategies and devolution and town deals, and forthcoming funds such as the UK Shared Prosperity Fund. To do this effectively requires ongoing consultation with the NHS and other regional anchors, such as universities and local government. The local economic and social impact of the investment in new hospital builds should also be explicitly measured. A recent publication between the NHS Confederation and partners highlighted this challenge[45]:

" Tackling stubborn inequalities and driving recovery and growth through a renewed focus on health requires bold actions. It means prioritising health in its widest sense: from improving societal health to strengthening research and development with industry on health technologies. It means anchor institutions – hospitals, universities, local and combined authorities – working together to engage communities and other partners on these efforts, but also boosting the role they themselves play as large employers and economic actors (who in turn will benefit from a healthier workforce).

This approach is increasing being acknowledged by NHS chief executives across the country:

" Hospitals are anchor institutions for our communities. We have a bigger role to play in the future than just providing healthcare.

Brendan Brown, Chief Executive, Airedale NHS Foundation Trust

Asks of the NHS and its partners

- **Becoming core business**: Tackling health inequalities needs to become core business for the NHS and social care, and the core focus of ICSs and their constituent place-based partnerships.

- **Designing and delivering culturally appropriate services and prioritising groups more likely to be affected by COVID-19 and health inequalities, at both a local and national level**: It will be important to ensure that services are culturally appropriate and that groups that are more likely to be adversely affected by COVID-19, and which have historically poorer access to care and lower recovery rates, are prioritised. These include BME and LGBTQ+ communities, children and young people and people with a learning disability and/or autism.

- **Tackling racism, discrimination and unequal representation**: A system-wide approach is needed to tackle racism and discrimination. The NHS has a crucial role in eradicating racism within its structures and processes, which will help to substantially reduce health inequalities. NHS organisations need to build diverse leadership capacity from among the communities they serve.[46] These leaders need to be supported to maximise their potential and effectiveness as role models.

  Our most recent report from the Health and Care Women Leaders network highlighted that while progress has been made to increase the proportion of women in leadership roles across the health service, there is much more to be done to meet the NHS target of 50:50 representation by the end of the year, a target set by the regulator. The same report also highlighted there were still 70 all-white NHS trust boards, and six all-white arm's-length body boards.

  It builds on a report from our BME Leadership Network in 2019 which revealed that in recent years, despite some progress in executive appointments, there has been a reduction in appointments of non-executive directors and non-executive chairs from women, BME groups and other groups covered by the Equalities Act 2010.

- **Addressing the wider determinants of health**: The health and care sector has an important role beyond that of just delivering care. Sustainable change means tackling the wider determinants of health: employment, skills, educational attainment, air quality and housing. Preventing ill health is a key component of tackling health inequalities and the sustainability of the NHS.

  A long-term and committed shift to investing in the prevention agenda is needed both nationally from government and locally as commissioners determine allocation and deployment of funding. As the largest employer in the country, the NHS has a key role as an anchor institution in helping to tackle inequalities locally in its procurement practice and employment and apprenticeship opportunities.

- **Leading change**: Whole-system culture change is required across public services and the NHS must offer leadership in this space, working alongside wider partners. A joint approach is essential and should include local authorities, social care, the voluntary sector, private sector providers, housing, environmental, employment and education and training services. ICSs are pivotal to bringing all of this together.

" It is now impossible to ignore the fact that our health is affected by the environment and community in which we live. Our approach to healthcare must recognise these structural inequalities if we are to build a better NHS.

Professor Donal O'Donoghue, Registrar, Royal College of Physicians

How we will support our members

We will be supporting our members to tackle inequalities in health, including through the work of the NHS Race and Health Observatory, which will focus on evidence-based, actionable insights examining ethnic health inequalities in outcomes for patients and communities. It will also link this back to the diversity and inclusion agenda within the NHS workforce.

We will also continue to work on improving and prioritising health inequalities, alongside our members – empowering diverse voices and helping to create a diverse leadership in the NHS is critical to this challenge. Our independent taskforce on increasing non-executive director diversity in the NHS, which will report in autumn 2020, will oversee the development of an equalities and diversity framework for the recruitment and retention of chairs and non-executives in the NHS in England.

We will continue to convene leaders, promote discussion and develop solutions to the challenges our members through our equality, diversity and inclusion networks and programmes: BME Leadership Network, Health and Care Women Leaders Network, Health and Care LGBTQ+ Leaders Network and NHS Employers' Diversity and Inclusion Partners programme, alongside public policy in this space.

Our BME Leadership Network will also soon publish the findings of a research study into the impact of COVID-19 on BME communities.[47]

Through our NHS Reset campaign, we have raised concerns over the health inequalities experienced by people with mental health problems.[48] The recently-launched Health and Care LGBTQ+ Leaders Network has also been exploring the particular health inequalities experienced by LGBTQ+ staff and patients during the pandemic and how this has affected their physical and mental health.

We have submitted a range of proposals to tackle health inequalities, based on member feedback, in our response to the government's Comprehensive Spending Review. We recognise the need to commit government resource to helping the health and care sector to develop truly accessible services, while also ensuring that policies that close the health inequalities gap are embedded in government fiscal policy.

These activities, alongside this report, form part of our work as a membership body to support our members to systematically address health inequalities, both within the NHS and wider society.

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